HANSARD 1 Q Column 20
7 February 1975.

98

Hospital beds for Bantu

*3. Mr. L. F. WOOD asked the Minister of Bantu Administration and Development:

How many hospital beds are available to Bantu in the (a) Bantu homelands and (b) White areas of the Republic.

†The DEPUTY MINISTER OF BANTU DEVELOPMENT:

(a) 34 901 Hospital beds are available for non-Whites in the Homelands.

(b) 76 712 Hospital beds are available for non-Whites in the White areas of the Republic.

The figures include beds for Coloureds and Asiatics.

Health and Disease
Hospitals and Clinics

Question.....
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HANSARD 2 Q. column 118-119

14 February 1975.

98

Dental clinics

*18. Mr. L. F. WOOD asked the Minister of Health:

(1) (a) How many dental clinics have been established in co-operation with the provincial administrations and local authorities in each province, (b) for which race groups have they been established, (c) where are they situated, (d) what is the State's annual contribution to dental services for each province and (e) what is the nature of the dental work undertaken;

(2) how many (a) White, (b) Coloured, (c) Asian and (d) Bantu persons were treated in each province during the year ended 31 December 1974.

†The MINISTER OF HEALTH:

(1) (a) Transvaal—8.
Cape Province—3.
Orange Free State—nil.
Natal—nil.

(b) For all race groups.

(c) In Pretoria, Johannesburg, Germiston, Benoni, Springs, Brakpan, Vereeniging, Orlando, East London, Port Elizabeth and Cape Town.

(d) Transvaal—R75 450-00.
Cape Province—R106 500-00.

(e) The nature of the work depends on the demand in a particular area. Facilities for comprehensive services are, however, available at all clinics.

(2) No statistics are available with regard to the various race groups, since the Department only records the number and nature of treatment.

Mr. L. F. WOOD: Mr. Speaker, arising out of the reply of the hon. the Minister, could he tell the House whether it is the intention to establish similar facilities in Natal and the Orange Free State in the near future?

The MINISTER: Mr. Speaker, it is the intention of the Department to increase its facilities wherever they are needed.

Mr. L. F. WOOD: In the near future?

The MINISTER: No, not in the near future. I cannot make such a promise.

NGK hands over hospital to Lebowa

RJM 2/4/75

POTGIETERSRUS. — The Groot Hoek Hospital established by the Nederduitse Gereformeerde Kerk would be used to serve a great part of Lebowa and provide the first service of this kind in a homeland, the Deputy Minister of Bantu Development, Mr A. J. Raubenheimer, said yesterday.

Speaking at a function to mark the taking over of the hospital by the State, the Minister said it was an historic occasion because it was a hospital under the control of the church that was being taken over by the State.

For the people of Lebowa it marked the first step in providing the Lebowa homeland with a State hospital.

Within a year health services, including hospitals, would be handed over to the Government of Lebowa as had already been done in the Transkei and in BophuthaTswana.

When plans for the development of the hospital were fulfilled, it would be able to provide specialist services to meet the needs of a large part of the homeland.

The hospital would also serve as a central training centre for nurses for the homeland. Through the years the hospital established by the NGK had, from a modest beginning, grown into a modern hospital with 1 213 beds.

Hospital services included general treatment, maternity, tuberculosis, isolation and phychiatric units.

The Government greatly appreciated the work done by the NGK at Groot Hoek.

The North Sotho people had also made their contribution. For example, there were 590 posts for Lebowa citizens on the hospital staff.

After saying that the Groot Hoek Hospital would become the biggest and best equipped hospital in Lebowa, which would also provide specialist services, the Minister said the intention was to create eight posts for specialists on the hospital staff.

These would include posts for health inspectors and para-medical personnel. — Sapa.

(98)

SUNDAY TIMES, May 4, 1975.

High fees warning to private hospitals

SUNDAY TIMES Reporter

THE DIRECTOR of Hospital Services in the Transvaal, Dr H. A. Grove, yesterday warned private hospitals that the authorities might be forced to control their fees to protect the public from exploitation.

Speaking at the opening of a clinic in Springs, Dr Grove said there was evidence that "some private hospitals are shifting the emphasis more and more to the profit-making aspect, and the tariffs cannot but be viewed with misgiving.

"The State has a duty to protect the public, and it may be compelled to consider some form of control over the tariffs levied by private hospitals."

A commission of inquiry into private hospitals last year made a number of allegations:

- Private hospitals made up to 89 per cent general profit.
- Independent operating theatres made profits of up to 171 per cent.
- Profits on medicine were as high as 160 per cent.
- Intensive care units were used to boost profits.

The commission's report, which was tabled in Parliament in October, also gave examples of patients' accounts:

- A patient who spent one day in hospital was charged R795 for medicines.
- Another who also spent one day in hospital was charged R850 for medicines.
- A patient was charged R1 800 for drugs. Drugs valued at only R300 were used.
- A charge of 45c was made for the use of a syringe. A disposable syringe cost only 12½c.

Recently a senior member of the SUNDAY TIMES staff was taken by his doctor to a private hospital.

"I spent less than five minutes in the plaster room. I received an account for R22,10c," he said..

He complained, and the bill was reduced to R20,10.

Since the publication of the commission's report, the Association of Private Hospitals has claimed that the allegations were isolated cases. and denied that private hospitals made excessive profits.

For the past few months the United Party spokesman on hospitals in the Transvaal Provincial Council, Mr Dave Epstein, has appealed for the phasing out of private hospitals and for their function to be taken over by provincial or State hospitals. He called for free hospital services throughout the Transvaal.

Black self-help centre launched

Daily Dispatch 19/4/75 (98)

KING WILLIAM'S TOWN — The Zanempilo Community Health Centre, a project of the Eastern Cape branch of Black Community Programmes Ltd, will be officially opened tomorrow as the first major project of the black self-help campaign being conducted throughout the country.

Sponsored jointly by the Christian Institute and the South African Council of Churches, Black Community Programmes Ltd became a registered company in 1973 to foster the principles of self-help among blacks in the country.

Run by blacks, it aims at fulfilling social needs such as clinics and information centres, to supplement existing social services and to improve black living conditions.

The Zanemipilo Health Centre which will be opened at 10.30 tomorrow morning with a number of official speeches including one by the Ciskei Interior Minister, Mr L. F. Siyo, and choir singing, is situated nine kilometres from King William's Town at the Zinyoka Location Anglican Mission.

The mission is at the centre of two large consortiums of rural settlements collectively known as Zinyoka Valley (west of the clinic) and Balasi farm area (east of the clinic). In this way the clinic is within reach of thousands of people who otherwise would have to be attended to in King William's Town at much greater cost in the form of transport and charges by private practitioners.

The community served will be mainly rural people living on trust lands, freehold lands and white farms between King William's Town and Frankfort. In the first six weeks of operation the clinic has seen close to 700 patients. Over this period the average daily intake worked out each week has built up to 41 patients a day. Most of the patients came from families with an average income of between R5 and R10 a week. The patients are mainly women, children and men over the age of 50 since most young men are on migratory labour.

Besides the Medical Officer, Dr M. A. Ramphele there are: two sisters, two staff nurses, an administrative clerk, two housekeepers and a groundsman. A few doctors in the King William's Town - East London area occasionally relieve Dr Ramphele for short periods.

The daily routine at the clinic takes the form of general curative medical service at the outpatients clinic and in the maternity section. In addition other subsidiary services are carried out mainly in the form of preventive medicine — baby clinics, under-five's clinics, ante-natal care, general health education, home economics, gardening and cooking, and immunisation.

These subsidiary services are being introduced at various stages in the life of the clinic. In addition to work done at the centre itself there is depot work already being done at one place (for children at the Ginsberg Creche) and also planned for two rural communities (Njwaxa-Ngwenya area near Alice and Tyolomnqa between King William's Town and East London).

The centre has been warmly welcomed by communities in the Zinyoka and Balasi areas, and the daily intake of patients is going up.

Including shortfall on construction and water supplies the budget for the first year, 1975, for the clinic stands at R55 000. Of this it is expected that R15 000 will come from fees and contributions by the community. The rest has to be met through donations. — DDR.

New hospital for homeland

Daily Dispatch 30/4/75

98

UMTATA — Thafalofef Mission Hospital of the Ned erduits Gereformeerde Kerl in the Kentane district wil be the second mission hospi tal in the homeland to b taken over by the Transkela Government.

The takeover comes int effect today when the Minis ter of Health in the Transke Chief J. D. Moshesh, pays a official visit to the hospita for the first time.

Dr N. D. Geldenhuys, only doctor and also medical superintendent at the hospital, said he would continue with his work as usual after the takeover. The hospital has 299 beds with a staff of 176 professional and non-professional. There will be no formal ceremony to mark the occasion. — DDR.

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Private hospitals/clinics 914

*2. Mr. L. G. MURRAY asked the Minister of Health:

(1) Whether a condition is imposed upon patients admitted to private hospitals and clinics to purchase all medicines from the chemist attached to such hospitals and clinics; if so,

(2) whether he intends to take any steps in regard to the matter; if so, what steps; if not, why not.

The MINISTER OF PUBLIC WORKS (for the Minister of Health):

(1) According to the Report of the Commission of Enquiry into Private Hospitals and Unattached Operating Theatre Units, it appears that there is situated in practically every building where a private hospital is housed, a pharmacy where medicines for patients of that hospital, is dispensed. The Commission did not state it clearly nor am I aware of any pharmacies that are attached to a private hospital. I am also not aware of any private hospital or clinic who employs a pharmacist for the dispensing of medicines for patients of that institution—such a step is regarded by the S.A. Pharmacy Board as an infringement of its Ethical Rules. I am also not aware of any conditions imposed by a private hospital or clinic on its patients to purchase all medicines from a particular pharmacy or pharmacist.

(2) In the recent amendment of the Public Health Act, 1919, provision was made for the promulgation of regulations to control Private Hospitals, and, if necessary and possible, the matter will be considered in the drafting of the regulations.

HANSARD NO. 13
APRIL 1976 (?)

915 FRIDAY, 30

2. PLANNING THE PRESENTATION.

2.1 Constructing your plan:
Two methods for planning your talk:

VERTICAL PLAN and HORIZONTAL PLAN

2.1.1 The Vertical Plan

1) Take a sheet of paper. Think about your subject. Jot down 20 to 30 words associated with it.

2) Working on a 5 minute talk, ring the three words you think are the most important on your list.

3) What do these words say to you? What specifically do you want your audience to think and do at the end of your talk? Now, write the aim of your talk in one short sentence.

4) Write your aim at the top of a clean sheet of paper.

The Body

5) Leave about six lines for the introduction. Write your three main points down leaving a few lines in between each.

6) Go through your list of ideas again. Underline those points that support your three main points.

7) Write two sub points under each main point.

8) At this stage you should refer to books, interview specialists, check figures and statistics, find quotations, apt examples or demonstrations.
Your talk should be an expression of your own ideas on the subject, backed by outside opinion.

98

~~101~~

Hansard No 14
6/5/76

966

[illegible] Hospitals in [illegible] Homelands

[illegible] Mrs. H. [illegible] asked the Minister of [illegible] Administration and [illegible] Development:

(a) How many (i) mission and (ii) [illegible] ... [illegible]

[illegible]

[illegible]

Homeland		Number of registered beds
Lebowa:		
Mission Hospitals	9	[illegible]
State Hospitals	7	[illegible]
Bophuthatswana:		
Mission Hospitals	[illegible]	[illegible]
State Hospitals	[illegible]	[illegible]
[illegible]:		
Mission Hospitals	3	[illegible]
State Hospitals	[illegible]	[illegible]
Transkei:		
Mission Hospitals	[illegible]	[illegible]
State Hospitals	[illegible]	[illegible]
KwaZulu:		
Mission Hospitals	20	[illegible]
State Hospitals	4	[illegible]
[illegible]:		
Mission Hospitals	3	[illegible]
State Hospitals	[illegible]	[illegible]
Venda:		
[illegible]	3	[illegible]
[illegible]:		
[illegible]	[illegible]	[illegible]
[illegible]		
[illegible]	[illegible]	[illegible]

Extensions:

[illegible] Mission Hospital [illegible] beds under construction [illegible] Mopuzi and Church of S[illegible] Hospitals—250 beds being planned.

Qwaqwa:

New Hospital:

Phuthaditjhaba Hospital—50 [illegible] being planned.

Lebowa:

New Hospital:

Namakgale Hospital—250 [illegible] will be completed during [illegible]

Extensions:

Masana Hospital—50 beds [illegible] be made available during [illegible]

Information in respect of [illegible] Transkei, Bophuthatswana and [illegible] is unfortunately not [illegible] available. Health matters [illegible] handed over to these home[illegible] before or during 1975.

HANSARD 16 Q. 1074-5

30 May 1975

(1) 98
(2) HH

Bantu hospital at Bourke's Luck

326. Mr. T. ARONSON asked the Minister of Bantu Administration and Development:

(1) Whether a Bantu hospital was built at Bourke's Luck near Blyde Canyon; if so, (a) what Bantu area was it intended to serve and (b) for how many beds did it provide;

(2) whether the area surrounding the hospital was declared an area for a particular race; if so, for which race;

(3) (a) where are the Bantu patients of the area being treated at present and (b) for what purpose is the hospital at Bourke's Luck being used.

The MINISTER OF BANTU ADMINISTRATION AND DEVELOPMENT:

(1) Yes.

(a) Lebowa.

(b) 334.

(2) Yes, for Whites.

(3) (a) Meetse-a-Bophelo Hospital.

(b) The buildings are used by the Department of Defence.

Race clamp on clinics

STAR 6/6/75 (98)

Science Editor

If private hospitals for Whites continue to use nurses of other races in operating theatres they will be closed.

The Director of Hospital Services in the Transvaal, Dr H A Grove, said today he had taken this decision following complaints from patients and White nurses.

In 1972 Dr Grove banned nurses of other races from nursing White patients but on that occasion theatres were not specifically included.

CIRCULAR

A circular from the department to all private hospitals says no registered nurse, enrolled nurse or enrolled assistant nurse other than White may be employed or undertake any duty of whatever nature in an operating theatre of a hospital or clinic registered for the treatment of White patients.

Dr Grové points out that the regulations provide that no private hospital shall be registered unless he, as director, is satisfieid that the staff is adequate and suitable.

Insofar as the nursing of White patients is concerned, only White nursing staff are considered as "adequate and suitable" to nurse White patients. states the circular.

It is not expected that the ruling by Dr Grové will cause any great hardship to the private hospitals concerned. Only a few of those in Johannesburg still employ non-Whites on theatre duties.

Nevertheless, the South African Association of Private Hospitals will meet on Monday to discuss the situation.

HANSARD 18 Q - 1115 - 16

10 June 1975.

Hospital at Umlazi

*1. Mr. G. N. OLDFIELD asked the Minister of Bantu Administration and Development:

Whether any progress has been made in regard to the establishment of a hospital at Umlazi; if not, why not; if so, (a) what progress has been made and (b) when is it expected that building operations will commence.

The DEPUTY MINISTER OF BANTU ADMINISTRATION AND EDUCATION:

Yes.

(a) The ground works at the Umlazi Hospital were completed during the course of the preceding financial year.

(b) The contract is in two phases. The first phase, namely the structural work was commenced with during January 1975 whereafter the building operations will be undertaken.

Mr. W. V. RAW: Mr. Speaker, arising from the reply of the hon. the Minister, can he give us an indication of the expected date of occupation of the hospital?

The DEPUTY MINISTER: I cannot give any specific date, but the first phase will be completed in 18 months' time. The work is going according to schedule.

Race order to hospitals stinks — MPC

(98)
RJM
10/6/75

Staff Reporter

THE Transvaal provincial hospitals' directive to private nursing homes to keep Black nurses out of operating theatres stank of race discrimination, the United Party's spokesman on hospitals in the Provincial Council, Mr Dave Epstein, said in Pretoria yesterday.

The move was also condemned by Dr E. L. Fisher, MP, the Parliamentary Opposition's spokesman on health.

The member of the Executive Committee in charge of hospitals, Mr Kalie de Haas said the directive had been made in conformity with policy.

Mr Epstein said the province should stick to public hospitals which it controlled and maintained.

MONSTROUS

The province's directive meant that patients might have to be moved from theatres because there was a Black nurse present.

The patient was in the theatre because of some emergency, and if the private hospital did not have enough White nurses to staff the theatre, the patient would have to be moved to another hospital.

"This monstrous ruling which stinks of race discrimination could mean the untimely death of patients because of delayed treatment."

Mr Epstein said the Prime Minister was leaning over backwards to convince the Western world that discrimination was disappearing in South Africa, but "with actions like this, his task is being made infinitely more difficult".

Dr Fisher said at a time when the Prime Minister and his Government were deeply committed to a policy of removing discrimination, it was inexplicable that a provincial administration should so blatantly discriminate against Black nurses.

The province had no right, moral or otherwise to interfere with the staff employed by private hospitals provided that staff was suitably qualified.

Dr Fisher said he warned two years ago that a situation was developing where Black nurses would have to be used in White hospitals because of a shortage of White nursing personnel.

NEEDED

"There is not the slightest reason why a qualified nurse, whatever her colour, should not be used where she is most needed."

The directive was nothing less than sheer race discrimination, which in this day and age should not be tolerated.

Mr Kalie de Haas, MEC, said the exclusion of Blacks from operating theatres had always been policy in provincial hospitals, and it naturally applied to private hospitals.

Asked whether the directive did not conflict with the Prime Minister's undertaking to remove race discrimination. Mr De Haas said he did not think so.

"We have reacted to complaints from both patients and staff at the private hospitals in reminding those running the hospitals of the policy," he added.

STAR 12/6/75

Pretoria Bureau

The main problem for the Department of Hospital Services has switched from a shortage of medical staff to a shortage of administrative and clerical workers.

The MEC for hospital services, Mr Kalie de Haas, told the provincial council last night that "the position is actually somewhat critical."

The department had had a measure of success in attracting staff from outside the service, but its big problem still lay in the lower ranks, which were responsible for production.

This problem existed everywhere in the civil service.

Mr de Haas said the public sector was in a more competitive position than it had been a few years ago, but it was obvious that the Department of Hospital Services had to temper its planning in the light of the availability of staff.

★ ★ ★

Dr Selma Browde Prog, Houghton) made a plea for breast cancer screening by the Provincial Administration, in co-operation with the National Cancer Association.

Speaking on the hospitals vote, she said a new technique — zero radiography — had been developed.

A screening programme for breast cancer was something the women of South Africa were tremendously anxious to have, she told the council.

If cost was the problem, a pilot programme could be started to at least screen "women at risk" — those with a known family history of breast cancer, for example.

Mr De Haas, said that such preventative medicine was not a function of the Provincial Administration, but of local authorities and the Government's department of health.

★ ★ ★

Higher pay for hospital doctors in the Transvaal was foreshadowed by Dr Browde, in an interview outside the council.

The move, which originated at cabinet level, was intended for doctors employed by the central Government, but was now being studied by the Transvaal executive committee for possible application to provincially-employed doctors, she said.

The suggested increases ranged between R4 400 for the lowest category of doctor to R5 664 for the highest.

TRANSVAAL PROVINCIAL COUNCIL

Better pay for artisans

Pretoria Bureau

A critical stage had been reached in the artisan staffing situation in Transvaal hospitals, the Administrator, Mr Sybrand van Niekerk, told the council last night.

But a new salary structure had been created, allowing the Provincial Works Department to offer rates of pay which were more competitive with those in the private sector, and the department now offered attractive careers to artisans.

Speaking on the Works Vote in the budget debate, Mr van Niekerk said the department had been losing trained artisans and not attracting ne wones. Apprentices left as soon as their training was completed.

SERIOUS

In all the province's hospitals, and particularly the Black ones, the shortage of artisans was "very serious," Mr van Niekerk said.

The new pay structure being implemented was a deviation from public service posts, and their conversion into provincial posts.

Mr van Niekerk said the works department hoped to start this year to provide services in Pilgrims Rest (the early Eastern Transvaal gold mining town which the province is buying to restore.)

98

(98)

McCord Zulu hospital faces close-down after 68 years

Sun Trib 15/6/75

MR FRANK MARTIN . . . Provincial subsidy will end

DURBAN'S McCord Zulu hospital, which has served the needs of thousands of Black people since 1970, will be shut down within four years.

This is a result of Government policy, a Provincial decision to stop subsidising the hospital when the new Umlazi Hospital is ready in 1978 and mounting opposition from White residents living near the hospital.

Mr Frank Martin, MEC in charge of hospitals, said this week that the Province's subsidy will be cut off when the Umlazi Hospital is finished.

Space problems

"Initially, we decided to stop the subsidy provided for Indians and Coloureds — more than 40 percent of the total — this year but agreed to continue until the hospital was phased out.

"We can't continue providing funds when there are adequate state hospitals in Durban — the R. K. Khan for Indians and Addington for Coloureds."

He said a decision to continue with Indian and

By DEVEN MOODLEY

Coloured patients at the hospital was a result of negotiations and because of space problems in the other private and mission hospitals in Durban.

Opposed

Mr Martin said another hospital would be made available to Indians in Durban, but refused to confirm whether the King George TB hospital in Springfield, an Indian area, would be converted into an Indian teaching hospital, attached to the new Durban-Westville medical school.

Prof W. E. Phillips, chairman of the McCord Hospital Council said yesterday he was pleased the Province would continue with the subsidy.

"We were promised that Indians and Coloureds could remain at the hospital until it is phased out. As soon as the subsidy is cut, we will be forced to shut down."

The hospital has three main sources of funds — payments by patients, subsidies from the State Health Department and the Province.

Mr G. R. L. Hourquebie, MP for Musgrave said residents in his constituency were opposed to the hospital remaining.

"I have had a number of complaints about congestion and traffic."

Residents told me this week that African labourers loiter on the pavement, there was excessive noise from talking and singing within the hospital and that the traffic was a hazard.

Pressure

Dr M. H. H. Mayat, superintendent of Shifa Hospital, said that there will be added pressure on Shifa when McCord shuts down.

A four-storey block will be added to Shifa within a year.

"We have other plans but cannot do anything until McCords is closed and a decision is made on King George Hospital."

98

Hospital spending up R11-m

ARGUS 19/6/75

THE Cape Provincial Administration had increased its capital expenditure on hospitals by R11-million in the past 10 years in spite of financial problems, the Administrator of the Cape, Dr L. A. P. A. Munnik, said last night at the annual graduation ceremony of the Carinus Nursing College.

Addressing a capacity audience at the City Hall, where 158 nurses from nine Peninsula hospitals graduated, Dr Munnik said much had been done to improve hospital facilities in the past decade.

In 1964 there were 10 397 beds in provincial hospitals, compared with 13 990 in 1974. In 1964 308 813 inpatients and 2 058 877 outpatients had been treated, compared with 469 703 inpatients and 5 776 970 outpatients in 1974.

Dr Munnik said the nurses' graduation was an important step in the expansion of Cape Provincial hospitals, which already had 18 000 nurses.

'The need for highly trained and dedicated nurse is constant, and the nurse, who undertakes further study not only ensures a rewarding future for herself, but serves her country as surely as if she were in the armed forces,' he said.

ENROLLED

The nursing curriculum was undergoing great changes to enable students to meet the challenges of the next decade, he added. The Provincial Administration provided many opportunities for nurses to study further, and it was imperative that they should keep in step with the great changes taking place in the world of medicine.

One hundred and twenty students qualified as registerd general nurses and 38 as enrolled nurses. Cape Provincial Administration bursaries were awarded to Miss A. C. Monro and Miss S. E. Melvin both of Groote Schuur, and Miss A. M. A. Colussi of Rondebosch Hospital.

Miss Monro also received a gold medal and Miss Melvin and Miss Colussi silver medals, in recognition of their outstanding results in the SA Nursing Council examinations.

D Dispatch 28/6/75

98

Province concern over King hospital

EAST LONDON — The Hospitals Department of the Cape Province is concerned about conditions at the Grey Hospital in King William's Town and will consider providing temporary facilities until a new hospital can be built, according to the Director of Hospital Services, Dr R. L. M. Kotze.

He was replying to a report on conditions at the hospital by a member of the Grey Hospital Board, Mr J. van der Zee, published on June 12.

In the report Mr Van der Zee claimed that the 116-year-old hospital, which is a national monument, was a fire hazard and could cause an epidemic.

In a letter to the Daily Dispatch, Dr Kotze said a start had been made on the planning of a replacement hospital at King William's Town in 1967.

"Unfortunately delays have been caused owing to various factors. First of all a number of amendments were requested by the local medical superintendent and his advisers. It was pointed out that these would cause considerable delay.

"Despite continuous contact and personal discussions these delays continued, and my department was compelled to revise the planning in toto. This was also necessary in the light of the new formally laid down norms and standards for the hospitals in the Republic."

"The highest priority is being given to the revised scheme, and it is anticipated we will be ready in early 1976 to call for tenders.

"As it will take some time before the replacement hospital is completed, we are prepared to consider the provision of temporary facilities as an interim measure. — DDR.

98

CLINIC IN NEED OF A NURSE

30/6/75 **The Argus Correspondent**

PORT ALFRED. — A medical clinic for the Coloured people of Port Alfred, which is now nearing completion, is liable to become a white elephant unless the services of a trained Coloured nurse can be obtained.

Mrs Iris Holloway, the chairman of non-European Affairs Committee of the Port Alfred Town Council said the vacancy had been advertised several times but not one application had been received.

She said should a nurse from elsewhere apply the council would have to consider allocating to her one of the houses in the new Coloured township.

Mrs Holloway said there were also several sites in the township which had been set aside for business purposes but since none of the local community appeared to have the financial resources to embark on trade it seemed evident that the businessmen would have to come from outside as well.

The council had decided to dispose of the business sites by tender the price being R700 as against R500 for stands for private houses.

However, as there were few Coloured people here who could afford to build their own homes but who were earning fairly good wages the council had applied to the Department of Community Development to embark on an economic housing scheme.

Funds are also being sought to enable the council to erect another 100 sub-economic units of two houses each in addition to the 117 already completed and occupied.

98

updating BARAGWANATH

ARTICLE: LIZ VAN WYK
PICTURES: LAMBERT SMITH

Mrs Mabaso and her four-day-old son, Calphs, in Baragwanath Hospital's new maternity section

Baragwanath Hospital, situated on the outskirts of Johannesburg's Soweto complex, is a hive of activity. This one-time military hospital which treated soldiers suffering from tuberculosis during the Second World War, is being modernised and extended at a rapid pace.

A new maternity hospital and intensive care unit have been built and the new nurses' homes, laboratories and mortuaries are already roof-high. An attempt is being made to rebuild the hospital from the inside, and existing facilities are being improved. Lawns and trees have been planted between the new wards where maternity patients will soon relax happily in the shade.

Baragwanath, which serves Soweto's estimated population of 1,2 million, boasts a staff of 550 doctors of all races and nationalities, 3 200 Black nurses and 50 matrons, 24 of whom are Black. The hospital's 2 561 beds, including cots, are almost always full. During 1974 80 500 patients were admitted to the hospital and altogether 1 088 000 outpatients were treated at Baragwanath and at its eight clinics which are situated at key points in Soweto.

Clinics

These clinics, which are administered by the hospital, were established to perform an out-patient function. The success of the clinics is exceptionally important, for if this service were to collapse, Baragwanath Hospital would be inundated by an additional 663 800 patients per year. At the clinics the referring of some patients to the specialist clinics at the hospital is controlled. The pressure on the hospital staff is thus relieved and patients receive G.P. level treatment at the clinics and specialist attention at Baragwanath. The equipment at the clinics is of the highest standard to be found in any clinic in any part of South Africa. Dental services are also provided at the clinics and the attraction of these services can be judged from the fact that younger children are constantly arriving at the clinics to have their teeth seen to.

At four of the eight clinics there are maternity facilities. During ante-natal care it is determined whether the expectant mother is to be referred to the hospital or not. While approximately 25 babies are born at the clinics each day, an average of 45 per day are delivered at Baragwanath's new maternity hospital.

Maternity

Nearly 16 000 confinements are handled each year at the maternity hospital which is well-known among expectant mothers throughout the Witwatersrand for its excellent services. Some come from as far as 80 km away to have their children delivered at Baragwanath. Both at the hospital and in the clinics ante-natal and post-natal services are provided.

The maternity section is run entirely by Black nurses and is the most up to date of its kind. After giving birth, a mother is transferred to one of the 12 lying-in wards. Each bed has a cot for the new-born baby next to it, as well as built-in resuscitation facilities. A mother is usually kept for three days

gers are taught to become expert marksmen and given training in handling their rifles.

John Mnisi is in constant touch with headquarters in the Kruger Park. He submits monthly reports covering everything which happens in the territory which he patrols, and is regularly visited by senior game rangers.

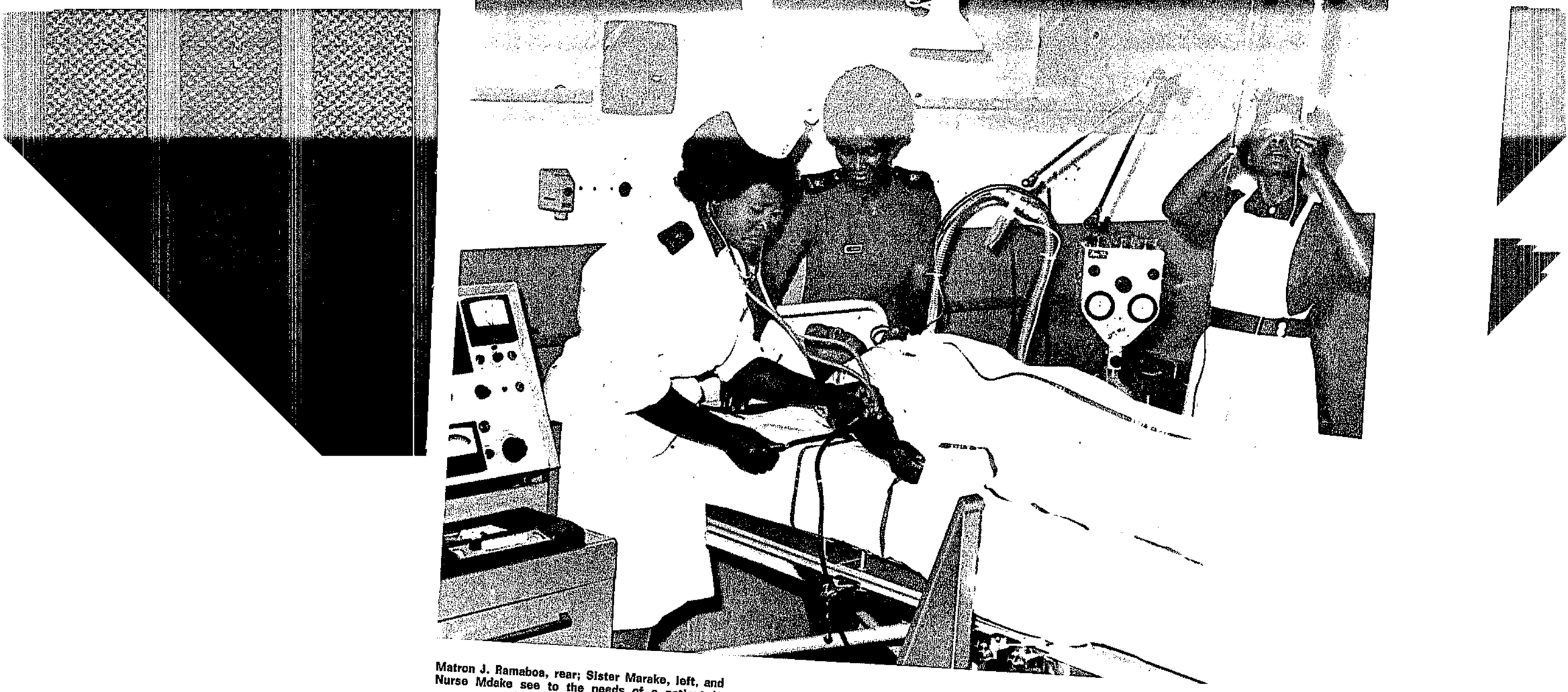
Poachers sneak into the Kruger National Park with rifles, hunting dogs and snares. They destroy valuable animals and do not hesitate to shoot when challenged by a game ranger.

Corporal Mnisi's main duty is to keep poachers at bay. At sunrise he usually makes for a water-hole deep in the bush where he inspects the water-level in the storage dam. A hot plunger pipe leading from the borehole to the windmill would mean a defect and a mechanic would have to come from headquarters to repair the pump.

Leaving the water-hole he sets out to inspect the surrounding area. If he spots a human footprint, he tracks it down to the game trap, usually cleverly concealed under the branch of a tree.

The poachers seek out little tracks which the animals use when they go to drink water. They then erect a wire snare on the track and, to make sure that the animals go to the snare on the track, they pull dead trees and thorn branches to form a crude wall, leaving only the opening on which the snare has been built.

After making sure that the poachers have left the vicinity, John Mnisi will destroy the snare, but in such a way as to make it appear as if an animal had been caught in it, but managed to break loose. Then he and his companion conceal themselves in the bush and wait for the return of the poachers . . .



Matron J. Ramaboa, rear; Sister Marake, left, and Nurse Mdake see to the needs of a patient in the intensive care unit

before being allowed to go home. Thereafter she receives daily visits for the next seven days from the district nursing service provided by the hospital.

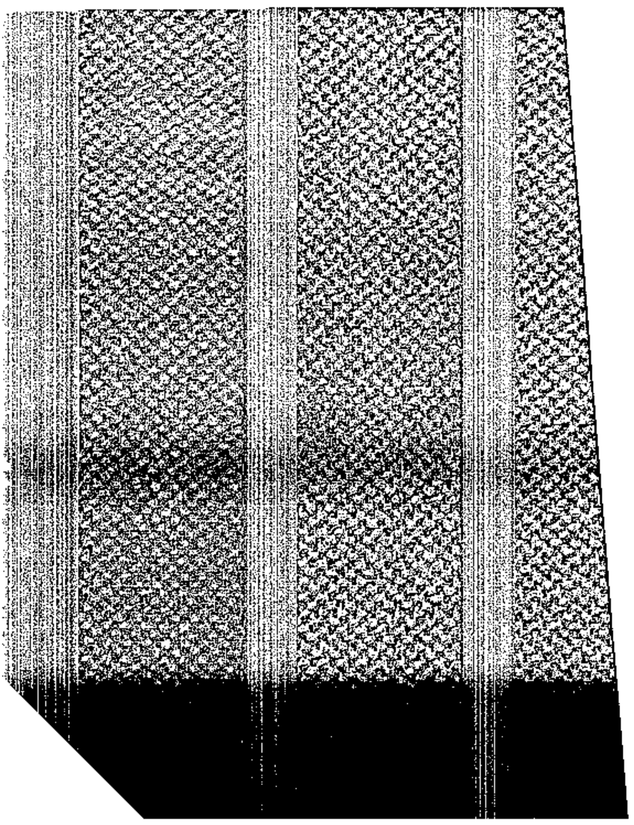
If a mother is admitted to hospital shortly after her baby has been born, she is put in the BBA (births before arrival) unit. Attached to the maternity section are lecture rooms where both mothers and student nurses are instructed in hygiene and baby-care. The labour ward has two operating theatres. The maternity hospital also has a septic area with its own theatre. A brand new gynaecological out-patients unit with eight cubicles and two resuscitation rooms has recently been erected.

The entire cost to the patient per birth, which includes ante-natal and post-natal care, the delivery, district nursing service and supplementary food in cases where the mother's milk is insufficient, in most cases is only R5.

Intensive care

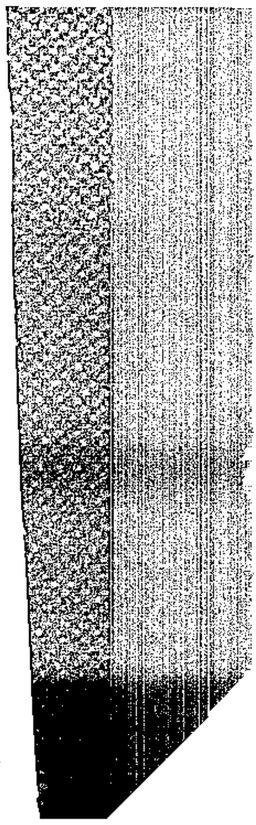
A new intensive care unit, covering two floors with 18 beds to a floor was opened in February of this year. Of the altogether 36 beds, 12 are isolation units. Patients are cared for day and night by the nurses, all of whom are Black, and doctors and surgeons are on call 24 hours a day.

Also functioning 24 hours a day, is the renal dialysis unit (artificial kidney room), which contains eight beds. Here haemodialysis of the blood is done,



Below: Benny Kwong-Foar, a student from the University of the Witwatersrand, doing research in Baragwanath Hospital's metabolic unit

Opposite page: Nursing staff in an isolation ward attached to the new intensive care unit, test incubator systems



for patients who have malfunctioning kidneys. A spokesman for the hospital said: "It is not generally known that we do some transplants and delicate heart operations like the replacing of faulty heartvalves with modern, expensive, well-functioning artificial valves at Baragwanath or that our 16 operating theatres are in constant use. To streamline the hospital's post-theatre work and to accommodate and care for the very sick who need constant attention, because of medical or surgical reasons, we have built the intensive care unit according to the most modern standards in the world."

Five new angiogram, or diagnostic, theatres have also been built. By injecting X-ray sensitive organic iodine salts into the bloodstream, radiologists can pinpoint the problem—be it urological, peripheral, cardio-thoracic or neurological — under a general anaesthetic. The angiogram theatres are next to the operating theatres so that the diagnostic and surgical section is self-contained.

Metabolic unit

Another interesting section of this large hospital is the fairly new metabolic and nutrition unit which is actually a joint venture between Baragwanath and the University of the Witwatersrand's Department of Paediatrics. Opened primarily to investigate metabolic and nutritional disorders in Transvaal children from birth to the age of 14, this section has now extended its research to the problems of malnutrition in the whole of Southern Africa. Here, applied research, which is more desirable than pure research, is done. This means that the environment where malnutrition was caused is examined before the patient is sent back to that area. Research is done on the food available in that area and a diet worked out on how to make the best use of the available foodstuffs, so that malnutrition is not extended once the patient has returned home. The findings of the metabolic section of the hospital are disseminated throughout Southern Africa, so that countries like Zambia, Malawi, Lesotho, Botswana and Swaziland, which have similar problems but insufficient research facilities, can benefit from them.

Various bodies, including selected nurses from the Transkei, are at present being educated in nutrition by the unit, which later this year will conduct courses in nutrition for other Transkei nurses and mission doctors.

In the Paediatric section, which harbours numerous children suffering from kwashiorkor (a protein deficiency), the value of foods are assessed

by measuring what a child consumes and excretes. A balanced diet of readily available foodstuffs is then worked out to rectify the child's deficiency. Lodger mothers, who are admitted so that they can breast-feed their babies, are introduced to and taught to eat protein-rich food, such as fish. A 24-hour service is provided for out-patient babies suffering from gastro-enteritis and who become dehydrated. Their fluid and normal ion balance are restored by means of intravenous drips. Up to 80 babies a day are treated in this way during the high summer season.

Various excellent facilities are available to all pediatric out-patients at Baragwanath. Besides being given refreshments while waiting, out-patients can make use of the ablution block to wash nappies in order to control cross-infection where babies or small children are suffering from gastro-enteritis.

Training

Every year 800 to 1 000 nurses are trained at Baragwanath's own nursing college. The standard is high and nurses write the same examinations as do their White counterparts in other provincial hospitals. An interesting fact is that Black nurses often obtain more distinctions in post-graduate examinations than do Whites. Many of those who qualify at Baragwanath, remain at the hospital where all patient-care is done by Black nurses. The Whites at the hospital share the administrative, training or teaching activities with Black colleagues.

Valuable remedial work is done in the Physiotherapy department, which is at present fully-staffed with 19 physiotherapists of various nationalities, including British, and at the occupational workshop, which is run by a staff of qualified occupational therapists. Here also, qualified tradesmen teach the patients how to do leatherwork and needlework. While patients are helped to adjust to their disabilities, they make valuable articles, such as shoes and satchels. Before being discharged, a patient must be able to look after himself at home, at work and at play. There are patients who have been in the paraplegic ward for a number of years.

A school is run by qualified Black teachers for long-term children in the Orthopaedic section. Instruction is given to all children from kindergarten up to standard six level and those who are unable to attend classes are taught in the wards.

General

To facilitate procedures, every vehicle belonging to Baragwanath and every clinic in the whole hospital complex has a radio telephone, whereby the hospital can be notified if an emergency case is on the way and delays on arrival eliminated. Many vehicle drivers at Baragwanath are women.

Because patients of various language groups are treated at Baragwanath, an interpreter has been placed at every point where medicine is dispensed. During 1974 just under 4 million items were handed out at all the dispensaries in the Baragwanath complex.

When off duty, hospital staff participate in various activities in the large recreation hall. The hospital choir, already making a name for itself, is at present making recordings at the South African Broadcasting Corporation and will soon be heard on the air.

Doctors and nurses living on the premises, can relax on the tennis courts and in the swimming pools near the living quarters. The general atmosphere at the hospital is a happy one, staff members are friendly and one gets the definite impression that everyone is striving to uphold the good name Baragwanath has already acquired.

VISITORS FROM RHODESIA

PHOTOS: ALF YSSEL

VINCENT VAN DER WESTHUIZEN

At the Union Buildings

At the beginning of December last year, twenty members of an organisation for Black women under the leadership of Mrs E. Mahlunge, a social worker from Highfield near Salisbury, Rhodesia, spent a week-long visit in Pretoria and the Witwatersrand. The purpose of the visit was threefold: to gain a closer acquaintanceship of the Bantu women of the Republic, to learn more about their environment and way of life, and to help strengthen the bonds between the two neighbour states.

Messrs W. T. Blie and M. P. Mtembu of the Department of Information acted as hosts and guides, and on December 1 welcomed the visitors at Hammanskraal near Pretoria. The following day they visited a clothing factory and a wig factory at Babelegi near Hammanskraal, where they were received by Chief H. Kekana. At the Hans Kekana Clinic they met the members of the Women's Committee, and in the evening attended a film show.

On the way to the Kalafong Hospital, the guests paid a visit to the Union Buildings. At the hospital they were met and entertained by the Superintendent, Dr J. D. Verster, and Matron A. S. Vosloo. Then followed a visit to the industrial centre of Ga-Rankuwa and also the Itereleng Training Centre for handicapped Bantu.

On the following day, after a visit to the University of South Africa, the guests saw the Pretoria Zoo, the Aquarium and the Snake Park. After this there were tours of the Habakuk Shikwane cane factory and the shopping centre of Hammanskraal.

In Johannesburg they visited the Oppenheimer Tower in Soweto and afterwards met members of the Urban Bantu Council. A tour of Radio Bantu followed the meeting.

The visitors were very impressed by all that the tour had offered, by the life style and working environment of the urban Bantu woman, and mostly by the facilities offered in the Republic in the field of hospitalisation and health.

State to take over mission hospitals from Methodists

The Argus Religion Correspondent 8/7/75

THE Government has told the Methodist Church of South Africa that it will take over total control of the church's four mission hospitals — Mount Coke Hospital near King William's Town, Manguzi and Bethesda in Zululand, and Moroka near Thaba 'Nchu.

The news of the takeover reached the Methodist Church by way of a circular letter from the Government to the staff at all the hospitals, stating the Government's intention and laying down the conditions under which staff would be employed after the takeover.

The new R3-million Moroka Methodist Hospital was scheduled to be taken over this month and the other three before 1979.

The Rev Vivian Harris, president of the Methodist Conference, said today that following an interview with the Minister of Bantu Administration and Development (Mr M. C. Botha) in Pretoria on June 24 these dates were now subject to negotiation.

'The minister said he was prepared to meet us as far as possible in easing the takeover, but not to reconsider the principle,' Mr Harris said.

While Mr Botha had given an assurance that the Methodist Church would have access to the hospitals for its Christian work, the Methodist missionary character of the hospitals would be destroyed, Mr Harris added.

'We still hope to have discussions with the homelands leaders about the hospitals in their areas. We feel we must take seriously what they feel about this.'

There was therefore a possibility that the church would go back to Mr Botha after talks with Black leaders.

The Methodist Church has a larger Black adherence than any other single denomination in Southern Africa. It is particularly strong in the homeland areas, with almost 2 00 000 Black adherents, according to the last census figures published by the Department of Information.

Like other mission hospitals, the Methodist hospitals were first established by the church in places where there was a need, and subsequently administered by them although the running costs were met by State subsidies.

METHODIST OPINION

Among the medical staff are doctors who are also Methodist ministers. At present Methodist bursaries are financing the training of five more doctors.

In an editorial article, the Methodist magazine Dimension said: 'The whole weight of Methodist opinion, Black and White, will be ranged against the Government's stated intention of taking over the mission hosptials of our church.'

It said the institutions were 'staffed by highly motivated, skilled and committed men and women,' and questioned whether the Government could find 'civil servant doctors' to serve for long periods in isolated places.

'The statesmanlike thing would be to leave well alone, and give thanks for what the church is doing at no profit to itself, but with every benefit to the well-being of the State — and the people who owe their lives to these hospitals,' the article said.

Church opinion 'anti-takeover'

Cape Times 9/7/75

THE REV VIVIAN HARRIS, president of the Methodist Conference, said last night that Methodist opinion in South Africa was against the Government's decision to take over total control of the church's four mission hospitals.

The hospitals are Mount Coke Hospital, near King William's Town, Manguzi and Bethesda in Zululand, and the new R3m Moroka Hospital, near Thaba Nchu.

Mr Harris said in a telephone interview from his home in Boksburg North that the church planned to hold discussions with homeland leaders about the hospitals in their areas.

"Depending on what emerges from these meetings, we may request an interview with the Minister of Bantu Administration, Mr M C Botha."

The Government announced its intention by way of a circular letter to the staff at the hospitals, laying down the conditions under which they would be employed after the takeover.

The Moroka Hospital was scheduled to be taken over this month and the others before 1979. These dates are now subject to negotiation following a meeting between Mr Harris and Mr Botha on June 24.

Mr Harris said that while Mr Botha had given an assurance that the Methodist Church would have access to the hospitals for its Christian work, the Methodist missionary character of the hospitals would be destroyed.

Running costs of the hospitals are met almost totally by the State. The Methodist Church has a larger Black following than any other single denomination in South Africa. It has more than 200 000 Black members in the homelands.

The latest edition of the Methodist magazine, Dimension, says in an editorial article that the institutions are staffed by "highly motivated, skilled and committed men and women". The article questions whether the Government will be able to find "civil servant doctors" to serve for long periods in isolated places.

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Aid for Soweto's aged 'will ease hospital load'

Rand Daily Mail 31/7/75

Staff Reporter

IN SOWETO there were no facilities for the aged, the crippled or the mentally retarded, said Dr Selma Browde, after yesterday's meeting of Johannesburg's action committee on the aged.

"Baragwanath Hospital takes in abandoned babies, cripples and the aged so there is no room for the acutely ill.

"It is a crazy waste of money to finance beds in a hospital for these cases," Dr Browde said.

By providing services for the aged, the action committee could relieve the load on Baragwanath Hospital, she said.

Although the policy was for the African aged to retire to the homelands, there was nowhere for people who had lived in the urban areas all their lives to go in the homelands, Mr Boyce Eagar, chairman of the action committee, said.

There were about 50 people, predominantly aged, at the Soweto transit camp intended to house the aged en route to the homelands for a maximum of 76 hours.

Dr Browde and Mr Eagar are to see Mr J. C. de Villiers, chief director of the West Rand Bantu Administration Board, who is responsible for the transit camp, to discuss what the action committee can do to ease the lot of African pensioners without contravening the laws of the land.

Meanwhile the priority aim of the action committee, to establish a comprehensive geriatric service in the heart of the city, has met with problems. So far none of the buildings considered has been suitable.

Since the establishment of the Senior Citizens' Foundation as a result of the Rand Daily Mail's investigation into the plight of pensioners, more than R1 500 has been donated and money was still trickling in.

In addition there was R16 000 which had been earmarked for a service centre after Mr Eagar outlined the need for such a centre in a newsletter earlier this year.

Munnik rejects claim

THE ADMINISTRATOR, Dr L A P A Munnik, yesterday rejected allegations that the province was not getting a fair deal from the Government.

Replying to an attack made in the Budget debate by Mr C L de Goede (United Party, Maitland) who had said it was a disgrace that the Government was not prepared to increase the Cape's subsidy, Dr Munnik said the creation of the subsidy was one of the best things that had ever happened to the province.

The Cape should be seen in the context of the Republic and one should not overlook the services provided directly by the Government.

As examples, Dr Munnik mentioned Coloured Education, the Saldanha project, the planned atomic power station and the dams on the Orange River.

He was satisfied that the subsidy formula was working exceptionally well and "if there is any grousing to be done it should come from the Transvaal which subsidizes the other provinces."

Dr Munnik appealed to

subsidy

Coloured leaders to encourage their people to practise birth control as only through birth control would conditions improve in the long term and shanty towns be eliminated.

● Provincial authorities will re-examine the annual "bus apartheid" subsidy of R320 000 paid to City Tramways.

Mr Frans Conradie, MEC in charge of Local Government, said that the original reasons for granting the subsidy when bus apartheid was introduced were sound but he was no longer sure that the reasons for maintaining it were still valid.

Hospital services in SA much in demand

Cape Times 6/8/75

IF Miss Annette Reinecke (UP Rondebosch) is right the hospitals of the Cape Province could become something of a tourist attraltion.

Yesterday in the Provincial Council, she said she knew of people who came to South Africa specially to take advantage of our excellent hospital services.

She quoted one case of an American doctor who had travelled to South Africa to have an operation in a Cape hospital and to enjoy a holiday.

He paid the maximum rate of R6 a day for his stay in the hospital and the total medical bill, plus holiday and travel expenses, came to roughly the amount he would have paid if he had stayed in the United States for his operation.

She said that before the trouble in Mozambique many people had come to South Africa and to Cape Town to take advantage of the hospital services.

She asked Mr P J Loubser, MEC in charge of hospitals to take a look at the question, particularly where it concerned people deliberately taking advantage of the situation.

She also pleaded for better salaries for nurses.

ARGUS 7/8/75

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Tygerberg 'runs like clockwork'

IN SPITE OF the many prophets of doom who had predicted that the Tygerberg Hospital would be a disaster, it was running like clockwork, Mr P. J. Loubser, MEC in charge of Hospital Services, said in the Provincial Council yesterday.

Speaking on the Hospitals vote in the Budget debate he said the Opposition in the council had predicted there would never be enough nurses and doctors to man the hospital.

When the hospital had begun to run smoothly they had talked as if it was likely to burst into flames at any moment. Yet it was staffed, standing and running well, he said.

'I won't say there were no problems or mistakes — a project of that size had to have them — but it was the manner of correcting these that counted,' he said.

1 719 BEDS

In July this year there were 1 507 beds available — 658 for Whites — and when completed there would be 1 719 beds.

During June the hospital handled 10 533 White in-patients and 20 589 Coloured in-patients. The average monthly out-patient turnover during the first quarter of this year was 19 399 Whites and 40 069 Coloureds.

In 1971 the family planning service at the hospital had dealt with 500 cases a month, but now it was handling 19 500 a month.

Mr Loubser also announced that a centralised computer storage system for patient records was being introduced in the Cape. This would allow a provincial hospital to call up within minutes the entire case history of a person who had been treated at any of the other provincial hospitals.

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Transvaal to spend R165-m on hospitals

RDM 7/8/75

Staff Reporter

THE Transvaal is committed to its biggest hospitals expansion programme, the United Party spokesman on hospitals, Mr Dave Epstein, MPC, said last night.

He told the Hebrew Order of David in Johannesburg that listed expenditure on hospital building and expansion amounted to more than R165-million.

Millions more were earmarked for up-to-date medical and surgical equipment.

Among the hospitals included in the programme were:

- The 2 000-bed Otto Beit Teaching Hospital in Johannesburg — estimated cost about R135-million.
- Extensions including accommodation for staff, at the J. G. Strijdom Hospital in Johannesburg — R11-million.

A start would be made soon on a R3,5-million 200-bed hospital for Indians at Lenasia after long and unnecessary delays.

A smiliar hospital was being planned for Indians at Laudium — also at a cost of R3,5-million.

The new African hospitals at Tembisa and Kalafong were now fully in use. Together they had a capacity of 1 800 beds.

Another African hospital at Lerateng near Krugersdorp was almost completed.

Plans were being completed for a R7-million African hospital at Pholosong near Springs.

And Klerksdorp's R2,5-million African hospital would be completed next month.

At Baragwanath a maternity hospital was being built at a cost of R2,850 000 and a R500 000 training college for African nurses was nearing completion.

Mr Epstein praised the Director of Hospitals, Dr Grove, and his staff, but attacked the apartheid-inspired attitudes of the Executive Committee.

These included the refusal to use Black nurses where no White nurses were available, and the rejection of equal pay for doctors with equal qualifications and responsibilities.

"The Nat politicians running the province have allowed the apartheid ideology to interfere with providing the best possible facilities and treatment for all race groups."

Hospital to close African section

RDM 8/8/75

98

Staff Reporter

THE African section of the H. F. Verwoerd Hospital in Pretoria will be closed down at the end of the year.

This was confirmed in Pretoria yesterday by the MEC for hospital services, Mr K. de Haas.

The section was being closed because Africans have alternative facilities at Kalafong Hospital, near Atteridgeville and Ga-Rankuwa hospital, he said.

Commenting on Mamelodi advisory board complaints that the nearest hospital for Mamelodi residents will be more than 40 km away, Mr De Haas said: "Only about 10 km will be added to the distance from H. F. Verwoerd Hospital to Kalafong Hospital."

He denied that the provincial council had turned down the Mamelodi Advisory Board request for a hospital in Mamelodi, Pretoria's biggest African township.

"This was not our decison. The decision was made by the Department of Bantu Administration and Development," he said.

The advisory board has been fighting for more than three years to have a hospital built in Mamelodi.

Mr Dave Epstein, MPC, the United Party spokesman on hospital services, said it was madness to close the African section at the H. F. Verwoerd Hospital when there were no alternative facilities.

Mr S. Kgatle, of the Mamelodi Advisory Board said that the African medical wards at the H. F. Verwoerd Hospital were closed on June 23.

He said Africans would be hard hit when the section closed completely and appealed to the hospital authorities to keep the wards open until the promised clinic was built in Mamelodi.

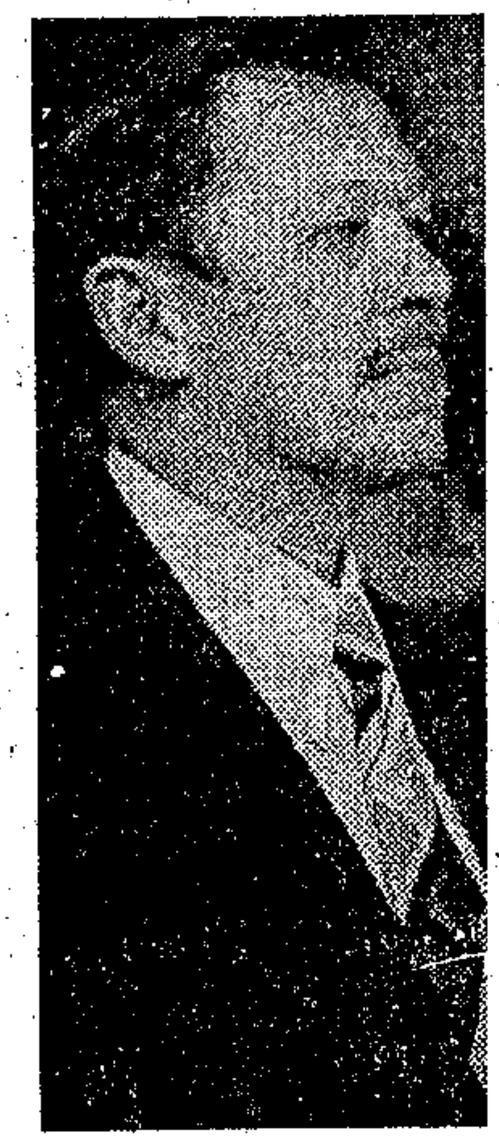
Hospital petition starts probe

(98)

17/8/75

SUNDAY TIMES Reporter

DOCTORS' complaints of overcrowding in Newcastle's White hospital are to be investigated by a commission of inquiry appointed by the Natal Executive Committee.



Dr P. Fitzgerald . . . "Doctors don't know."

A petition and a list of complaints have been submitted by 23 doctors to the Administrator of Natal, Mr Ben Havemann, and the MEC in charge of hospital services in Natal, Mr Frank Martins.

Petitioners include all the town's doctors — White and Indian — except two. The reason for the petition, they say, is to expedite the building of the new hospital and draw attention to the existing situation.

The commission will consist of the deputy director of hospital services in Natal, Dr V. A. van der Hoven, and the chancellor of the University of Natal, Mr Bernard Armitage. According to Mr Martins, the date of their arrival in Newcastle has not been decided.

A spokesman for the petitioning doctors said that the hospital was "grossly overcrowded".

"It is impossible to practise any reasonable type of medicine." He added that the situation at the Black hospital was "far worse". A number of women had given birth in the corridors because of the crowded conditions.

Too full, say doctors

Another doctor claimed that a patient recently admitted with a coronary thrombosis was sent home after two weeks instead of the normal eight. He said that people who had tonsils removed were released on the same day as the operation.

"We have to release them as soon as they are reasonably fit so as to make room for more patients," he said.

A recent statement by Mr Martins that there was no waiting list at the hospital was refuted.

"I would hate to see what would happen if there was a disaster at Iscor — we would be unable to cope," said a senior doctor.

It is claimed that the authorities were warned of the town's rapid growth when the new Iscor was announced. In 1969 Iscor's medical director visited Newcastle to discuss medical provisions.

Doctors claim that Newcastle people requiring Hospital said: "We can alhad to go to Dundee and Ladysmith.

Dr P. Fitzgerald, superintendent of the Newcastle hospital said: "We can always cope in an emergency and have done so."

He told the SUNDAY TIMES that "there is always a bed in an emergency." He agreed that the beds were "full up to capacity."

Of the criticisms of the hospital he said: "Doctors don't know how to administer a hospital as they don't think of the ancillary services that must be provided."

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.

(98)

STAR
19/8/76

A Phalaborwa pensioner and his wife have sunk their savings into building a clinic for Africans while their house stands incomplete nearby.

The couple — Mr Johan J Oosthuizen and his wife, Muriel — are living in a caravan 20 km from Phalaborwa while they complete the clinic, which, they say, is more urgently needed than their home.

"There is no hospital for Africans in Phalaborwa. The nearest hospitals are Acornhoek and Shiluvane, both of them about 120 km away," they say.

For years Africans in the far Northern Transvaal town of Phalaborwa depended on witchdoctors for "medical services." But now there is promise of a new dawn.

The clinic, rising in the bush on the Oosthuizens' tiny, undeveloped farm about 40 km outside the town, is being built by 62-year-old Mr Oosthuizen himself.

Three Africans — a man and two women — are helping him make the cement bricks and put up the building, which is already nearing completion.

The clinic is to be run by Mrs Oosthuizen, a nursing sister of 25 years' standing.

Maternities

It will handle general medical services, including maternity cases. There will be child welfare and family planning as well as nutritional education lessons.

A feeding scheme is to be run too, providing, free-of-charge, vegetable soup and milk. Plots, where vegetables can be grown, are being prepared.

The idea of the clinic was born after the Oosthuizens arrived on their farm. "We came here barely two years ago," chuckles Mr Oosthuizen, "for a quieter, more peaceful life."

Without much ado, the 62-year-old pensioner began, almost immediately, putting up a makeshift kitchen, a borehole for water, and a house while they lived in the caravan.

Malnutrition

News of the "new farmer" trying to build a haven for his family filtered through the bush. Africans, men and women, some with babies on their backs, came forward seeking work.

And as they rolled in, Mrs Oosthuizen, then still in full-time employment outside the area, was struck by their condition. They suffered from food deficiency diseases — kwashiorkor, malnutrition, pellagra and other related ailments.

"In the evenings," says the pensioner, "my wife would spend hours telling me about the plight of these people. She said they were ill and needed help. I started looking closely at them, then realised just how right she was."

What aroused their conscience even more sharply was the realisation that the hospital in town did not accept Africans.

Attends sick

Between them, the couple agreed to do something. They stopped building their own house, with walls already standing above window level.

First, Mr Oosthuizen built an 82 kilolitre dam, specifically for the clinic.

But there was still a problem — his wife was in full-time employment and not free to attend to the many sick people who turned up almost every day.

She has now resigned, and, as construction of the clinic continues, attends to the sick, giving them not only medicine but also milk to feed children.

"It was pathetic to see the number of underfed, sick children brought to me. I could not help because I was still working. Neither did I have the facilities," said the matron-to-be.

"If my husband told them I was not around, they would not believe him. They would sit under a tree, waiting in vain until dark. Then they would take their children home. Often to die . . ."

There were also, said the matron, "pathetic cases of bleeding before or during deliveries, difficult labours, often resulting in the death of the baby — this is the pattern that repeats itself from day to day here."

Ignorance, as well as lack of money, she emphasised, was at the root of their problems. There was need for a "terrific amount" of health education.

Determined

Still living in their caravan, Mr Oosthuizen, his wife and stepdaughter are determined to see the clinic function, no matter how limited their resources, by the end of the month.

"We will open the clinic, even if there are so many things we still need. We will open with the minimum. I am sure we'll be blessed in this effort. Funds will become available. We have already had one or two offers," says the matron.

Seeing the "home" in which the Oosthuizens live, I thought as I watched them go about their business — attending to the sick and building the clinic — that they did not care much about their own comfort.

When I mentioned this to Mrs Oosthuizen, she laughed. "Their need is greater than ours. Ours can wait."

D 98

Injured of all races go to first hospital

STAR 20/8/75

Own Correspondent

MARITZBURG—Written instructions are going to all Natal provincial hospitals that accident victims with doubtful injuries must be taken to the nearest hospital for treatment before being taken to a hospital for their own race group.

This was said today by Mr Frank Martin, MEC in charge of hospitals in Natal, after an African was injured outside an Indian hospital and had to wait half an hour for an ambulance to take him to another hospital 16 km away.

The injured African, who was taken to Edendale Hospital from the Northdale Indian Hospital, was discharged after treatment.

"Our policy is that anyone who needs emergency treatment will be taken to the nearest hospital immediately," Mr Martin said. "They will treated there and only moved when their condition has improved."

He said it was very often the responsibility of the ambulance driver to decide whether someone needed urgent treatment.

"These people are very experienced, but if they have any doubt they should take the injured to the nearest hospital anyway. It then became the responsibility of the hospital staff to ensure that they are taken care of properly."

Natal neem voortou

Van PIET DE KLERK

DURBAN.

NATAL gaan sy hospitaaldeure vir alle rasse oopgooi oor dit erg beseerde slagoffers van ongelukke betref.

'n Aankondiging in dié verband gaan binne die volgende paar dae gedoen word deur mnr. Frank Martin, LUK belas met hospitaaldienste in Natal.

Hospitale se plig is om lewens te red, ongeag die beseerde se kleur," sê mnr. Martin, „en elke hospitaalbeampte wat die nuwe bepaling verontagsaam, sal summier ontslaan word."

Mnr. Martin se besluit volg op 'n geval verlede week toe 'n erg beseerde swartman lank buite die Northdale-Hospitaal vir Indiërs op Pietermaritzburg gelê het voordat hy na die Edendale-Hospitaal, sowat 15 kilometer verder, gebring is.

Volgens die nuwe bepaling sal dit by die ambulansbestuurder berus na watter hospitaal die beseerde gebring word. As hy enigsins twyfel oor die erns van die beserings, moet die pasiënt na die naaste hospitaal gaan.

Dieselfde reël sal geld wanneer 'n beseerde 'n noodoperasie moet ondergaan. Die pasiënt sal na die hospitaal vir sy eie ras oorgeplaas word sodra sy toestand dit toelaat.

Op 'n vraag of blankes en nie-blankes in dieselfde saal sal lê, het mnr. Martin gesê daar sal sover moontlik geprobeer word om in sulke uitsonderlike gevalle pasiënte in private kamers te hou.

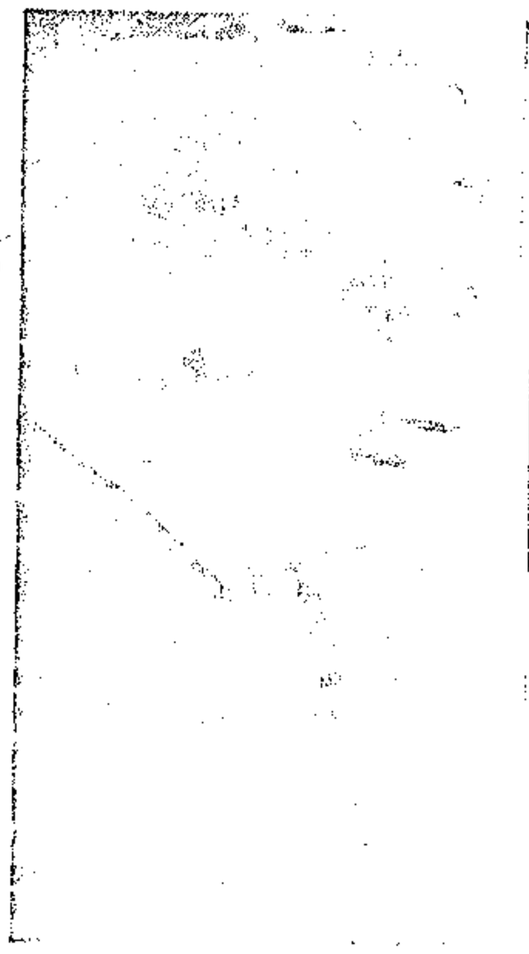
Talle hospitale in Natal het egter geen private kamers nie.

Mnr. N. MacKay, hoof van ambulansdienste op Pietermaritzburg, sê hy is verheug oor die hospitaaldienste se nuwe reëling.

„In die verlede was daar talle gevalle waar my manne nie-blankes na blanke hospitale gebring het en dan aangesê is om hulle weg te neem. Ons manne is nie gekwalifiseer nie en word ook nie toegelaat om 'n mening oor 'n persoon se beserings te waag nie."

Hy het bygevoeg 'n besluit van die Regering se kant dat beseerdes, ongeag hul kleur, na die naaste hospitaal gebring kan word, sal nou verwelkom word.

Die Sekretaris van Gesondheid, dr. J. de Beer, sê die Edendale-Hospitaal in Pietermaritzburg val onder beheer van die Regering en sal dus nie deur Natal se nuwe bepaling geraak word nie.



MNR. FRANK MARTIN, LUK, „Hoor hulle se plig is om lewens te red, ongeag die kleur", sê hy.

Mnr. [illegible] by hospitaal die [illegible] sal 'n blanke [illegible] die hospitaal toegelaat word.

'n Woordvoerder van die Edendale-Hospitaal sê as 'n blanke daar opgeneem word, sal hy in die afgesonderde saal moet lê omdat daar geen private kamers is nie.

Die Grey-Hospitaal in Pietermaritzburg sal, soos alle ander provinsiale hospitale in Natal, by die nuwe reëling inval. Bantoes sal so ver moontlik in private kamers geplaas word.

98

Emergency: Hospitals in Cape open to all

ARGUS 26/8/75

EVERY hospital in the Cape with the exception of a small one in Rondebosch has been designed to accommodate emergency patients of all racial groups, Dr Radie Kotze, the Cape Director of Hospital Services, says.

He was commenting on developments in Natal, where written instructions are being sent to all hospitals in the province that accident victims with doubtful injuries must be taken to the nearest hospital for treatment before going to one specifically for their own race group.

NATAL

According to Mr Frank Martin, Natal's MEC in charge of hospitals, this circular is being sent out to clarify general policy after a recent accident when an African pedestrian was knocked down and had to wait more than half-an-hour for an ambulance to take him 16km to hospital.

Mr Martin said it was often the responsibility of the ambulance driver to decide if a person needed urgent treatment.

'Our policy is that anyone who needs emergency treatment will be taken to the nearest hospital immediately.'

'They will be treated there and moved only when their condition has improved,' Mr Martin said.

'DISCRETION'

Cape Director of Hospital Services Mr Kotze says this policy clarification is not really necessary in the Cape, where all large hospitals take in patients of all races.

'We only ask our people to use their discretion, in any case, in the interests of saving human lives,' he said.

98

Hospital in Lenasia by 1979—MPC

STAR 26/8/75

Lenasia will have a 200-bed, R5,7-million hospital in 1979, Mr Dave Epstein, MPC for Hillbrow said today.

Mr Epstein, United Party Provincial Council spokesman on hospital affairs, said he had been intimately involved in every phase of the campaign to get a new general hospital for Johannesburg since it started 20 years ago.

"And I am regretfully only too conscious of the agony such delays cause the public," he said.

He suggested it would take one year to complete planning for Lenasia Hospital, two years or less to call for tenders and award the contract, and one year or less to equip and complete the hospital before it was opened to the public.

ADVANCED

There were four reasons why the hospital project was well advanced, Mr Epstein said.

- The need for a hospital at Lenasia was accepted as absolutely urgent.
- On February 12 this year the Administrator of the Transvaal said planning for the hospital had started.
- Money for the hospital would be made readily available.
- The unity of the Indian community would give impetus to the project.

The 8 ha for the hospital chosen recently would allow an extension for 150 beds when the need arose.

Because a hospital in Lenasia would not cater for the needs of the entire Transvaal Indian community, the Provincial Administration had agreed to build a second hospital at Laudium, Pretoria.

98

Hospitals drop race bar in urgent cases

STAR 26/8/75

Science Editor

People seriously injured in accidents in the Transvaal will be treated in the nearest hospital irrespective of race, a spokesman for the Department of Hospital Services said today.

"It is hardly necessary to state this principle — it is logical and human," he said.

He was commenting on a move in Natal whereby instructions had gone out to all hospitals that accident victims with doubtful injuries must be taken to the nearest hospital for treatment before going to one specifically for their own race group.

The Director of Hospital Services in the Cape, Dr R Kotze, has said that a policy clarification in this respect is not necessary in the Cape as all large hospitals take in patients of all races.

EMERGENCY

The Transvaal Hospitals Department spokesman said that in an emergency a patient must be taken to the nearest place where he could receive treatment.

For example, a White person severely injured in the vicinity of Baragwanath Hospital would be taken there first.

Similarly, a Black patient would be taken to a hospital for Whites for emergency treatment if there was no hospital for Blacks in the vicinity.

Ambulance men could use their discretion in this respect as they were trained to recognise serious injuries and other emergencies.

GRAHAM CRASHES IN...

He's the first Black baby born at Grey's Hospital

Mrs Ndlovu and son yesterday

98

Sunday Tribune Reporter 31/8/75

LITTLE Graham Ndlovu crashed through South Africa's race barriers yesterday.

He was born in the all-White Grey's Hospital in Pietermaritzburg only a week after Natal's MEC in charge of hospital services, Mr Frank Martin, said he had instructed all provincial hospitals to treat or admit emergency cases regardless of colour.

Nurses at Grey's Hospital which has not had Black patients for some years, yesterday were excited about their unusual Black patients. Many of them took turns to hold the newly born Black baby before he left for Edendale Hospital.

"We were very surprised at first — it is a lovely baby," said one of them last night.

When Mrs Ndlovu (41) went into labour at her Cato Ridge home yesterday afternoon she immediately hired a car to go to the Edendale Hospital.

But the baby wouldn't wait and the desperate driver took Mrs Ndlovu to Grey's Hospital.

She was immediately admitted and Graham was born soon after.

They were then transferred to Edendale Hospital where mother and son were making good progress last night.

Mrs Ndlovu, who has six other children, said she is very grateful for the help she received from the staff of Grey's Hospital.

"I only wish my husband was with me to share my happiness. He is in Durban and will only be coming home in a few days' time."

Although Mr Martin insisted that his instructions were not new the head of ambulance services in Pietermaritzburg, Mr N. Mackay, said that it had reached the stage where his men had given up taking non-Whites to White hospitals because they were so often turned away. He said that he was delighted to hear about the instructions.

[redacted]

(1) 48
(2) 261

Concern over hospital move

STAR 3/9/75

(1) 107

(2) 98

(98)

Science Editor

A group of doctors associated with a mission hospital in kwaZulu have expressed their grave misgivings of the Government's intention to take over mission hospitals in South Africa and turn them into State institutions.

Writing in the South African Medical Journal, they point out that nationalisation appears to have been decided on without consideration of other alternatives, such as those in Malawi, Lesotho and Zambia.

They maintain that no adequate explanation has been given as to why the mission hospitals cannot be allowed to continue to work on the present "agency" basis which works well and gives health care more cheaply than State hospitals have been able to do.

"It is disappointing that the many who have given years of service in the rural areas of this country have not been employed in helping to design the new rural comprehensive health service," they write.

A second objection is that the State Health Department will now take over staff recruitment, a function at present of 10 or more churches or mission societies.

This has potentially serious consequences as many doctors still have to be recruited overseas because of the shortage of doctors in South Africa.

The fear is that many of these doctors would be prepared to work under the banner of a mission society but not under that of the Government.

QUESTION

In their letter the doctors also question the practicability of controlling hospital staff by three State departments, which is a side-effect of nationalisation.

"With these factors in mind, we wish to make a renewed public appeal for greater consultation at all levels in the planning of health services in this country, and to express grave doubt as to the wisdom of the present changes," they write.

Coloured doctor is appointed

13/9/75 **Mercury Reporter**

A DURBAN Coloured doctor, Dr. L. I. Robertson, has been appointed to the Addington Hospital Advisory Board, which is chaired by Mr. Alan Wilson, a former Chief Magistrate of Durban.

This is the first time that a non-White has been appointed to the nine-man board.

When asked to comment yesterday, Mr. Wilson said that he was "very pleased" with the appointment.

"When a vacancy occurred, the thought came to me that it would be no more than equitable to have a representative of the Coloured community on the board.

"After all, Addington Hospital caters for more than 250 Coloured patients.

"I am happy to say that Mr. Frank Martin (MEC for Hospital Services in Natal) received the suggestion favourably, and hence the appointment of Dr. Robertson," Mr. Wilson said.

The other members of the board are: Mr. Vause Raw, MP, Durban Point; Mr. W. B. Reynolds, MPC; Mr. G. Milner-Palmer; Dr. P. Klenerman; Mrs. J. Stretton-Barry; City Councillor Margaret Maytom; and Mr. E. L. A. Volker.

(1) ~~15~~
(2) 98
(3) ~~262~~

(98)

STAR 16/9/75

Coloureds get new clinics

John Patten,
Political Correspondent

The Minister of Health, Dr van der Merwe, has approved expenditure of more than R850 000 on improved health services for Coloureds.

In terms of existing legislation, the Department of Health will subsidise the schemes by seven-eights — making a total state contribution to the services of R757 500.

The Minister made it clear in a statement today that the amounts approved are for the improvement and provision of clinic facilities for Coloureds.

During the present financial year the amounts have been approved for 17 local authority schemes in the Cape, of which the largest (R136 000) is in the Chatty residential area in Port Elizabeth.

Other areas where new or improved clinic facilities have been approved are: De Aar, George, Grabouw, Heidelberg, Aliwal North, Port Alfred, Uniondale, Tulbagh, Caledon, Moorreesburg, Hopefield, Ceres, Cradock, Namaqualand and Knysna.

In the 1976/77 financial year, the largest scheme entails spending R206 000 in Cape Town at Mitchell's Plain.

Other areas that will benefit include George, Elsies River, Scottsdene (Stellenbosch), Oudtshoorn, Gelvandale in Port Elizabeth and Randfontein.

98

Hospital share plan gets go-ahead

Natal Mercury 17/9/75

RJ

Mercury Reporter

PIETERMARITZBURG. THE GOVERNMENT has given approval for the sharing of facilities at the "super specialist" R17-million addition to Durban's Wentworth Hospital.

But Mr. Pat Gordon, director of building services, said yesterday that wards for Whites and Blacks would be separate.

Plans for the additions have already been approved, but the Government has yet to give the financial go-ahead.

Specialist services for all races will be concentrated in the new building because of the high cost of providing and maintaining them at hospitals throughout Natal.

A heliport will allow emergency cases to be flown straight to the hospital.

Mr. D. Stewart, principal architect with the department, said the new centre would eventually have 634 beds, — 355 for Blacks and 279 for Whites.

Among the facilities are four transplant wards, one pediatric ward, six operating theatres, two neuro-surgical theatres, and three linear accelerators for cancer treatment.

The basement "bunkers" housing the accelerators will have 3,5m thick walls.

Mr. Stewart said the centre would have a segregated service floor between the other levels, joined to the present section of the hospital by a bridge walk and all essential services will be carried out from this floor.

All patients at the hospital are referred, and only they will be treated in the centre's outpatient section.

Tenders for the R17-million additions should be called for at the end of 1977.

Building is expected to take four years.

Crisis looming in Vaal hospitals

Star 11/10/75

Muhammad Ali, Richard Burton and Elizabeth Taylor were part of a moneymaking set that gave the South African public false values and preoccupations in the face of serious problems like the growing understaffing of hospitals, Mr Dave Epstein, MPC for Hillbrow, said last night.

He told a United Party meeting in Johannesburg the real heroes of society were the overworked nurses, superintendents and doctors staffing hospitals on the Reef — people, who should be given better allowances to make posts at hospitals more attractive, he said.

Edenvale Hospital had closed as a result of staff problems and the near-complete 350-bed Kempton Park Hospital would not open for another year because it could not be staffed, he added.

Mr Epstein said the main issue currently with hospital staff was the delay in the issue of "special allowances" for an excess of 16 hours' overtime a week. Hospital staffs in Natal were eligible for special allowances but not hospital staffs in the Transvaal, the Free State and Cape.

"In view of deteriorating economic conditions it is possible that the proposals for special allowances have been watered down to the ultimate detriment of the medical profession.

"I make a final appeal to the Province: deal justly with your staff or face an unprecedented crisis in our hospitals.

"As it is we are short of hospital staff and further exploitation of staff will defeat the very purpose for which the special allowances have been devised," he said.

98

Mixed nursing, but bathing...

Daily Dispatch 17/10/75

EAST LONDON — There was no harm in mixed nursing in hospitals — but mixed bathing was another matter.

This was said at a report-back meeting here last night by the MPC for East London City, Mr J. Hunt.

Mr Hunt told the 70 people present that although mixed nursing was not United Party policy, people should be given the chance to choose whether or not they wanted to be nursed by black nurses.

"There is a great shortage of nurses in our hospitals," he said. "And there is no differentiation in training, examinations and qualifications. I can see no harm whatsoever in allowing black nurses into white wards.

"By all means, have white wards as well, but allow the individual to choose."

Mixed bathing was also not United Party policy, Mr Hunt said, "and I don't believe in it.

"Many people make the mistake of thinking that non-white people are dying to use our facilities. They're not. They are completely happy with their own beaches. But perhaps the Coloured people are more fairly treated than blacks.

"I challenge anyone, not only the Nats, but the UP as well, to wade waist-deep into one of their beaches. You can't even do that," he said. "And the toilet facilities are absolutely shocking."

Some beaches had been set aside for blacks but the East London City Council had not applied for funds.

Mr Hunt said people most concerned had not objected to the proposed coastal expressway. They were the guigney ratepayers.

"The only people who have objected are some of the people in Bunkers Hill. And they are only indirectly concerned.

The MP for East London City, Mr H. G. H. Bell, told the meeting that the attendance only served to emphasise the apathy of East Londoners.

People should take an interest in politics for the sake of their children, he said.

United Party policy on the Liquor Amendment Act was that hoteliers should be able to choose for themselves whether to apply for permission to accommodate blacks.

The Progressive Party's attitude had been that all hotels should be open to blacks unless they applied for white-only permits.

"This is enforced integration," Mr Bell said.

Asked about coalition between the United Party and the Nats, Mr Bell said he doubted this would happen because of the fundamental policy differences.

Until one or the other changed, there could be no merger, he said. —DDR

98

Bantu boards to help with farm labour

ltr 17/10/75

(1) 4 (3) 323 (5) 98
(2) 319 (4) 48 (6) ~~Hampers Testing~~ (7) 205

Farming Editor

Bantu administration boards have asked organised agriculture how they can help farmers with their African labour force.

Mr Manie Mulder, chairman of the West Rand board told farmers this at the Transvaal Agriculture Union symposium here yesterday.

Mr Mulder suggested boards could assist with:

- the building of houses by the board's building teams;
- provision of recreational and welfare facilities;
- medical services and clinics on farms;
- family planning;
- education and the provision of bursaries for farm children to attend city high schools;
- in-service training of farm labourers and selection of employees;
- mobile registration units to visit farms.

He reminded farmers that their registration fee of 40c a labourer a month would not be enough to finance all these projects.

Mr J J Druwer, director of the Division of Agricultural Engineering of the Department of Agricultural Technical Services, pointed out that overseas farm workers with Standard 8 were given intensive training in the handling and maintenance of farm machinery.

In South Africa, illiterates were pitched into their jobs without even in-service training. The result was that South Africa's tractor maintenance cost 40 percent more than in overseas countries.

At the turn of the century the country would need about 400 000 tractor operators and if current training provisions were not stepped up considerably only 25 000 would be qualified.

If 20 000 tractor operators were not trained within the next few years agricultural mechanisation was bound to remain inefficient and capital losses would be enormous, Mr Gruwer said.

NGK call to avoid RC clinics

Members of the Nederduits Gereformeerde Kerk were asked by the Northern Transvaal synod of the church in Pretoria yesterday wherever possible to avoid entering Roman Catholic hospitals and maternity homes.

Medical practitioners were asked to co-operate and parents were reminded of the decision of the general synod of the church not to send their children to Roman Catholic institutions.

In a report to the synod it was stated that 94 children of Nederduits Gereformeerde Kerk parents received education in RC institutions, but that no disciplinary steps had been taken.

Many members of the church still made use of RC hospitals and it was feared that they were conditioned by medical practitioners who virtually forced them to enter those hospitals because they did not operate elsewhere.

Shortages of beds in State hospitals was a contributing factor.

On the other hand, church members were enticed to RC hospitals by loving care and the peace and quiet atmosphere.

Women preferred Roman Catholic maternity homes because of greater sympathy they said they received and because their night's rest was better as a result of the removal of their babies.

The report stated that the factors of love and sympathy played an important role and unless the Church could prove to the contrary, the Church was in a rather embarrassing position.

(See Page 29)

P-D. 24/10/75

New King hospital when there's cash

98

KING WILLIAM'S TOWN — Though he could make no promises about dates, he could give King William's Town the assurance that a new replacement hospital for Grey Hospital was on the priority list, the Administrator of the Cape, Dr L. Munnik, said here yesterday.

He was speaking at a civic luncheon given to mark his first official visit as Administrator.

At present there were financial problems facing the Administration, but when the time was ripe economically King would certainly get its new hospital.

In the same way, the Administration would see King William's Town's educational requirements were met in the form of any new school buildings that were needed. — DDR.

HOSPITAL THAT DISPENSES HOUSEHOLD HINTS

MORE THAN JUST A HAVEN FOR THE SICK

By NOEL GLASS

CARRY the medicine into the bush and hit disease before it starts.

That is the aim of Dr. Angus Cameron who, since taking over the running of the Church of Scotland Mission Hospital at Tugela Ferry six months ago, has set about developing a preventive medicine campaign.

"Gone are the days when a hospital was merely a haven for the sick — although of course we still have the usual facilities at our hospital," he said.

There are about 15 000 Zulu people in the Msinga district which the hospital serves. But most families are made up of woman and children as the men have gone off to the mines.

This, Dr. Cameron explained, created enormous difficulties in the production of food since none of the men was available to do the ploughing. And many of the wives, having up to ten children, were often too busy or unfit to tend the land.

As a result malnutrition was a problem, especially among the younger children.

Poor living standards were as low at Tugela Ferry as anywhere in Africa with the local inhabitants living on an average of R14 a month. only an average of R10 a month was sent back by miners to their families, Dr. Cameron said.

"No wonder most of the children live on a diet of porridge and sour milk."

"This is why we go out to the people and try to cure them before they become seriously ill."

For this type of approach a hospital needed to have many out-patients' clinics and the number of these had been doubled in the past seven months to 11, but many more still had to be established.

Ideally a clinic should be within 7km walking distance otherwise people did not bother to report sick until they were very ill, he said.

An essential part of the out-patient practice was the education programme which started at an extremely simple level such as telling mothers to keep their water pots covered against flies.

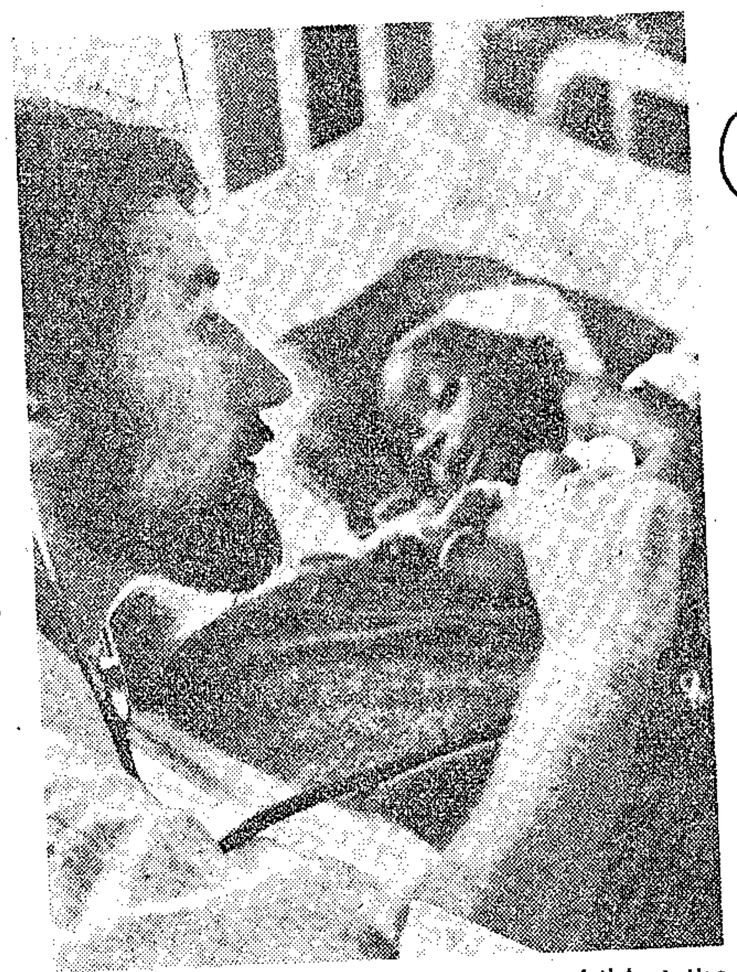
Dr. Cameron (27) is a third generation doctor from Glasgow — both his father and grandfather worked in the notorious Gorbals slum district.

He came to South Africa a year ago, three years after qualifying as a doctor, and is married to a fellow Glaswegian who is also working at the Tugela Ferry hospital.

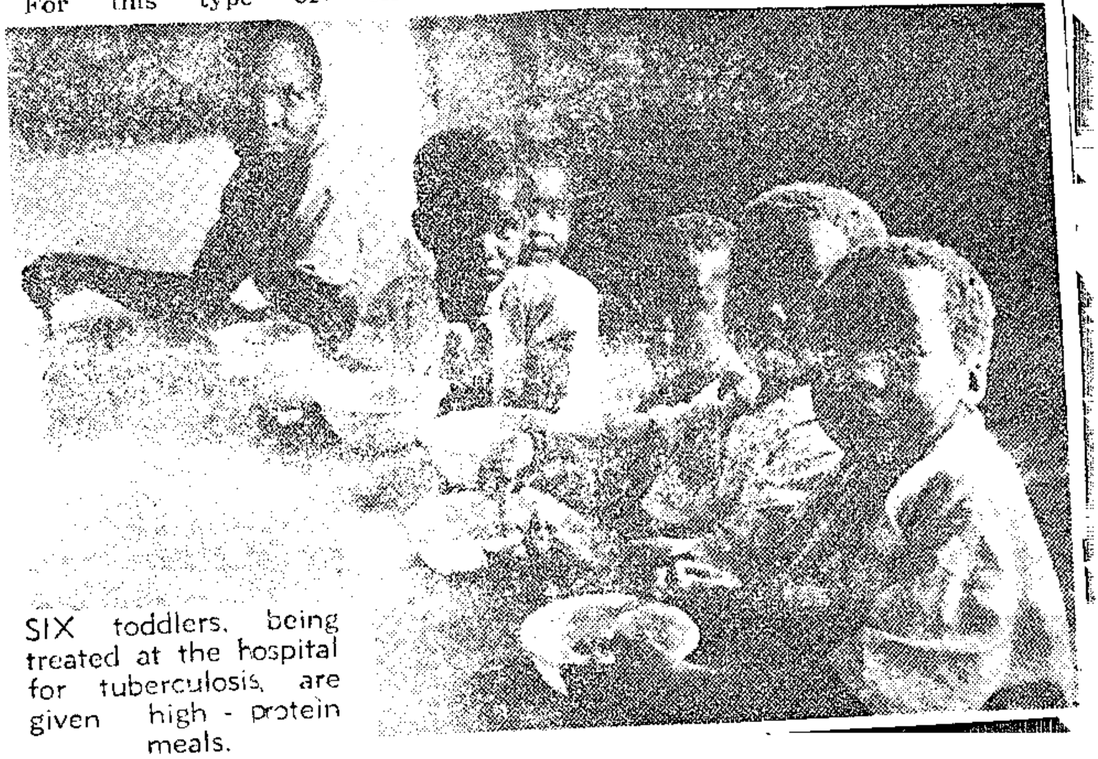
The hospital employs a young man, Mr. Derrick Iken, who has given up his job as a systems analyst in Johannesburg for a year, to develop the agricultural side at the hospital.

"We want to give an example to the folk who come here and show them that they can also produce green vegetables — but unless we do it ourselves many people just wouldn't believe us," Mr. Iken said.

When people come to the hospital they are, in addition to treatment, given advice on cooking and on the importance of eating a balanced diet, he said.



DR. ANGUS CAMERON examines a child at the Tugela Ferry Hospital. Below: with the help of a weight chart a nurse explains to a mother that her child is underweight for its age.



SIX toddlers, being treated at the hospital for tuberculosis, are given high-protein meals.

1 261 - Natal
2 98

SUN. TIMES 23/11/75

'Apartheid' visiting hours upset Hindus

By G. R. NAIDOO

TWO Indian friends of Mrs Peta Irving-Brown, a follower of the Hindu faith, were told that they could not visit her during visiting hours at the Newcastle Provincial Hospital.

Mrs Irving-Brown, 23, known to Indian friends as "Guruma" (spiritual teacher) lost her husband, a homeopath, in a motor accident this month. She suffered concussion, muscle injury and internal bruising. Her two-year-old son suffered a broken arm, and her one-year-old child escaped with minor injuries.

The evening after the accident two of Mrs Irving-Brown's close friends from Newcastle, Mrs Pat Naidoo and Mrs Jaya Chetty, visited her in hospital.

Mrs Naidoo told me: "We continued our visits until Wednesday night when we were told that on the instructions of the medical superintendent we could not visit Guruma. We were most upset at this and so was the matron on duty. After making representations she took us to the ward about 8 pm after normal visiting hours, to see our friend."

Mrs Irving-Brown, who is pregnant, has been discharged from hospital but is still ill.

Permission

Dr P. Fitzgerald, the medical superintendent of the hospital, said that Indians were not allowed to visit White patients during normal visiting hours. They were, however, allowed to visit them before or after visiting hours.

"We can't allow Indians walking all over the place. I will not allow my other patients to be upset," said Dr Fitzgerald. "This is my ruling at my hospital."

Mr Frank Martin, MEC in charge of hospitals in Natal, said there was no ban on non-Whites visiting Whites in provincial hospitals.

After taking up the complaint with the Deputy Director of Hospital Services, Mr Martin said Mrs Irving-Brown's Indian friends were allowed to visit her, but when the visitors swelled in numbers, this was stopped and Indian visitors were asked to call before or after visiting hours.

98

Mdantsane hospital opens new services

D.D. 28/11/75

EAST LONDON — Phase two of the opening of the new Mdantsane Hospital will swing into action on Monday with the opening of an extended outpatients service and a 24-hour minor casualty service.

The hospital's senior medical superintendent, Dr P. E. Pistorius, said the scope of the hospital's services was to be increased substantially from Monday. Since June 2 it has been providing an outpatients service on a fiveday week basis, but not offering other services.

Dr Pistorius said the expansion of the existing service to outpatients, together with the 24-hour treatment of minor casualties, would take some of the existing pressure off Frere Hospital.

The Mdantsane Hospital will also be opening a certain number of beds for convalescent medical and surgical patients and this is expected to alleviate the overcrowding in these categories among blacks at the Frere Hospital.

The bus service which has been operating between Frere Hospital and Mdantsane is to be suspended.

Dr Pistorius said acutely ill or seriously injured people would still be transported to the Frere Hospital. The Mdantsane Hospital would be responsible for providing this transport.

He said the opening of hospital services in Mdantsane would continue over the next year or two until an entire medical staff had been built up and all the hospital's departments were functioning. — DDR.

Cottage Hospital has become redundant

Letters

From Mr P J LOUBSER, MEC:

I CONSIDER it my duty to react to the report (Cape Times, November 26) under the heading "Honikman against hospital closure".

Regarding the meeting which was held earlier last week in connection with the closing of the Rondebosch-Mowbray Hospital, I must point out that it is not customary that officials of the Provincial Administration attend public meetings to discuss matters, intentions and resolutions.

The unusual step to request the Director of Hospital Services and other senior officials attached to the Hospitals Department to be present at the meeting which was arranged by the ratepayers of Rondebosch to discuss the proposed closing of the Rondebosch-Mowbray Hospital, was taken by me after an assurance by Mr Rupert Hurley, chairman of the Ratepayers' Association, that it would not be a protest meeting. It was with regret that I had to learn that of the assurance with regard to the meeting, of which Mr Hurley was the chairman, concerning the nature and spirit thereof, nothing came about.

The meeting was fully informed of all the related considerations which led to our decision but nevertheless resolved that arrangements be made for a deputation to discuss the matter with His Honour the Administrator. Some of the spokesmen of that community, however, deem it fit to make statements in the meantime which are apparently eagerly being taken up by your paper. The statements create impressions which I must rectify, otherwise I would be failing in my duty.

Main reason

The main reason for deciding to close the Rondebosch-Mowbray hospital was never the amount of money which would have to be spent to renovate the hospital. It is, however, unrealistic to spend R750 000 on a hospital of this size in an urban area which would then still be of antiquated design with inadequate facilities and an inefficient flow pattern of services.

Secondly the hospital became redundant because adequate alternative accommodation is available for the patients. The costs involved have been determined as a result of thorough investigations which were carried out by experts in their field and have been substantiated by figures.

To refer to the Rondebosch-Mowbray hospital as a R10 000-a-bed hospital, is misleading. The renovations alone would have amounted to more than R10 000 a bed. Similarly it is false to state that the Tygerberg Hospital cost R46 000 a bed. The 1 600-bed (not 1 500) Tygerberg Hospital was erected at a cost of approximately R32 000 per bed, including teaching facilities for doctors, laboratories, etc. It is in any event ridiculous to draw a comparison between a large teaching hospital such as the Tygerberg Hospital and a small cottage type hospital such as the Rondebosch-Mowbray hospital. One wonders whether inhabitants of Rondebosch and vicinity desire that the comparatively new Karl Bremer Hospital should not be reopened.

Not the last

Another fallacy is that the Rondebosch-Mowbray hospital is the last open hospital in the Peninsula where patients could be treated by their own doctors. What about the Conradie Hospital, the Somerset Hospital, the Woodstock Hospital, the Victoria Hospital in Wynberg, the False Bay Hospital in Fish Hoek and the Karl Bremer Hospital when it is reopened?

I would also like to say that, much value as we attach to sentiment, the Provincial Administration deals with the taxpayers' money. It is also incumbent upon us to keep abreast of the development of medical science and modern methods of patient treatment.

It is trusted that you will give as much publicity to this letter as you did in the case of the article to which I am responding.

98

Go-ahead sought for R100m hospital

RDM 2/12/75

Staff Reporter

THE Transvaal Provincial Executive has asked the Cabinet for permission, despite the heavy clamp-down on capital spending, to go ahead with the planning and building of a R100-million hospital in Pretoria.

A Provincial Works Department spokesman said that an initial survey had established that the hospital was urgently needed, and that building must start soon to prevent a probable crisis in hospital accommodation in the city arising in three to four years time.

Three sites were under consideration, he said. They were to the north, south and east of Pretoria.

However, it is understood the site most likely to be used is a big piece of ground to the north-east, adjoining the new eastern bypass road to Pietersburg from the Johannesburg-Pretoria freeway.

The Cabinet is believed to be waiting for a report on the project from the State Department of Planning before taking its decision.

But the province confidently expects a "go ahead sign before Christmas".

The new hospital will be a "teaching" hospital, and will be nearly as big as the new Johannesburg Hospital, which has taken 10 years to complete.

Initial plans are to provide at least 1 200 beds, with a maximum of 2 000.

1. (98)
2. 88

Indian hospital to be built

Star 9/12/75

The Transvaal Provincial Council is to build a 200-bed hospital for the 40 000-strong Indian community of Lenasia in Grasmere, about 18 km from where they are presently settled.

This was disclosed today by Dr Salim Tayob, convener of the Lenasia Hospital ad hoc committee, which had talks with the Director of Public Works and the Director of Hospital Services.

According to Government plans Grasmere will be incorporated into Lenasia to resettle Indians living in Johannesburg and to provide homes for the natural growth in population for the year 2 000.

Grasmere will then form the southern boundary of Lenasia.

ACCEPTABLE

Dr Tayob said that "a geologically acceptable" site has been found for the hospital on the southern boundary of Lenasia by the authorities. (Dolomite rock formations have limited the area available for development.)

"It is estimated that planning would take 18 months and the hospital ready for use in 1980," Dr Tayob said.

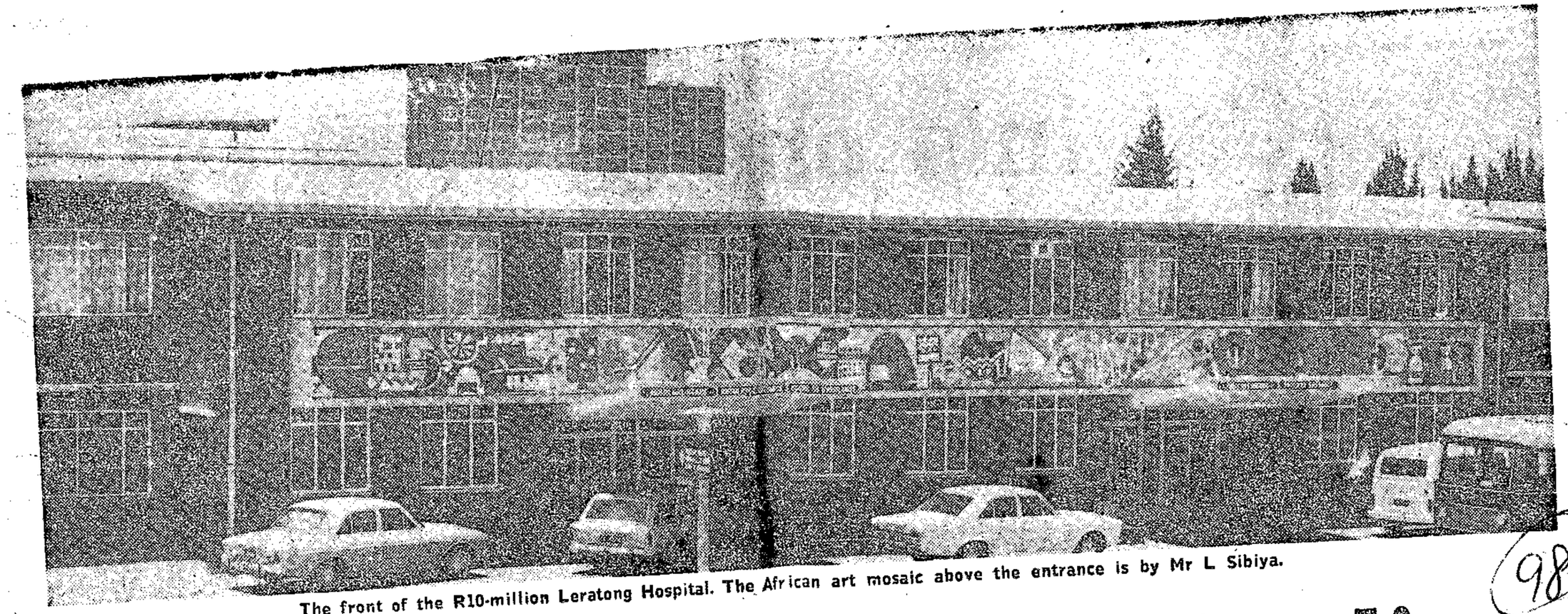
"It is the department's intention to provide four intensive care units, operating theatres a renal dialysis unit, chechesd, a maternity wing and a home for nurses.

"In the meanwhile the authorities intend to build a day care centre.

"The day care centre will take at least two years to build and will basically have an outpatients department and facilities for emergency requirements," said Dr Tayob.

The ad hoc committee is scheduled to meet next month to discuss the matter.

Two radiographers, Miss S Patel and Mrs L Ayres, deal with "patient," Miss T Modise.



The front of the R10-million Leratong Hospital. The African art mosaic above the entrance is by Mr L Sibiya.

A 'place of love' and healing

West Rand Bureau

The new R10-million Leratong Hospital which is to serve the African, Indian and Coloured population of the West Rand opened its casualty and out-patients departments today.

The hospital which was equipped in three months, will eventually have 780 beds which will be brought into operation in sections starting with 300 beds.

Initially it replaces the departments for races other than White at Paardekraal Hospital, Krugersdorp. The similar sections of the Discoverers Memorial Hospital, Roodepoort, move there next year.

CLOSED

In the next week, as other departments are brought into use at Leratong. (the Tswana word for "Place of love") their counterparts at Paardekraal will be closed.

The hospital is one of the best equipped of its kind in the country.

It had ample facilities for most fields of medicine and provision had been made for future expansion, said the principal superintendent of Paardekraal and Leratong Hospitals, Dr J B M Botha.

11 THEATRES

He added that the hospital would include 11 up-to-date operating theatres, a large X-ray department, physiotherapy and occupational therapy departments, a laboratory, a blood service and supporting services and a dispensary.

An intensive care unit would be put into use later.

Dr Botha said the staff position for the new hospital was reasonably good but he could not give statistics at this stage as appointments were still being made.

The wards are on both sides of a long central "spine" — a passage about half a kilometre long.

Medical services and theatres are at one end of the passage and the kitchen and stock rooms at the other.

LAND DONATED

The Krugersdorp Town Council, which pressed for more than a decade for the hospital, donated the 34 ha site to the provincial authorities in 1964.

The new hospital will relieve the strain on the Paardekraal Hospital and on the Discoverers' Memorial Hospital, the only two provincial hospitals between Carletonville and Roodepoort serving all races.

The buildings, which include a nurses' home complex, are conveniently situated on the direct link line from Randfontein to Roodepoort near African, Indian and Coloured townships.

It took five years to complete the hospital, the official opening of which will take place some time next year.

Matron Bertha Ramasodi and Senior [illegible] Sekaledi discuss last minute preparations [illegible] theatre light.

Left: Principal Matron U J Laubscher, in the ambulance room of the casualty department.

Right: Hospital staff make up beds in the rush to get ready for today's opening.

The Star Wed The Star

98

Women in labour on hospital floor

98

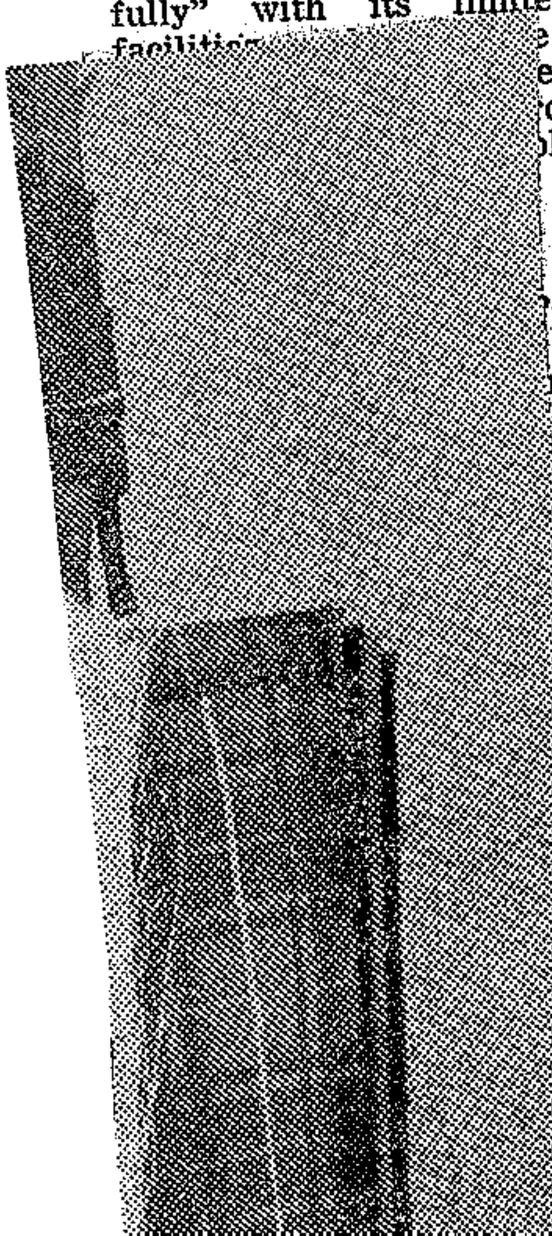
East Rand Bureau

Maternity patients, some of them in labour, must lie on the floor because of the shortage of beds for Black and Coloured women in the Far East Rand Hospital, Springs.

About 150 patients are without beds and maternity patients are discharged the day after their babies are born so other patients can have their beds.

The superintendent, Dr J Jurgens, admitted patients lay on the floors at the hospital.

He would not confirm the figures but said his staff managed "wonderfully" with its limited



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'HIGH RISK OF FATAL DELAY' IN DISTRICT

Mercury Reporter 12/12/75

EMPANGENI — More than 10 000 people in the Empangeni and Richard s Bay area are dependent on three ambulances from the Empangeni Provincial Hospital for emergency services, it was revealed this week.

Ambulances for the rapidly expanding area are supplied by the Ngwelezane and Empangeni hospitals. The Ngwelezane Hospital supplies vehicles solely for the African population, and the Lower Umfolozi War Memorial Hospital in Empangeni runs three ambulances for the remaining race groups.

Richards Bay, the scene of rapid industrial development, has, however, no ambulance service. The only two ambulances in the vicinity belong to private organisations, the RB6 Consortium, developers of the harbour, and Alusaf.

"There is no guarantee of an ambulance for use by the community in time of need," a Richards Bay Town Board spokesman said. "In the Empangeni and Richards Bay complex the White population is in excess of 10 000. Couple this with the heavy traffic in the area, and the possibility of shark attack or drowning on the beaches, the chances of a fatal accident are high.

"Household accidents, such as serious burns, demand immediate attention. The delay while an ambulance is summoned from Empangeni can prove fatal," he said.

In a recent accident in Richards Bay, Hendrik de Lange (17) died after receiving an electric shock from a bedside lamp.

In a letter to a Zululand newspaper a few weeks later his father said doctors "were forced to go and get oxygen and then the ambulance from RB6.

"We are thankful for what RB6 did, but they also need their ambulance." And he added: "Our population is increasing every day and we can expect emergencies."

South African Police and traffic police could do little to aid badly injured people at the scene of an accident, the Town Board spokesman said. "Delays for ambulances of up to an hour have been experienced."

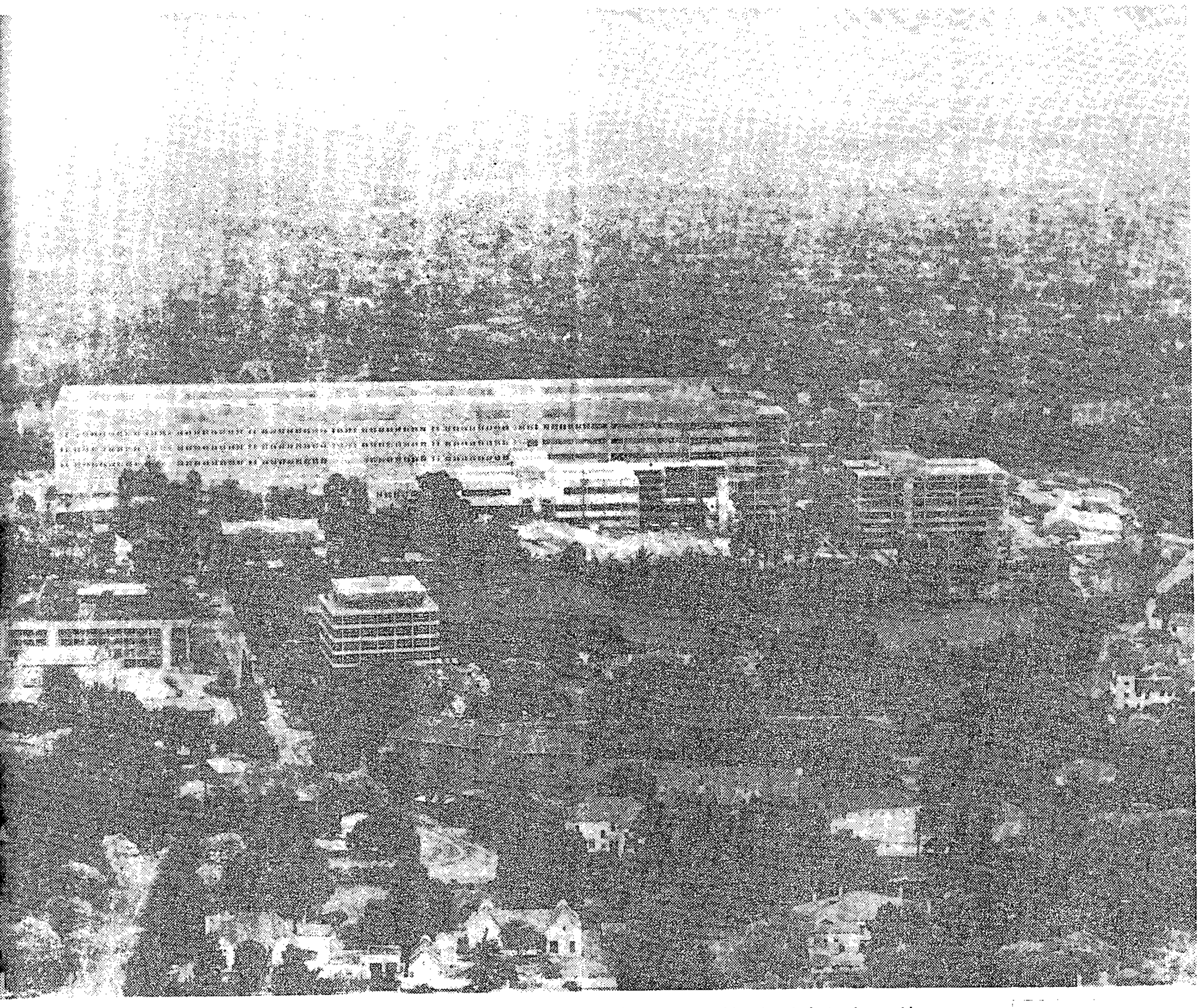
An Empangeni Hospital spokesman agreed that Richards Bay should have their own ambulance service.

Mr. J. P. J. Truter, Town Clerk of Richards Bay, said that the responsibility of providing an ambulance for the town rested with the NPA.

There was, however, a group of citizens who were campaigning for an ambulance in the area, he said.

The Star Tuesday Nov 18 1975

The new General Hospital is five months ahead



The new Johannesburg General Hospital taking shape in Parktown — one of the largest teaching hospitals in the world.

Going up — and fast — is Johannesburg's new General Hospital. To date, the growing giant at Parktown is five months ahead of schedule.

The date originally set for completion was early 1979. But at the present progress rate, the contract will be completed towards the end of 1978. This means that the entire complex, the hospital itself, teaching facilities for medical students and nurses' quarters will be built in just six years.

The complex covers an area 30 percent more than the Carlton Centre.

"Good organisation of the contractors and the industrial methods of casting prefabricated components," is the verdict of Mr Gilbert Colyn, leader of the consortium of architects for the complex.

Pre-stressed

Two factories, one on site and the other at Chloorkop, Kempton Park, manufacture pre-stressed beams, wall panels, floor slabs and ceiling panels.

The sections go to the construction site when required by the builders for slotting into place.

The finished product, with a 2 000-bed capacity, will be one of the largest teaching hospitals in the world.

It is, according to the architects, the largest building contract undertaken on the continent.

Each month, more than R3-million is spent on the construction. At the end of it all, it is estimated that the hospital will have cost more than R100-million.

The first of five 400-bed units is already completed.

The most recent development was the laying of foundations for the 16-storey nurses' living quarters.

Work on the superstructure will start early next year and should take 14 months to complete.

There will be accommodation for 1 800 nurses and doctors.

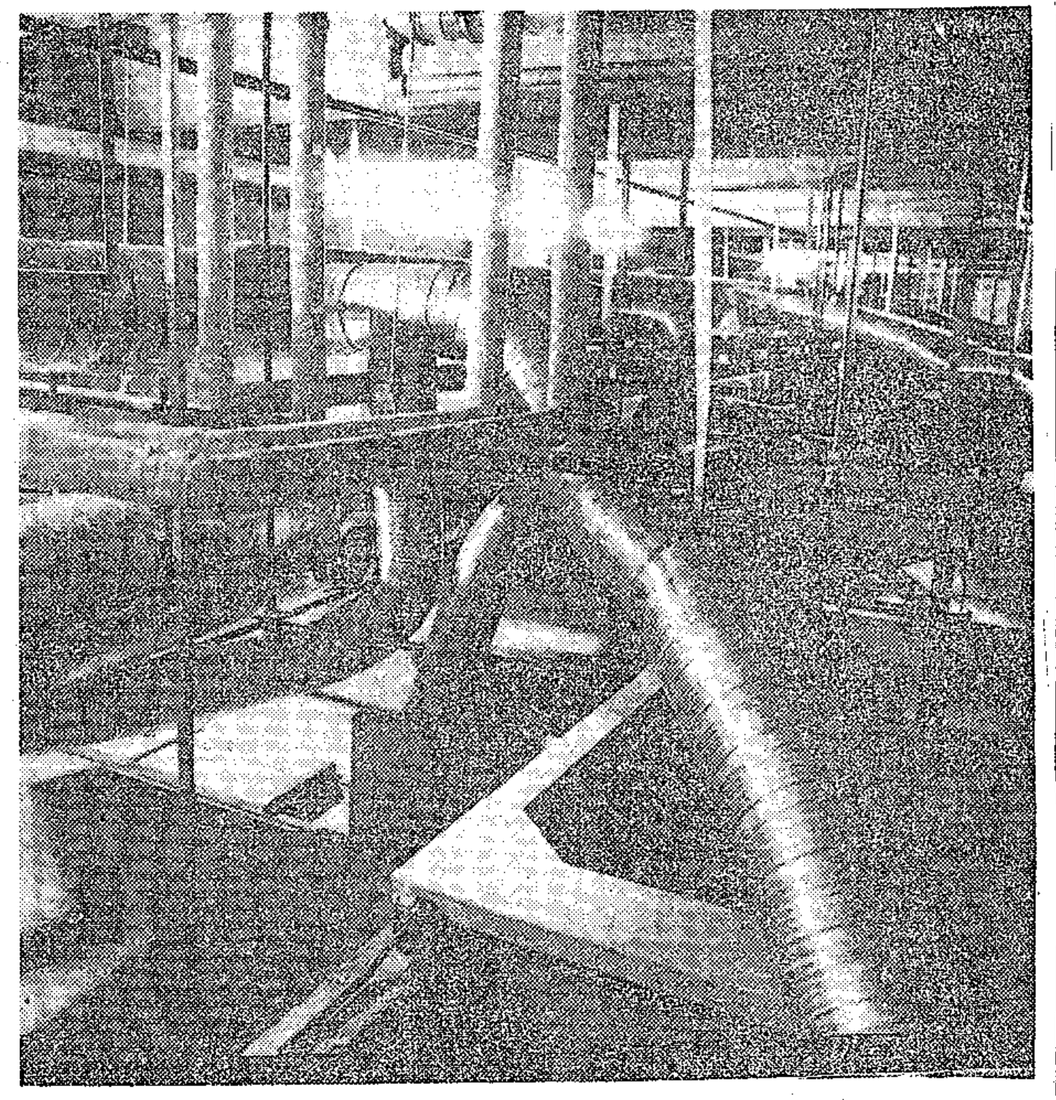
The view from the M1 motorway is of a giant grey building which seems to dwarf humanity.

Nearer it's essentially for people. The central courtyards will one day boast trees and shrubs. The central Mall running the length of the building will have a post office, bank, restaurant, bookshop, cafeteria and hairdresser to make it a village on its own.

For the patients to be, the hospital promises to be not only peaceful, but inspiring too. The views from the larger wards are panoramic, stretching, on a clear day almost forever. It's enough to make anyone feel better.

LIZ BROWN

Pictures: Geoff Causton and Peter Jordan



Interstitial floors, each more than 2 m high, are a maze of worm-like pipes conducting heat, electricity, water and other services.

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THE ARGUS, WEDNESDAY FEBRUARY 11 1976

Hospital apa to be raised

THE question of racial segregation in hospitals will almost certainly be raised at the forthcoming session of the Cape Provincial Council, according to Mr Cyril Brett, leader of the Opposition in the council.

Mr Brett, MPC for Cape Town Gardens, referred to a recent incident in Port Elizabeth, where an Indian doctor was refused permission to attend one of his White patients in a hospital for Whites.

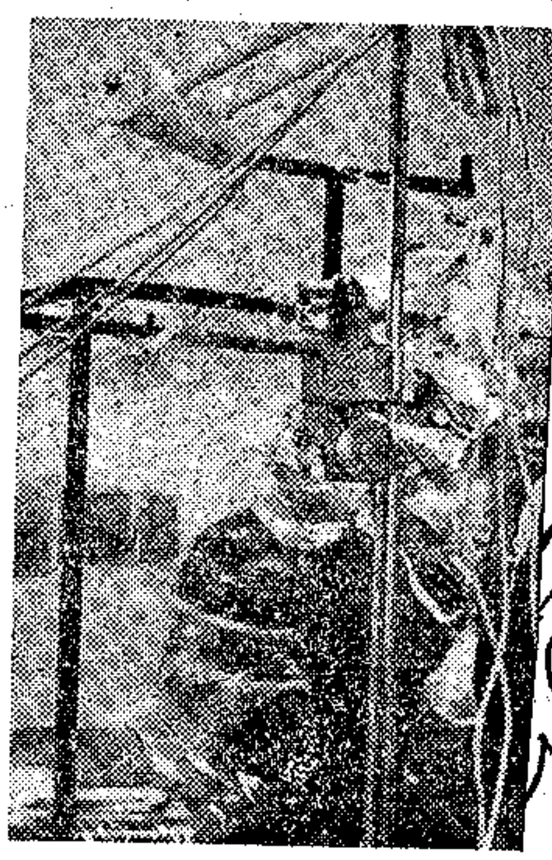
'It is shocking that a patient cannot be attended to by the doctor of his own choice,' said Mr Brett, 'especially when the young patient asked specifically for his own doctor.'

He said that the United Party member of the Provincial Council had not held a caucus meeting yet, but he had no doubt that the matter would be raised.

HIRSCH

Mr Herbert Hirsch, the only Progressive Reform Party member of the Provincial Council, said that he would raise the hospital question during the session, which starts on February 17.

'This sort of thing should have been sorted out years ago,' he said, 'but if we can get it ironed out now — better late than never.'



A BLACK d

Barred doctor tells of his humiliation

By SEAN O'CONNOR

AN INDIAN doctor this week spoke of his deep sorrow and embarrassment after South Africa's racial laws had barred him from assisting in an operation on an 11-year-old White boy who was more to him than just a patient.

The boy needed a delicate groin operation and had placed complete trust in the doctor, who practises in Port Elizabeth.

But as the pain wore off, the child became confused and hurt when the doctor did not appear at his bedside.

He was too young to realise the cruel role the country's racial laws had played.

The doctor, who cannot be named, said: "I was shattered when told I would not be allowed to assist in the operation. I had been discriminated against on the grounds of my colour and it hurt deeply.

"Not only that, but it was a personal kind of operation, and little Michael wanted me to be with him all the time."

Michael's father, who does not want his name revealed, said he had been a close friend of the doctor for nearly two years.

"He was in are than just our family doctor and I have been shocked at the humiliation he has suffered", he said.

Michael was taken to the doctor for an examination three weeks ago. It was decided he would have to undergo the operation.

And on Monday at 9 am Michael was wheeled into the operating theatre at the Port Elizabeth Provincial Hospital unaware the man he trusted with his life would not be at his side.

The doctor said he had accepted an invitation to assist in the operation.

"But on Sunday the specialist who was carrying out the op told me a snag had arisen and I would be prevented from assisting. I am qualified in every respect to help in an operation, but my colour let me down", he said.

Under these circumstances, the doctor could have cancelled the operation and arranged for it to be done at a private hospital where he would have been able to assist.

"But this would have incurred further cost for the parents and subjected the child to the prolonged trauma of waiting.

"I was hurt and embarrassed that in the medical world, where detente is absolute, such a situation could arise.

"I have lodged a complaint with the South African Medical Association and I am waiting for a reply", he said.

The Express established this week that Dr R. L. M. Kotze, director of hospital services in the Cape, and Mr P. J. Loubser, MEC for in charge of hospital services in the province, investigated the incident and were "very sympathetic".

Dr Kotze told me: "This is a situation which has never arisen before and we will arrive at a solution. It needs a solution and it is being attended to closely."

THE PAIN OF APARTHEID

TWO provincial administrations are to "thrash out" South Africa's medical apartheid system which bars Black doctors from treating patients at White hospitals.

This follows an incident at the Port Elizabeth Provincial Hospital on Monday when an Indian doctor was barred from operating on an 11-year-old White boy.

The doctor, "deeply hurt and embarrassed" by the 11th hour decision, lodged a complaint with the South African Medical Association who approached the Cape Provincial Administration.

The matter was investigated and Prof J. N. de Klerk, chairman of the federal board of the Medical Association, said the provincial hospital body had been sympathetic and he was certain the problem would be solved.

The Transvaal and the Cape administrations will be holding talks to reach a satisfactory solution.

Dr R. L. M. Kotze, Director of hospital services in the Cape, disclosed this week that provincial hospital departments and the Medical Association would meet to "thrash out" a solution.

Dr Kotze said he was not able to say whether Black doctors would be allowed to use the facilities of White hospitals.

"Other alternatives will also be considered," he said.

In the Transvaal, Black doctors are also not permitted to operate in White hospitals.

But, after the Port Elizabeth incident, Mr K. S. de Haas, MEC in charge of hospital Services in the Transvaal, said the matter would now be assessed.

When I telephoned Mr De Haas he said he asked Dr H. A. Grove, the Director of Hospital Services to discuss the matter with him.

The Free State Provincial Administration does not intend taking action.

Dr J. H. Kruger, director of Hospital Services in the Free State, said no assessment would be made and the matter would be left until a medical body or individual requested permission to use White facilities.

The Natal Provincial Administration has a clear-cut policy on the question and does not intend re-assessing the merits of its present scheme.

Dr W. Botha, director of Hospital Services in Natal, said:

"White patients who insist on being treated in hospitals by their Black doctors can be admitted to Black hospitals or Black sections of other hospitals."

Top level talks on hospital ban

By SEAN O'CONNOR

98

Doctors study hospital decision

Staff Reporter

THE MEDICAL Association said yesterday it knew of no instance where a White had been denied a private hospital bed because it was filled by a Black patient.

The association's president, Dr Jonathan Gluckman, was commenting on a decision by the Department of Community Development to make it more difficult to admit Blacks to Johannesburg private hospitals.

A department spokesman in Johannesburg this week gave as a reason for the decision, complaints by White doctors that Blacks were not leaving enough beds for Whites.

Dr Gluckman said the law allowed for Blacks to be admitted to White hospitals when suitable facilities for Blacks either did not exist at Black hospitals, or could not be provided quickly enough.

"This is a provision that the association would like to see continue."

He added that the department's decision had been brought to the association's attention and its implications were being studied.

A spokesman for the Department of Community Development's head office in Pretoria said this week he knew nothing of the Johannesburg decision

98

Hospital only 22/12/75 in 1983

By AMEEN AKHALWAYA

LENASIA will not have a hospital before 1983 at the earliest — and that will depend on the availability of funds.

Mr I. Burger, director of the Transvaal Works Department, said yesterday the hospital was currently in the planning and designing stage.

"I cannot say when plans will be completed. It is going to be a big hospital which makes intricate planning neccessary, and we cannot rush the work," he said.

A site for the hospital five kilometres from Lenasia on the Lawley road had been approved by his department and the Transvaal branch of the South African Indian Council.

SPECIAL

Approval for the site still had to be obtained from the Department of Hospital Services, the Department of Community Development and the executive of the Transvaal Provincial Administration, Mr Burger said.

"I cannot see building work starting before 1978 at the earliest, provided there are enough funds available. Then it will take another five to six years to complete," he added.

The nearest hospital for Lenasia's 55 000 inhabitants is in Coronationville, 35 km away.

Health + Disease — Hospitals

word nuwe 'Nico-kwessie'

Rapport 8/2/76

Van Ons Politieke Beriggewer

DIE kanse is goed dat nie-blanke dokters in sekere gevalle toegelaat sal word om op hul blanke pasiënte in 'n blanke provinsiale hospitaal te opereer of om by te staan by die operasie.

Dit kan die afloop wees an Kaapland se splinternuwe oort „Nico Malan-kwessie".

Die superintendent van die blanke Provinsiale Hospitaal n Port Elizabeth het vandeesweek geweier dat 'n Indiërdokter assisteer by die operasie op 'n twaalfjarige seun, wat 'n pasiënt van die dokter is. Die dokter het gesê hy gaan by die Mediese Vereniging teen die besluit beswaar gemaak.

Hy sê hy het baie blanke pasiënte in Port Elizabeth en Uitenhage. Wanneer hulle in 'n blanke hospitaal opgeneem word, is dit nie vir hom moontlik om hulle by te staan nie.

Die geval geniet nou aandag op hoë vlak.

Gister is aan my gesê 'n finale beslissing kom sodra die Kaaplandse LUK belas met hospitaalsake, mnr. Piet Loubser, en die Mediese Vereniging volledige samesprekinge gevoer het.

Die Provinsiale Administrasie se beleid tot dusver was om aan swart dokters alle moontlike geriewe te verskaf om swart pasiënte in hospitale te behandel.

Prof. J. K. de Klerk, voorsitter van die Federale Raad van die Mediese Vereniging, het in 'n verklaring gesê. „Alle dokters moet toegelaat word om, ongeag ras of kleur, hul professionele pligte na goeddunke uit te voer."

Hy het bygevoeg dat hy reeds met mnr. Loubser en met die Direkteur van Hospitaaldienste in Kaapland, dr. Rabie Kotze, gepraat het.

„Die situasie wat in Port Elizabeth geskep is, is simpatiek bespreek deur almal wat daarmee gemoeid is, en ek twyfel nie dat die probleem tot die bevrediging van almal opgelos sal word nie," het prof. De Klerk gesê.

Voorbarig

* Op goeie gesag word verneem dat dit feitlik 'n uitgemaakte saak is dat 'n formule gevind sal word sodat nieblanke dokters in sulke gevalle hul eie pasiënte kan bystaan — ook in sekere gevalle in blanke hospitale.

Niks verhinder blanke pasiënte om nie-blanke dokters te raadpleeg nie. Die betrokke Indiër-dokter het vandeesweek gesê dit is die eerste keer in sy loopbaan dat hy voor so 'n probleem te staan kom, al het hy baie blanke pasiënte, van wie die meeste Afrikaanssprekend is.

Mnr. Loubser, LUK, het gister aan RAPPORT gesê dit sou voorbarig wees om nou standpunt te stel oor die spesifieke geval. Hy wil nie die samesprekinge met die Mediese Vereniging vooruitloop nie. „Ons gaan met 'n oop gemoed praat."

Gevra wat die breë beleid van die Regering is, het die Minister van Gesondheid, dr. Schalk van der Merwe, gesê hy kan hom nie oor die spesifieke geval uitlaat nie. Hospitaaldienste val onder die provinsies. Dit is Regeringsbeleid dat hulle hul eie sake behartig.

Dr. Van der Merwe sê 'n mens het ook te make met gebruike. Dit kan nie sommerso omvergewerp word nie — dan kry jy revolusionêre verandering en chaos.

Die Regering se beleid is om sover moontlik alle geriewe aan nie-blanke dokters te verskaf om nie-blanke pasiënte in hul eie hospitale te behandel.

In noodgevalle word uitsonderinge gemaak. Dit geld bv. vir ambulanse. Hy het dit reeds duidelik gestel dat ambulanse vir blankes ook nieblankes in noodgevalle sal help en andersom.

Die Indiërdokter het gesê die weiering was klaarblyklik omdat hy nie-blank is. Sy pasiënt is intussen sonder sy bystand as huisdokter in die provinsiale hospitaal geopereer.

„Terwyl ons besig is om détente tussen swart en wit op die sportveld te verbeter, wil ek vra waarom dit nie ook op mediese gebied gedoen kan word waar die lewe van mense op die spel is nie."

Hy sê reëlings vir die operasie is 'n week voor die tyd getref, maar hy is eers die aand tevore in kennis gestel dat hy nie mag assisteer nie.

Health Dis - Hospitals

Govt policy on hospitals 'a scandal'

SUN TIMES (Extra) 8/2/76.

A WHITE medical practitioner from Paarl, Dr H F Möller, yesterday described Government policy which forbids Black doctors from treating White patients in provincial hospitals as "a scandal one could only find in this country which is still hopelessly ill with the disease of apartheid".

By NORMAN WEST

Dr Möller was commenting on the recent case of an Indian doctor from Port Elizabeth who has become the centre of the latest race row following the refusal of the PE Provincial hospital authorities to allow him to assist with an operation on one of his White patients, a young boy.

This is the result of Government policy which prohibits Black doctors from attending White patients in provincial hospitals where Whites and Blacks by law have separate wards.

In the White wards, Whites nursing staff have to look after White patients — Blacks are not allowed to nurse Whites.

Policy

Because Government policy frowns upon Black doctors giving instructions to White nursing staff, Black doctors like the Port Elizabeth Indian doctor, are expected to hand their patients over to White colleagues once they are to be hospitalized.

This has led to several hospital rows in the past, especially in Platteland towns where Black doctors are not allowed to do minor operations on Black patients because most Platteland hospitals have no separate theatre for Black patients and with a Black theatre staff.

To overcome this problem, provincial authorities have in Oudtshoorn, for instance, built a separate wing to the existing hospital to avoid a recurrence of the national hospital row which flared up there when the local Coloured doctor was refused permission to attend to a pregnant patient.

But in other towns, like Paarl, where there are several Coloured doctors, the deadlock continues.

The present situation, where a Black doctor wanted to attend his White patient in a White hospital has landed the provincial authorities in a quandary.

This was admitted this week by Dr L M Kotzé, Director of Hospital Services in the Cape who described the present case as "a new situation".

The doctor in question has a large White practice and is used to treating his White patients in the St Joseph Hospital which is a private hospital in Port Elizabeth.

He has never had any problems there.

Discussed

The case of the Port Elizabeth doctor was discussed this week by Professor J N de Klerk, chairman of the Federal Council of the Medical Association of South Africa and Dr L M Kotzé, and also the MEC in charge of hospital services, Mr P J Loubser.

Professor De Klerk said later that all doctors, irrespective of their race or colour, should be allowed to perform their professional duties in a way they deem fit.

"I do not doubt that the problem which arose with regard to the Port Elizabeth situation, will be solved to the satisfaction of all concerned," he said.

Private hospitals under fire

STAR

19/2/76.

98

Political Staff

THE ASSEMBLY — Private hospitals charging "exorbitant" fees and drawing patients and staff away from provincial hospitals have come under fire in the Assembly.

Speakers also criticised the role of doctors who had financial interests in some private hospitals.

These were among issues raised during the second-reading debate on the Public Health Amendment Bill which provides for stricter control over private nursing and maternity homes, and over certain places where surgical activities are carried on.

The Bill provides for the registration and inspection of such places and empowers the Minister of Health, after consultation, to prescribe fees to be paid, the registers to be kept, certificates to be issued and other requirements to be complied with.

The official Opposition's chief spokesman on health matters, Dr E L Fisher (UP, Rosettenville) said private nursing homes were providing salaries far in excess of what provincial hospitals could pay.

CONTRIBUTION

Dr W J Snyman (NP, Pietersburg) said private hospitals and nursing homes were making an essential contribution as a supplementary health service in South Africa. The proposed legislation was necessary, however, to protect the public against exploitation.

The accounts of some of the private institutions were "tremendously high." Dr Snyman read out details from one account which totalled R2 064 for a patient who had spent 29 days in a private institution for "an average operation."

Replying to the debate, the Minister of Health, Dr S W van der Merwe, said it was true that accounts were exorbitant in some cases. It was the Government's intention that a fair profit be determined for private hospitals.

The minister said doctors with interests in private hospitals should not be too severely criticised as some doctors had virtually broken themselves financially to establish private hospitals because there were not enough beds in provincial hospitals.

It was, however, not the policy of the Government that private doctors should have shares in private hospitals.

Martin warns private hospitals: 'Dumping' patients may cost licence

5 Trib. 29/2/76

By DEREK TAYLOR

DOCTORS using private hospitals and clinics are using provincial hospitals to "dump" patients who run out of money or develop serious post-operative complications.

Angry doctors employed by the provincial hospital service accuse some members of the profession in private practice — who own shares in lucrative private hospitals and clinics — of:

• Milking chronically ill patients of their medical insurance resources and savings and then sending them to Addington and Grey's Hospitals as soon as their money runs out.

• Undertaking operations in private institutions which lack facilities to cope with post-operative emergencies — "then loading them into ambulances to our intensive care units."

Aware

"We are aware of this problem and we have warned the managers of private institutions their licences may be affected if these practices are not controlled," Mr Frank Martin, MEC in charge of Natal's hospital services, told me this week.

The complaining doctors in provincial service — and Mr Martin — emphasised that private hospitals and clinics represented a valuable supplement to provincial hospitals and that there were honourable exceptions to abuses of commercialism.

"But the greed of a few now verges on the unscrupulous," said a specialist physician. "And this is not a problem confined to Natal. This use of taxpayers' money to protect and bolster lucrative private institutions is a national scandal.

Position

"It is exactly the same position as a private garage-owner dismantling a car, finding that the problem is beyond him, and taking the bits off to a State garage to be fixed for him."

Many doctors in private and State practice believe the excesses of their get-rich-quick colleagues are hastening the introduction of a national health service.

Mr Martin agreed this week that the days of private hospitals are numbered.

"And it is the man in the street who feels he is being fleeced who will create a climate of opinion that will force the Government to take over private hospitals at any cost," he said.

"I would not like to see the introduction of the British type of national health service. To begin with, I feel its combination of the departments of health and social welfare is wrong.

"But the extension of our present system, whereby hospital patients pay according to income, could well be the answer," he said.

"The extension of the system to a national contributory scheme would mean working out a method whereby the middle income groups would not be disproportionately hit."

Within the limits of grave staffing shortages, and consequently the numbers of hospital beds, the provincial hospital services cope adequately with the lower income groups.

But middle income groups — those above the income ceiling which cuts off free or nominal charges for treatment at a provincial hospital — are now hardest hit by soaring medical prices for private treatment.

Shares

"Consider this case," said a provincial hospital administrator.

"A seriously ill widow, call her Mrs B, — is persuaded to enter a private hospital by her physician — who has shares in it.

"After some days of treatment her medical insurance benefits are exhausted. Treatment is continued until her savings of R1 200 are absorbed by the private hospital.

"As soon as she is destitute, Mrs B. is dumped at Addington, where she is treated for three more weeks and discharged. The hospital writes off her bill of R250 because she is indigent.

"Contrast this with a young colleague of mine who has been in practice for a few years. He has just contracted to buy into a practice for R30 000 and, he told me, not only will he be able to pay off this sum but he also intends to retire in ten years."

Services

The traditional defence of the high price of private practitioners' services is the fact that it takes about seven years to qualify.

Medical students' fees for tuition average R1 000 a year in South Africa. But the taxpayer contributes another estimated R7 000 a year towards the cost of each medical graduate.

Extension of national medical services above the indigent and low-income levels is at the moment barred by the Medical Association's notorious "fourth principle".

"In effect," a Government doctor explained, "this means: thou shalt not compete with the private practitioner for the treatment of anybody who has the money to pay my scale of charges."

But as the traditional directions and proportions of service in the medical profession have radically changed over the last ten years, the fourth principle is rapidly becoming indefensible.

Fulltime

As more and more doctors avoid Government or welfare medical service — both fulltime and in contributory terms — for the high rewards of private practice and specialisation, there is a growing minority feeling within the profession that the public cost of their qualification should be repaid.

"At the moment the taxpayer indiscriminately pays the same high subsidies for the doctor who works for the province or State, the doctor who may practise in a vital but unrewarding rural practice, the doctor who works with a religious mission — and those who make enormous amounts of money and retire early from private practice," said a State doctor.

"It is time we started demanding repayment of the taxpayers' subsidies from those practitioners who make the top money.

"Society can use the couple of extra years' practice before early retirement to the farm or golf course.

"The money can train another doctor. And incentives should be found to encourage a better deployment of our medical practitioners — a lower income tax for approved areas or sectors of practice, perhaps."

Spokesmen for private hospitals have denied the De Villiers Commission of Inquiry findings that excessive profits were made. They emphasise that their tariffs are agreed with the Association of Medical Aid Societies in consultation with the Association of Private Hospitals.

Control

The managers of private hospitals and clinic do not control the medical decisions of the doctors who treat the patients.

The manager of one gave a representative comment on the problem:

"When we get a patient we try to look after him for as far as we can. But we do not employ the medical practitioners who look after the patients. We merely provide the services. It is the practitioner who decides where and how he wishes to treat the patient and if he wants to transfer him somewhere else, it is, unfortunately, out of our hands."

98

Hospital fees up 100 percent

Cape Times 11/3/76

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Staff Reporter

HOSPITAL fees are to rise by more than 100 percent from April 1, the Administrator of the Cape, Dr L A P A Munnik, announced yesterday.

The increase means the daily maximum fee will rise from R6 to R12. In the case of Groote Schuur, Tygerberg, Karl Bremer, Red Cross, Mowbray Maternity and Peninsula Maternity hospitals which provide specialized services the maximum daily fee will be increased to R14.

Outpatient fees have also been increased. The present fees range from 20c to R3 per daily attendance. The new fees range from 50c to R8 daily.

Fees for private patients have been increased from R2,40 to R6 at non-teaching hospitals and from R3 to R10 at teaching hospitals.

As is the case at present, a primary (one payment) fee will, in addition to the daily fee, be charged according to a sliding scale based on declared income. The primary fees have also been increased but at the same time the income groupings on which this fee is based have been amended in such a way that the lower income groups will benefit.

General ward patients in the lower income groups are liable only for the payment of the primary fee. Visitors from abroad will, irrespective of income, be liable for payment of the maximum daily fee plus the maximum primary fee.

Dr Munnik made it clear that the fees system still makes provision for relief in deserving cases and no patient would have financial difficulties owing to his hospital account.

Hospital fees to double

DD
12/3/76.

EAST LONDON — Hospital fees will double throughout the Cape Province next month.

This was announced by the Administrator of the Cape, Dr L. A. P. A. Munnik, who said hospital fees throughout the Cape would rise by 100 per cent or more.

This means the daily maximum fees will rise from R6 to R12 and out-patient fees, which at present range from 20c to R3,00, will now range from 50c to R8,00 per daily attendance.

Fees for private patients have been increased from R2,40 to R6 at non-teaching hospitals and from R3 to R10 at teaching hospitals.

Though Frere Hospital is a training hospital it is not a teaching hospital.

It also does not fall into the category of special service hospitals.

For these the daily maximum fee will be increased to R14.

Groote Schuur, Tygerberg, Karl Bremer, Red Cross, Mowbray Maternity and Peninsula Maternity Hospitals fall into this category.

The chairman of the Frere Hospital Board, Mr D. Lazarus, said the maximum fee for a man paying over R160 a year in tax was R6 a day for a general ward at the Frere Hospital.

"A semi-private ward would cost this man R7 a day and a private ward R7,50 a day.

"For people paying less than R160 in tax the fees are less, depending on how little they pay in tax," Mr Lazarus said.

He said he had received no official statement on what the increases would be, but presumed the maximum daily fee for a general ward would now become R12 at the Frere Hospital and other fees would increase accordingly.

"Whatever one's personal feelings we must realise the cost of living is increasing and the hospitals, like everyone else, have to pay higher prices for commodities and administration.

"This is presumably why the hospital fees have been increased.

"I think fees are still considerably lower here than in other provinces," Mr Lazarus said.

He said hospital fees did not benefit the individual hospitals, but went to the Provincial Administration.

The medical superintendant at Frere Hospital, Dr F. Visser, said he had received no notification of the fee increases and was therefore unable to comment. — DDR.

(1) Health + Dis - Hospitals

98

The Star Saturday Marc

Clamp on clinics

13/3/76
STAR.

Officialdom has cracked down on the admission of Indian and Coloured patients to Johannesburg's private hospitals.

The initial squeeze came late last year when the Department of Community Development began to refuse virtually every application from Coloured and Indian people for treatment at private hospitals.

Medical men, who have described the step as a "crisis situation" and "a tragedy," are puzzled by the sudden switch at a time when Coronation Hospital is overcrowded.

For most of last year, hospital permits were made available without too much difficulty.

Now the authorities are allowing only a trickle of permits through.

Inquiries by The Star this week at private hospitals and with Indian and White doctors produced a mainly cautious reaction.

The Secretary for Community Development, Mr L Fouche, was the only person in the department who would comment.

"Each application is considered on its merits," was all Mr Fouche would say.

One private hospital administrator in Johannesburg said the Provincial Administration had ruled that permits could only be issued in cases of urgency and where the appropriate facilities were not available elsewhere.

Spokesmen for several of Johannesburg's most select clinics say they are willing to take patients of colour and regretted the clamp down.

But even if Indian and Coloured patients get in, they still face a further price hurdle — they are obliged to take a single ward.

After years of going to witch doctors for "medical services" these rural Blacks have a new lifeline.

98

STAR 29/3/76

Clinic for Blacks— a symbol of goodwill

For years the Black community living on farms south west of Phalaborwa depended on witch-doctors for "medical services." Now they have a new lifeline—a clinic.

The clinic, situated in the bush about 40 km outside the town, has been built by pensioner Mr Johan J Oosthuizen and his wife, Muriel, a nursing sister, out of their own savings.

A shining symbol of goodwill and the pride of local Blacks, the clinic was completed at the end of last year. It has since been handling on average 100 patients every month.

The tiny brickwalled building with a flat roof, has two rooms — a dispensary, full of medicines, and a room for consultations. An examination bed within a screen cubicle and two benches furnish the bare consulting room.

Outside a lighting plant has been installed. But matron Mrs Oosthuizen is still not satisfied with her clinic.

Running water

"I am particularly worried by the rough cement floor as well as lack of a basin with running water next to the examination bed," she said.

Mr Richard Banda, one of the people living on the farms in this wild country alongside the Kruger National Park, said:

"The clinic is helping us a great deal. We get medicines, pills and injections there. Before the nurse came we consulted witchdoctors whenever we fell ill. There was nowhere else to go."

Another labourer, Mr Gabriel Thantsa said: "The nurse helps everybody. She attends to the sick at the clinic and visits those too ill to get to the clinic at their homes."

The "nurse," they also said, often sent serious cases away. Although they did not know exactly where she sent them, they knew they were usually well when they returned.

What Mr Banda, who said he originally came from Malawi, and Mr Thantsa from Pietersburg told The Star was confirmed in interviews with several other people on farms within the area. The Black people in the area knew of the clinic and where it was situated. And they did not hide their pride in it.

No doctor

Sister Oosthuizen said she has been handling on average 100 patients a month since January this year. As there was no medical doctor at the clinic, serious cases had to be sent to the Acornhoek Hospital about 120 km from Phalaborwa. This is the nearest hospital.

She also spoke of a day when a mother brought in a child, who had been bitten by a snake. The child's foot, tied with a string above the knee, was terribly swollen.

"Because of distance, the mother had been walking, with the child on her back, for 24 hours to reach the clinic. The condition of the child was so bad I felt as I gave a snake bite injection, the foot would probably be amputated even if the child lived. However, he has fully recovered," she beamed.

"We feel we are doing something for mankind in this clinic. But our biggest problem is lack of money to buy medicines. Prices are so high. As a result we owe R1 000 for medicines which we bought on credit."

Sympathetic people had donated a total of R120 towards the clinic, she pointed out. But basically the costs of running the clinic are borne by the Oosthuizens' pensions.

She also said a big new hospital has been built by the Department of Health at Namahale Township, 8 km outside Phalaborwa. It has not yet started operating.

Although the new hospital — the only centre for medical services for Blacks in Phalaborwa — is 55 km away from the clinic, Sister Oosthuizen felt it would complement her work even though there was no public transport between the two places.

Serious cases

"I will no longer have to call for an ambulance from Acornhoek Hospital. Instead, the new hospital will take all serious cases at the clinic," she said.

In addition to attending to patients at her clinic, Mrs Oosthuizen holds family planning "clinics" among the Black community for the Department of Health.

Here, she explained, mothers were given talks on family planning, hygiene, nutrition and child welfare. They received free parcels of powdered milk too.

Mr and Mrs Oosthuizen still live in a makeshift cottage near the clinic. But Mr Oosthuizen said he has now gone back to putting up their house, which he had stopped work on after the couple decided that the clinic needed.

"Hopefully, the house will be completed by June," he said.

— Harry Mashabela

Hospital is a 'first'

A modern hospital has been built at a cost of R1½-million at Namahale Township, outside Phalaborwa. It is the first such institution for the 25 000 Black inhabitants who work in the town.

A spokesman for the Bantu Administration Department said finishing touches were still being made on the hospital. It was expected to be ready by the beginning of next month.

He said the hospital would be handed over to the Lebowa Government which takes over health services in the homeland on April 1 this year.

Dr J H Fleming, a Phalaborwa medical practitioner, said the hospital was built by the Department of Health at a cost of R1-million Phalaborwa Mining Company contributed R300 000 towards construction of the hospital.

He also said the hospital would serve the 25 000 Black people living in Namahale Township and the immediate neighbourhood.

The hospital was 8 km outside the town.

98

Hansard 11 col 795
7/4/76

Private hospitals

639. Dr. F. VAN Z. SLABBERT asked the Minister of Community Development:

(1) How many (a) Indians and (b) Coloured persons applied during each month of 1975 for permits for admission to private hospitals in White group areas;

(2) how many of these applications were (a) granted and (b) refused in each month.

The MINISTER OF COMMUNITY DEVELOPMENT:

	Indians			Coloureds		
	(1) (a)	(2) (a)	(b)	(1) (a)	(2) (a)	(b)
January	27	27	—	—	—	—
February	34	28	6	5	3	2
March	40	35	5	1	1	—
April	32	32	—	10	8	2
May	30	30	—	3	3	—
June	32	32	—	—	—	—
July	42	42	—	6	6	—
August	41	41	—	4	4	—
September	36	36	—	2	2	—
October	34	33	1	6	6	—
November	44	9	35	1	1	—
December	24	18	6	2	2	—

98

Babies in jeopardy: Black clinic may close

24/4/76 STAR.

Science Editor

The Alexandra Health Centre and University Clinic in Sandton — haven for the sick of Alexandra Township and surroundings for the past 40 years — is in the red.

Last year it spent R263 000. but its income was only R233 000.

"And if the trend continues. we shall have to close down at the end of next year," says Dr George Cohen, a member of the executive.

"By that time our liquid assets, down from R92 000 in 1973 to R37 000 this year, will be exhausted."

Alexandra Health Centre exists on a lot of goodwill. For example, gifts of money from numerous firms and individuals totalled R22 000 last year, and bequests came to R6 000. The centre is a regular beneficiary of University of the Witwatersrand's Rag and received R28 000 last year.

Fees

Then there are grants and subsidies — the Transvaal Provincial Administration contributed R20 000, the West Rand Bantu Administration Board R5 200 and the State Health Department R65 000.

Patients' fees account for R57 000. They pay a mere 50c a week for medical treatment and a flat 50c for surgical and dental attention. In all instances medicines are included in the fee.

But all this is not enough. The centre is battling with rising costs. Its wage bill is skyrocketing, even though the five permanent and six part-time doctors on the staff work for rates of pay below those paid by the State and province.

Drugs

The salaries of its 36 qualified nurses are partly offset by the Health Department grant, but it has to employ domestic, administrative and clerical workers, and drivers.

Although several pharmaceutical companies have generously supplied drugs free or at a discount, the centre's drug bill is also increasing. For example, drips which were previously free now have to be bought at a cost of some R400 a month.

The question is — is the centre necessary?

"It fulfils a vital role," says Dr Cohen. "It is the only health centre serving a large area which includes the northern areas of Johannesburg, Sandton, Randburg and up to Tembisa, which is about 32 km away.

"It is taking a tremendous load off Tembisa Hospital and the Johannesburg non-European Hospital and offers a really low-cost medical service to people who cannot afford to pay much.

Contribution

"In fact, this centre is making a tremendous contribution to the health and welfare of thousands of people in the low income group.

"The Wits Medical School benefits because the clinic is an important training centre for its students and will become increasingly so as the concept of community medicine develops.

"We are standing with our backs to the wall. This is no idle fear: unless the public comes to our aid this centre will have to close down. We are launching new appeals for support and can only hope that this catastrophe can be averted."

Every day some 700 people bring their pains, fevers, and injuries to the centre. About six babies are delivered daily after the mothers have received antenatal treatment for the full period of the pregnancy at a total, all-inclusive fee of R5, which includes post-natal care.

Foods

Every year the baby clinic sees 250 000 patients and gives 1-million individual treatments. The infants are weighed, immunised and checked regularly to see that they are healthy. The mothers are taught to care for them and give them nutritious food.

In addition, the doctors, on a busy day, treat about 150 sick babies. Essential foods are given free to such children.

At the other end of the scale are the chronically ill — those who suffer from heart ailments, diabetes, epilepsy, high blood pressure, and so on — who turn up in their hundreds every week.

(4) 88
(2) 98

Lenasia to get new hospital

Star 3/4/76

Staff Reporter

The Department of Community Development has allocated two sites in Lenasia for an outpatients' clinic and a 200-bed hospital.

This is disclosed in a SA Indian Council executive report.

The clinic — described as a "day hospital" — will be built in Extension 5 of the Asian township. The 200-bed hospital will be built on an 8,5 ha plot in the vicinity of Lawley at a place called Gatsrand, about 5 km from Lenasia.

The clinic will be administered by Coronation Hospital until Lenasia's major hospital, which is said to have been "approved in principle," gets under way "in the near future."

A Provincial Administration spokesman in Pretoria confirmed that the outpatients clinic or "day hospital" would be built in Lenasia as a "priority requirement" this year.

Lenasia's 60 000 residents have been crying out for a hospital in the township for close on five years. They are not allowed to use the nearest hospital — Baragwanath — and must travel about 45 km to the Coronation Hospital.

The first Transvaal training college for Coloured and Indian nurses will be completed in about two months.

A 17-storey residence for nurses and recreation centre is also being built and will be completed next year. Both projects will cost about R3½-million.

The complex is being built next to the Coronation Hospital.

Dr M H E Kalmyn, superintendent at the hospital, said today that a six-storey building, consisting of 119 single rooms, would be built for the trainee nurses.

Part of the college project would include a 380-seat auditorium which would be well equipped.

152/98

No hospital stay-away

Staff Reporter

ATTENDANCE of Black staff at provincial hospitals in the Western Cape yesterday and on Wednesday — the two days of striking by African and Coloured workers — was completely normal, the MEC for Hospital Services, Mr P J Loubser, announced yesterday.

In a statement Mr Loubser said there were cases where staff reported late for duty at certain hospitals due to reduced public transport facilities in certain areas and because some staff members had to leave their homes later.

"I would like to express my appreciation to all non-White hospital staff members that they, in spite of threats and personal inconvenience, remained so faithfully at their posts."

This showed a deep sense of duty and the acceptance of the primary purpose of hospitals — to provide an essential service to the community.

Mr Loubser expressed the "sincere thanks" of the Provincial Hospitals Department to the police for providing protection both to and from work for a number of Black staff members of provincial hospitals.

Natal's Black hospital 'a shameful institution'

26/9/76 5 EXP.

ABOUT 75% of doctors employed at South Africa's second largest Black hospital, King Edward VIII in Durban, would endorse an English medical doctor's allegation that it is "an institution which every South African should be ashamed of".

This claim was made yesterday by several doctors at the hospital who said they fully supported Dr Rupert Gude's scathing attack on the institution and who also refuted an earlier statement this week by the superintendent, Dr H J R Wannenburg, that Dr Gude's criticisms were the attitude of one doctor out of 350.

By TIM CLARKE

One of the doctors said: "Dr Wannenburg's remarks are shameful and absolute rubbish."

Most of the doctors were "disgusted" and "miserable" at the service they were giving and felt there was vast room for improvement.

He felt many of the outpatients should be admitted instead of being prescribed drugs or pills.

"In any case the limiting of prescriptions to three drugs only in effect means that if you are treating a patient for, say, diabetes and hypertension you may wonder if it is worth examining further in case you find something like a urinary tract infection.

"What do you prescribed then?"

The row over the hospital, which caters for about 750 000 people, started when Dr Gude, who worked there for a year before returning to England, said it was overcrowded, understaffed and underfinanced.

He said at least three major hospitals were required to cope with such a demand.

He was also critical of the fact that most mothers were discharged after their children were born, that the hospital only had one social worker, and that there was a general apathy among the nursing staff leading to patients being treated as numbers rather than people.

Dr Gude's stinging attack drew a hostile response from Dr W K Botha, Director of Hospital Services in Natal.

An indignant Dr Botha said he was "not prepared to investigate allegations against my colleagues".

He said: "This man can make statements that would take a team weeks to prove or disprove. I think so little of his opinion that I will not even investigate them.

"Some of our nurses have won gold medals and there are other achievements which Dr Gude from his narrow point of view is not aware."

Natal's MEC for Hospital Services, Mr Frank Martin, said that all the major problems at the hospital could be directly attributed to Government policy.

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98

KwaZulu hospitals hit by loss of Army men

10/11/76 nm

Mercury Correspondent

JOHANNESBURG — The Army has had to come to the rescue of KwaZulu's ailing medical services — with hospitals fighting a losing staff shortage battle since the takeover by the State of mission hospitals in the homeland on June 1.

But now a new mini-crisis has arisen in the new system of the Department of Defence of seconding to KwaZulu young, recently - qualified National Servicemen doctors to help out.

Last week, 16 of the Army doctors were abruptly removed, placing a number of hospitals in the homeland in a serious position.

Dr. J. Gilliland, Deputy Secretary for Health and co-ordination director of the department, told me yesterday: "We are very very grateful for the help being given us by the Army and these young men — but at the same time the young doctors are gaining valuable experience of a particular type of medicine."

Doctors serving at some of the hospitals told me: "Were it not for the Army, there would be chaos."

The State Department of Health took over all 30 mission hospitals in KwaZulu on June 1, in spite of entreaties from the KwaZulu Government to leave them in the hands of missionary doctors.

Then followed the resignation of many mission doctors.

10 000 beds

KwaZulu has four State hospitals in addition to the mission hospitals, and a total hospital bed count of slightly more than 10 000.

The doctors withdrawn for duties in the operational area are to be replaced, but only after the present intake of servicemen - doctors has completed basic training.

At four hospitals, I learnt yesterday, the position is critical.

At the 500-bed Nongoma Hospital, which normally has four State and three Army doctors, two Army doctors have been taken away, one State doctor has resigned and two are on leave — leaving two doctors to serve the hospital.

One doctor

At Mahlabatini, a 100-bed hospital, there is no State doctor and only one Army doctor.

At Hlabisa, also a 100-bed hospital, there is only one State doctor.

At Ngwelezana, a 700-bed hospital, which is flooded with up to 700 patients on occasion, there are nine State doctors and five Army — three of whom have now been sent to the border.

Dr. Gilliland said the department was fully aware of the problems in KwaZulu and was planning to meet them. From time to time medical establishments were not up to strength, but the Army doctors were fulfilling a valuable role, he said.

"Medical officers are scarce — they don't grow on trees," he added. "But where we are struggling there is a strong spirit, with colleagues mucking in and doing extra work to keep an efficient service going."

107/98

11/11/76 JF

Army to the rescue in KwaZulu hospitals

PRETORIA. — The army has had to come to the rescue of KwaZulu's ailing medical services — hospitals fighting a losing staff shortage battle since the takeover by the State of mission hospitals in the homeland on June 1.

But now a new crisis has arisen in the new system of the Department of Defence to second to KwaZulu young, recently-qualified doctor-national servicemen to help out.

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Doctors serving at some of the hospitals told me: "If it were not for the army, there would be chaos."

The State Department of Health took over all mission hospitals in KwaZulu — 30 of them — in spite of entreaties from the KwaZulu government to leave them in the hands of missionary doctors.

Resignations

Following the resignation of many mission doctors, the army was called on to help meet the doctor crisis.

KwaZulu, with a population of 2,5 million, has four State hospitals in addition to the mission hospitals, and a total hospital bed count of slightly more than 10 000.

The doctors withdrawn for duties in the operational area are to be replaced, but only after the present intake of servicemen-doctors have completed their basic training.

At four hospitals, I learnt this week, the position is critical. At the 500-bed Nongoma Hospital which nominally has four State and three army doctors, two army doctors have been taken away, one State doctor has resigned and two are on leave — leaving two doctors to serve the hospital.

At Mhlabatini, a 100-bed hospital, there is no State doctor and only one army doctor; at Hlabisa, also a 100-bed hospital, there is only one State doctor; at Ngwelezanu, a 700-bed hospital which is flooded with up to 700 patients on occasion, there are nine State doctors and five army — three of whom have now been sent to the border.

Cottage Hospital to close next year

THE Rondebosch Cottage Hospital, one of the oldest hospitals in Cape Town, will close on January 31, 1977.

This was announced in a statement issued by Mr P J Loubser, MEC Hospitals, yesterday.

The decision was taken "after careful consideration by the Hospitals Department, and consultation with the hospital board and medical committee concerned", Mr Loubser said.

"Bearing in mind the tradition of a hospital which was erected in 1899 and the sentiment of a community that has been associated with it throughout the years, it was not an easy decision to take," he added.

The statement said that the hospital building provided inadequate facilities and required renovation. The estimated cost, together with the provision of limited additional facilities, would be R750 000.

Inadequate

"After that it would still be a hospital of antiquated design with inadequate facilities and an inefficient flow pattern of services."

Provision of a new hospital was also considered but the site, planning and construction would cost at least R3m and take years to complete.

Experience had proved, and it was generally accepted, that a hospital of such a size in an urban area was "completely unpractical and uneconomical," Mr Loubser said.

Provision for the patients would be made at other hospitals.

Mr A H Honikman, chairman of the City Council's Utilities and Works Committee, and Mr Fritz Botha, MPC, together with representatives of the Ward 11 Ratepayers' Association, will meet Mr Loubser today to discuss the closure.

(98/340

Pricey clinics are paying Black maids R40 a month

14/11/76 Sunday Express

A waiter is searched at the clinic as a woman, going off duty, walks by. PICTURE: ANNIE COETZEE

Search me too, says matron as clinic nurses stripped

Matron M. E. Conradie

A WHITE matron at an exclusive Johannesburg private clinic demanded to be body-searched in front of Black nurses

She lifted her skirt to her waist when she heard nurses

security firm which had been called in to stop pilfer

"I was satisfied with the search procedure and we have no hesitation ... ensuring

By JENNIFER HYMAN and WELCOME KHUZWAYO

• Last week's Express report which highlighted the searching of staff at certain clinics.

SOME of Johannesburg's most pricey and exclusive private nursing homes are paying a number of their Black workers below-the-breadline starting wages.

Two of these nursing homes are losing so much money through pilfering that they have engaged security firms to body-search all Black employees twice a day.

By JENNIFER HYMAN

The Express learned this week that the starting wage for maids in the Clinic group of nursing homes — whose director is Mr Barney Hurwitz — is R40 a month. Male cleaners start at R50 a month.

Minimum rates in these categories, which are laid down by the Department of Labour for the Transvaal, are R51,60 for women and R64,50 for men.

However, a Department of Labour spokesman pointed out that private hospitals do not fall under a Department wage determination. They determine their own wage scales, he said.

Hospitals in the Hurwitz group include the Rand, Garden City, Rosebank and Park Lane Clinics.

Fees for patients at these nursing homes range from about R20 a day for a general ward (R17 for medical aid patients) to R35 a day for private wards with bathrooms.

The Park Lane was taken over by the Hurwitz group only a few months ago and wages there are believed to be slightly higher than at the other clinics in the group.

Workers at the Park Lane and Rand clinics cited low wages and poor working conditions as a reason why the hospitals had such great pilfering problems.

"If they pay people R40 a month in this day and age, what do they expect," one woman said.

The Park Lane provides no fringe benefits for its Black staff — such as a pension fund or transport subsidy.

The independently-controlled Brenthurst Clinic, on the other hand, pays its Black staff R10 a month to cover transport costs and provides a pension fund.

The transport allowance raises the basic wages at the Brenthurst from R45 to R55 for women and R55 to R65 for men — just above the Department of Labour minimum.

According to the Johannesburg Chamber of Commerce, a Soweto family of five need about R129 a month to maintain a minimum existence above the breadline.

Bitterness among Park Lane employees at the new searching procedures is increased by dissatisfaction with their conditions of employment.

Black employees have had to sign a new contract since the take-over which cuts the required period of notice from two weeks to 24 hours. This means that if they are summarily fired — as many have been — they will be unable legally to claim notice pay.

The Johannesburg Legal Aid Bureau told the Express that in June-July it handled the cases of about 20 African employees of the Park Lane who were summarily dismissed without leave or notice pay.

"These people were earning as little as R40 a month," a spokesman said. "We wrote letters on their behalf and the Park Lane eventually met its obligations and paid them out."

Managers of individual nursing homes in the group implied in interviews that staff who divulged their wages to the Press would be "dealt with."

Employees who spoke to the Express claimed they would lose their jobs if they took their. grievances to the management.

They stressed that they needed their jobs, however badly they were paid, as there was a glut of unskilled workers on the market and they would find difficulty getting others.

Private hospitals in the other major Johannesburg group, which include the Florence Nightingale, the Princess and the Lady Dudley, declined to give exact minimum rates for Blacks but claimed they were "well above" the statutory minimum.

Most of these hospitals said they had a high percentage of Black employees who had worked for them for many years and were earning "much more."

Mr David Epstein, Opposition spokesman on hospital affairs in the Provincial Council, said the province wanted private hospitals brought under their control, particularly in regard to their fees.

He was particularly shocked to hear of the frisking and searching of qualified nursing staff, which he described as "an insult to the nursing profession."

DD 8/12/76

R400 000 fire at hospital

GRAHAMSTOWN — Damage estimated at R400 000 was caused to extensions at the Settlers Hospital by a fire which destroyed 18 months' work in a little more than two hours early yesterday.

The entire east wing of the new building, including four ten-bed wards, was razed. The building was completed on Monday and the architect was due to inspect the building today for take-over.

The fire was first spotted at 11.20 pm on Monday by a building foreman, Mr S. M. Majat, from his bungalow above the building site. He sent a workman to the fire station and the fire brigade was on the scene within three or four minutes.

The firemen battled until 2.45 am yesterday but were unable to halt the blaze which had taken a firm hold on the asbestos compound building lined with wood panelling.

A spokesman for the fire brigade said: "By the time we arrived there was nothing we could do. We had to battle to stop the fire from spreading to the west wing."

The extensions were to rehouse patients from the Prince Alfred Hospital for chronic and geriatric patients. None would have been moved for some weeks until an access road was completed, the medical superintendent, Dr J. Gahle, said yesterday.

Onlookers who gathered at the scene said the asbestos exploded like gun shot. One said: "It was like a bonfire. No one could have stopped the blaze."

Yesterday the site was a heap of charred rubble topped by mangled piping. The builder, Mr A. Massali of Cape Town, who has been living in Grahamstown since October, could not say how long it would take to rebuild.

He said the building itself would possibly take as little as six months. The difficulty would be in getting the materials, some of which had to be specially made.

"With rising costs these could be almost doubled," he said.

The cause of the fire is not known. Mr Majat said he thought it started in the roof.

A spokesman for the fire brigade said: "It is known that electrical tests were being conducted on Monday but it is not possible to say whether it was an electrical fault." — DDC.

This was all that was left of the 80-bed east wing extension of the Settlers Hospital in Grahamstown yesterday after a R400 000 blaze swept through the building. In the foreground — a bath amid the ruin.

8D

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Press slammed for probing

By MIKE DUTFIELD

THE Administrator of the Transvaal, Mr Sybrand van Niekerk, yesterday attacked the Press for "insisting that hospitals give information about cases the newspapers claim were injured in the riots".

In an apparent reference to Press inquiries into allegations that Black schoolchildren were blinded when police fired birdshot during the Soweto riots, Mr Van Niekerk said in a statement:

"Hospitals do not have the right or duty to ask what the cause is of the patient's illness. Nor may they make statements about the admission of the patient, treatment or progress.

"When a patient asks that statements about his own treatment or condition be made, the request is considered on its merits by the hospital.

"Even inquiries from relatives or friends about the condition of patients are treated with caution," Mr Van Niekerk said.

Meanwhile, Baragwanath and St John Eye Hospital authorities are still trying to identify the doctor who made the original allegations in the Press a week ago. It was learnt yesterday that an investigation is under way to find the doctor and ask him to substantiate his claim.

The Director of Hospital Services in the Transvaal, Dr H. A. Grove, yesterday refused a request to comment on a Press report about a 10-year-old Soweto boy allegedly partially blinded by police firing birdshot.

Asked yesterday if hospital records could be examined to verify the report Dr Grove refused.

This week Mr Dave Epstein United Party spokesman on hospital affairs in the Provincial Council, said he would ask for the allegations to be confirmed or denied when the council meets in February.

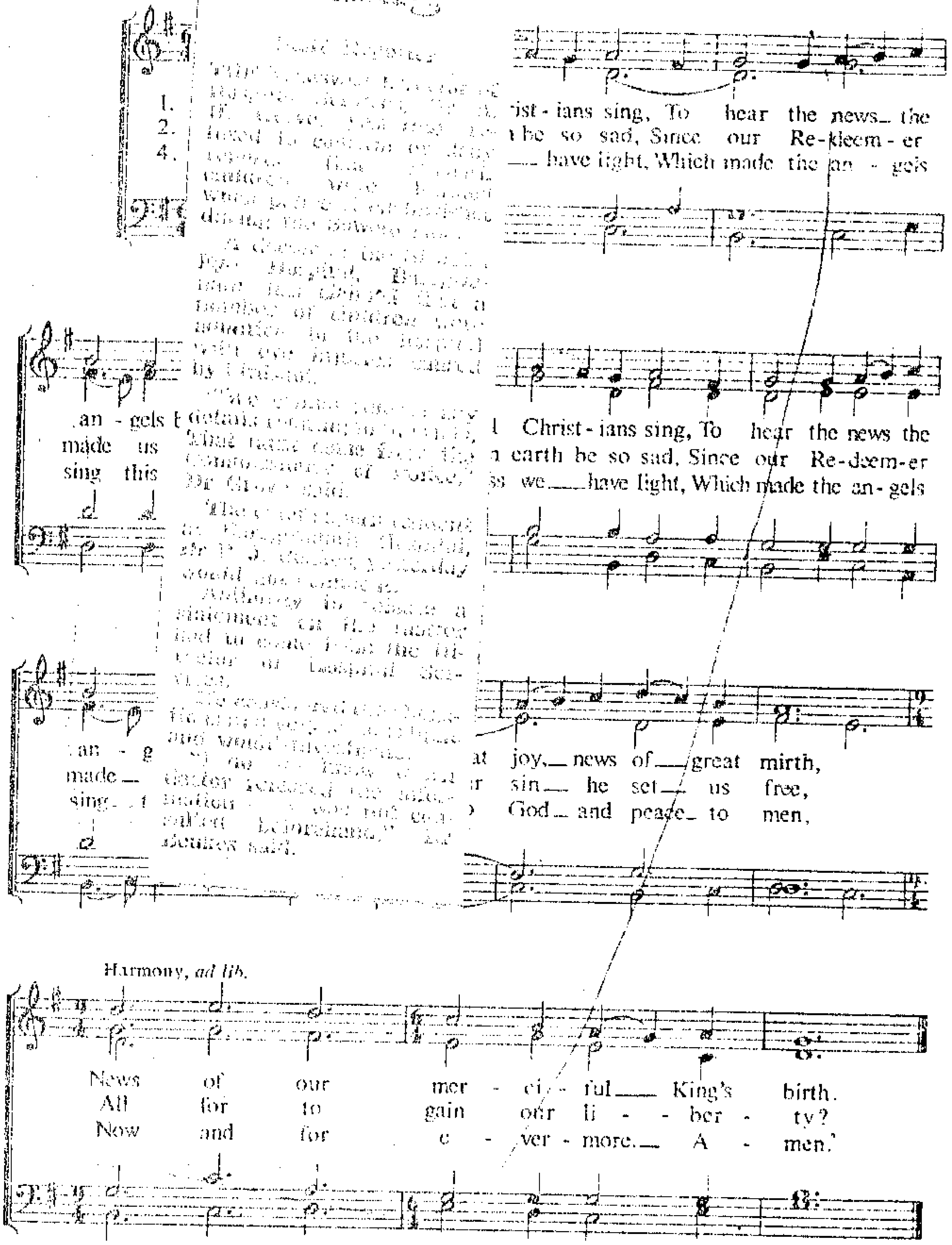
Silence on riot 'blinding'

AROL

(AS)

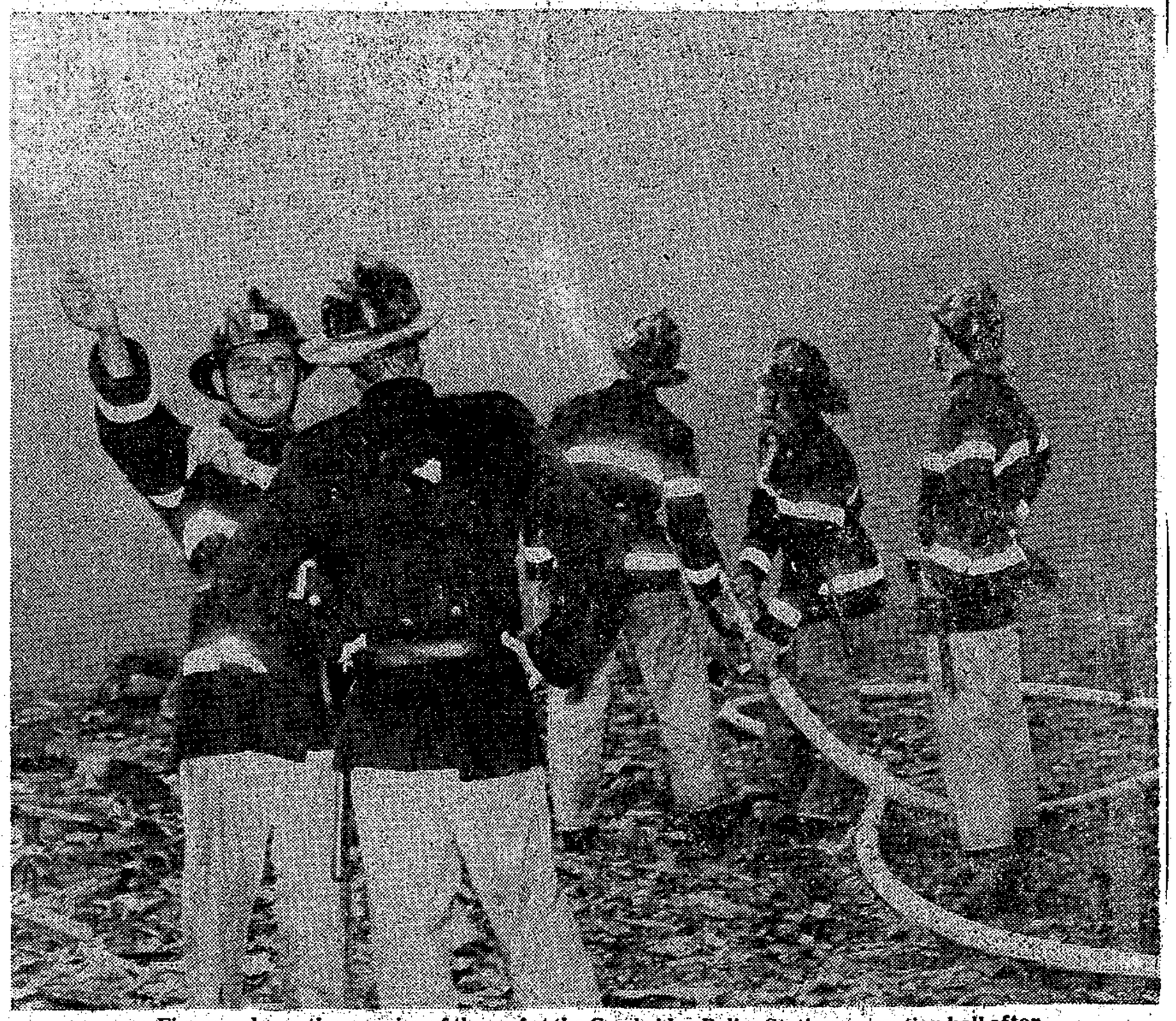
Traditional

Ibid. (R.V.W.)



25/12/76. DD

Police centre gutted



Firemen douse the remains of the roof at the Cambridge Police Station recreation hall after the fire last night.

EAST LONDON — The Cambridge police station recreation centre here was gutted by fire yesterday.

This was the first in a series of mishaps which hit this city, making for a gloomy Christmas eve, and which sent dozens of people to hospital.

The caretaker of the police recreation centre, Sgt Ernest Wilken, spoke of the unhappiest day in his life: "I was serving drinks in the police canteen when my daughter ran in and said there had been an explosion in the recreation hall. That was it. When we investigated, the hall was ablaze. Nothing we could do but call the fire brigade," said a weeping Sgt Wilken.

The hall was gutted. Glass fittings and the roofing in the expensive complex melted in the heat of the fire. Firemen had to wear oxygen tanks and protective clothing to fight the fire.

"I thank God the hall was not occupied when this terrible thing happened. Nobody knows how it started," said Sgt Wilken.

A Daily Dispatch reporter and photographer were then told to leave the scene of the fire by a senior police officer.

Meanwhile, ten people were assaulted, most of them stabbed, in one half hour period here yesterday.

Ambulance officials reported that between 3 pm and 3.30 pm, ten calls to collect assault victims were received.

All the victims were blacks.

In Woolwash Road, Buffalo Pass here, eleven people were injured when a mini-bus and a car collided.

The two vehicles collided near the Buffalo Pass garage at about 3.30 pm. Two ambulances sped to the scene.

Those injured were: Alfred Dyani, Tembile Mbilastilu, Moses Gobozi, Nolungila Yami, Zukelwa Yami, Tata Mzongwana, Wellington Vuzo, Maswagoduke, Howard Toyo, Sidney Gobozi, and Vame Soponti. — DDR

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31/12/76

5 000 sign petition to save hospital

ALMOST 5 000 signatures on a petition protesting against the proposed closing of the Rondebosch Cottage Hospital by the Cape Provincial authorities were collected in a few days by the committee of the Rondebosch Ratepayers' Association, Mr Rupert Hurly, the chairman, said yesterday.

"We collected these signatures in about two weeks earlier this month without any advertising. It was amazing how many people came forward to sign and to say that they had some relative or friend who had at some time or other been treated at the Rondebosch Hospital. They all spoke very highly of the services rendered there."

Mr Hurly said he and many others felt the hospital could be of immense importance in times of national emergency. It was situated next to the common where helicopters could land easily with patients.

"I submit that the Rondebosch Hospital would admirably suit the Civil Emergency Services. We need more such places. Existing establishments of this kind should not be closed down in these times," Mr Hurly said.

Mr Hurly, Dr William Wilkie, a city surgeon, Mr A H Honikman, a city councillor, and Miss Majorie Nash, a former matron of the hospital, yesterday took part in an early morning SABC Special Report on the English Service programme. They discussed the Rondebosch Hospital issue. Earlier Dr R L M Kotze, Director of Hospital Services, broadcast the viewpoint of the provincial authorities on the matter.

Dr Wilkie said yesterday that the reasons given by the provincial authorities that the Rondebosch Hospital was in a state of antiquity and disrepair and that it would cost R750 000 to renovate, did not hold water.

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Police in wards anger Howa

5/1/77

CAPE TOWN — Policemen seem to be crawling out of the woodwork at the Somerset Hospital, according to Mr Hassan Howa, president of the Western Province Cricket Board.

Mr Howa, who left the hospital at the weekend after treatment for a heart condition, said it was disconcerting to wake and find the ward "swarming" with policemen who were guarding prisoners or potential prisoners in adjoining beds.

"I would be the last to object to prisoners sharing my ward," Mr Howa explained, "but surely it would be better for the hospital and the police or prison authorities to come to some alternative arrangement?

"The sight of armed and uniformed men patrolling the ward is hardly conducive to rapid recovery," he said.

He left the hospital earlier than he should because he found the police guards "somewhat depressing."

The medical superintendent of the Somerset Hospital, Dr A. Rosenberg, said yesterday that he was concerned purely with the treatment of patients — "Whether they are prisoners or not." He would not refuse a bed to anyone.

Dr Rosenberg said he had been informed of Mr Howa's complaint and had discussed the problem with staff.

"Whenever possible we try to keep prisoners in a separate ward but sometimes an overflow is unavoidable," he said.

He would make every effort to find accommodation elsewhere in the hospital for a patient who felt uneasy about sharing a ward with prisoners.

A senior police officer commented yesterday: "It would be impractical for men guarding a prisoner, possibly a dangerous one, to be stationed outside the door of the ward."

Several hospitalised prisoners had escaped in the past, he said, and it was common sense to have them guarded at all times, as prisoners could hardly be chained to their beds. — DDC.

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their being relatively over-populated and/or ... re quite
different problems.

Not only is the amount of labour on whit ...) farms
greater than one would expect (given the rela ... nts), but
its price is also lower than one would expect from a comparison with
wages in other sectors, and even with incomes in Bantustan agriculture.

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3 new medical research units formed

Science Correspondent

THE establishment of three new medical research units will be announced today by Professor A. J. Brink, president of the South African Medical Research Council.

Two are situated at Tygerberg Hospital in the Cape, and a serogenetics research unit is based in Johannesburg.

The last will carry out field work to establish the susceptibility of the different population groups to various diseases and to find out why some illnesses — such as porphyria among Afrikaners and albinism among Negroid populations — are hereditary.

One of the Tygerberg units will study the nervous system, an area of research described as vitally important because of the major public health problem presented by nervous and mental disorders.

It is hoped that this research, directed by Professor B. C. Shanley of the University of Stellenbosch, whose work is internationally respected, will contribute significantly to future knowledge.

The other new unit, which is concerned with dentistry, will conduct field surveys of mouth conditions which may develop into cancer. It will also study dental decay and other mouth states.

E, 98

Nursing outlook

Science Editor

The nursing situation in the Transvaal is satisfactory, says the Director of Hospital Services, Dr Hennie Grove.

"We will not know until the beginning of next month what the total intake for the year is going to be but so far it has been good," he said.

Dr Grove said that only two hospitals in the Transvaal were causing concern because planned expansion depended partly on the number of nurses available.

They were Kempton Park Hospital and Sybrand van Niekerk Hospital in Carletonville.

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Hospital is accused

12/11/77. Star

Mrs Wilhelmina Mufulwane today claimed that after entering the African section of Johannesburg General Hospital with spine and kidney injuries she was not seen by a doctor for 50 hours.

The injuries were caused when Mrs Mufulwane, who is 27 and lives in Parkmore, was hit by a car. That was on Sunday.

She says she was X-rayed and given painkillers. Then she was wrapped in a blanket and put on an examination table in a dark, busy passageway. She had neither sheets nor pillows, she adds.

Mrs Mufulwane says she was in great pain. She could not move the lower part of her body. And she had not eaten because of a badly cut mouth and a sore stomach.

The cuts on her body were cleaned, she adds.

Last night she was transferred to Thembisa Hospital. A doctor examined her. She was X-rayed. And moved to a ward.

At Johannesburg General Hospital Dr M Kalmyn, a superintendent, said the matter would take a few days to investigate.

Consumer Mail

Every Monday,
Wednesday,
Thursday and Friday.

The cost of going to a private clinic

CAROL DALGLISH reports

BEING sick in a private clinic can cost between R17 and R38 a day, depending on whether you share accommodation or have a private ward with a television set and telephone.

With the recent increases in tariffs at private clinics, Consumer Mail examined accommodation costs, methods of payments and facilities at 11 clinics in and around Johannesburg.

While some clinics volunteered the information freely some were reluctant to divulge details.

Mr A. Gordon, a spokesman for Princess, Florence Nightingale and the Lady Dudley nursing homes, was too busy to supply tariff costs despite several telephone calls.

It is necessary to be careful when making telephone inquiries at the clinics. Staff at the Garden City and the Rosebank Clinic provided information which proved to be inaccurate when spot checks were done at the clinics. The figures supplied did not reflect the highest accommodation charges. Spokesmen for the clinics said the staff did not know the charges.

Consumer Mail researchers found a few discrepancies. Inaccurate information was given at the Lady Dudley. When we telephoned we were told television was available. But when a Consumer Mail researcher visited the clinic she was told there were no television facilities.

Four of the 11 clinics offered television while two others had an arrangement with a private hire company. Video tapes were available to supplement the SABC-TV service.

A receptionist at the Florence Nightingale Clinic sent our researcher to a nursing sister on the third floor to find out about maternity charges.

Most of the clinics use their discretion about charging full-day rates for patients who arrive before noon (say, 11.45 am). Arrivals after noon are charged half-day rates, with the reverse situation applying for departures.

All clinics have restricted visiting hours, two or three times a day, except Garden City which welcomes visitors from 9 am — 8 pm.

Telephones have to be requested at most clinics and are charged for whether used or not. At the Brenthurst a telephone and free local calls are included in the tariff in their private rooms with bathroom.

Clinic	Cost per day private room with bathroom * without	Semi private two bedded room with bathroom *without	General ward	Labour ward fees	Nursery charges	TV availability and cost	Telephone rental and cost per call	Visiting hours	Theatre fees
SANDTON	R32,50 Mat R35 M&S	R25 Mat R27,50 M&S	R20 Mat R22 M&S	R35	R6 pd	Can be arranged privately between pat & outside co	R2 pd local calls free	3-4 pm 7-8 pm	Caesarian R47,50
BRENTHURST	R38 M&S	*R25 R26	R19 M&S	—	—	"	private ward tel local calls free semi p R1 pd local calls free	3-4 pm 7-8 pm	From R36
PARK LANE	R30 Mat *R25 Mat R35 M&S	R25 Mat R25 M&S *R21 M&S	R17 Mat R19 M&S	R35	R7 pd	R3,25 pd	R4 pd & local calls free	3-4 pm 7-8 pm	From R35 for first 15 min
MARYMOUNT	R27 with Tel *R24 with Tel *R20	R17 Mat	R15 Mat	R25	No charge	—	private wards tel local calls free phone not available to other wards	3-4 pm 7-8 pm	—
KENRIDGE	R28 M&S	R20	R17 Surgery R18 Medical	—	—	R2,50 private semi private R1,50 general ward	R1 pd local calls free	11-12 noon 3-4 pm 7-8 pm	1-16 minutes R30
UNION	R30 M&S	*R25	R17 Surgery R18 Medical	—	—	R3 private R2,50 R1,75 general	R3,50 hire fee R1 pd local calls free	10.30-11 am 3.15-3.45 pm 7-8 pm	From R35
GARDEN CITY	R30 Shower R32 M&S	—	R19 M&S	—	—	R3,25 pd if 6 people are sharing pay one-sixth	R1,50 pd local calls free	9 am-8 pm	From R30
ROSEBANK'.....	R32 M&S	R26	R19 M&S	—	—	—	R1,50 pd local calls free	3.30 pm-8 pm	From R30
LADY DUDLEY	R35 M&S *R30	—	R19 M&S R20	—	—	—	R1,20 pd local calls free tel only available to private wards	11-12 noon 4-5pm 7-8 pm	
FLORENCE	*R27,50 R30 Mat R35 M&S R30 M&S	R20 Mat *R22 M&S	R17 Mat R19 M&S	R25	R3 pd	—	R2,75 pd local calls free Tel only available to private wards	11-12 private ward only 3-4 everyone 7-8 pm	First hr approx R45
PRINCESS	*R30 M&S R35	*R22	R19 M&S	—	—	—	R1,20 pd local calls free tel only available to private wards	3-4 pm 7-8 pm	—

• Mat is maternity; M is medical; S is surgical; pd is per day.

Surplus medicine left over at the end of treatment at the Sandton Clinic, Florence, Park Lane, Rosebank and Garden City is credited to your account.

Theatre fees start at R30 for the first 15 minutes and go up in leaps and bounds.

The clinics offer a choice of menu to private ward patients.

Private ward patients are allowed visitors in the morning in most homes because it doesn't interfere with other patients' sleep.

All the clinics require patients to pay their accounts on the day of discharge, unless previous arrangements have been made. Clinics require confirmation that accounts will be paid by Medical Aid Societies.

There is a big difference in prices between private clinics and Provincial Hospitals.

All the Transvaal Provincial Hospital rates are the same and depend on your income and number of dependants, with incomes between R200 and R8 450 per year.

If you are married with two children and earning between R5 200 and R5 580 per year you pay R8 a day in a provincial hospital. Pensioners receive treatment and medicine completely free.

Depending on your income group you could pay as little as R5 per day for a bed in the maternity wards.

RDM 27/1/71

SA hospital ad lands UK paper in court

Own Correspondent

LONDON. — A "Whites only" advertisement for nurses to work in a Johannesburg hospital has led to the first prosecution under the advertising section of Britain's stringent race laws.

The Race Relations Board is prosecuting the Associated Newspaper Group, publishers of the Daily Mail, together with the Nurses Association, a recruitment agency. It is over an advert published in Britain and Ireland last year announcing vacancies at the Florence Nightingale Hospital in Johannesburg.

The advert offered free travel, food and accommodation and included the words, "all White patients only".

Outlining the prosecution case, Mr Anthony Lester QC, an authority on race relations law, said it was unimportant to the law what race relations conditions applied in South Africa.

What mattered was that any reasonable person with a limited general knowledge would realise that a South African hospital catering for only White patients would not want Coloured or Black nurses.

The advertisements were published in the Irish Independent on May 6 and in the Daily Mail on July 11, last year.

The case arose after the Race Relations Board received seven complaints about the advertisement.

Mr Lester said the advertisement clearly discriminated against applicants who were not White and that the only reason for inserting the words "all White patients only" was to make it clear that the Nurses Association would only channel applications from White nurses to the hospital.

The prosecution is a civil one in which the Race Relations Board is asking only for a declaration that neither the newspaper group nor the Nurses' Association will repeat the advertisement.

The relevant section of the race laws says that it is an offence to publish or cause to be published an advertisement which indicates or could reasonably be interpreted to indicate an intention to discriminate.

Mr Lester said that the Act did not seek to prevent racial discrimination anywhere but in Britain, but the wording of the offensive under the race laws will continue to-day.

Quick-thinking nurse saves 40

West Rand Bureau

A keen sense of smell and quick action of a nursing sister helped to save 40 patients and staff when fire destroyed a R250 000 section of the Sterkfontein Mental Hospital near Krugersdorp yesterday.

Sister Elsa Kreinz said she had smelt smoke about 5.30 pm and had asked a patient to see if a cigarette had been left burning in a wing of the building being renovated.

"When he was slow returning, I rushed there and saw smoke. I immediately snatched a fire extinguisher and tried to put out the flames but soon realised my efforts were hopeless.

"My next thought was to save the 32 patients in the rest of the complex."

With the help of other staff, she quickly and calmly, evacuated everyone without raising the alarm.

Picture, Page 5.

Court told of strange practice at hospital

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 M. 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 [illegible] counts of fraud.

Dr Joubert is alleged to have defrauded the Workmen's Compensation Fund of more than [illegible] 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.

[illegible] the State prosecutor, Mr [illegible], said Dr Joubert was not entitled to a fee for [illegible] and [illegible] 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 [illegible]

[illegible]

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A worker at the Sterkfontein Mental Hospital near Krugersdorp inspects damage caused by the fire.

Cigarette blamed for hospital fire

Staff Reporter

CARELESSNESS [illegible] have caused a fire which this week caused [illegible] of thousands of [illegible] worth of damage at the Sterkfontein Mental Hospital near Krugersdorp.

The fire, which broke out on Wednesday night, swept through one of the buildings and within an hour had destroyed furniture, clothes and bedding.

The inferno brought down the roof, making it difficult for firemen to enter the building.

About 20 patients were evacuated to other parts of the hospital complex.

Some were treated for shock, but nobody was injured.

A nursing sister at the hospital, Mrs E. van Dyk, was treated at Paardekraal Hospital after being overcome by thick smoke while trying to move patients.

Damage in the fire has been estimated at more than R200 000.

A spokesman for the Krugersdorp fire department said it was unlikely the fire was caused by an electrical fault.

The blaze probably started in a room which was being painted, he said.

Inflammable paint thinners was being used and it is thought that a cigarette may have been thrown carelessly.

HEALTH ∝ DISEASE

HOSPITALS & CLINICS.

FEB. 77 – DEC. 78.

Hansard 2 col 102 2/2/77

Salaries of professionally qualified persons in State/provincial hospital and health services

54. Mr. D. J. DALLING asked the Minister of the Interior:

What were the salary scales laid down as at 31 December 1976 for (a) White, (b) Coloured, (c) Indian and (d) Black professionally qualified persons in State and provincial hospital and health services.

The MINISTER OF THE INTERIOR:

(a) to (d).

(i) 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)

(i) Rank

	Salary scale (R per annum)		
	White	Coloured/ Indian	Bantu
Medical Officers			
Chief Medical Officer	13 200 (fixed)	11 250 (fixed)	9 540 (fixed)
Principal Medical Officer	12 600 (fixed)	10 800 (fixed)	9 180 (fixed)
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 Medical Officers.

(iii) Pharmacists: Salary scale (R per annum).

Rank	White	Coloured/ Indian	Bantu
Chief Pharmacist	9 900 × 450–11 700	8 100 × 360–9 540	6 060 × 240–6 300 × 360–7 380
Senior Pharmacist	7 740 × 360–9 540	6 060 × 240–6 300 × 360–7 740	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	3 450 × 150–4 200 × 180–4 560
Trainee Pharmacist	4 020 (fixed)	3 150 (fixed)	Male: 2 100 (fixed) Female: 1 980 (fixed)

The above-mentioned scales do not include allowances payable to the personnel.

Hansard 3 Q col 201 8/2/77

(98)

Hospital beds for Bantu

(3.) Mr. L. F. WOOD asked the Minister of Bantu Administration and Development:

How many hospital beds are available to Bantu in the (a) Bantu homelands and (b) White areas of the Republic.

The MINISTER OF BANTU ADMINISTRATION AND DEVELOPMENT:

(a) 13 447.

The figure mentioned above is only applicable in respect of those Homeland Governments who have not taken over health services as yet. Figures in respect of the Homeland Governments who have already taken over health services, are not readily available.

(b) 71 491.

Hansard 3 @ col 220 8/2/77

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Bantu hospital at Umlazi

347. Mr. G. N. OLDFIELD asked the Minister of Bantu Administration and Development:

(1) (a) What progress has been made in regard to the establishment of a new Bantu hospital at Umlazi, (b) what amount has been expended to date and (c) what is the total estimated cost of the proposed hospital;

(2) whether steps have been taken or are contemplated to expedite the completion of the hospital; if so, what steps; if not, why not;

(3) what is the anticipated date of completion of the hospital.

The MINISTER OF BANTU ADMINISTRATION AND DEVELOPMENT:

(1) (a) Structural framework is being erected and anticipated date of completion is March, 1977.

(b) R 2 500 000.

(c) R15 000 000.

(2) Structural Contract has been entered into and work is being done whilst the rest of the documentation is being completed. Phasing of subsequent contracts to provide earliest availability of portions of the hospital complex is contempleted.

(3) 31 March, 1983.

Hansard 6 Q cols 550 - 551 3/3/77

Ga Rankuwa Hospital

(98)

495 Dr. E. L. FISHER asked the Minister of Bantu Administration and Development:

(1) Whether all the wards in the Ga Rankuwa Hospital are being used; if not, why not;

(2) what is the establishment of the hospital in respect of (a) (i) full-time and (ii) part-time doctors, (b) nursing sisters, (c) staff nurses and (d) nurses;

(3) whether there are any vacancies in respect of these categories; if so, how many in respect of each category.

The MINISTER OF BANTU ADMINISTRATION AND DEVELOPMENT:

(1) No. The Hospital opened less than three years ago and is still in the process of development. Wards are being opened and used within the framework of available funds and filling of medical posts.

(2) (a) (i) 127.

(ii) 4.

(b) 195.

(c) 105.

(d) Nursing assistants 179
Student nurses 228

(3) (a) (i) 46.

(ii) None. Twenty-one part-time doctors are employed in this category and the surplus are being carried against vacant posts of full-time doctors.

(b) 1.

(c) 55.

(d) Nursing assistants ..... None
Student nurses 32

Health & Diseases
Hosp & Clinics
98

...ville District Building.

Some hospital fees to double

SAT 15/3/77

Pretoria Bureau

Hospital fees in the Transvaal will rise from April 1, some of them being doubled.

This was announced today by the administrator of the Transvaal, Mr Sybrand van Niekerk.

Mr van Niekerk said he was announcing the increases now, without prematurely affecting the forthcoming provincial budget in May, so as to have the increases effective from the start of the next financial year.

He said the increases were expected to bring in an extra R10-million to the provincial revenues.

CONTRIBUTION

The increases would not cover the total cost of running the department of hospital services, but would raise the public's contribution from 8,5 percent to 12,5 percent of the total.

The increases were devised in such a way as to accommodate the lower income groups in particular.

Mr van Niekerk said irrespective of the patients' income group, where hardship was experienced through extraordinarily high medical costs, relief was available on application to hospital superintendents.

ATTRIBUTED

The application must however be made before or while the service was being rendered, and not after the treatment was completed.

Mr van Niekerk attributed the increases — the first since 1973 — to general cost increases of medical and other supplies, as well as increased salaries.

Outpatients' fees for all races will rise from 50c to R1 a visit for up to five visits a month for non-members of medical schemes, and for every visit by members of medical schemes. Further visits in the month would be free of charge.

For private patients the outpatients' fee will rise from R3 ot R5 a visit.

For in-patients of all races, the daily tariff will rise from the nominal fee of 50c to R1 for the lowest income groups, and from R4 to R5 per day for the highest income groups and for white members of medical schemes.

For private patients, the fees will rise from R4 to R7 per day for the lowest income group and from R7,50 to R14 per day for the highest income group and for white members of medical schemes.

EXPRESSCOPE

'YES' TO PRIVATE

MEDICAL history will be made in South Africa if the Government approves a scheme to build a private nursing home in Soweto and to provide medical aid cover to Blacks on a large scale.

Spearheaded by a consortium of Black doctors and businessmen, the project will signal a breakthrough in the provision of private medical services to Blacks.

The envisaged hospital will provide an alternative, say the doctors, to the "assembly-line" medicine of the provincial hospitals.

Blacks willing and able to afford private care will get it, while doctors in private practice will no longer be hamstrung by lack of facilities.

Acting for the group of doctors is the merchant bank of Hill Samuel, which estimates the cost of building the nursing home at R4-million.

In the past the Government has frowned upon the establishment of private medical services in Black townships.

An attempt by Black doctors to build a private nursing home 15 years ago was turned down flat, but doctors behind the scheme hope now such a hospital will be seen to be vitally necessary.

The planned hospital will have 120 beds and four operating theatres. Fees will range from about R13 for a general ward to R21

Dr Mbere's

Trained in London's finest, yet he can't do his job at home

By JENNIFER HYMAN

DR JIYANA MBERE is a gynaecologist who trained and qualified at London's leading Hammersmith Hospital. Yet he cannot practise as a gynaecologist in his home town, Soweto.

Dr Mbere has spent the last two years working as an ordinary doctor — the fate of many specialists wishing to remain in private practice.

In fact, no private Black doctor can practise as a surgeon, anaesthetist or physician.

Nor can a private Black doctor see his patient once he is admitted to hospital. He cannot help in his further treatment and does not receive reports on his progress.

The plight of Dr Mbere highlights the problems facing private medicine in Black townships.

As a gynaecologist he requires facilities where he can confine patients and deliver babies, where he can operate and carry out tests.

A private doctor in Soweto has none of these.

If he wishes to use such facilities he has no option but to work for the provincial hospital service — at a salary about 30% lower than that of his White colleagues.

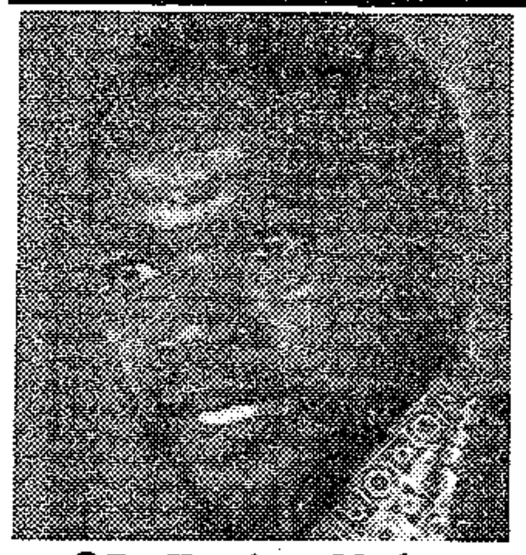
Yet this is what Dr Mbere has decided to do. "It is tremendously frustrating working as a GP when I am trained as a specialist — so I chose the lesser of two frustrations," he said.

Dr Mbere will earn R9 108 a year in the Hospitals Service, while a White gynaecologist of equivalent training and experience earns between R20 000 and R24 000 in private practice.

Other Black specialists who refused to compromise have emigrated — including a paediatrician and an orthopaedic surgeon.

If the situation is restrictive for private Black doctors, it is worse for their patients.

They require specialised treatment and surgery as often as anyone else. But whether they are willing and financially able to pay for private care or not, they are



●Dr Harrison Motlana

'I last saw an op in medical school'

is the administrative board's only White member.

Expresscope this week investigated the situation of Black private medicine and found that:

- All major medical services are provided by the State through the provinces — both to the indigent and unemployed for whom free services were originally intended and to those who are both willing and able to pay for something better;
- Black doctors on the Witwatersrand receive daily requests from patients to be

forced to wait their turn in the overcrowded, State subsidised hospitals which monopolise Black medical services.

Black private doctors — there are 15 in Soweto and about 75 nationwide — are increasingly dissatisfied with the system.

However, a two-pronged plan under Government consideration hopes to change all this. It involves:

- The building, partly with White finance, of a fully equipped and top quality private nursing home on a site to be selected in Soweto, and;
- The launching of a new medical-aid scheme for Blacks which will cover 100% of all medical requirements, including private hospitalisation.

Behind the scheme is a consortium of Black doctors and businessmen, and a dedicated White doctor who

treated by private specialists or operated on in private nursing homes;

- A few White nursing homes are allowed to admit Black patients, provided they obtain the necessary permit. But, says Dr Joe Jivhuho, who practises in Orlando: "By the time they get the permit, my patient could be dead."
- The lack of private medical facilities makes medical aid unpopular among Blacks, of whom there are about 100 000 on medical aid schemes throughout the country.

One of the doctors behind the scheme for a private hospital, Dr Harrison Motlana, explained:

"Blacks can and do benefit from medical aid, as far as ordinary consultations and medicines are concerned. But if they require specialist treatment, or tests, or surgery, they all end up at

BLACK NURSING HOME WILL MAKE HISTORY

for a private ward — well below the fees in nursing homes.

Dr Harrison Motlana, one of the directors of the scheme, said: "We intend the running costs of the hospital to be covered by fees, paid by medical aid societies.

"We are confident that once a private nursing home exists, there will be a greater incentive for Blacks to join medical aid schemes and for employers to offer them."

Black members of medical aid societies were now subsidising White members, since their contributions were proportionally the same but the benefits Blacks derived were so limited.

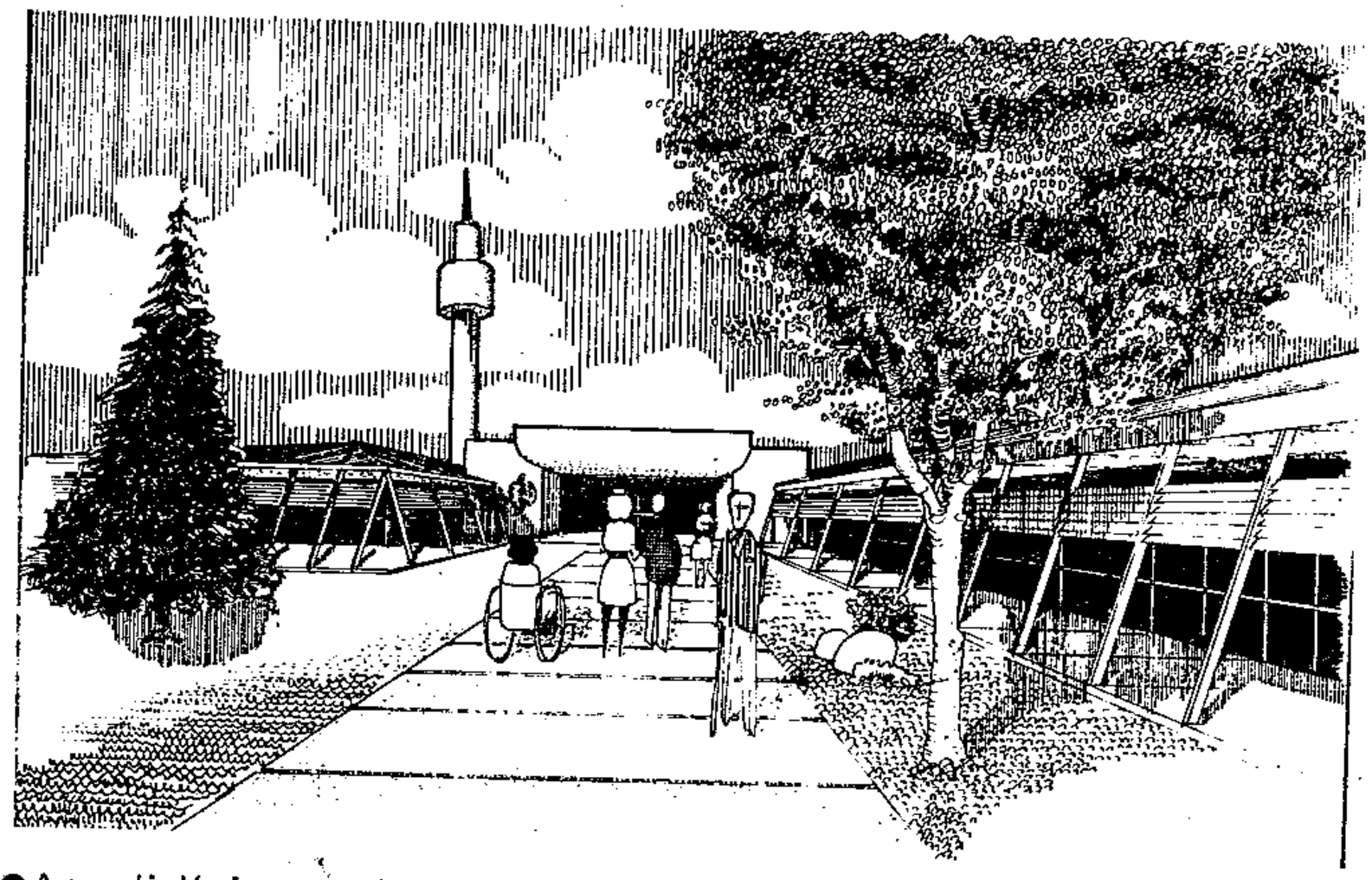
27/3/77 SC

Several firms have already expressed interest in the project and medical aid societies are also excited.

Mr Philip Parvus of Medical Services Plan, which offers a special cover to low-income groups, said private nursing home facilities would make it "lots easier" to market medical aid to Blacks.

The new medical aid society planned will have a target of 100 000 members. Firms will be encouraged to subsidise their employees' contributions by 50% and the scheme will offer full cover for any eventuality — including hospitalisation, dentists and specialist treatment.

bitter pill



●An artist's impression of the Soweto nursing home which could greatly ease the current over crowding in Black hospitals as shown in the picture on the right.

Baragwanath or other provincial hospitals where they pay their 50 cents like anyone else.

"Whites, on the other hand, go to a clinic and get a could refer them to a specialist of our own choice and admit them to a hospital of their choice, depending on what they were prepared to pay.

bill for R500. Having medical aid doesn't bring a single benefit to Blacks when it comes to major treatment."

He said many Black members of medical aid schemes were paying as much as R180 a year in subscriptions, but receiving only R20 of benefits. "Blacks are subsidising White members of their schemes," he said.

All Black doctors interviewed had problems, the most crucial of which is the fact that they constantly lose patients by having to refer them to provincial hospitals.

Said Dr Motlana: "If I see a patient and decide he will need X-rays, I can either refer him to a private White radiologist, which he can't afford if he is not on medical aid, or I can refer him to Baragwanath.

"So I do the latter and my patient is then taken out of my hands entirely. I get no reports on his condition or results of tests. I cannot take part in his further treatment."

He said that his patients were often not even admitted as hospital clerks had the right to turn them away.

Dr Jivhuho confirmed this, saying that it was insulting not to be informed of a patient's admittance and progress "particularly when we have gone to the trouble to write out a full medical history".

"If we were White doctors," he said, "our patients would be on medical aid, we

"As the patient's private doctor, I would also probably be asked to assist in an operation. But when my patients go to Baragwanath, I need a permit to enter the hospital."

Dr A E Tlakula, who has been ten years in Tembisa, said that doctors and their patients suffered from the impersonal, overcrowded conditions of provincial hospitals.

"People spend hours, even days, waiting in queues. When I refer a patient to Tembisa Hospital, as I do daily, it doesn't mean an hour for X-rays, it means the whole day, at least."

The doctors interviewed criticised "assembly-line" medicine available to Blacks but agreed that the provincial hospitals, understaffed, overcrowded and pitifully few for the huge Black urban communities, were doing their best.

"It is monstrous to think of a community of one million people in Soweto having only one hospital," said Dr Jivhuho.

After canvassing their own community, the doctors and businessmen involved in the scheme have concluded that there is a real and urgent need for private hospital and medical facilities.

Their multi-million rand project is seen as the beginning — further schemes for medical complexes in the township, complete with specialist facilities, are envisaged.

R21 000 hospital bill

PRETORIA — The workmen's compensation commissioner has been formally asked to investigate a bill of R21 175 for 94 days of hospital treatment of a crocodile attack victim.

The account has been submitted to the commissioner following its presentation to the victim, Mr Tom Yssel, a Kruger National Park ranger who was savaged by the crocodile while on official duty in the park in November last year.

Mr Yssel, at present recuperating at the home of his parents, was admitted to the intensive care unit of the Eugene Marais Hospital, Pretoria, on November 25 — and kept in the unit until February 26, shortly before his discharge.

A spokesman for the hospital refused to comment yesterday on the matter, except to say that Mr Yssel had received extensive, round the clock attention in the battle to save, first his life and then his leg.

He confirmed the amount of the account which works out to more than R220 a day for the time Mr Yssel was in the hospital. — DDC.

Hansard 15 col 1062 9/5/77

98

Hospital beds

909. Dr. E. L. FISHER asked the Minister of Health:

How many hospital beds provided by his Department were available for (a) White, (b) Coloured, (c) Asian and (d) Bantu patients in the Republic outside the Bantu homelands at the end of 1976.

The MINISTER OF HEALTH:

	White	Coloured	Asian	Bantu	Total
Psychiatric	8 839	2 461	227	4 336	15 863
T.B.	171	1 370	119	2 658	4 318
Leprosy	50	100	30	820	1 000
General	—	—	—	1 258	—
Total	9 060	3 931	376	10 330	22 439

(98)

COUNTRY FOCUS

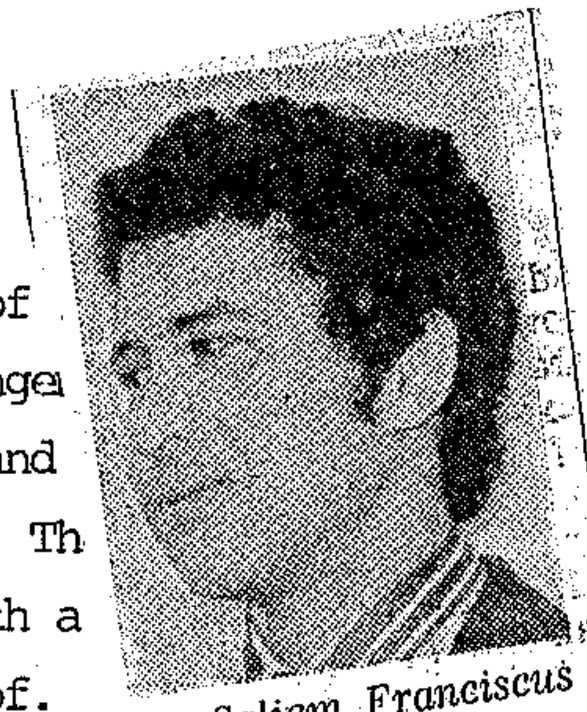
WORK ON R25 000 DAY CLINIC UNDER WAY

WORK has started on the new R25 000 day clinic to serve the Coloured population of the ELGIN-GRABOUW area.

It will consist of a maternity room and recovery room, a family planning clinic, a general clinic for minor ailments and TB control and a social worker's room.

The Elgin Round Table has given R5 000 toward the cost of the clinic and the balance will be raised from the Grabouw municipal funds and State Health subsidies.

The clinic will form part of a complex which includes the library and recreation hall for the Coloured people. These are already in use.



Mr Saliem Franciscus

Hospital services milestone

ARGUS 3/6/77

MR Saliem Franciscus, 30, of Athlone has become the first non-White secretary of a hospital in the Western Cape.

At a ceremony yesterday at the Provincial Administration offices in Cape Town, Mr P. J. Loubser, MEC in charge of hospital services, said the appointment was senior and marked a milestone for the hospital services.

Mr Franciscus, who had been appointed to the G. F. Jooste Post Acute Hospital in Manenberg, was one of the youngest people in the hospital services to hold a position of this rank.

Mr Franciscus matriculated at Roggebaai High School in Green Point and joined the hospital services as a clerk at Somerset Hospital in 1966.

He was made a senior clerk at Somerset in 1975 and was promoted from there to his present position.

He said he felt honoured by the promotion and considered his new job a challenge.

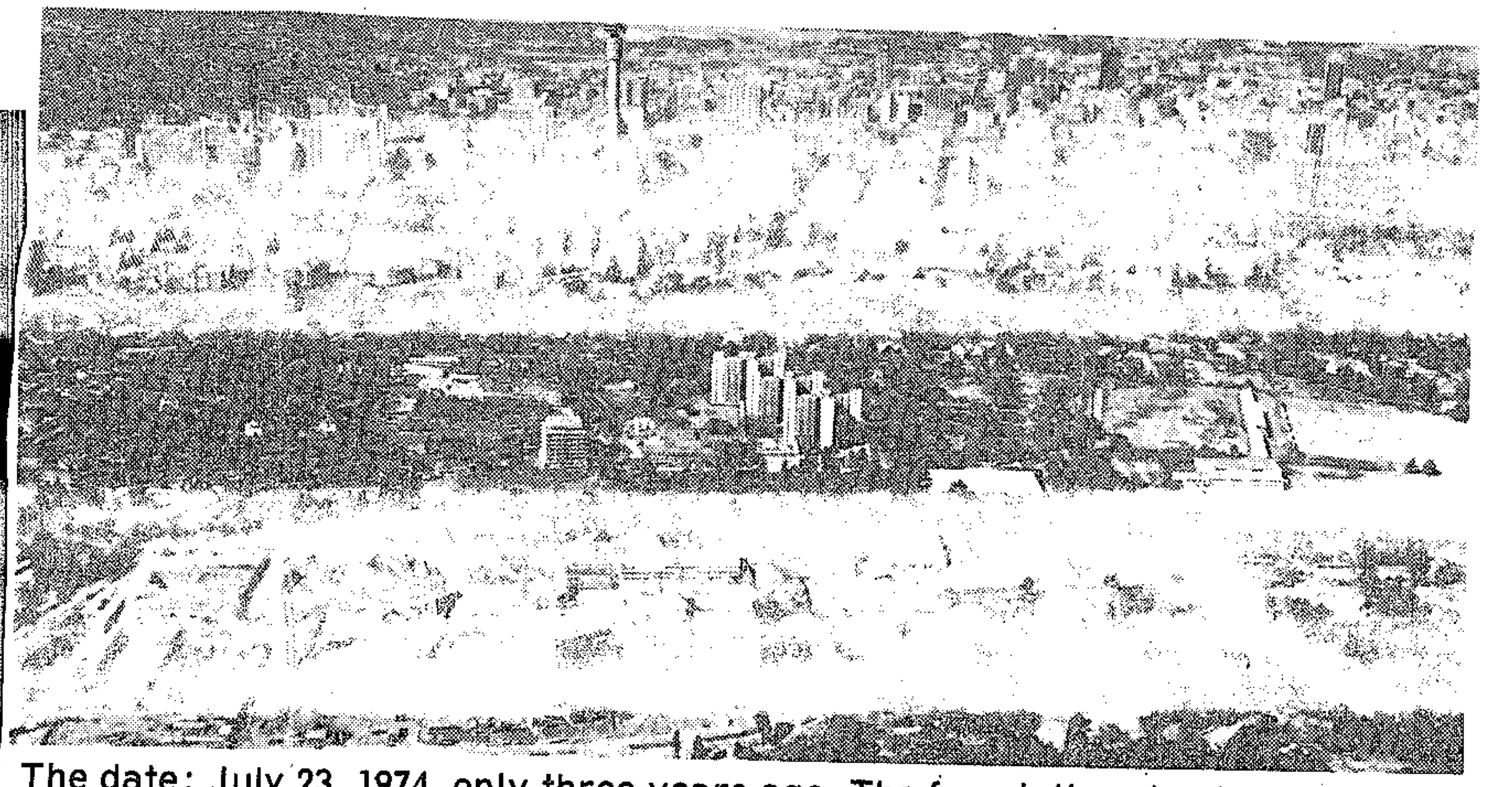
Housing facilities

The general quality of only in structural terms but in terms of location and arrange other houses. A large proportion is still the"wattle and h unsightly sheet iron rooms or enclosures annexed. Th house has mud and iron annexes with very poor roofing with a itres) providing drinking water, from rain off the roof. non-existent and the area in front of the house is usually h d normally swept clean, slightly raised at the wall, provid eating. Floors are made of cow-dung and even in the spaci cow-dung is used by choice as it provides soft and well-wea he farmer appears to take little care of the state of emplo ves them to their own devices. The rooms are generally nea bedding, but a dresser and dining-room table and chair writer employs a Black tractor driver whose basic wage is F saves R10-R15 p.m. This man wanted to build his own mud from the others and he has no beds at all in his house. as necessary as the dresser in the front room). One must r ow-dung floor is very comfortable, some even make patterns on th of clay for darker or lighter shades. Cooking is done out even though most houses have a fire-place with chimney. T because of the smoke, because there is often a fire inside o weather is cold. It is interesting to note that this c conomically produced using one or two logs burning for a l r barbecue-type fire would require very much more wood, and he women-folk normally collect the wood, there is a lot hod. Homemade mud and reed houses always have roundish with a diameter of ± 15 cms. (6 ins) and there are only one or Door spaces are always lower than an adult's height. I nhabitants the reason for this, but there is no answer. Ap stems from the traditional practice that when a stranger or intruder entered the house, he would have to crouch, and if there were evil intentions, the owner of the house would be at an advantage to overpower him.

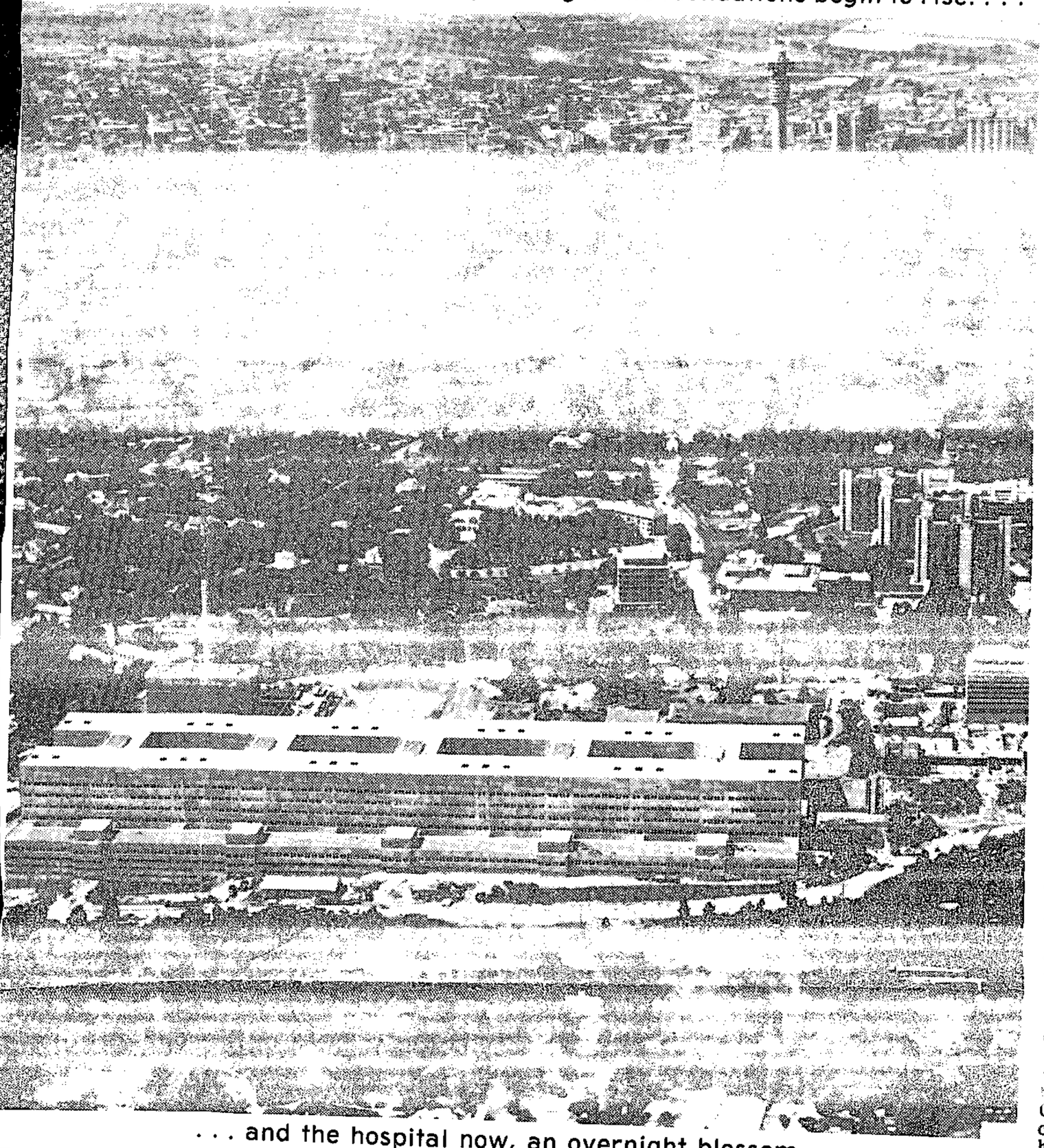
The majority of farmers appears not to be doing anything right now, although there is at the present time a lot of talk about providing better living conditions. The Government provided most attractive incentives to facilitate building new houses and modernising old. This was a loan for 30 years at 1% interest. However due to lack of funds this has been stopped temporarily, but

Inside Mail

Jo'burg's new hospital — the



The date: July 23, 1974, only three years ago. The foundations begin to rise. . . .



. . . and the hospital now, an overnight blossom.

The best

Bright colours abound hospital. Mr F Graf zu Cast architects, indicates a nur the main block

IT'S CERTAINLY the biggest. Many say it's the best and some say it's the ugliest

over to its owners on September 1.

By the end of this year the first patients should be receiving treatment at the city's newest record breaker. The first section, of 400 beds and ancillary facilities, represents 20% of the hospital which, less than five years ago, was just a drawing.

The remaining 1 600 beds will be handed over in stages

will also twin-bed singles

ture in metre four city way fro the Carl

In ma city cen will hav restau cafeteri library, parks a system

contract date

General's largest wards accommodate 30 beds the new hospital will go no bigger than a six-bed ward. There

medica

The main Hospit

dummy with a trump and finesses the queen of clubs, which loses to the king.

West returns the ten of clubs to declarer's ace. South now enters dummy with a trump, discards a diamond on the jack of clubs, but eventually loses a diamond and goes down one.

♣9 8 7 6 ♣5 3

SOUTH
♠A J 9 6
♥A 9 5
♦9 8 2
♣A K 10

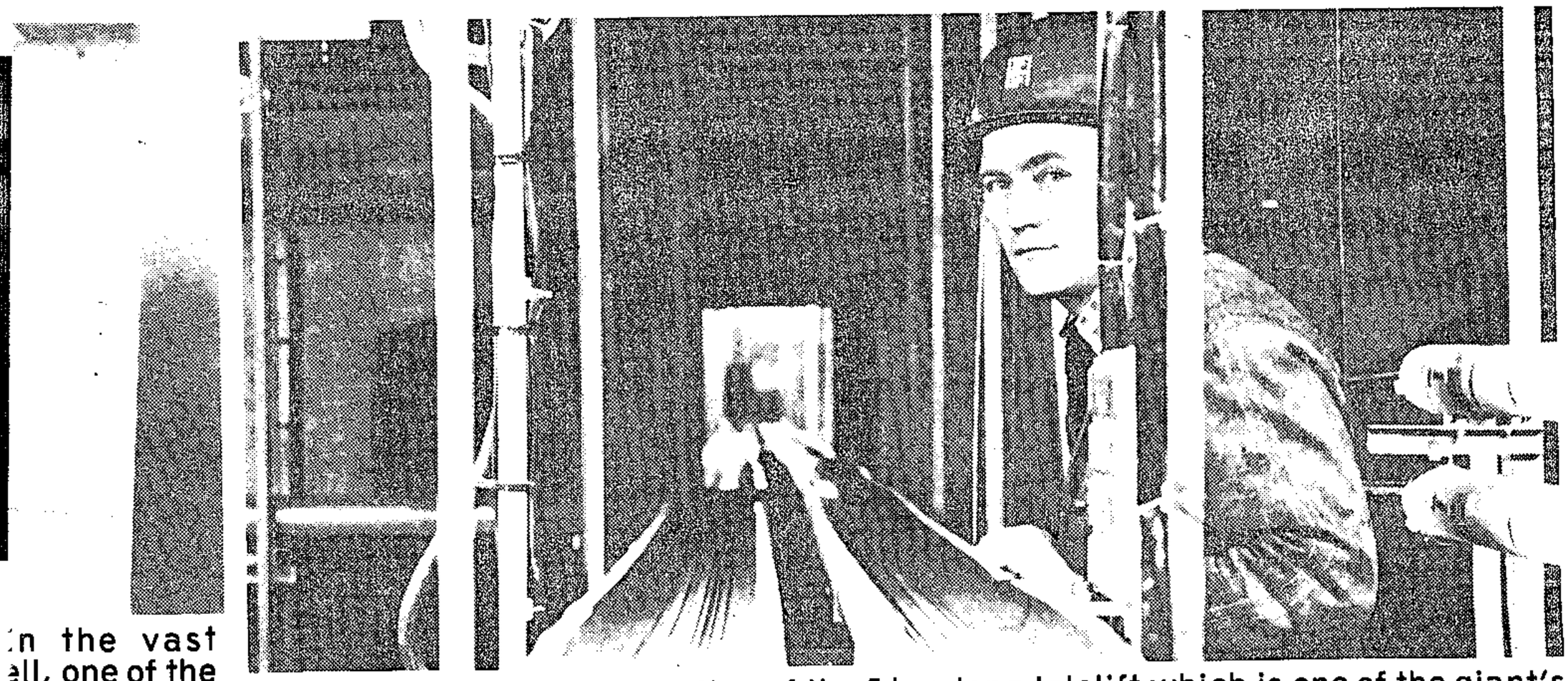
The bidding:

South	West	North	East

apply to the auctioneers. — M
COMPANY, Auctioneers and
Street, (Between Pritchard a
nesburg. Telephone 23-3538, 2

R156m 'city' that's called . . .

biggest, the ugliest



Mr Castell looks down a section of the 5 km-long telelift which is one of the giant's main arteries.

The countdown has begun. In the next three months the Transvaal's newest "town" will come to life. The first phase of the province's new Academic Hospital may even be handling its first patients before the end of the year. Municipal Reporter CHRIS SMITH gives a guided tour of the complex which rivals many Transvaal towns for population, consumption and output.

:n the vast
ell, one of the
:es station in

be a number of wards and even with their own and toilet.
lly it is the largest ated hospital struc- the world. Its 370- ength would cover blocks — all the n the City Hall to on Centre.
ay respects it is a re all on its own. It a post office, bank, ant, bookshop, , hairdresser and It will have its own d a mini "railway" At the push of a but- five kilometres of ill carry articles up weight at 30 metres nute between ories, nurses' sta- d dispensaries.
oing to need all those s. The 2 000 patients e a back-up force of aff and up to 1 000 students.

nall between the two nks has been dubbed l Street and, during peak hours, will carry upwards of 3 000 visitors. This population adds up to a town not much smaller than Westonaria.

Its normal electricity requirements are equivalent to that of Rustenburg and its standby power capacity matches the demands of Heidelburg.

The new hospital has also gone big on cost, although the prefabrication technique and the limitations on frills have kept it lower than it might have been.

When it was planned the contract sum was R72-million, although allowances were made for escalation at 6% a year. This figure doubled during the building time and the Administrator of the Transvaal, Mr Sybrand van Niekerk, recently put the final cost at R156-million. And that's before equipping the complex and building the squash courts and swimming pool.

Those who demand the best will be pleased with the hospital. The leader of the architectural team, Mr Gilbert Colyn, has put the accent of efficiency.

The revolutionary assembly technique will reduce maintenance costs and aid flexibility. Each department can grow or shrink, according to changing needs. It will even be possible to move the 36 operating theatres around the building.

This is because of the brand new idea of 2m-high service levels between each floor.

"It is possible for different tradesmen to work in the service areas simultaneously, without interrupting the normal functions of the hospital," Mr Colyn said. This also meant a considerable saving on construction time.

For efficiency the superintendent of the General Hospital, Dr John McMurdo, gives the new complex high marks. He cites the integration of the medical school, the linear design which makes it "seem more alive" and the ward design, as points in its favour. He has also praised the short, six-year construction time, which is, he claims "a world record".

An illustration of the speed at which the hospital went up can be gained by comparing it to the Tygerberg Hospital in the Cape. This 1 600-bed building took 14 years to build.

Dr McMurdo also has a word for those who have called the new hospital the ugliest construction in Johannesburg.

"One should wait until the entire complex is complete before finding fault," he said. He pointed out that the gardens and shrubs "will mellow the rather severe lines".

Mr Colyn is less defensive. "We could have designed it as a more positive statement but it would have dated," he said. "It is a functional building and it doesn't pretend to be anything else. Criticism doesn't bother me." He also predicted that once trees have grown around the building it will "blend" with the surroundings.

However forbidding the hospital may be from without it is positively gay on the inside. Each of the five sections is painted in a different colour, which will serve as codes for card systems and visitors alike. The walls and doors are an unhospital-like assortment of reds, greens and yellows.

The total effect sums up the attitude of the people who commissioned the building — the provincial administration. It may be ugly, but it wasn't designed to be looked at. For patients and staff alike, what matters is that it is the "biggest and the best".

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98

A 'shrink tank' at work on hospital

Mercury 14 June 77

Mercury Reporter

PIETERMARITZBURG PLANS for the new Grey's Hospital here may have to be revised to reduce the number of beds to 700 from 1 000 originally intended.

The Department of Health has stepped in and suggested that the size of the hospital be reduced because of the enormous costs involved.

Disagreement between Provincial authorities and the State over the size of the hospital will probably delay the call for tenders, according to Mr. Derrick Watterson, MEC, who said yesterday that plans would first have to be amended.

He said the Province was "quite prepared to go along" with the Health Department's suggestion provided that services related to the original intended size of the hospital were incorporated in the new plans.

The issue had not yet been resolved said Mr. Watterson, who added that the Province considered a 1 000-bed hospital would be needed in time.

"At the moment it is a question of reducing the number of wards and reducing the number of beds from 1 000 to about 700," he said.

Site works for the new hospital — to be built on Town Hill — are nearing completion.

Tabel 2 Persentasie samestelling van die gereelde- en seisoens-arbeidsmag volgens ras Natal, 1954/55 tot 1973/73

Jaar	Blankes Getal	Blankes %	Kleur[...] Getal	[...]	Bantoes Getal	Bantoes %	Totaal Getal
1954/55	523	0,3	6669*	[illegible]	[...]1347	95,7	168539
1959/60	725	0,5	330	[illegible]	[...]9794	95,1	147085
1963/64	1711	1,2	495	[illegible]	[...]7954	93,9	146868
1968/69	2202	1,2	242	[illegible]	[...]9912	96,2	176712
1972/73	2139	1,4	220	[illegible]	[...]6271	96,1	152219

* Kleurlinge plus Asiate

Bron: Landbou sensus

Jaar	Blankes Getal	Blankes %	Kleur[...] Getal	[...]	Bantoes Getal	Bantoes %	Totaal Getal
1954/55	-	-	-	[illegible]	-	-	-
1959/60	43	0,1	83	[illegible]	[...]768	98,7	63568
1963/64	-	-	-	[illegible]	-	-	-
1968/69	62	0,1	18	[illegible]	[...]935	98,5	100464
1972/73	31	0,0	19	[illegible]	[...]755	99,7	82071

Bron: Landbou sensus

HANS. 21
24/6/77
Col. 1395

98

Permits for non-Whites for private nursing homes

*3. Mr. H. E. J. VAN RENSBURG asked the Minister of Community Development:

Whether steps are to be taken to discontinue the practice whereby non-Whites have to apply for permits before being admitted for treatment at private nursing homes in White areas.

†The MINISTER OF COMMUNITY DEVELOPMENT:

No. For the hon. member's information it may be mentioned that applications in terms of the Group Areas Act, 1966, for permits of this nature are sympathetically considered on merit and are readily granted in instances where adequate hospital facilities are not available in the applicants' own group areas.

Regional (98)

R60m being spent on 5 psychiatric hospitals

By VICKI ROSENTHAL

PLANS for a R34-million psychiatric hospital for coloureds and four psychiatric hospitals for black patients in white areas have been announced by a Department of Health official.

Until now all black mental patients have been admitted to hospitals serving all race groups or to homeland hospitals.

However, the building of four hospitals for blacks outside the homelands does not mean there will be more beds available, Dr P H Henning, deputy director of psychiatric services, told the Press during open day at Sterkfontein Hospital yesterday.

These hospitals would replace private institutions run by the Smith-Mitchell group which house 8 000 black patients.

The four hospitals, to be built over the next 10 years, would provide 5 000 beds.

They will cost R60-million and will be at Mamelodi, Vereeniging, Daveyton and Soweto.

"There will be a drop in the number of beds for black patients in white areas, but that does not mean less efficient care," Dr Henning stressed. "Fewer beds is in line with a switch from custodial to community-based care.

The hospital complex for coloureds, which comprises 2 500 beds for psychiatric patients and mentally retarded children, is to be built at Mitchell's Plain, near Cape Town.

Dr Henning said plans for more psychiatric hospitals for homeland areas were in the pipeline.

Rebuilding projects for white psychiatric hospitals worth several million rand had been approved.

Dealing with the black staff situation in psychiatric hospitals, Dr Henning said it was disappointing that no blacks had chosen to train as psychiatrists.

Black medical graduates total about 25 a year.

There were two black clinical psychologists in training, he said, and one in practice. The brunt of psychiatric work with black patients was born by psychiatric nurses.

The ratio of nurses to patients was about the same for blacks and whites — roughly one to 10.

Reburial for 1 600 blacks

Staff Reporter

THE remains of 1 600 blacks buried in the Springs New Era industrial area are to be moved and reburied in 25 mass graves in Kwa Thema township.

The Springs Town Council has accepted a R15 000 tender from a firm of undertakers.

The Administrator of the Transvaal Mr Sybrand van Niekerk has consented to the opening of the graves on condition that undertakers do the job.

Twenty-five graves in Kwa Thema have been bought from the East Rand Administration Board for the mass reburial.

An African woman has asked for permission to have the remains of her father buried in a single grave and the undertakers have been told to discuss the matter with her.

POLITICAL comment in this issue by Allister Sparks, Benjamin Pogrund and John Ryan; newsbills by John Ryan; headlines and sub-editing by John Leask; all of 171 Main Street, Johannesburg.

Page 5 / .....

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THE ARGUS, WEDNESDAY JUNE 29 1977

(98)

Atlantis hospital opens

The Argus Correspondent

MALMESBURY. — On Friday the R1-million Wesfleur Hospital at Atlantis, the new township for Coloured people, will admit its first patients.

The building is the forerunner of a larger hospital to be built in the west coast township and will eventually be converted into a day hospital with an obstetric unit.

Plans for the bigger hospital have been drawn, and it will be built when the population of Atlantis justifies it, a spokesman for the Department of Hospital Services said.

Dr E. Erasmus, the medical superintendent of Swartland Hospital in Malmesbury, said the new hospital was the 'most modern and beautiful of its size in the Cape.'

The building has a modern maternity section, an out-patients section with 31 beds, an operating theatre and an X-ray installation.

It will be run and staffed by Coloured people, though hospital administration will be controlled by Dr Erasmus.

The matron will be Mrs M. Potgieter and the secretary Mr C. L. Kotze. Both are staff members at Swartland Hospital in Malmesbury.

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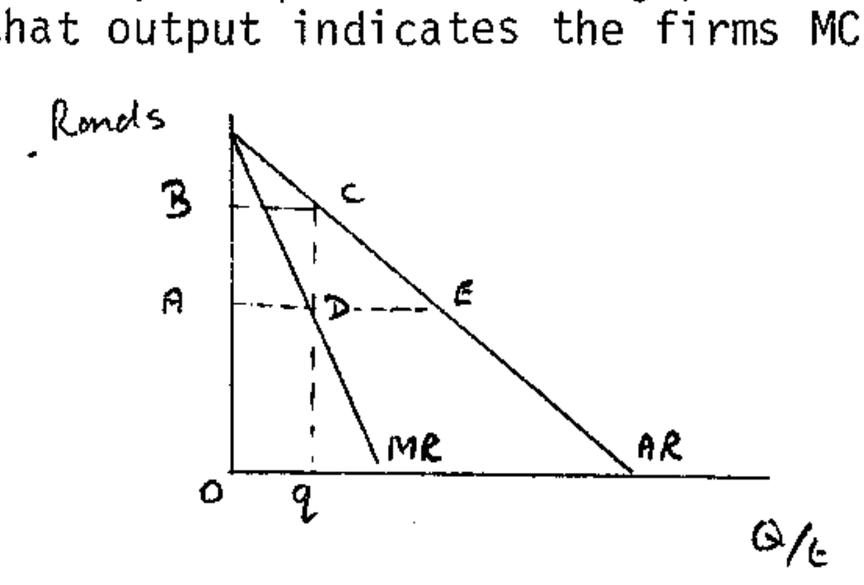
19. A consumer will obtain the most utility from his income when he spends it in such a way that

(1) he concentrates expenditure on those goods which are scarce in relation to his wants
(2) the expenditure of an additional unit of income would yield a diminishing marginal rate of satisfaction
(3) the price paid for the last unit purchased of each commodity is equal to its marginal utility
(4) the average return on his expenditure on each item purchased is maximised
(5) the relationship between marginal utility and price is the same to him for all commodities

20. A monopoly in equilibrium at output Oq is maximising profit (shown by rectangle ABCD). Which letter at that output indicates the firms MC ?

(1) A
(2) B
(3) C
(4) D
(5) E



ECONOMICS

SOME OLIGOPOLY

ra Mark

Oligopoly analysis lacks the preci
or theory of monopoly since oligo
market cases so that, strictly spe
of oligopoly models, each emphasi
shared in the same way, or in the
really is absurd to talk about a
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are meaningless. There are so ma
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Any classification of oligopoly ma
is no clear-cut dividing line.

The following selected models have
For a closer look at the essential
theory, students should refer to th
oligopoly - 2 sellers) Models of Co
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1. PURE (UNDIFFERENTIATED) OLIGOPOLY.

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∴ Prices must be identical.

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(a) ASSUME - Identical Cost Curves.
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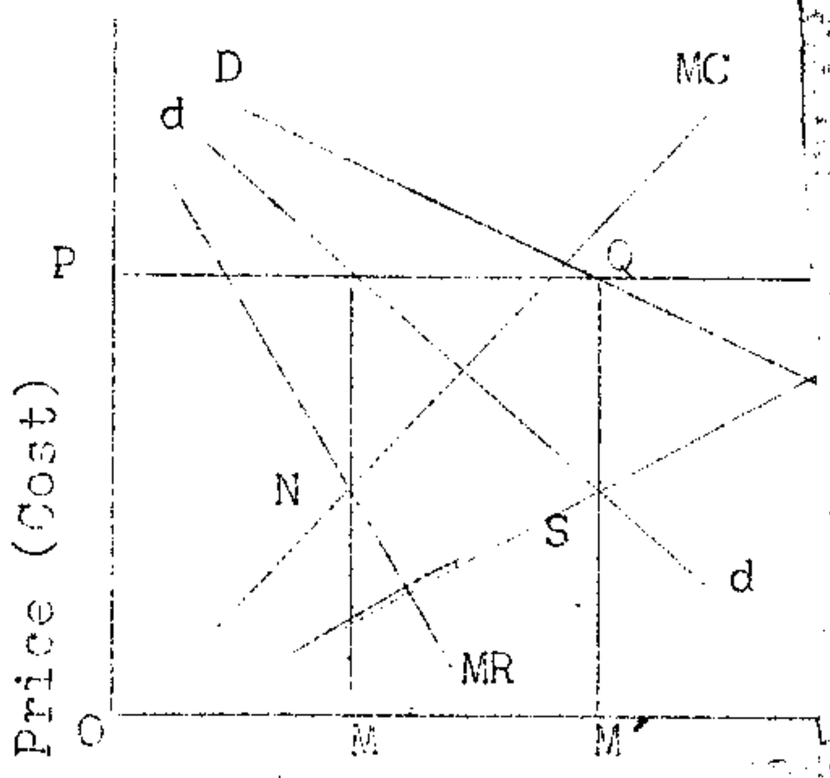

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Spending

In the 1975/76 financial year, his department had used R52 million from the funds of the Bantu Trust for health services and hospitalisation.

This figure was second only to the R54,4 million spent on land acquisition in the same year.

The Sauspoort Hospital had 774 beds, of which 282 were for psychiatric patients, 150 for tuberculosis patients and 342 for general surgical, orthopaedic and obstretic patients and children.

This hospital also served 27 satellite clinics. — (Sapa.)

'Guidance'

"You can be assured that the Government of the Republic, and in particular the personnel of my department, will always willingly give the necessary technical and scientific guidance and advice if your Government asks for it.

"I believe, however, in the potential of your people I believe in the viability of your country and therefore I believe your country has a fine future."

Mr. Botha said high priority was being given to taking over mission hospitals and handing them over to homeland governments, and that the programme would be completed within a four-year period.

Since the programme began on April 1, 1975, the running and personnel of 58 of the 92 missions had already been taken over.

Officiating at the handing over of a former NG Kerk Mission hospital to the Bophuthatswana Government, Mr. Botha said the homeland had taken over its own health services and would probably wish to man them gradually with its own people.

He said: "This can become a reality only if the necessary facilities are made available to train your own people such as medical, nursing, administrative, management and technical personnel and artisans.

SAUSPOORT — South Africa was willing to help Bophuthatswana to establish facilities to train its own doctors and other medical personnel, the Minister of Bantu Administration and Development, Mr. M. C. Botha, said here yesterday.

Hospitals in homeland to be aided

2/7/77 N/MERCURY

STAR 30/6/77

(98)

ACADEMIC HOSPITAL CALLED A 'DISEASE PALACE'

British medic hits at SA hospitals

Marais Malan
Science Editor

Strong criticism of the "prestige syndrome" prevalent in South Africa in respect of hospitals has come from a British doctor who visited this country.

He is Dr David Morley, reader in tropical child health at the Institute of Child Health, University of London, who participated in a community paediatric conference in Johannesburg.

In a report on his visit, he says that on arrival in Johannesburg one of the first buildings he saw was a "disease palace" — the new Johannesburg Academic Hospital.

It is estimated that this will eventually cost about R150-million and that the running costs will be some R45-million a year, he adds.

"In 10 years it is unlikely that any improvement in the health of the Johannesburg population will be identified as a result of investment in the prestige syndrome," Dr Morley writes.

EMPTY WARDS

"Already there are empty wards in Johannesburg hospitals owing to a limitation of nursing resources. And there was some question as to how the salaries would be paid in the existing general hospital in one period of 1977."

Dr Morley contrasts this cost with the approximate amount of R45-million spent in 1975 on health care in the black homelands — a figure supplied by the Institute of Race Relations.

Dr Morley says South Africa has been cut off from recent developments in the evolution of health care systems. There are apparently no health economists or effective health planning units employed by the Government.

There is as yet no evidence of a freeze on hospital building and in fact "disease palaces" are still being built and planned.

MISSIONARY

A Witwatersrand University professor comments:

"One must remember that Dr Morley is a missionary and may be inclined to overstate the case.

"One should nevertheless look carefully at what he has to say about the economics of health planning. For example, are we not spending excessive amounts on hospitals and hospital treatment instead of diverting more money towards primary community health care?"

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workshops and lectures which led to discussion with

'Disease palace' era is ending

STAR 5/7/77

Science Editor

The era of the large hospital — the so-called "disease palace" — has come to an end in South Afrita, according to the Secretary for Health, Dr Johan de Beer.

This principle, already in operation in most Western countries, had been accepted by the Treasury, and further health programmes would be developed along these lines, he said in an interview.

Dr de Beer was commenting on criticism by a British doctor at the "prestige syndrome" from which he alleged South Africa suffered in respect of hospitals.

In a recent report on a visit to this country, Dr David Morley, of London University, cited as an example the new Johannesburg Academic Hospital, which cost R150-million to build and some R45-million a year to run.

CO-OPERATION

Yet, he added, it was unlikely that any improvement in the health

"Some hotels invest up to R350 000 in sophisticated equipment," Mr Pieterse said today.

"The Minister's statement in Parliament took us by surprise but it turned out to be a bit of a misunderstanding," Federasa president Mr Mike Pieterse said today.

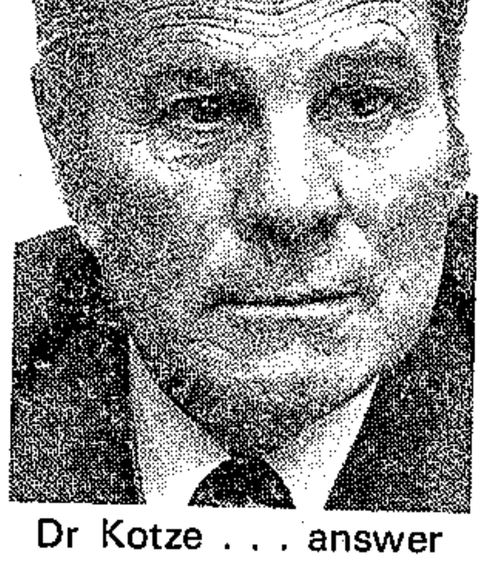
Hoteliers throughout the country protested and in a later meeting with the Minister pointed out that the industry would lose between R5 m and R7 m if they were not allowed to charge tariffs.

Senator van der Spuy of Posts and Telegraphs said hotels should abandon service tariffs.

Cape medical services reaching out to the whole community

CAPE TIMES 18/7/77 (98)

letters



Dr Kotze . . . answer to criticism.

From Dr R L M KOTZÉ, Director of Hospital Services, Cape Province:

1. IT IS noted in the editorial column of the Cape Times (July 12) that you level reproach at this Administration on its attitudes towards certain hospital and health matters. This rare opportunity was offered by utterances of an overseas critic, Dr Morley of England, which you have only too willingly lapped up, labelling him as an eminent medical man who saw South Africa as "cut off from recent developments in the evolution of health care systems," etc. You have made use of deductions from his criticism of the new Johannesburg Academic Hospital and his reference to a "prestige syndrome" which South Africa is alleged to be suffering from in respect of the erection of hospitals of such size, to drag in our Tygerberg Hospital as another example of the disease, in order to attack this Administration. Incidentally, Dr Morley has, to my knowledge, not even taken the trouble to discuss his views with, nor sought genuine information from, any informed person attached to my staff.

Best value

2. I have personally seen, and thoroughly studied, both in your critic's home country and in other countries, quite a number of the top new hospitals similar in size to the Tygerberg and Johannesburg Hospitals, costing considerably more yet not being able to offer anything near a similar scope of efficient services. I can assure you that, for its size and potential, the Tygerberg Hospital is probably the best value in hospitals that money has ever purchased. Instead of contending with hospitals spread over the entire larger Cape Town area with professors, lecturers and students wasting much valuable time in travelling to and fro to different places, we planned a hospital of that size, in one complex in order to offer facilities for the training of and making available to the country 150 doctors a year in addition to in excess of 200 specialists continuously in training there. Besides this, the hospital acts as a training centre for just about every possible hospital career in the nursing, technological, dietetic, bio-engineering and every other thinkable field. There is today no time that can be allowed to go to waste when medical training has to keep pace with rapidly changing modern developments. Also to be borne in mind is the fact that teaching staff for the training of the different categories of health personnel is limited and has to be concentrated in a large institution.

To keep abreast

3. Your critic may say what he likes about academic hospitals of this size but I can assure you that circumstances demand that they be

Treasury a thorough study has been carried out by South African experts and the so-called SAHNORM report has been made available to all health authorities in South Africa. According to this report ample provision is made for proper facilities to be provided in academic and other hospitals and if hospitals, for certain valid reasons, have to be erected of a greater size than the "economic size" of 600 beds, approval can be obtained to do so.

4. In regard to your critic's allegation that South Africa is cut off from recent developments in the evolution of health care systems, and there being no health economists or effective health planning units employed by the central government, I can only say that he cannot possibly be referring to the situation as it prevails in the Cape Province, otherwise he would be making a totally unfounded indictment. As a result of the Administration's continued vigilance it has for a long time been fully realized that the provision of health services for which this province carries the responsibility and which includes hospital services, had reached the crossroads, and that a new goal should be set, taking into consideration the prevailing economic and social conditions in the province and the country as a whole. Responsible authorities are meeting more and more problems in finding an answer to this, and it has become increasingly difficult for the supply to meet the demand by using present methods only. This Administration has succeeded over the years in building a very respectable hospital service which has deserved the praise it has earned, both inside and outside our borders, and which has stood up well in comparison with comparable services elsewhere in the country and abroad. The needs of the community have, because of various factors, undergone a marked change. These factors have collectively called for a revision of the traditional pattern which had been followed in providing these services, namely, to only provide hospital beds augmented by out-patient services, and district surgeons and district nursing services provided by the Department of Health.

ample a nurse with further training. Conditions which are mostly encountered, calling for treatment at that level, are in the geriatric, paediatric, psychiatric, obstetrical, family planning and community health fields.

6. We find ourselves, therefore, in the fortunate position of having at our disposal graded facilities. The most highly specialized degree of service is seated in our hospitals with in- and out-patient services, of which the highest efficiency is at our larger academic teaching hospitals. Treatment here could be regarded as tertiary care. This is followed by our regional specialized and general hospitals, and, in turn, followed by district and cottage hospitals as well as our day hospitals and doctors' practices, bringing us to the level of secondary care, and, ultimately, to primary care at the periphery of the community, as will exist in the "mini"-community health centre already described. We thus have a pyramid of medical services reaching to the total community. In a sense the service will be hospital-centred, but only in so far as that the academic hospital will be the apex of the pyramid based on a broad structure of primary care service. This pattern protects the academic hospital from being over-run by a large number of neglected cases requiring beds to be treated in. It could be said that our medical services are truly moving outwards because they are moving outside of hospital walls as far as a large share of our responsibility towards the community goes. Our facilities are, therefore, continuously and realistically adapted to the needs.

In bad taste

7. I would like any critic to offer a more sound concept of planning of medical services to a community in a country such as ours. As far as I am concerned the kind of comment, regarding conditions here, as quoted by you, is uncalled for and in bad taste. Dr Morley must surely be aware of the shortcomings in health services in his own country and will be well advised to spend more time in sweeping before his own door.

[Our criticism was based

persisted in, in South Africa and in other countries, naturally with adaptations, to keep abreast of sophisticated patient care and the training of people to carry out the task. At the instigation of the

New concept

5. Ten years or more ago, a start was made in this province by further augmenting these services with a new concept, the establishment of day hospital services and detached clinics. We found that by this move we saved many hospital beds and we realized that we can still improve on this aim of keeping more patients out of beds. In order to achieve this we have set our course by adopting the concept of establishing even smaller units where necessary, as will be the case in isolated areas in the province. By this means we are able to provide for everyone, at elementary level, preventive services, early detection and identification of disease as well as treatment at an early stage, which means that we will be providing primary (or basic) care services to the total community. For a basic service of this nature it is also possible to make use of someone less trained than a doctor, for ex-

on a previous Cape Times investigation, not on Dr Morley's views which merely tended to confirm our view. It is open to debate whether Tygerberg Hospital and similar massive showpieces are the best means of improving our medical services; we have, for instance, the view of the Secretary for Health that the era of the large hospital has come to an end. Many people still have to be convinced that there is no place in the hospital services of the Cape Province for one of the Peninsula's best-loved institutions, the Rondebosch Cottage Hospital. — Editor, Cape Times.]

D.D. 24/7/77

Tea sales swell Santa coffers

98

EAST LONDON — Thanks to the stout effort of volunteer workers at Marina Glen tea garden the coffers of the East London branch of the South African National Tuberculosis Association have swelled to over R14 000.

In the set of financial statements for 1977 presented at the annual meeting of the East London branch of Santa last night, the profit made increased from R4 817 in 1976 to R14 229 this year.

The board of trustees and members of the executive committee elected last night congratulated the volunteer workers for what was described as a "terrific achievement".

Presenting his report, the chairman of the Santa branch, Dr A. Freer, said 858 patients had been admitted by Santa for treatment, of whom some 715 had later been discharged fit for work.

The average daily bed occupancy was 266,15, while the average number of patients treated for up to six months was 252,75.

Following the chairman's report saw the election of a new board of trustees and members of the executive committee.

There was overwhelming applause for the services of Mr I. D. Ross Thompson, who retired last night as president of the board of trustees.

Mr D. Rathbone, who was elected president for this year, said Mr Ross-Thompson had devoted "a great many years to Santa, had been associated with them for over nine years and that the association owed him a great debt of gratitude for his dedication and service".

Vice-presidents elected to the board were: Mr P. Sutton and the Medical Officer for Health for East London, Dr J. Van Heerden.

For the executive committee, Dr A. Freer was re-elected chairman, while Mr M. Luck, Mrs L. Pistorius, Mr J. Ross, Mrs A. Anand, Dr L. Schneider, Mr J. Price and Mr P. Kietzmann were elected members.

Following the meeting, the chairman of the South African Christmas Stamp Fund for the Border area, Mr J. Gloster, presented Santa with a cheque of R3 000 for the purchase of a mobile clinic. — DDR

15th August: the social and economic consequences of Roman imperialism
Lewis and Reinhold i, chapter 3 refers.
Scullard History of the Roman World and Brunt Social conflicts ... for general introduction.

16th August: Tiberius Gracchus and the beginnings of the Roman Revolution.
For background reading see: Scullard Gracchi to Nero 3rd ed. '70).

17th August: ATHENS : THE ACROPOLIS (Professor L. Baumbach)

18th August: Gaius Gracchus
Lewis and Reinhold i, 240 sq. refers

19th August: Marius and the Italian connection
Note T.F. Carney's Biography of Marius Salisbury 1972.

22nd August: Marius the Social War and the first coup d'état.

23rd August: Sulla the deadly reformer
Lewis and Reinhold i, 269 ref
E. Badian Lucius Sulla (Xero [illegible] llection).

CAPE TIMES 9/8/77

Municipal health aid free to all

98

MUNICIPAL health services "from the womb to the tomb" are now available free to all sections of the community as part of a major reorganization of City health clinics, according to a City health department statement yesterday.

The reorganization, begun in 1974 and now almost complete, has been achieved solely by increased staff productivity, the statement said.

The scope of the services — with emphasis on the prevention of illness before it can occur — extends through ante and postnatal services; mother and child welfare; immunization, child assessment; eye, ear and dental clinics, and family planning.

There is close liaison with the Day Hospitals Organization and the City Health Department has divided its operations into three main zones.

These are Claremont to Kalk Bay including Guguletu, catering for 320 000 people; most of the Cape Flats including Mitchell's Plain — about 285 000 people; and Camps Bay to Milnerton covering central City area and Langa — about 280 000 people.

Householders or family members can get further details from the City Health Department, Libertas, Foreshore, or ring 41-3411 during office hours.

ARGUS 9/8/77

2 Indian interns for Groote Schuur

98

GROOTE SCHUUR HOSPITAL will appoint Indian doctors as housemen for the first time next year.

A hospital spokesman said today two Indian medical students from the University of Cape Town would serve their internship at the hospital next year. The spokesman declined to give their names.

Somerset Hospital in Green Point has up to now been the only Cape Town hospital to accept Indian interns.

The Deputy Director of Hospital Services in the Cape, Dr J. L. Jordaan, said today other Cape hospitals that accepted non-white doctors as interns were Livingstone Hospital in Port Elizabeth and Lovedale Hospital in Alice.

Hospital paralysis

M-Mercury 29/8/77

THE FINDINGS of a recent Durban Chamber of Commerce survey on hospital facilities for Blacks in Durban should cause deep public concern in a country where disease and malnutrition are endemic among a large number of African people.

In 1967 Mr. A. D. Gourlay, a member of the chamber, was in charge of a survey into the critical shortage of hospital beds for Africans in this city. He has recently completed a similar survey. 'It is difficult to believe, but the chamber's investigations reveal that in the intervening 10 years "hardly an extra hospital bed for Blacks has been provided."

Kwa Mashu still has to make do with a polyclinic and two Durban Corporation clinics. Plans for a hospital in the township appear to have been abandoned. The 1 200-bed hospital for Umlazi, originally planned for completion in 1968, will not be ready until 1983 at the earliest, according to the survey.

For pity's sake how does the Government justify this situation? The original argument was that no extensions would be made to King Edward VIII Hospital because it was in a White area. It would make way for a White institution as soon as adequate hospitals had been built in KwaZulu.

It was suggested that a polyclinic could be established to treat, and then transfer emergency cases still living in White areas.

If anyone still doubts that theory is not matching practice then let them go to King Edward and watch the long queues of sick waiting for attention. Let them see that patients do not only sleep on top of beds but under them as well. It is a sight which should shock even the most heartless.

The Regional Chambers of Commerce have called on the Government for a review of its health policies. We hope that businessmen can shake the authorities out of their lethargy.

colour bar. Scientific Publications London. pp 256. of the native miners lay in this, by GRIMES, B.H., & HUBBARD, M.C.E., 1971. A comparison of film type and counterparts winning substantial wage concessions. Yet if they struck, the importance of season for photo interpretation of coastal marshland the police were called in and their leaders imprisoned. The cost of and vegetation. Photogramm. Rec. 7(38):213-222. living had increased but their wages remained static. Native miners were prevented from bargaining for higher wages by the pass laws and HAMILTON, G.N.G., & COOKE, H.B.S., 1965. Geology for South the contract African students. C.N.A. Ltd. or S.A. 5th Ed. pp 441. system. Thus the labour of native miners was made more 1st Edition, 1939. easily exploitable by the implementation of a policy of segregation where HARMSE, H.J. von M., & DU PLESSIS, M.M. Notes on the Algemene Bodemkunde. unpubl. Navorsingsinstitute van die Hoeveldstreek, Potchefstroom. The S.A.P. also maintained the principle of segregation by making laws HARMSE, H.J. von M., & GROBLER, J.H., 1966. Soil regions in the Hoe- which applied to whites and not to natives. This was especially not- veldstreek. Tech.Med.Dep.Landbteg. Dienste 55:38 iceable in the field of education. It was compulsory for whites to HARRIS, R.W., 1951. Use of aerial photographs and sub-sampling in range attend school yet natives had few educational facilities. Education inventories. J. Range Mgmt. 4(4):270-278. was the means of getting the vote in the Cape and entry into the system. HATCH, F.H., & CORSTOPHINE, G.S., 1909. The geology of South Africa. MacMillan & Co., Ltd., London. pp 379.

(12) This is one of the arguments presented by both Johnstone and Legassick.

(13) Hancock, Commonwealth Affairs, p. 54.

98

Standstill on Black hospitals

24/8/77

Mercury Reporter

HARDLY a single extra hospital bed for Blacks has been provided in the Durban area in the past 10 years, according to a Durban Chamber of Commerce survey.

Mr. A. D. Gourlay, a member of the chamber, surveyed the critical shortage of beds in 1967 and again this year and found that none of the promised solutions had materialised.

Hospitals at Kwa Mashu and Umlazi, planned to ease pressure at King Edward VIII Hospital and eventually replace it, were nowhere near complete.

Plans for the Kwa Mashu hospital seemed to have been scrapped completely and the 1 200-bed Umlazi hospital, originally promised for 1968, would not be ready until 1983 at the earliest.

The Government had refused any extension of the overcrowded King Edward Hospital because it was in a White area and planned the Umlazi and Kwa Mashu hospitals instead.

Reconsider

As a result of the survey the Regional Chambers of Commerce congress has called on the Government and the Province to reconsider the policy of big-hospital health services and to bring health under a single co-ordinating body.

At Kwa Mashu the only health services were a provincial polyclinic and two Durban City Health clinics.

The Phoenix Indian area with a planned eventual population of 200 000 did not even have a clinic, apart from one for family planning.

Queues

The result was a massive surplus at King Edward VIII Hospital which treated 600 000 patients a year, leading to long queues and patients sleeping "not only on every bed but under the beds."

The report proposed that King Edward be retained — contrary to the Government's plans to scrap it — but only as a base, in-patient hospital.

The out-patient service should be transferred to clinics in the Black residential areas on the principle that health services should go to the people, not vice-versa.

These would be cheaper than the proposed hospitals which have been scrapped or delayed because of vast cost.

Mike Barkusky
Economics Honours 1977.

Researc

(98) FM 9/9/77

Thursday 29th August
2.15 PM.

Price and Output Determ Manufacturing

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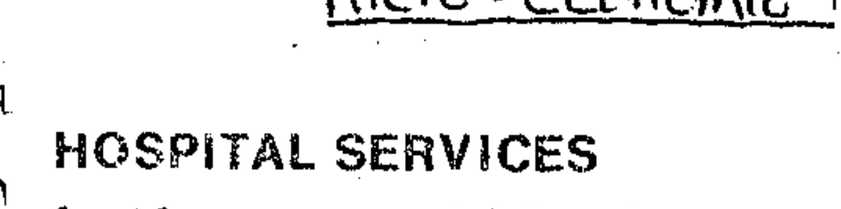

HOSPITAL SERVICES

Lethargy and ideology

Natal's senior MEC, Frank Martin, whose portfolio includes hospitals, remarked dryly at the recent regional chambers of commerce congress in Durban that "Health does not enjoy a high priority in SA."

The comment was provoked partly by the scandal of Umlazi Hospital, which was started in January 1968. Almost a decade and R3m later it has advanced no further than the structural skeletons of a nurses' home and an outpatients' department and some castings on the site of the hospital itself, designed for 1 200 beds.

Every time the issue is raised, government shrugs its shoulders and pleads lack of funds. The latest revised date for completion is 1983. The effects of the delays have been aggravated by government's refusal to allow expansion of Durban's big hospital for blacks, King Edward VIII, because of its position in a "white" area.

King Edward has had to bear an impossible load, coping with more than 600 000 outpatients a year and full occupancy of its 2 200 beds. Only a dedicated medical staff has made this possible. Ironically their very success has worsened the position: the hospital's reputation is attracting black patients from all over Natal.

Meanwhile Umlazi township, which is now part of KwaZulu, has to make do with clinics. In 1975 the Umlazi polyclinic handled 225 024 cases, KwaMashu polyclinic 158 992. Another 80 000 patients were treated at additional clinics in both townships.

These are some of the problems the KwaZulu Department of Health is going to have to cope with when it comes into being on October 1. Another is the perpetual battle to find staff. "Don't ask me where KwaZulu is going to get them from," says Martin.

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both product, fashion product, manufacture. No. of firms in the industry, competition, marketing and production practices. Diversification of ranges, brand differentiation, temporary price inflexibility.

SECTION III PRICE AND OUTPUT DECISION PROCEDURES - THE RISK OF SUB OPTIMALITY

Procedures used to set prices. Sources and extent of possible suboptimality.

SECTION IV OUTLINE OF A POSSIBLE MODEL

Modelling the multi product firm. Mathematical generalisation of monopolistic competition model to the multi-product case. The Clemens model. - application of price discrimination analysis to the multi-product case.

SECTION V ESTIMATION OF COST FUNCTIONS

Estimation of empirical cost functions by regression analysis on adjusted time series data.

September 22, 1977

N. Mercury (98)

HERS
WOMAN'S PAGE

A pressing need for clinics

THERE IS A PRESSING NEED for more menopausal clinics in the Durban area where women can discuss their problems, and there is a marked apathy among some Durban doctors to treat women experiencing menopausal symptoms.

These two points came out strongly during a series of film shows in Durban recently demonstrating the therapeutic uses of natural oestrogens, hormones which often become deficient in women once their childbearing years are over, causing a variety of symptoms from hot flushes to deep depressions, and even brittle bones prone to fractures.

Many of the 1 500 women attending the film lectures in Durban questioned: "Have the doctors seen these films?" or said: "My doctor just gives me tranquillisers and tells me to pull myself together."

"Have the doctors seen these films?"

In an article on this page in August HERS outlined the symptoms and treatment of menopausal deficiencies as outlined in the film lecture series.

The response was phenomenal, all pointing to the facts that (a) women have insufficient knowledge about this stage in their lives and (b) they are not getting the treatment to which they are entitled.

A doctor from the Department of Social Work, University of Durban, Westville, attending one of the film shows highlighted the need: "Women themselves must press for more menopausal clinics" he said.

There are clinics at Groote Schuur Hospital in Cape Town and Johannesburg General Hospital. At Addington Hospital, Thursday clinics at 1 p.m. can only be attended by women referred by their own doctors, if they are assessed as a hospital patient (that is if their income is below a certain level) or referred from outpatients in the hospital itself. If a woman's doctor won't refer her there (or to a private gynaecologist), that is he considers her merely neurotic, all she can do is shop around for another doctor, which can be difficult because of the reluctance of doctors to take on another colleague's patient without referral.

Here are some of the general questions most women asked during the lectures:

Q. What is the effect of a hysterectomy on the average woman? 1. A total hysterectomy. 2. Leaving one ovary only. 3. A partial hysterectomy.

A. 1. Total hysterectomy. In this case the ovaries and uterus are removed. If she is menopausal or post-menopausal she will not be affected as her ovaries have stopped functioning. If she is on oestrogens she will have no withdrawal bleeding. If she is, say, 30-plus and her ovaries

"My doctor just gives me tranquillisers and tells me to pull myself together."

still function, by removing them she is likely to have typically menopausal symptoms.

2. One ovary left. One ovary is usually sufficient to carry out the normal function.

3. Partial hysterectomy. The ovaries will function to produce oestrogen and progesterone but there is no uterus. If the woman is young she will not need oestrogen. If older she may.

Q. What is the difference between a natural and a synthetic oestrogen?

A. Natural oestrogen is only obtained from human or animal sources. The medical form is "conjugated natural oestrogens USP."

"Women themselves must press for more clinics."

It therefore relates to the natural hormones in the body. A semi synthetic oestrogen is obtained in the laboratory by adding various chemicals to the natural substance some of the compounds having similar names to the natural ones, which can be confusing. A synthetic oestrogen is made completely in the lab. The oral contraceptive pill contains a single synthetic oestrogen. Natural oestrogen is given in a far lower dosage than the synthetic oestrogen in the pill.

The single synthetic oestrogens in the pill are unable to treat all the menopausal symptoms. Natural oestrogens are considered safer than synthetic ones with fewer side effects.

Q. How does my doctor diagnose the menopause and my need for natural oestrogens?

A. By recognising the symptoms during discussion or by taking smear tests to assess oestrogen levels.

Q. Is there a male menopause?

A. There are no defined symptoms, but how many men go through a trying time because their wives are suffering from the menopause without knowing it? (Dozens of those attending the film lectures were men!)

ANN MARSHALL

(98) RDM 20/10/77

Botha opens R6m hospital

ROODEPOORT. — The Minister of Bantu Administration and Development, Mr M C Botha, officially opened the R6 500 000 Leratong Hospital near Roodepoort yesterday.

The hospital, which will eventually cater for more than 700 black in-patients, is designed to serve the municipal areas of Krugersdorp, Randfontein, and Roodepoort.

It has recently been approved as a training centre for black nurses, and additional facilities costing nearly R3 000 000 are planned. — Sapa.

R6,5-m hospital for blacks opened

(98)
Argus 20/10/77

The Argus Correspondent

PRETORIA. — A new R6,5-million hospital for blacks near Krugersdorp has been opened by the Minister of Bantu Administration and Development, Mr M. C. Botha.

The hospital Leratong, at present has 600 in-patients, with out-patients and casualty sections, and departments of surgery, gynaecology and obstetrics, paediatrics, internal medicine and diagnostic radiology.

There are 13 theatres.

The Minister said the cost of equipment in use at the hospital amounted to about R750 000.

There are 1 095 nursing, clerical and general posts at the hospital.

Mr Botha said the hospital was for blacks and that they had to help the authorities in whatever way they could to keep it running as an institution of which they could be proud.

98

Star 23/11/77

Rebuke to council over new hospital

The Administrator of the Transvaal, Mr S G J van Niekerk, has accused the Johannesburg City Council of objecting to having the new Parktown hospital in Johannesburg.

The council had asked the provincial administration to pay R972 000 for roads to serve the new hospital but this was turned down last year. The city council then appealed directly to Mr van Niekerk.

The council claimed certain roads, such as Princess of Wales Terrace, would not have had to be reconstructed if it were not for the hospital. A new bus service would have to be provided to serve the hospital.

But following the council's latest appeal to him, Mr van Niekerk lashed out at the council.

"These objections are tantamount to objecting against having the hospital in Johannesburg," he said.

PROUD

"The Provincial Administration has provided your city with a hospital of which it can justifiably be proud, and I think your council should willingly accept its responsibilities in regard to the provision of suitable access roads."

"Under the circumstances I regret . . . that I see no exceptional circumstances which justify the payment of a subsidy," Mr van Niekerk wrote to the council.

Polaroid pull-out saves cash

By RENNIE BOTHA

SOUTH African medical experts produced a cheap and effective substitute for X-ray plates for mainly bought from Polaroid, the American photographic giant which this week announced it was pulling out of the country.

Mr Dave Epstein, opposition spokesman on hospital affairs in the Transvaal Provincial Council, said yesterday: "The X-ray pictures in our hospitals used Polaroid X-ray plates.

"We foresaw the company's action and prepared for the use of other plates by a minor modification of the unit. Each costs about R350.

"We have found that X-ray plates can be made in South Africa at one-fifth of the price of the Polaroid plates, saving us hundreds of thousands of rands.

"The plates are now being locally produced.

"The overall results are, in fact, better than the Polaroid system."

Polaroid announced its pull-out after ending its South African distributorship. Frank and Hirsch. It secured the firm of selling equipment valued at about R8,5-million a year to the Government.

Mr Helmut Hirsch, joint managing director, said yesterday: "We never supplied the Government directly. We supplied retailers, who in turn supplied various Government departments. Polaroid was fully aware of this.

"A large percentage of Polaroid cameras and film is bought by blacks. Polaroid's action will not only affect South African blacks, as well as whites, but black states in and around South Africa.

"Thousands of people have bought expensive Polaroid cameras. Now they won't be able to get any film."

Mr Hirsch was speaking before leaving for America to discuss the matter with Polaroid executives.

He said: "When I meet them I will try to explain the true picture in South Africa. I believe there is a lack of knowledge of what really goes on here.

"I will tell them that they are about to hurt the people they initially tried to help, our blacks.

"If I am not successful in having the embargo withdrawn, the effect on our company will be substantial.

"There is no racial discrimination in our company whatever. Our black employees are among the highest paid in the country.

"Black members of Polaroid have given me gifts as a token of thanks for what we are doing for the blacks in South Africa. Now the company turned its back on us."

Mr Hirsch said Polaroid had not withdrawn its grant of R48 000 a year to a trust fund

MR DAVE EPSTEIN
"He saw it coming."

for the improvement of the lives of black people in South Africa.

It had been contributing to the fund for eight years and is committed to continue until 1978.

A spokesman for Frank and Hirsch said it will continue advertising Polaroid products until the end of the year because it still has big stocks.

DD 9/12/77 (98)

Pefferville clinic plan

EAST LONDON — The City Council is planning to build a comprehensive clinic in Pefferville at an estimated cost of R152 000.

The Medical Officer of Health, Dr J. van Heerden, showed the members of the Coloured Management Committee the plans of the proposed clinic and said a similar clinic was planned for Buffalo flats.

He said once this clinic was built it would provide better facilities than the clinic at Parkside. He also told the CMC there were three vacancies for Public Health nurses.

The CMC agreed that the council could go ahead with the planning of the clinic and agreed that the one at Pefferville should be developed first instead of the one at Buffalo Flats. — DDR

Cape Times 6/1/78

98

Doctors vote against overtime threat

Own Correspondent

JOHANNESBURG. — More than 60 of the Johannesburg General Hospital's doctors yesterday vowed to fight "to the point of resignation" against a departmental threat that they will be sacked if they do not agree to work unlimited overtime.

Doctors made this decision at an afternoon meeting at which they also learnt for the first time, that "sick leave, even for illness contracted through hospital infection, will in future be deducted from their one month's annual leave".

"To come with threatening circulars when the shortage of doctors is crucial, is an insane thing to do," one senior doctor said.

"As for deducting sick leave from our annual holiday — obviously doctors are exposed to infections. Should a doctor get hepatitis which puts him out of action for a month, he would forfeit his whole year's leave."

The doctors have already protested to the hospital's chief superintendent, Dr John McMurdo.

Dr McMurdo refused to comment.

The department's ultimatum to the doctors arrived in two circulars.

The doctors, who have already agreed to work a minimum of 40 hours overtime a week, are asked in one circular to agree to work an unlimited number of hours or forfeit all overtime pay. If they refuse to sign this, and so far not one doctor has, they are asked to sign a second undertaking that they understand they will be called on for extra duties. If they refuse to sign this one they will be fired.

• JOHANNESBURG, JANUARY 8, 1978

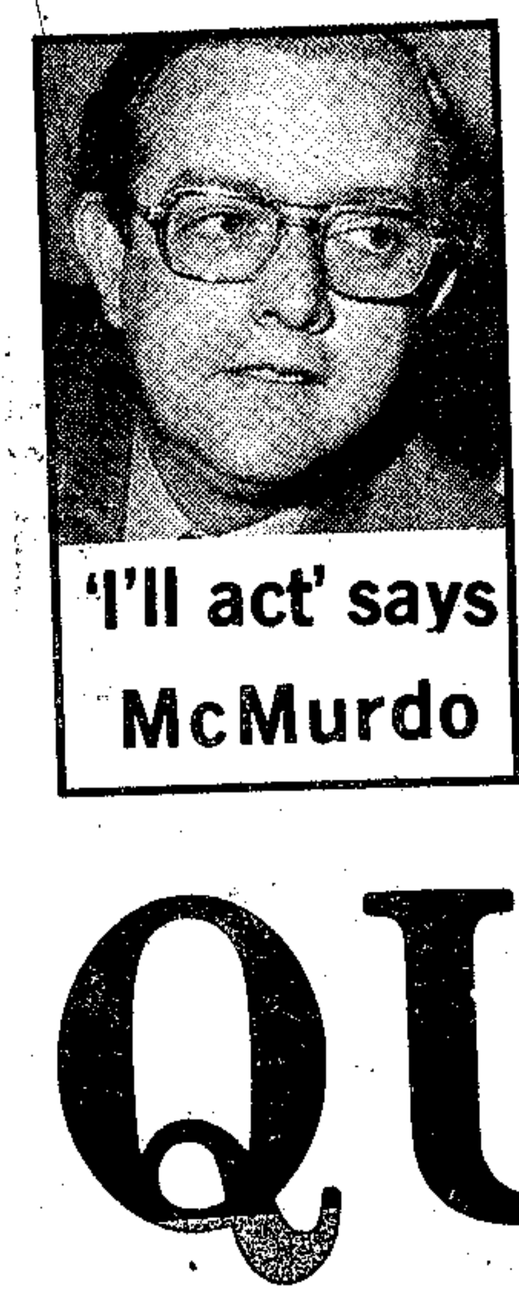
Rand man hauled off international flight at Lusaka — held in jail

PAGE 3

98

Sun Express 8/1/78

ANGRY DOCTORS WARN: WE'LL QUIT SA



'I'll act' says McMurdo

Doctors' threat

From Page 1

have sought advice from the Medical Defence Union and will take their findings to the Medical Association of South Africa.

Refering to the protest of doctors at the General Hospital as merely "a tremendous storm in the tea cup", the chief medical superintendent of the hospital, Dr John McMurdo, admitted there was a shortage of doctors at the hospital which called for more overtime but said the situation was not yet critical

He said the shortage of doctors was being created by escalating emigration and an increasing flow of doctors to the army at a crucial stage in their junior career.

He said doctors who planned to leave the country over the present issue were "free to do what they wanted". But doctors who planned retaliatory measures would be dealt with in a "disciplinary manner".

ANGRY doctors at Johannesburg General Hospital are threatening to quit South Africa in a group unless there are changes in "harsh" working conditions laid down by Provincial circulars.

The Sunday Express spoke to several doctors this week about their deep dissatisfaction over the circulars which they have been told to sign.

One doctor said he and his colleagues would emigrate if they resigned over the issue — "which we plan to do" — because other provincial hospitals would not admit them into service if they quit.

The doctors also threatened to:

By BARRY LEVY

- Detain patients in hospital for longer than necessary, thus keeping beds occupied;
- Perform unecessary blood tests;
- Use hospital equipment in an "expensive" manner;
- Make personal long-distance calls on hospital telephones.

The doctors have been angered by various clauses in the circulars including one which demands that they work unlimited overtime.

Their other objections are to stipulations that:

- The authorities have the right to move them from hospital to hospital;
- If they accumulate leave, they will not be entitled to normal holiday overtime pay when they take it.
- They will not be entitled to normal holiday overtime pay for any sick leave over 30 days a year, even if they suffer from an illness contracted while on duty.

Although the circulars are merely a reaffirmation of previous ordinances and regulations with the exception of a maximum of 30 days leave a year with renumeration, the doctors say they are "insulting" to their integrity. They say that because of the "harsh" tone taken it is time "to reconsider the entire regulations".

The doctors also fear the circulars will result in enforcing work over the average 60 to 80 hours a week which they do now.

They say it is not "humanly" possible to work effectively under such conditions.

A group of about 60 dissatisfied doctors already

To Page 3

HANSARD NO. 2 COL. 29 7/2/78

98

Hospital beds for Bantu

3. Mr. N. B. WOOD asked the Minister of Bantu Administration and Development:

How many hospital beds are available to Bantu in (a) the Bantu homelands whose governments have not taken over health services and (b) White areas of the Republic?

The MINISTER OF BANTU ADMINISTRATION AND DEVELOPMENT:

(a) 668.

(b) Hospitalization of Bantu in the White areas of the Republic of South Africa is the responsibility of the Provincial Administrations concerned and the Republican Department of Health. The required information is not being kept by the Department of Bantu Administration and Development and can therefor not be furnished.

HANSARD No. 2 cols. 33, 36, 37, 38 8/2/78

(98)

Salary scales for professionally qualified persons in hospital/health services

49. Mr. D. J. DALLING asked the Minister of the Interior:

What were the salary scales laid down as at 1 February 1978 for (a) White, (b) Coloured, (c) Indian and (d) Black professionally qualified persons in State and Provincial hospital and health 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	7 170–7 440 × 390–9 000	6 090 × 270–7 440
Pharmacist	6 090 × 270–7 440 × 390–8 220	5 010 × 270–6 900	4 110 × 180–5 010 × 270–5 820
Trainee Parmacist	4 470 (fixed)	3 570 (fixed)	2 454 (fixed)

The above-mentioned scales do not include allowance payable to the personnel.

Star 9/2/78 (98)

Hospital plan for blacks

The director of hospital services, Dr H Grove, has confirmed that about 20 ha of ground in New Canada, near Soweto, has been bought for the construction of a black hospital.

He said the project was in the planning stages and no particulars on when construction would begin were available. The current indication was that the hospital would have more than 1 000 beds. —Sapa.

HANS. NO3. Col. 154 17/2/28

X

98

Hospital at Umlazi

*3. Mr. G. N. OLDFIELD asked the Minister of Bantu Administration and Development:

(1) (a) When did work commence on the building of a hospital at Umlazi and (b) what progress has been made to date;

(2) whether building operations were suspended; if so, (a) for what period and (b) for what reasons;

(3) when is it anticipated that the buildings will be completed.

Vra

1. Naam (eerste
2. Ouderdom
3. Ras
4. Tuiste (dorp,
5. Soort werk
6. Skooljare voltooi
7. Span
8. Nommer in span: skeerders dagsmanne
9. Hoe lank het u al die werk gedoen?
10. Hoe het u geleer om dit te doen?
11. Het u al ooit ander werk gedoen?

Indien wel, kort besonderhede van vorige werk:

	Plek	Tydperk	Soort werk	Weeklikse loon	Rede waarom u die werk verlaat het
1.					
2.					
3.					
4					
5.					

12. Het u al ooit daaraan gedink om ander werk te doen?

Indien wel, waarom verander u nie van werk nie?

13. Vir watter deel van die jaar doen u hierdie werk?

14. Hoeveel plase besoek u elke jaar?

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, radio-active 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

Sta 28/2/78

Two new hospitals (98)

Own Correspondent

The Transvaal Provincial Administration plans to spend about R15-million building and equipping two hospitals for Indians — one in Pretoria and the other in Lenasia.

A spokesman for the province's Hospital Services said yesterday that the Laudium, Pretoria hospital would be built in 1979. Tenders for this R2,8-million, 98-bed hospital would close in November next year.

This hospital could be extended to take 128 beds if necessary, the spokesman said.

school.

Hospital posts are 'on ability'

Mercury Reporter

PIETERMARITZBURG — Promotions at provincial hospitals are based on a person's ability and not this colour, Mr. Frank Martin, MEC in charge of hospital services, said at the Northdale Hospital here yesterday.

Speaking at the 15th annual meeting of the NPA Hospital Non-European Staff Association, Mr. Martin said that the progress made in the hospitals was "phenomenal" and urged hospital staff to avoid wastage in every department.

"All I want is a good and efficient hospital staff, no matter what colour they are. There is no artificial barrier and it is not our policy to keep any person down," he said.

Members of the association said they were grateful to Mr. Martin for making representations to get the hospital employees on the permanent staff and for the recently introduced pension fund.

Political comment in this issue by: M Mattson, G Fishley. Sub-editing by G W Fichorn. Contents bills by J Campbell.

PENNY SWIFT peeps behind the scre

GOVERNMENT GETS OUT THE SCALPEL

THE Government is taking steps to eliminate excessive profits and major abuses in some private hospitals.

This follows continued public outcries and a special commission of inquiry which uncovered excessive profits — ranging up to 171 percent — and serious exploitation of patients in private hospitals and unattached operating theatres.

Drastic measures to prevent abuses were recommended by the De Villiers Commission which sat during 1973 and 1974.

These included increasing control of the hospitals, eliminating excessive fees, and prohibiting doctors from having shares in hospitals and clinics.

The commission's shock report, which led to immediate denials by the private hospitals and calls for urgent action by politicians, has been studied by the Department of Health.

Now a statutory tariff of fees will be introduced and an attempt made to introduce a national policy to control the hospitals.

Several of the commission's major recommendations will be implemented within the next few months.

Secretary for Health, Dr Johan de Beer, said controversial draft amendments to the Medical Schemes Act before Parliament provide for statutory fees for medical scheme patients.

The tariff of fees would be determined on a negotiated basis by the Representative Association of Private Hospitals and Medical Aid Schemes, with the Government-appointed Central Council for Medical Schemes acting as arbitrator, Dr de Beer said.

Although the hospitals would not be compelled to adhere to the statutory fees, there would be an increased risk of non-payment if they did not.

Changes

"If they do contract in, they charge the agreed fee and are paid direct by the medical schemes. Otherwise the patient is held responsible with a certain amount of risk attached."

And he believed the Central Council could play an important role in persuading them to accept the statutory tariff.

"It would be so much better for everybody concerned to have a daily fee, as in provincial hospitals, which embraces the use of cotton wool, small amounts of alcohol and that sort of thing."

It was "ridiculous" to itemise all medicines, but acceptable to charge extra fees for pharmaceuticals and instruments which were not ordinarily used, he said.

Apart from changes to the Medical Schemes Act, provision had also been made for regulations relating to private hospitals to be promulgated under the new health act which replaced the Public Health Act of 1919 last year.

Dr de Beer said registration would probably be with the Department of Health, but regular inspections — to ensure the hospitals complied with certain minimum requirements — would be carried out by the provincial authorities.

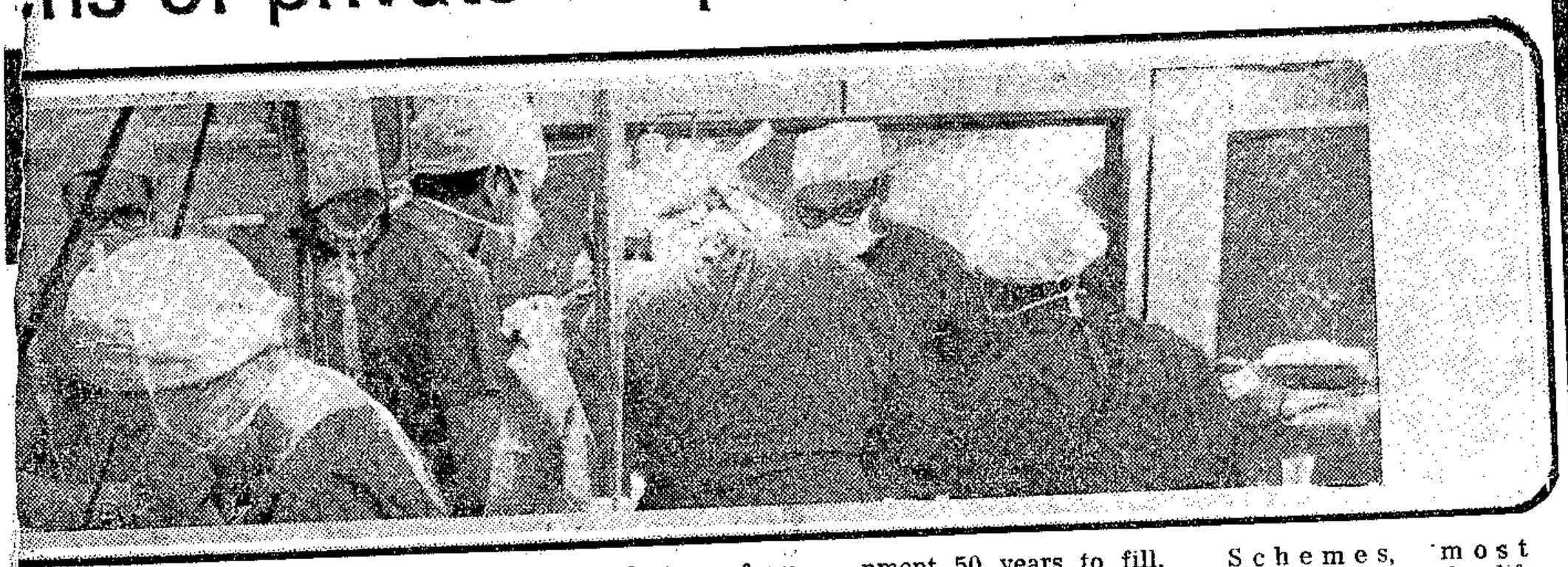
"There's a different system, with a different

FRANK Martin: P must insist on vincial hospital prefer it.

set of requiremen every province. A existing regulatio so elementary a basic one can h say they are far the standard that have been laid dow

A national pol control and a n set of standards be drawn up b Department of He

ns of private hospitals



collaboration with the provincial authorities; and the private hospitals would be asked for comment.

But the equally controversial issue of whether doctors should have financial interests in private hospitals, nursing homes and clinics has been avoided.

According to Dr de Beer this is a "rather delicate" subject.

The commission report stated that there was evidence that doctors were often forced to buy shares so they could work in certain hospitals. It found that doctors' financial interests could lead to their virtually compelling patients to go to the private hospitals concerned.

The Government was asked to consider prohibiting doctors from having direct or indirect interests in hospitals or operating-theatres not connected with their practices.

This recommendation will not be implemented.

Mr Dan de Villiers, the man who chaired the commission of inquiry four years ago, said he believed the main issue at stake was the fees private hospitals charged.

The need for comprehensive fees and the need to prohibit hospitals from demanding deposits from patients on admission and from compelling them to settle accounts before discharge, were also recommended.

Private hospitals performed a useful service and filled a gap which would take the Government 50 years to fill. But although private hospitals were entitled to a reasonable profit, the commission found some of their charges — especially for medicines — exorbitant.

Mr de Villiers, chairman of the Central Council for Medical Schemes, said the Government was doing all it could by setting up the machinery for a statutory tariff of fees.

Policy

The medical aid schemes have welcomed the Government move to introduces comprehensive fees and a national policy for the control of private hospitals.

According to Mr John Ernstzen, chairman of the Representative Association of Medical Schemes, most of the practical difficulties fixed by medical aid societies handling hospital accounts are caused by fragmented accounts. Comprehensive fees would therefore be "most desirable".

Backing the attempt to establish a national policy, he said: "One would hope they could achieve a uniformity in the hospital service."

Mr Frank Martin, Natal MEC in charge of hospitals, believes private hospitals have a role to play. But he also believes provincial hospitals have better facilities. And he says that if patients can't afford private hospital fees they must insist on going to a provincial hospital even if it means changing doctors.

Almost 100 medics still hold shares in private hospitals

ALMOST 100 doctors, dentists and specialists have shares in Durban's private hospitals and clinics.

The reason, many of them say, is because they get preferential treatment for beds and theatre times although their financial benefits are said to be small.

But the de Villiers Commission of Inquiry, which investigated private hospitals several years ago, found it inadvisable for doctors or specialists to hold shares.

Witnesses giving evidence to the commission said some Natal doctors compelled patients to go to private hospitals in which they had interests, resulting in patients falling into debt. These patients were sometimes referred to provincial hospitals where treatment was much cheaper.

It was said that some doctors refused to treat patients anywhere but the hospital of their choice and that private hospitals recruited doctors to ensure patients would be admitted. Doctors were also often compelled to buy shares in private hospitals to obtain the right to work there.

Other witnesses said it was more convenient and time saving for doctors to use a particular hospital, as they got to know the staff and routine and often referred patients there even if they did not have shares.

In recent weeks the call to stop doctors holding these shares has been

titioners, five are dentists and one is an anaesthetist.

Entabeni Hospital Ltd., has 12 directors who received R4 500 between them during the last financial year.

Of the five directors who are not retired men, only one practices medicine and he is a specialist anaesthetist who holds 105 shares.

Thirty-eight other doctors are listed as holding between five and 500 shares each — a total of 1 527, R2 shares. But these are a small percentage of the total 62 400 shares issued by the company. And each share was worth only 10 c in dividends last year.

Three of the four directors of St Augustine's Hospital (Pty) Ltd., are from Johannesburg. Two are pharmacists, Mr Barney Hurwitz and Mr Levinsohn.

All but one of the 1 000 shares — held by Mr Hurwitz as nominee — are held by St Augustine's Holdings (Pty), Ltd. The pharmacists are two of four directors, and two other companies of which they are directors hold more than half the shares.

Parklands Nursing Home (Pty) Ltd., has a minor shareholding.

Mr Hurwitz and several other Johannesburg men are directors of Parklands. And Mr Hurwitz and about 14 doctors hold shares. Another eight doctors are directors of companies which hold shares.

Doctors' share in hospitals criticised

6/4/78 Star 98

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."

Frere services will continue — Munnik

(98) BD 7/4/78

EAST LONDON — None of the existing services at Frere Hospital here would be discontinued until the Cecilia Makiwane Hospital in Mdantsane could provide the same services, the Administratog of the Cape, Dr Munnik, said in a statement yesterday.

Reacting to suggestions by East London city councillors that there had been undue haste and confusion in routing black patients to the hospital in Mdantsane, Dr Munnik said the provincial administration provided the highest possible standard of hospital services and medical care for all.

The Administrator said that two years ago a committee had been established with members from the Department of Health, the provincial hospitals department, the Medical Association, the University of Cape Town and the Government of the Ciskei to ensure the change-over did not disrupt the care of patients.

"The prime consideration of all these members at all times is that the patient must come first and be protected. They are all experienced people in their field and are certainly not lacking in humanitarianism."

Dr Munnik said he wanted to give all sections of the community in East London the assurance that none of the existing services at Frere Hospital would be discontinued if they could not be provided at the Cecilia Makiwane Hospital.

"The needs of the black people in East London do not have to be raised by politically motivated white city councillors. They can do this directly with the Hospital Board," he said.

He said the liaison committee's next meeting would be in East London on April 18 when the necessity for keeping certain services for black people at Frere or elsewhere in East London would be considered.

The councillor who brought up the subject of the closing of various sections at Frere, Mrs R. Belonsky, said yesterday she was pleased to hear the Administrator did not intend to close down the day hospital service at Frere if the same service could not be offered at the Cecilia Makiwane Hospital.

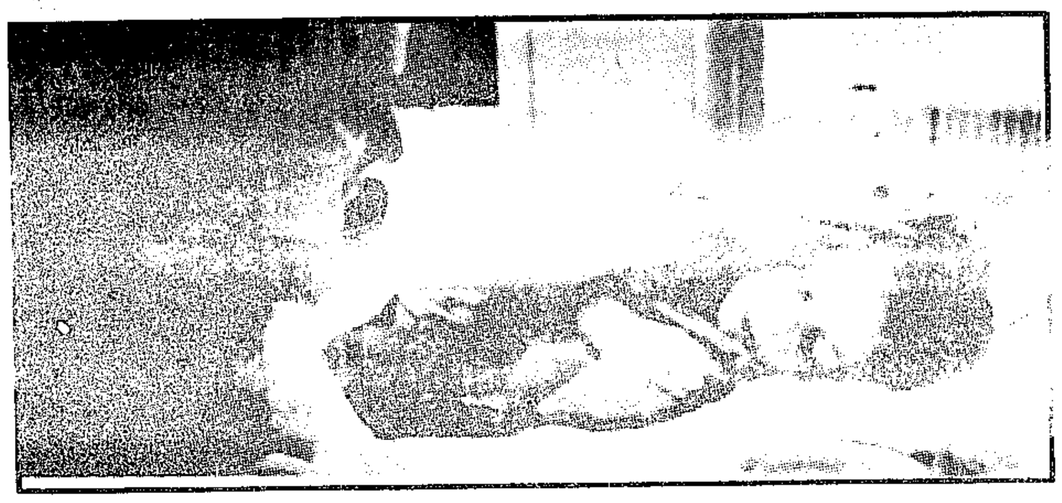
"I don't see how, at this stage, they can offer the same curative service where between 200 and 400 children are treated every day for serious diseases and emergencies. There is also the family planning service attended by hundreds of women, the detecting and controlling of common diseases like measles and the malnutrition clinic.

"It now seems logical that all the services at Frere will be retained and possibly improved because the conditions at Frere are inadequate," Mrs Belonsky said. — DDR.

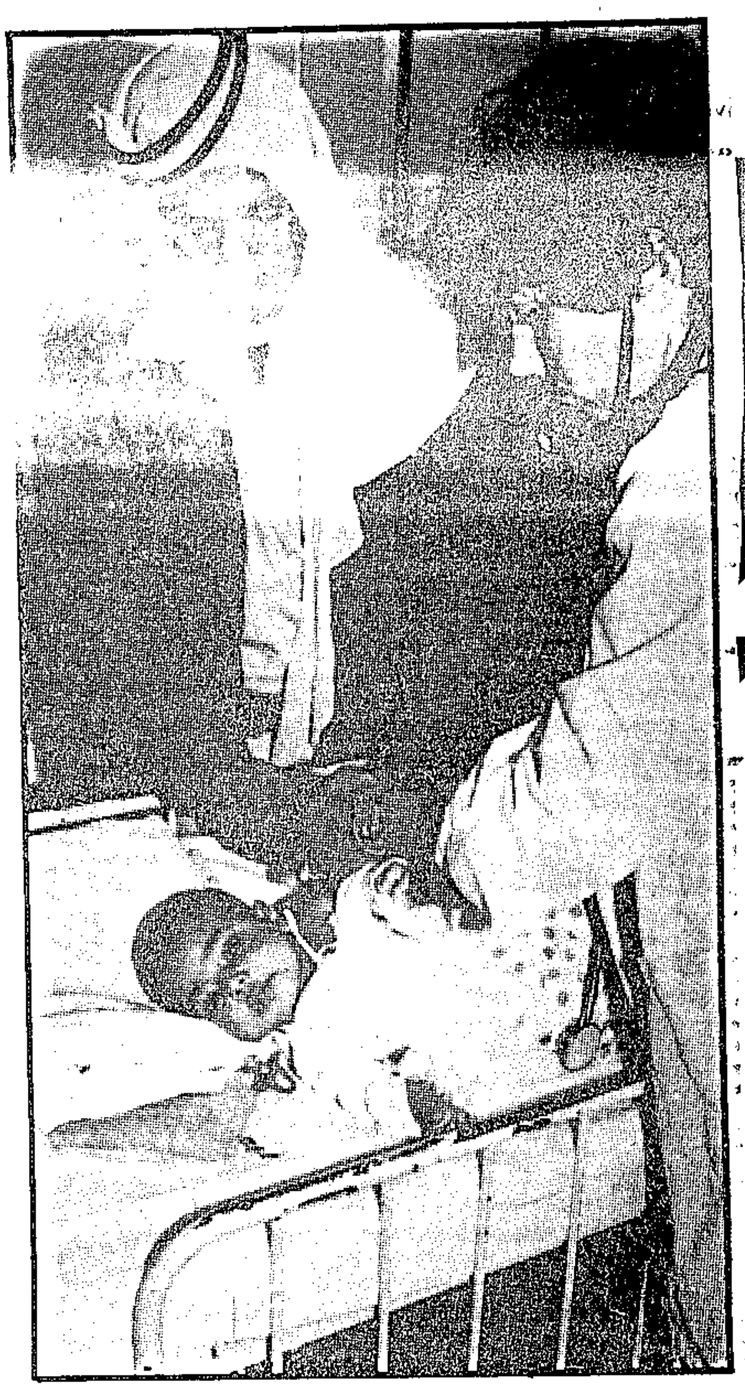
SOURCE:

Flair

Model in health care



Community health at the Beersheva medical centre.



MOSHE AND RUTH PRYWES are two dedicated community workers who live in the ancient desert city of Beesheva, capital of Israel's southern district of the Negev.

They live a simple and meaningful life, involved in a pilot project which has merged medical education with medical care and integrated hospital and clinical services. This experiment is monitored by the World Health Organisation of the United Nations as a potential model of medical education and health care for other developing countries.

The establishment of this experiment at the Ben Gurion University Centre for Health Sciences marked a departure from the traditional concept of an institution for medical education. Its goals are to train a new kind of physician and medical student for service in developing communities and to work towards an improved health system.

Prof Prywes is the Dean of the Faculty of Health at the university while his wife carries out research on the pill, how it affects the health of mother and child and the kind of people who take it — "they seem to be more educated and younger," she said. She is also involved in other interesting projects.

In South Africa last week as a guest of the University of the Orange Free Sate, Prof Prywes also addressed the SA Associates of the Ben Gurion University and the Israeli Medical Association.

"At our centre students come into contact with patients on the very first day of enrolment," he said.

THE COMMUNITY
Anne Baron

"They also learn about various aspects of medicine — we don't really have a building because the medical school is everywhere. It's in pediatric clinics, community outpatient sections, geriatric centres and even in homes where they study post-hospital rehabilitation.

"Students are given families who they are responsible for — if the mother is pregnant he will consult her throughout pregnancy, be with her during the delivery of the baby, under the supervision of a qualified doctor and watch the growth and development of the child."

Chosen for their ability to apply themselves to community work, students don't necessarily have to obtain high marks in the sciences. The requirement for application is two B s. A student can be accepted even if he got a B for Biblical studies. Over 1 300 applications are received and only 45 students are chosen.

"We look for a very special quality," said Prof Prywes. "Sensitivity, a very human element and a desire to help others because the patient is always the most important person."

Need to contact parents

AN OPEN forum for the parents of children with learning problems held recently at the University of the Witwatersrand was so successful that an association of parents will be formed as a result.

"There were about 600 parents at the meeting and from the questions they asked we realised their confusion about how to help their children," said Mrs Luce Rubin, one of the organisers.

"They said they needed guidance and would like to be able to attend lectures and seminars. An association would be able to arrange this but first we need to contact the parents again."

Anyone interested can telephone Mrs Rubin at 786-9871.

Death is not the enemy

The doctor's role is to maintain the quality of life, writes Prof Chris Barnard. In the second of a weekly column, which will appear in FLAIR each Monday, he focuses on the controversy surrounding the "moment of death".

"DO NOT GO gentle into that good night," a famous Welsh poet told his dying father in a poem which is now almost a classic affirmation of life in the face of death.

The poet was Dylan Thomas whose own flame of life was such that he burnt himself out in his early 30s but not before he had left behind a wealth of poetry and prose that praised the life force in all its forms.

The real enemy, according to Thomas, wasn't death. It was all those creeping, petty betrayals of good, well-rounded living; the tickey-snatching lives of middle-class respectability; the neatly-ordered mind of the bureaucrat; the drunken and disorderly mess of existence lived by the truly poor and, in fact, anything that inhibited a gut reaction to life and love.

I never met Mr Thomas who died some time during the 50s but I know I would have liked a man whose advice to the terminally ill was to "rage against the dying of the light", meaning not a niggling, complaining whine against illness but total defiance of all death can do until the last defeat pulls you down.

Yet Thomas and I would have sharply disagreed on my role as a doctor in the fight between life and death. I don't accept the common view that the aim of every doctor should be to conquer death, nor do I

pleasure, possibly in the belief that if they suffer enough now they may not feel so much pain at the end. Many immerse themselves in work, politics, religion and sometimes activities which shorten their life span but seem to stop the pain of the inevitable from getting through.

Whatever they do, each person knows what quality of life is acceptable and when this is gone will reject mere existence or the pointless breathing in of air.

To me, the doctor's role is clearly one of maintaining the quality of life for as long as possible, not to beat death or even to stave it off. A good life deserves a good death — that "good night" of Thomas' poem.

Thousands of words have been written in an attempt to define the moment of death but it is important to recognise that death is a clinical impression — it is

by all those — friends and relatives — who know the patient's requirements for being alive.

This has become the physician's dilemma in an age of modern technology, an era in which "life" may be supported by heroic measures that can sustain but not cure vital organs. These measures may appear almost miraculous but often they prolong the onset of death rather than the process of life.

Yet, as any doctor will confirm, the human ego is such that it can only feel a sense of guilt and defat in the face of another's death.

The story of 78-year-old, terminally ill Eli Khan makes the point better than I could. His last request to his hospital doctors was to be allowed to die with dignity — not like the man in the next bed who had "tubes sticking out all over". He did not want his children to remember him that way.

His doctors promised to honour his last wish but when the time came they could not resist the temptation to start intensive care which involved intravenous feeding and intubation to a respirator.

Later that night Khan awoke, reached out and switched off his respirator.

When his doctors went to see him again he was dead. On the bedside table was a note, scrawled in his uneven hand: "Death is not the enemy, doctor. Inhumanity is."

surrounding the "moment of death".

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Yet Thomas and I would have sharply disagreed on my role as a doctor in the fight between life and death. I don't accept the common view that the aim of every doctor should be to conquer death, nor do I go all the way with Thomas' description of death as an adversary or an opponent. Too often have I seen it come as a friend, a welcome release.

Human impotence in the face of death was brought home to me by a New York cab driver. "Step on it," I told him. "I must be there by 8.15." He eyed me in the mirror, shifted a fag-end from one corner of his mouth to another and spoke out of the side of his mouth. "Relax, mister," he told me. "There are only two things y'gotta do. Y'gotta pay taxes and some day y'gotta die."

I've no doubt that he made the same crack to all his passengers but I've never forgotten that cab driver's oversimplification of what life is all about.

There may be some dispute about taxes but death for all of us is a certainty. From the instant of conception we are all dying. Each has a life expectancy which is programmed by the genes. It is finite and diminishes with every second that passes.

It is an awesome thought for the human mind to comprehend and everyone has their own formula for coping with it.

Some live it up. Others deprive themselves of all pleasure, possibly in the belief that if they suffer enough now they may not feel so much pain at the end. Many immerse themselves in work, politics, religion and somtimes activities which shorten their life span but seem to stop the pain of the inevitable from getting through.

Whatever they do, each person knows what quality of life is acceptable and when this is gone will reject mere existence or the pointless breathing in of air.

To me, the doctor's role is clearly one of maintaining the quality of life for as long as possible, not to beat death or even to stave it off. A good life deserves a good death — that "good night" of Thomas' poem.

Thousands of words have been written in an attempt to define the moment of death but it is important to recognise that death is a clinical impression — it is diagnosed when certain symptoms or signs are present.

For hundred of years English common law ruled that life does not end as long as breathing continues and the hearts beats — an erroneous concept as the beating heart and the expanding lungs are there to keep the brain alive.

As the brain is the organ which determines the quality of life, the need for these functions ceases when the brain has died.

The cessation of heart beat and breathing may occur before (as in the case of a heart attack or electrocution) or after (as in the case of a head injury) brain death.

But once the brain has died there is no further need for these other organs and they die at various intervals afterwards. Total death of the body is therefore by degrees, as the lungs stop drawing in air, the heart ceases to beat, the circulation slowly trickles to a halt and the blood cools.

There can be few doctors who have not seen life become intolerable before the heart stops its spontaneous beating. The moment of intolerance is felt not only by the dying person and the doctor but by all those — friends and relatives — who know the patient's requirements for being alive.

This has become the physician's dilemma in an age of modern technology, an era in which "life" may be supported by heroic measures that can sustain but not cure vital organs. These measures may appear almost miraculous but often they prolong the onset of death rather than the process of life.

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When his doctors went to see him again he was dead. On the bedside table was a note, scrawled in his uneven hand: "Death is not the enemy, doctor. Inhumanity is."

Waal.

Hospital's bid to break sick leave racket

STAR 20/4/78 (98)

Baragwanath Hospital has introduced a new system to stop a medical certificate racket on the Reef.

It was recently estimated by Mr Jimmy Thomas, secretary of the Industrial Council for the Transvaal Clothing Industry, that one out of every three claims for sick leave granted during the past three years was fraudulent.

Today Dr P J Beukes, medical superintendent at Baragwanath, said the matter had been investigated and a new system was being introduced to try to beat the racket.

A circular explaining the system is being sent to doctors.

MAJOR CAUSE

A major cause of the problem, he said, was that in the past medical certificates of private firms and piece of paper or certificates of private firms and accepted by firms. The new system would have the following features:

- only the official hospital form could be used;
- It must be completed fully, including the full name and particulars of the patient. Doctors must sign the forms with their full names and give their registered qualifications;
- a record of all certificates issued would be kept in a central register;
- all certificates would be specially stamped. The official stamp had the date, a number identifying the place where the certificate was stamped, and a complicated border with a flower pattern;
- specific people would be responsible for the forms and the returns would be checked in the evenings.

A further advantage of the new system was that queries from employers about the validity of certificates could be checked without delay.

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Hospital race step hailed

Star 24/5/78

Political Reporter

CAPE TOWN — The decision by the Minister of Health, Dr van der Merwe, to lift the race bar for hospitals and ambulances on the treatment of seriously injured or sick people has been hailed by Opposition spokesmen as a "giant step away from apartheid."

The Minister set out the government's new attitude, which allows white or black patients to be treated at hospitals reserved for other race groups, during the Health Vote in the Senate.

The lifting of this race barrier follows several years of heated controversy involving hospitals and ambulances refusing to treat patients of a race group other than the one reserved for them. Several deaths have occurred as a result.

NO PROBLEM

Dr van der Merwe said he could see no reason why any person — black or white — suffering serious injuries or illness should not be admitted to the nearest hospital, regardless of what race group it is reserved for.

Ambulance drivers, he said, must make up their own minds whether a case is serious enough — and there would be no problem if he made a bona fide decision and was proved wrong later.

Mr Horace van Rensburg, the PFP's Chief spokesman on health, who asked the Minister to spell out the Government attitude, has described the decision as a major departure from the existing hardline apartheid attitude and a major change in Government policy.

He said it meant that in future any ill person or victim of an accident or assault could be taken to the nearest hospital for emergency treatment.

Dr Van der Merwe was asked by Mr van Rensburg about cases specifically relating to Baragwanath Hospital (for blacks) and the J G Strijdom Hospital (for whites) in Johannesburg.

In replying, the Minister broadened the principle to include all hospitals and ambulance units throughout the country when he set out the Government's new attitude.

PRETORIA NEWS

25/8/1972 93

Too many white hospitals — Moss

Pretoria Bureau

The Transvaal provincial administration has been providing an excess of hospitals for whites but not enough for other races, Mr Sam Moss (PFP, Parktown) told the Provincial Council.

He pleaded with the administration to become aware of gaps in its hospital policy and do something about the "grey areas."

Mr Moss paid tribute to the hospital services department and dedicated hospital personnel.

But there were the grey areas — inadequate planning for black hospitals and the "brain drain" of doctors leaving the country.

He pinpointed Baragwanath Hospital where there was overcrowding and the staff worked under difficult conditions.

Mr Moss criticised the closing of the black section of Edenvale Hospital and noted that no hospital had been planned for Alexandra where there was only a clinic.

After 10 years of talking, the administration had also done nothing about the planned Soweto hospital.

The rising cost of medicine would force more people to use provincial hospital services.

Mr Joel Mervis (PFP, Orange Grove) described the Johannesburg hospital as a "monumental blunder" and an indictment against the administration.

The hospital, "stuck on Parktown Ridge like a giant tombstone," was a perpetual shrine to the blunder.

It was planned at a time when it was shown throughout the world that it was wrong to build very large hospitals. Running costs would be about R60-million a year which would exceed the building costs within three years.

He also criticised wage differences between black and white hospital staff with equal qualifications.

Dr Servaas Latsky (NP Alberton) replied that blacks were given subsidies such as those on housing and transport.

Row over blacks at Frere

CAPE TOWN — A heated row has developed in the Provincial Council after the Progressive Federal Party MPC for Constantia, Mr Roger Hulley, demanded to know whether all blacks in the East London area would eventually have to get medical treatment in Mdantsane.

The Administrator of the Cape, Dr L. Munnik, said in interjections: "I think you are a baby in the woods" and "You sound like Andrew Young."

And the Nationalist MPC for East London City, Mr Petro de Pontes, who had just started replying to Mr Hulley when the House rose last night, criticised Mr Hulley's speech as "scurrilous and unfounded."

It is understood other MPCs, including the New Republic Party MPC for East London North, Mr Robyn Hobbs, a member of the Frere Hospital Board, will participate when the debate resumes today.

In his speech, Mr Hulley said the Administrator had implied in a statement on black medical facilities in the East London/Mdantsane area that when services for blacks were provided at the Cecilia Makiwane Hospital, they would be discontinued at Frere Hospital.

Dr Munnik: "Why do you want two lots of services for the same people?"

He wanted to know why this decision was taken in respect of blacks living in East London, why this was for blacks only, and why services available to blacks were being cut off.

Dr Munnik: Do you want us to send the whites to the Ciskei hospital?

Mr Hulley: Why should anybody in South Africa have to receive attention in a neighbouring state, in an area which is proposed to be a neighbouring state?

He also wanted to know how the council could be satisfied that patients in its care would be properly catered for if this racialistic policy was ever carried out.

"It is as carzy as an Italian visiting France beign told he must have medical service in Germany," Mr Hulley said.

Frere Hospital was providing a necessary service in a convenient locality and, if expansion was required, it should be provided on the spot or elsewhere nearby in the municipality.

The policy, which the Administrator had confirmed, was "ideologically motivated instead of being motivated by the medical and health considerations of the people under our care. I must reject it," Mr Hulley said.

Mr Hulley said: "I understand black Transkeians in the East London area are unhappy about being treated in a Ciskeian hospital."

In his statement, the Administrator had confirmed that the East London City Council was unhappy about the proposed move of black health services to Mdantsane, Mr Hulley said.

In his opening remarks, Mr De Pontes called Mr Hulley "the roving human rights ambassador from Constantia" and said the PFP's fact-finding mission to inspect beach apartheid in the Eastern Cape had been a fraud.

Mr De Pontes said he doubted whether the "roving ambassador" even knew where Frere Hospital was, let alone the Cecilia Makiwane Hospital, yet he deemed himself better qualified to speak than the people who lived in the area.

He will [illegible] reply to Mr Hulley when the debate on the Health vote continues today.

Clinic closes, page [illegible]

DD 2/6/78

(98)

Nutrition clinic closes

EAST LONDON — The nutrition clinic for blacks at Frere Hospital has been closed.

For the past two weeks black mothers bringing their malnourished children in for foodstuffs have been told they must go to Mdantsane.

This follows the recent closing of the black paediatric section at Frere Hospital and is in line with the government's policy to move black services from Frere to the Cecilia Makiwane Hospital at Mdantsane as soon as the equivalent services are available in Mdantsane.

This move has met with strong resistance, both from the people of Duncan Village and the paediatricians, who felt facilities at Mdantsane were inadequate.

The head of the paediatric department and paediatricians on his staff resisted verbally and in writing, but despite a delay after the Ciskei Health Department requested extra time before the hospital in Mdantsane be asked to take over paediatric cases, the section at Frere was eventually closed.

Blacks in Duncan Village now have to make the trip to Mdantsane in order to attend the paediatric section or nutrition clinic.

Many of them, especially those who do not have enough to feed their children and desperately need the help of the nutrition clinic, can't afford the busfare to Mdantsane. There are no ambulances available to take these people from Duncan Village to Mdantsane. — DDR.

JN 3/6/78 (98)

Day hospital for blacks

CAPE TOWN — A day hospital is to be established by the Cape Provincial Administration for the estimated 90 000 people in Duncan Village.

This was announced yesterday by the MPC for East London City, Mr Petro de Pontes, and later confirmed by the MEC in charge of hospital services, Mr P. J. Loubser.

Mr De Pontes made the announcement during a speech in the Provincial Council in which he continued a scathing attack on the Progressive Federal Party MPC for Constantia, Mr Roger Hulley, who wanted to know if black people would in future have to use medical services at the Cecilia Makiwane Hospital in Mdantsane which is part of the Ciskei.

Yesterday, the MPC for East London North, Mr Robyn Hobbs, who like Mr De Pontes, is a member of the Frere Hospital Board, said Mr Hulley did not serve on any hospital boards in his own area yet he had the audacity to criticise an operation which was situated at the other end of the province.

"It is an operation about which he knows absolutely nothing except that which has been told to him by other persons who, like himself, walk around wearing mono-chromatic mental screens over their warped minds and who revel in making political issues out of subjects which should,for the good and well being of our country, be treated with circumspect and responsibility," Mr Hobbs said.

Both MPCs lashed out at the people who had provided Mr Hulley with his information.

Mr De Pontes said: "Don't get your information in respect of East London's hospitals from the Progressive elements in the East London City Council — the Yazbeks and the Belonskis — do not go to the people who were rejected with contempt by the voters of East London for your facts. Rather go to the people who know."

MR DE PONTES . . . emergency services at Frere.

Mr Hobbs said: "I know very well where his information and questions come from. I suggest he goes back to these people and tells them to get their facts straight before coming here and embarrassing his fellow MPCs."

Mr De Pontes said the Cecilia Makiwane Hospital was about 20 km from Duncan Village and not the 32 km which Mr Hulley had said — and this was much closer to a hospital than some of the Cape Town suburbs such as Guguletu.

Mr Hobbs said there was public transport by bus between East London and Mdantsane every three minutes and negotiations were underway for special patients to be transported from East London to Cecilia Makiwane by bus and ambulance when the need arose.

Mr De Pontes said he had discussed the matter with the authorities. "I can give the assurance from what I was informed that no service for black people at Frere Hospital will be done away with before a completely equal service can be given at the Cecilia Makiwane Hospital.

"The Frere Hospital will at all times have emergency services available and will give emergency services to any person — white, black Coloured or Indian. If it is necessary to transfer such a person to Mdantsane, it will only be done when, out of a purely medical point of view, it is safe and desirable," Mr De Pontes added.

He urged the provincial administration to establish the day hospital as soon as possible.

Mr Hobbs said: "In so much as the Frere Hospital is concerned I can assure the member that Frere will never turn away emergency black cases. It should also be noted that paediatric accommodation at the Cecilia Makiwane is far superior to that at Frere." — PC.

Another section to close, page 7.

Sil—

Council plea for talks on hospital turned down

EAST LONDON — A request by the East London City Council for an urgent meeting with various bodies concerned in implementing the controversial closure of the Frere Hospital's black paediatric section has been turned down flat by all concerned.

Instead, council representatives were offered the opportunity of addressing a meeting of the Mdantsane Implementation Committee, where they were "treated with contempt", according to a council spokesman on health, Mrs Ruth Belonsky.

The representatives, Mrs Belonsky, Mr Ivan Zulman, and the Medical Officer of Health, Dr J. R. van Heerden, were first invited to attend the meeting of the committee, but when they arrived they were told they could address members before the meeting commenced. They were not allowed to be present at the meeting itself.

Mrs Belonsky added that until invited to address the meeting of the committee, the council had been kept so ill-informed on the whole issue they hadn't known of the committee's existence for the two years since it was formed.

In February, the council unanimously agreed to seek an urgent meeting between the Director of Hospital Services, Dr Kotze, State Health, the Ciskei Department of Health, the Medical Superintendent at Frere Hospital and the Medical Association.

Dr Kotze replied to the council's request by disclosing the existence of the implementation committee, which he said consisted of representatives of State Health, the Medical Association, the University of Cape Town and the Ciskei Government.

He said he was satisfied the committee could satisfy any questions on the issue of phasing out black services at the Frere Hospital.

He pointed out that the council had a representative on the Frere Hospital Board, Mr R. L. de Lange (Sr), and he saw no reason why he, Dr Kotze, should attend a meeting with the council.

He suggested the council contact the implementation committee with the object of sitting in on one of their meetings.

The Medical Superintendent at Frere, Dr F. Visser, said policy decisions of this nature were made by the Hospitals Department. He was not prepared to comment to the council.

The Department of Health in Pretoria suggested council representatives and the Medical Officer of Health attend a meeting of the implementation committee where matters of "mutual interest" could be discussed.

They said it was their intention to suggest to council the MOH become a member of the committee.

The Medical Association said any discussions on the matter should be held with State Health.

Mrs Belonsky said the council's request to the Ciskei Health Department had also come to nothing.

The representatives of the council were then invited to attend a meeting of the committee, where they found they were only to be allowed to address its members.

"When we put our case we were literally treated with contempt. They were decidedly rude to us.

"But what distressed me most is that the committee's chairman, Dr Field, who is also the Secretary for State Health; Dr Kotze, and the chairman of the Frere Hospital Board, Mr D. Lazarus, showed more concern about statements made in the press and about the Daily Dispatch

State Health to probe Frere committee row

EAST LONDON — A senior official in the Department of State Health in Pretoria is to investigate the absence of the East London City Council on the implementation committee responsible for phasing out black services at Frere Hospital here.

The co-ordinating director for the department, Dr J. Gilliland, said yesterday he saw no reason why the council shouldn't be represented, and was sure the director of hospital services in the Cape, Dr R L. Kotze, felt the sar way.

But the committee, chaired by a member of Dr Gilliland's department, Dr K. H. Field, turned down an application by the council for representation recently, and refused to let council representatives sit in on one of their meetings at which the matter was discussed.

The implementation committee met for two years before the council knew of its existence.

When council representatives, Mrs R. Belonsky, Ir I. Zulman and the ledical Officer for Health n East London, Dr J. van Heerden, met members of the implementation committee they were "treated with contempt", according to Mrs Belonsky.

Dr Van Heerden and Mr Zulman yesterday confirmed they received scant sympathy from Dr Field and Dr Kotze in particular.

"We believed Dr Van Heerden may be chosen as our representative on this committee, but we have since heard this has been turned down and the council is to take the matter further," Mr Zulman said.

In view of the council running clinics in the area for blacks and having to refer patients to Frere for treatment, they had every interest in the proceedings of the implementation committee.

"In addition to this direct interest there is also the humanitarian interest in what is happening to people in our city," he said.

Dr Gilliland said his department would welcome a delegate from council on the committee. "And in saying this I am sure I can speak for Dr Kotze as well," he said.
— DDR.

State official's assurance to black patients

EAST LONDON — The paediatric outpatients service for blacks at Frere Hospital will not be discontinued until there is either an equivalent service at a clinic in Duncan Village or transport is more readily available from Duncan Village to the Cecilia Makiwane Hospital in Mdantsane.

This assurance was given by the co-ordinating director for the Department of State Health in Pretoria, Dr J. Gilliland, who said patients would at no time suffer through the government's policy of phasing out services for blacks at white hospitals in favour of equivalent services at black hospitals.

And yesterday the city councillor in charge of the health portfolio, Mr I. Zulman, said council had received a similar assurance. He believed services at Frere wouldn't be substantially curtailed until such time as the day hospital which was promised by the MPC for East London City, Mr P. de Pontes, in the Provincial Council two weeks ago, was established.

The paediatric outpatients service at Frere treats between 200 and 400 black children a day and is grossly overcrowded at present.

The tentative date for it to close was June 30, but it now seems this will be postponed indefinitely as it would cause massive hardship among black Duncan Village patients were it to close before either cheap transport to Mdantsane or facilities closer to home were available.

Dr Gilliland said he could not give any schedule or timetable for services at Frere to close. This depended on how rapidly alternative services became available at Mdantsane.

Obstetrics, gynaecology and paedatric in-patients services had already been closed and the rest would be done in phases.

All services for blacks at Frere except emergency casualty services (which were always available at the nearest hospital, and specialised services not available at Mdantsane, would eventually be closed, Dr Gilliland said.

The services being provided at Mdantsane were better than those at Frere, where there had been overcrowding during recent years.

The Cecilia Makiwane Hospital, he said, operated as a central hospital where patients were brought from peripheral clinics. There were six such clinics in Mdantsane.

The ideal was for patients to have a clinic in their neighbourhood. Ambulances were kept at these clinics to take seriously ill patients to hospital, and with this concept in mind the question of such a clinic for Duncan Village had already been discussed, Dr Gilliland said.

When the problem of mothers with malnourished children not being able to afford the 72 cents return bus fare to Mdantsane when outpatients services at Frere closed was pointed out to Dr Gilliland, he gave his assurance these people would not be made to suffer through any change in services contemplated.

"The whole concept of treating malnutrition patients in hospitals is changing throughout the world to one of increasing community health services to handle this problem," he said.

Asked about the closure of the nutrition clinic at Frere last month, he said nutrition clinics were the responsibility of the local authority. They were subsidised for seven-eighths of such feeding by his department.

But the Medical Officer of Health in East London, Dr J. R. van Heerden, yesterday explained that such a subsidy extended only to tuberculosis patients.

Patients receiving these food parcels had to be certified by him as TB sufferers, and it was not possible to provide food for the rest of their family, which also may suffer from malnutrition.

He said in addition to this service the municipality here offered another infant feeding scheme where skim-milk and Pro-Nutro was supplied. The skim-milk was bought at a reduced cost through State subsidisation and the Pro-Nutro paid for in full by the municipality.

The deputy superintendent at Frere Hospital, Dr F. Viedge, said last week the nutrition clinic — which used to cater for malnourished patients and former patients at the black paediatric section — had been closed because the paediatric services were moving to Mdantsane. — *DDR*

poësie in die eerste plek bedoel om gesing te word.

Die eerste opgetekende Nederlandse liedere is nie gedruk nie, maar kom voor in handskrifte soos bv. die Doornikse handskrif waarmee in 1511 begin is. Die eerste gedrukte bundel met wereldlike liedere wat ons ken is die sgn. Kamper liedboek wat omstreeks 1540 te Kampen deur Jan Peterszoon uitgegee is. Dit behoort tot die groep van meerstemmige liedboeke waarin van die teks alleen één koeplet, meestal die eerste - en dit soms nog onvolledig - afgedruk is. Tot dieselfde periode behoort Het Ierste en Tweetse Musyck Boexken wat deur dié Antwerpse drukker en komponis Tielman Susato in 1551 uitgegee is, dié Ierste Boeck van den Nieve Duytsche Liedekens (Maastricht, 1554) en die Duytsch Musyck Boeck wat in 1572 in Leuven verskyn. Hieraan geoordeel wil dit beslis lyk of die 16de-eeuwers graag gesing het!

Die eerste belangrike liedereversameling wat bewaar gebly het, 'n bundel wat internasionale beroemdheid verwerf het, is die sg. Antwerpse liedboek, Een schoon liedekens Boeck wat in 1544 in Antwerpen gedruk is en waarin 217 afsonderlike liedere voorkom. Naas liedere wat deur rederykers vir die bundel geskryf is, is dit ook duidelik dat baie van die liedere van ouer datum is en dat daar ook uit ouer versamelings geput is. Van hierdie liedboek is slegs een eksemplaar gevind. Die res is klaarblyklik almal opsetlik vernietig omdat die boek in 1546 op die Index van ongewenste leesstof van die teologiese fakulteit in Leeuven geplaas is.

Sunday June 25 1978

'BARA'

JOHN BURNS of The New York Times recently paid a visit to Baragwanath General Hospital. This is his report.

A night in the life of Africa's biggest black hospital

The first man to come in from the night, blood trailing on the linoleum floor behind him, had a thumb-sized stab wound on the back of his head. A minute later, a young woman staggered through the door on the arm of her mother, with five deep gashes on her face, head and shoulders that she said were inflicted by her boyfriend.

Next came a 19-year-old youth unconscious from a gaping stab wound in his back, the result of a clash with "tsotsis," the Zulu term for the gangs of unemployed youths who roam the dusty, darkened streets of Soweto after dark. The youth, Michael Masinga, was rushed to the resuscitation unit, where Basil Gampel, a white surgeon, revived him, then cleaned and stitched the wound.

It was 9.45 pm on Friday, the beginning of the rush hour in the casualty department of the Baragwanath General Hospital, the largest black hospital in Africa. For the next four hours a team of doctors, mostly white, worked swiftly to repair the carnage of a typical weekend night in Soweto, where violent crime runs at a level that might make a Harlem resident blanch.

By 2 am, Dr Manfred Beck and his colleagues had treated a total of 105 cases, including numerous stabbings with sharpened bicycle spokes and knives, one human bite, one ruptured spleen from a drunk-driving accident, as well as diagnosing and referring dozens of non-traumatic maladies, ranging from syphilis to pneumonia. For Soweto, where there are as many as 20 murders and 50 criminal assaults reported each weekend, and many others that go unrecorded, it was a relatively quiet evening.

"It can be far worse than this," said Perpetua Makhetha, the nursing matron in the department.

☆ ☆ ☆

The casualty operation provides a vivid glimpse of the problems facing "Bara," as the hospital is known among the 1-million residents of Soweto, the sprawling black ghetto outside Johannesburg. With 2 600 beds and a staff of 7 000, including 150 fulltime doctors and 3 700 nurses, the hospital treats more than 1,1-million outpatients and 85 000 ward cases a year, the heaviest caseload of any medical facility in South Africa.

The scale of its operations and their quality, generally acknowledged as the equal of any white hospital in the country, has made Baragwanath a showcase of what the South African Government does for its black population of 18,6-million people.

After a two-day tour of the facility, a visitor can only be impressed. Its 17 departments, engaged in everything from open-heart operations to plastic surgery and kidney dialysis, are striking to the layman's eye, even more so to the expert's.

Even anti-apartheid figures in the medical community concede Baragwanath's high standards. But they argue that the hospital, good as it is, must be seen in the context of a medical system that favours whites over blacks, inasmuch as the Government spends disproportionately high sums on hospitals for whites only, leaving blacks with facilities that, generally, are chronically overcrowded and not on a par professionally with Baragwanath.

A case in point is the new Johannesburg General Hospital, a R140-million concrete structure that has just opened on a ridge above Parktown, a well-to-do white suburb. Although there are white hospitals in the city that have a bed occupancy rate of less than 60 percent, the new hospital's 2 000 beds and its extensive teaching facilities are restricted to whites, except in specialities like nuclear medicine that are not available in black hospitals.

Meanwhile, at Baragwanath, the bed occupancy rate is running at about 105 percent, meaning that at any one time up to 130 patients are bedding down on stretchers or mattresses on the floor, or, in extreme cases, on chairs in the wards.

☆ ☆ ☆

Despite pleas to the Transvaal Provincial Administration, the authority responsible, plans for a new 2 000-bed hospital in Soweto are still uncertain after nearly a decade of discussion.

Across the country, the picture is in some respects bleaker still. The last time that anybody computed the figures, in 1970, there were 38 685 hospital beds for whites, 97 685 for blacks, Asians and those of mixed race, or one bed for every 98 whites against one for every 179 blacks. Since then the gap has narrowed only marginally, although the accident and disease rates are far higher among blacks.

Examples abound. In 1974, 1,8 whites in every 10 000 suffered from tuberculosis, against 27,9 in the black community and 32,5 among those of mixed race.

Malnutrition, practically unknown among white children, is endemic among blacks. A recent survey in Mdantsane, a black township outside the coastal city of East London, showed 68 percent of the black children under five suffering from the disease. Another study, by the University of Pretoria, estimated that 75 black children die every day from the malady.

☆ ☆ ☆

The statistics translate into enormous pressures at Baragwanath, which draws patients from as far afield as Zululand, 480 km away. In addition to tuberculosis and malnutrition, the hospital has a heavy caseload of diabetes, rheumatic heart disease, hypertension, epilepsy, scabies, diarrhoea, infectious kidney diseases, and two eye afflictions, trachoma and glaucoma, all of which result in some measure from the overcrowding and poverty among blacks, and the consequent ease of infection.

The variety and severity of the cases is a major draw for doctors and medical students from the University of the Witwatersrand, for whom Baragwanath is a major teaching hospital.

"This is a clinician's paradise," said the bearded Dr Beck, a pathologist, relaxing over a cup of tea during his part-time duties in the casualty department. "You see things here that you'll see nowhere else."

For the patients, treatment at the hospital comes cheap. If they can convince the admissions clerk that they are unemployed, they pay nothing. Otherwise, they pay R1.00 a visit, to a maximum of R5.00 a month.

The outlay covers everything, including prescriptions, wardcare, operations and transportation by ambulance. Of the hospital's 1978 budget of R22,5-million, only five percent, R1,1-million, comes from patients, the rest from the taxpayer.

As remarkable, maternity care, from an initial inspection by an obstetrician through confinement and post-natal care, costs only R10,00, against about R500 for a white mother in Johannesburg.

With population growth among blacks running at a rate of 2,7 percent a year, a rate higher than India's, the hospital's 600-bed maternity unit is one of the busiest sections, with more than 70 births a day.

☆ ☆ ☆

The maternity wards, set in bright, airy one-storey buildings, are among the newest in the 56 ha facility. Others date back to 1940, when the British Government built a military hospital on the site to treat war casualties from North Africa. The British facility, named after John Albert Baragwanath, a Cornish mining speculator who originally owned the land, was transformed into a black hospital in 1948.

Inevitably, institutional arrangements reflect the Government's racial policies. Although the 50 black doctors mix easily with their white counterparts in the wards and operating theatres, their eating and sleeping quarters are segregated, as are those for white and black students.

Also, salaries vary according to race, with white chief specialists receiving R13 450, Indians R11 385 and blacks R9 702. The Government has pledged to close the gap, but progress is slow.

One of the hospital's greatest prides is the intensive care unit, whose two 18-bed wards make it the biggest facility of its kind in the country. One day recently, the patients in one ward included an adult from a rural area suffering from malnutrition, a woman with cancer of the oesophagus, another man suffering from kidney failure, and a 19-year-old youth, Arthur Mhumalo, who had been rushed to the hospital the previous night from the township of Leslie, 80 km away.

Like all nurses at the hospital, those in the intensive care unit are black. Among them, moving quietly back and forth amid the intravenous drips and electrocardiographs, were several from black-ruled states further north, sent to Baragwanath for training. One, from Kenya, smiled when asked how it felt to be training in a white-ruled African state.

"Oh, fine," she said. "There is no discrimination here."

☆ ☆ ☆

Despite their condemnation of apartheid and strictures against Western countries that have close economic ties with South Africa, several black states also send chronically sick patients to Baragwanath. One facility that has treated foreign blacks is the 111-bed St John's Eye Hospital that is part of the Baragwanath complex.

The eye facility, equipped with microscopic operating units and sophisticated laser equipment, is reckoned one of the most advanced eye hospitals in the world.

Another o[...] hospital's strong [...] the absence of pe[...] ing bureaucratis[...] ficially, it is open [...] residents of Sowe[...] to emergency cas[...] other black areas[...]

In practice, ac[...] to deputy superin[...] Christo van den [...] "No sick person is [...] away."

Under Dr va[...] Heever, the hospi[...] is taking a more [...] view of the witchc[...] craft. Even in [...] the most sophis[...] black community [...] country, witchdoc[...] main active, [...] strong hold on [...] numbers of peopl[...]

Some white d[...] regard them [...] menace, but Dr [...] Heever, an exp[...] tribal custom[...] speaks three A[...] languages fluently [...] couraging them [...] another look.

"As in our pro[...] they have their fa[...] of quacks, but th[...] some darned goo[...] titioners among [...] Some of them [...] patients to us, an[...] even register as [...] here themselves."

Praise for author[...]

Dr C[...] van den Heever, Deputy Superintendent of Baragwanath [...]

Frere stays open to blacks

EAST LONDON — Black paediatric services at Frere Hospital here will not close at the end of the month.

The Director of Hospital Services in the Cape, Dr L. Kotze, has issued a directive postponing the closure until he has satisfied himself transport facilities between Duncan Village and the alternative services at the Cecilia Makiwane Hospital in Mdantsane are adequate.

This was confirmed by the deputy superintendent at Frere, Dr F. Viedge, last night.

Dr Viedge had previously directed his staff to inform people attending the black paediatric outpatients section at the hospital that this section would be closed on June 30 and they would have to go to Mdantsane.

"This has been changed within the last few days. No new date has been fixed for the transfer of services," Dr Viedge said.

Dr Kotze had indicated he wanted to be satisfied that the best possible transport facilities existed before closing the service at Frere. Dr Viedge did not know whether Dr Kotze would be visiting East London himself to investigate the situation or not.

The news that the service will remain open follows a storm of protest at the proposed closure.

The Joint Advisory Board (representing the people of Duncan Village and Cambridge Location) protested on the grounds that transport to Mdantsane was not good enough and people with malnourished children attending Frere would not be able to afford the 72c return busfare to Mdantsane.

This protest was carried over to state and provincial health officials by the chairman of the Eastern Cape Administration Board, Mr G. Coetzer, who added his own "very special" appeal on behalf of black residents.

The East London City Council, though excluded from negotiations about the transfer, also expressed concern, as did the councillors on the health portfolio and the Medical Officer of Health, Dr J. van Heerden.

Dr Kotze's directive to postpone the closure on the grounds of transport problems appears to be the first published recognition from either state or province that this problem exists, though the MPC for East London City, Mr Petro de Pontes, did mention incorrectly, in the Provincial Council, that a bus ran from East London to Mdantsane every three minutes.

The decision to phase out black hospital services at Frere is one based on government policy, and a special Implementation Committee has been appointed to conduct this phasing out.

It has already phased out black obstetrics, gynaecology and paediatric in-patients services, and plans to phase out all other services for blacks at Frere except emergency services.

The service which was next on the list was the paediatric outpatients service, which treats between 200 and 400 patients a day. — DDR.

No-one turned away, page 8.

QUICK QUIP

" 'Five-room country home,' they said; but they didn't tell us it's a scrapped post office . . .

(98) #0 29/6/78

No-one turned away says hospital chairman

EAST LONDON — The pamphlet being circulated in East London about the closure of black hospital services at Frere creates a wrong impression, according to the chairman of the Frere Hospital Board, Mr D. Lazarus.

Mr Lazarus said yesterday the pamphlet, circulated by the Progressive Federal Party's youth movement, created the impression facilities for the treatment of black children in East London and the vicinity were inadequate. This was incorrect.

He said no sick black child who reported for treatment had ever been turned away.

The pamphlet was incorrect in saying facilities for black children were to be closed at the end of June. This was not so. (The PFP youth were unaware of this decision — taken during the last few days — at the time they distributed the pamphlet.)

Mr Lazarus said the instruction not to close the service yet, given by the Director of Hospital Services, Dr L. Kotze, was in accordance with a press statement given by the Administrator, Dr Munnik, in April.

Mr Lazarus quoted from a speech by Mr P. J. Loubser, MEC in the Provincial Council on June 2 to the effect all services for blacks at Frere would be continued until the Cecilia Makiwane Hospital could take over.

Patients would not suffer in the operation, which was being done in cooperation with the Ciskei Homeland Authority, Department of Health and Mr Loubser's department.

Mr Loubser said the Ciskei Government was anxious to assume its full responsibilities and it was wrong to prevent them from doing so.

He said his department had decided to: transfer services gradually and in a well planned manner; persuade the black public with the necessary patience and kindness; not to send any patient away without being attended to; not to take risks with acute or serious cases, and rather to accommodate them at Frere on a temporary basis; to keep facilities open for casualty treatment; to attend to transport facilities and to urgently plan a Community Health Centre for primary care in Duncan Village, linked to Mdantsane with efficient ambulance and patient transport facilities.

Mr Lazarus said yesterday his board had the interests of black patients here at heart. "Everyone can rest assured that the interests of all patients, irrespective of the population group to which they belong, is the board's only concern," he said.

He had found state health, the hospitals department and Ciskei Government all dedicated to the same cause. — DDR.

MR LOUBSER . . . patients won't suffer.

Why weren't people told of change asks PFP

EAST LONDON — The Progressive Federal Party's youth movement was not aware when it put out a pamphlet criticising the proposed closure of black paediatric services at Frere Hospital that the closure of these services had been postponed.

The decision to postpone the closure was taken "within the last few days," according to the deputy superintendent at Frere, Dr F. Viedge. The pamphlet was circulated on Tuesday, probably just after the decision was taken.

"Had we known we wouldn't have distributed the pamphlet. This is great news for us," the youth organiser, Mr R. P. Snodgrass, said last night.

But at the same time he strongly criticised officials at Frere and the Director of Hospital Services in Cape Town, Dr L. Kotze, for not making their decision public.

"It is only a matter of days until the date it was to have closed and they didn't bother to inform the 90 000 people of Duncan Village and the 60 000 others affected through the medium of the press," he said.

He also strongly criticised a statement by the City Council representative on the Frere Hospital Board, Mr R. L. de Lange, to the effect the PFP pamphlet was the most despicable document he had ever seen.

"If the facts on the reverse side are completely incorrect could he kindly tell us what the correct facts are.

"Meanwhile to use words like dirtiest and despicable to describe a group of young people's concern for their less fortunate fellow South Africans is appalling and unwarranted," he said. — DDR.

(c) Prepositions with ...

in : Abl. = in,

on behalf of or to the advantage or disadvantage of the person or thing indicated by the case. This case is called the Dative (derivcd from do, dare, because it is so often used with this verb). We find here a very common pattern in Latin consisting of the subject (nominative), the object (accusative), the indirect object (dative), the predicate (verb).

words are in a case which indicates t

Hobbs against closure of Frere services

8/7/78 (98) AM

EAST LONDON — The New Republic Party MPC for East London North, Mr Robyn Hobbs, has denied he in any way attempted "to whitewash the implementation of hospital apartheid."

He was replying yesterday to an editorial in the Daily Dispatch. He opposed the closure of black services at Frere Hospital, he said.

Mr Hobbs admitted he had said in a Provincial Council debate earlier this year that a bus ran from East London to Mdantsane every three minutes, a statement which was incorrectly attributed to his colleague for East London North, Mr Petro de Pontes.

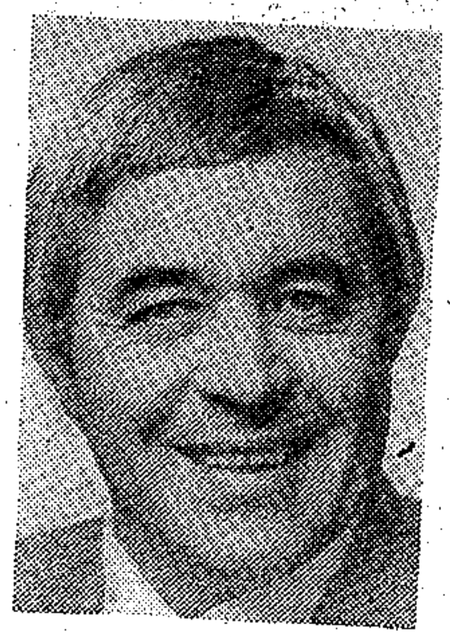
"I have confirmed this with a senior executive of the Ciskei Transport Corporation," Mr Hobbs said.

"Before I get blamed for being subservient to government dictates, let me put my personal point of view: The government has said that the blacks will be moved. There is nothing that we can do or say that will change this, so let us make the move as easy as possible for those concerned.

"Let us ask Province immediately to provide a special bus from Frere to the Cecilia Makiwane Hospital in Mdantsane The Ciskei Transport Corporation say they can do this if asked.

"Province must treat with urgency the establishment of a day hospital at Duncan Village to look after the needs of the blacks until they are moved to Mdantsane," Mr Hobbs said.

From an economic and convenience point of view blacks should be thankful for the provision of facilities at Mdantsane.



MR HOBBS

"By far the greater majority of the black population live at Mdantsane. Now all the thousands of patients, including sick and undernourished children that had, at great expense to themselves, to pay for transport from Mdantsane to Frere, have the facility on their doorstep.

"I am sure there will be fewer black patients going from Duncan Village to Mdantsane than there were from Mdantsane to Frere. How can you please everybody?" Mr Hobbs asked.

There had been deputations from the Coloured community to Frere, asking for separate facilities. This request seemed to have been assured.

Mr Hobbs said the question in the Daily Dispatch editorial had been badly phrased. The editorial asked: "Do you support the transfer of black patients to Mdantsane?"

"A patient is a person who has presumably already been admitted to a hospital. No, I do not support moving a person who has been admitted unless the hospital to which this patient is being moved can provide specialised treatment to cure the patient," Mr Hobbs said.

"If you (the editor) wanted to know whether I support the government policy of not admitting blacks at Frere the answer is No.

"On the other hand it has worked elsewhere, for example at the Livingstone Hospital in Port Elizabeth.

"If you want to know whether I support separate facilities the answer is Yes. I support segregation in this sense because it seems to be what the majority of the people want and it has worked for many years.

"As a public representative I would like to say that the matter is not being ignored.

"Ways and means are being explored to alleviate the problems which have been forced upon us. You will no doubt be informed in due course," Mr Hobbs said. — DDR.

the function of a word in its sentence is indicated e.g. "John sees Peter" is very different from "Peter sees John". Though word order is also important in Latin, it is not the means whereby the function of a word in its sentence is indicated. For this purpose Latin uses inflection, i.e. changes in the endings of words, which we call declension in nouns, adjectives and pronouns, and conjugation in verbs. So the English sentences quoted above will be "Johannes Petrum videt" and "Petrus Johannem videt" in Latin; you can change the word-order within these sentences, but the function of each of the words in its sentence will still be the same. English and Afrikaans have to a large extent dispensed with inflection, except in a few cases, e.g. I see him, he sees me; the function of inflection is taken over by the word order, and by an extended use of prepositions.

3. Inflected languages differ from languages like English in a further important respect. In the conjugation of the verb, for example, the different personal endings remove the need for expressing the subject if it is a personal pronoun. This is a pattern to which the English speaker must at once accustom himself, whereas Italians and Spaniards will not find the

Medical centre proves sure bet

The new medical centre at Turffontein racecourse — installed in April — has already saved lives.

"There is no doubt that three patients would have died if our intensive care unit at the centre had not been operating," said Sir Humphry Hawkins, Medical Officer at Turffontein.

He said the centre had been a great success.

The centre is served by three intensive care specialist nurses and six St John's Ambulance attendants. There are three beds in the intensive care unit alone.

As soon as a patient has been settled down and is out of danger, he or she is transferred to the General Hospital.

Sir Humphry strongly recommended that any person who had suffered two heart attacks should not go racing.

"I know it is like speaking to a brick wall," he said, "because racegoers are a law unto themselves. They can be at death's door, but they'll still go racing. It is unbelievable. We had one chap who collapsed between the entrance gate and the grandstand. He was a chronic heart case.

"What is more, I have found that in nearly all cases patients have collapsed after a losing bet — not a winning one. You can draw your own conclusions."

The medical officer at another Rand course said that in his opinion it was futile to try to prevent heart cases from attending race meetings.

"We place so many restrictions on them, such as warning them off certain foods, sexual excitement and excessive exercise that you might as well ignore their racing activities. It wouldn't help anyway — if they like the game, they'll go."

July 16 1978

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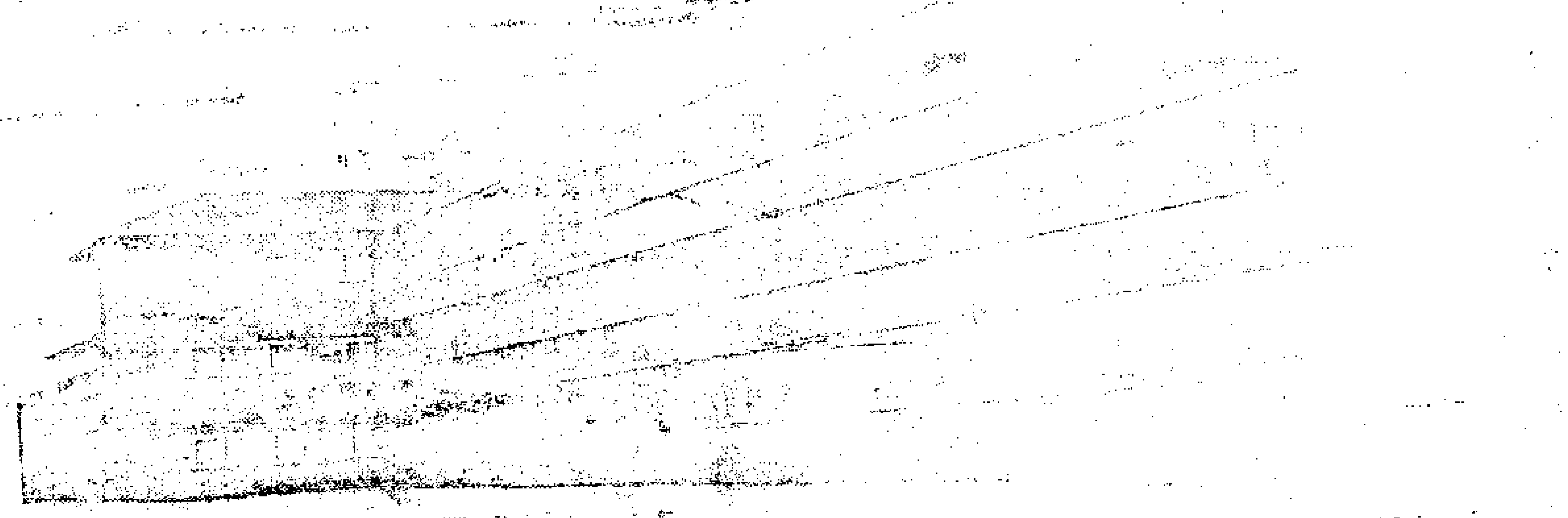


Witbank Hospital ... a poor reflection on [illegible] and on the Witbank [illegible]

SUNDAY EXPRESS INVESTIGATION

WITBANK residents say conditions in Witbank Hospital are so appalling that Black patients are compelled to sleep on the floor and pregnant White women go through labour in full view of the public as there is no waiting room to accommodate visitors to the maternity wing.

The Sunday Express was told this week that a group of Witbank businessmen had collected R200 000 towards a private nursing home because the present Witbank hospital was "a poor reflection on hospitals and the Witbank community".

A spokesman for the group said the hospital failed to meet Provincial Health Regulations in many respects.

He said: "Corridors have to be a minimum of two metres wide, but those in the hospital are about one metre — so narrow that prescribed trolleys with oxygen tanks cannot pass [illegible]

The [illegible] new nursing home [illegible] patients all White, but would be extended [illegible] Blacks and Indians, depending on demand.

He said: "We will have to go into the market to look for staff as there is only one resident specialist in the area and he cannot cope with the demands made on him."

A Witbank general practitioner told the Sunday Express the hospital had no specialised surgeons or phy- [illegible]

[illegible] gynaecologist told the Sunday Express the hospital had two fulltime medical officers, a fulltime superintendent and three housemen who were perfectly competent at doing Caesarians.

The GP said husbands of expectant mothers were compelled to wait in the corridor next to the labour ward. The ward door was often left open.

"The public can look directly into the ward — an appalling situation," he said.

The gynaecologist [illegible] once two women had given birth in the same labour room alongside each other. He said he had been [illegible] that at times [illegible] were transferred from the maternity ward [illegible] a few days after giving birth.

"The most sensitive and emotionally delicate person in the world is [illegible] who has just had a baby. A move of this kind can be extremely upsetting."

He added, however, that the calibre of staff at the Witbank hospital was equal to that of most hospitals.

A hospital spokesman told the Sunday Express the labour ward door was always shut and the curtains drawn, but when we visited the hospital we found the door wide open.

Inside was a woman in labour. We were able to walk into the room where there were no attendants save for a nurse who occasionally popped in to see what progress she was making.

The GP said a new maternity wing planned seven years ago had been shelved apparently due to lack of money.

"Yet recently I was told [illegible]

[illegible] wards in the hospital were overcrowded patients and their beds were pushed into corridors.

An Indian resident said there was [illegible]

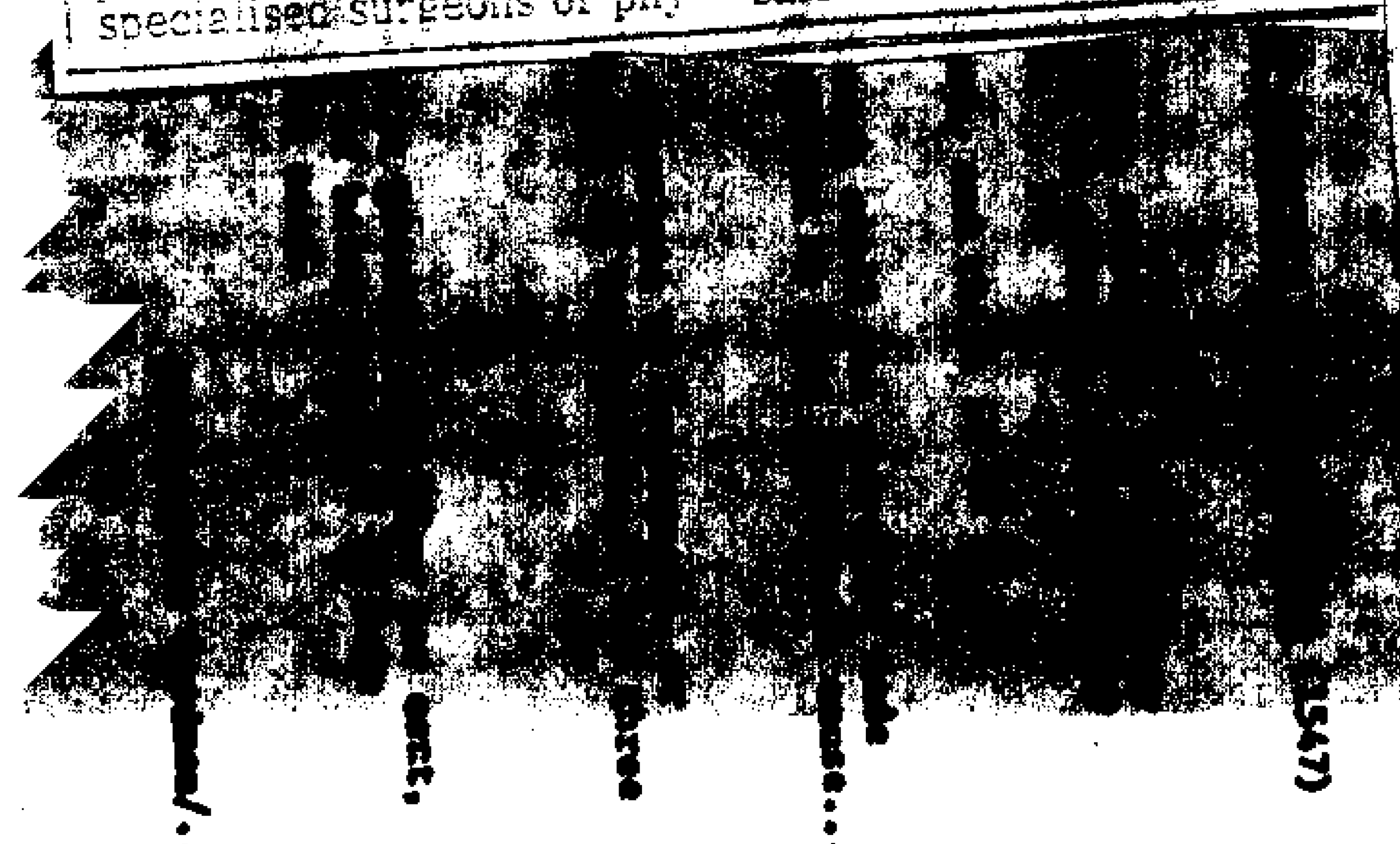
The surgical ward [illegible] had enemas had to stand in a queue to use the toilet.

The facilities are [illegible]

[illegible] sent to a Member of Parliament."

[illegible] wards were not overcrowded [illegible] there are [illegible] they [illegible] on a private basis.

'The ward [illegible] wide [illegible]



21/7/78 pg 98

Rural hospitals

There has been news of a shortage of medical personnel in rural hospitals. This shortage is unnecessary. Why not ask the missionaries — Protestant and Catholic — to join these hospitals?

Nursing nuns and doctors from religious orders pioneered medicine in this country. What's the hurry to get rid of them? They are needed everywhere. And if it were known that permits could be got to enter South Africa and the homelands to work in hospitals they would come.

Living quarters, convents and a chapel would have to be provided and just wages paid them, but it would put South Africa on the medical map again. The rural mission areas are the places suffering from a lack of personnel — dentists, doctors, nurses. Why not drop the red tape and get our rural hospitals going?

Also we have not enough medical beds in town, so why not subsidise voluntary private nursing homes and hospitals that meet the standards? We want a healthy nation.

D. J. Hatton.

395 Bosman St. Pretoria

Officials seek site for new day hospital

21/7/78 (98)

EAST LONDON — None of the facilities for blacks currently available at Frere Hospital will be done away with or closed until a day hospital is opened in Duncan Village or at an alternative suitable site to render these services.

This assurance was given to the MPC for East London City, Mr Petro de Pontes, this week by the deputy director of hospital services, planning, in the Cape, Dr M. Jooste.

Dr Jooste, the medical superintendent at Frere, Dr L. Visser, the chairman of the Hospital Board, Mr D. Lazarus, the Ciskei Secretary for Health, Dr J. Klopper, Administration Board representatives, Mr P. Sutton and Mr P. Opperman, the MPC for East London North, Mr R. Hobbs, and other officials toured Duncan Village with Mr De Pontes in search of a suitable site for the establishment of the proposed day hospital.

"The establishment of this hospital is receiving urgent attention from province," Mr De Pontes said. He added that there was "no doubt whatsoever" about Dr Jooste's assurance.

He could not estimate how long it would take for the day hospital to be established, as this depended on the availability of a suitable site, or possibly a building which could be suitably altered.

The tour of Duncan Village included a visit to the Lloyds municipal clinic and the smaller municipal clinic further into Duncan Village, and Mr De Pontes said he was appalled at the conditions prevailing at these clinics.

"Though the staff are doing what they can with the means at their disposal one would think that those city councillors so concerned with health services for blacks would keep their own house in order before criticising others, especially in view of the fact the municipality gets a seven-eighths subsidy from the government for these services," Mr De Pontes said. — DDR.

Army doctors for EL?

EAST LONDON — The shortage of doctors at Frere Hospital may soon be relieved by the acquisition of a number of doctors doing military service.

The MPC for East London City, Mr Petro de Pontes, said yesterday he was trying to secure the services of some of these doctors in the same way other hospitals in the country had made use of them when short staffed.

At present there is a shortage of 18 doctors at Frere. "I don't know how many military doctors we can get, but I'm hoping some will be assigned here soon," Mr De Pontes said. — DDR.

THE INFANT-INDUSTRY ARGUMENT

in the form of a debate between

MR PROTECTIONIST AND MR FREE TRADER

Mr Free Trader: It is obvious, thus, as illustrated by Ricardo's Theory of Comparative Advantage that free trade between nations will inevitably promote the world's economic welfare (or, at any rate, increase its gross production) and all the participant countries will share in the general improvement.

Mr Protectionist: Free trade will, no doubt, secure these benefits in the short run. In the long run, however, the interests of individual less-developed economies may be better served by temporarily protecting their infant industries against foreign competition. Such industries given the opportunity may ultimately be capable of establishing a comparative advantage viz-a-viz their foreign competitors. In the absence of protection during the initial stage of their development, the loss suffered may be so great as to render their survival unlikely.

The two reasons that explain the growth and maturing of infant industries are:

(1) Economies of time.

(2) Economies of scale.

"Economies of scale" involve the reduction in average cost per unit (and therefore an increase in efficiency) with the increase in scale. The suggestion here is that many industries cannot operate efficiently below a certain minimum size. Infants have first to grow up before they have any chance of proving viable and growing up is often an arduous and slow task. A little foreign competition may spur the infant on – too much competition may crush it out of existence.

"Economies of time" refer essentially to the reduction of costs (or increase in efficiency) that takes place over time for any given scale of production. An essential ingredient in the development of skills and know-how is "learning-by-doing" or "on-the-job-training". Again a little competition may be helpful; too much may overwhelm the infant. If it collapses, its full potentialities may never be realised.

These points form the basis of the argument in favour of some form of protection of certain infant industries for a limited period of time. It is difficult to know whether, in the long-run, the welfare of the world will thereby be improved, but from the nationalist viewpoint of the relatively less developed country, there can be no doubt that such a course is at times desirable.

Mr Free Trader: That is all very well. Obviously, economies of scale and time are important in the real world, but why should that necessitate state intervention and protection as suggested above? Why should society bear the burden of the anticipated loss until the infant grows up (if it ever does)? Surely the infant can budget for his own loss during the first few years of operation. Ultimately, if the new venture is at all worthwhile, the erstwhile infant will make a profit and survive. Until then, let him pay for hiw own loss! If he lacks sufficient capital to endure a prolonged period of losses, let him borrow the capital!

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Mr Free Trader: Wh Government technocr to risk the taxpaye entrepreneurs are untried schemes.

Mr Protectionist: times when the tech instances where the own money at risk. industries that we shipbuilding in Ja Germany, Iscor and so often stood in

Mr Free Trader: St of white elephants!

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Mr Protectionist: from the same above capital market is very long term inves return for long in proven in a step-by- giant strides (indiv

Mr Free Trader:

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SUPREME GRAND CHAPTER OF THE HOLY RO
OF SOUTH AFRICA

SCHEDULE OF STOCK HELD AT 30-6-19

ITEM	NO. HELD	GRAND CHAPTER UNIT SELLING PRICE	UNIT ... FOR B/ ... WHERE ... ABLE
GRAND CHAPTER REGULATIONS	1051	50c	
RITUALS			
R.A. (English)	11	2,80	
R.A. (Afrikaans)	200	0,70	
M.M.M.	–	2,10	
E.M.	–	0,80	
Apron Badges		[illegible]00	
Certificates & Diplomas			
M.M.M./E.M.	29	0,60	
Affiliation	135	0,60	
Installation	222	0,60	
REGALIA			
R.A. Collarettes	7		4
R.A. Collarettes	4	15,00	5
Principals Chains	4		3,10

NOTE: All other Grand Chapter Regalia on Hire to Grand Chapter Officers
Accounting purposes.

2 SUNDAY EXPRESS July 23, 1978

(98)

SA hospitals expect flood of test tube baby pleas

By JENNIFER HYMAN

BIG South African hospitals are expecting a flood of demands for test tube babies as soon as the world's first is born normal and healthy in Britain — and at least two hospitals told the Sunday Express this week they were technically able to do the job.

But the hospitals are not prepared to go ahead until possible hazards in the process are discovered and eliminated.

"The process is untried, and fraught with unknown dangers," said one gynaecologist. Others suspected the test tube baby might be just a "lucky fluke".

Some experts, including Professor Willie van Niekerk of the University of Stellenbosch Medical School, fear test tube babies may have congenital defects because they are conceived in an unnatural, laboratory environment.

Gynaecologists at Groote Schuur Hospital in Cape Town, the Johannesburg General, and Tygerberg hospitals all agreed the research pioneered by a British consultant gynaecologist, Mr Patrick Steptoe, and Dr Robert Edwards of the Cambridge University Medical School, marked a tremendous breakthrough in the treatment of infertility.

This team is now awaiting the natural birth of a baby to Lesley Brown and her railwayman husband Gilbert. If successful, the event will crown more than 12 years of research — in a field that has been fraught with controversy and "Brave New World" overtones.

In South Africa, where leading hospitals all run infertility clinics, women whose inability to conceive is due to blocked Fallopian tubes are being cautioned not to become too optimistic about an easy "test tube" remedy.

"We have to remember that this technique is still in its early research stage," says Professor Van Niekerk.

And Professor L G R van Dongen, head of obstetrics and gynaecology at the Johannesburg General Hospital, believes that only when 100 healthy babies have been born by this method can it be considered practicable.

But all the hospitals agreed that the technique itself was relatively simple. Once the method had been successfully imitated by other researchers, they foresaw it coming into general use.

"We have all the necessary equipment," said Dr J Meiring, who runs the infertility clinic at Groote Schuur. "All we really need is a nice fat research grant and we could get off the ground."

The General Hospital, too, claimed it had all the equipment necessary, but said it would have to acquire the knowhow.

"The only mystery surrounding the whole experiment is the solution in which the egg is fertilised," said one doctor. "But we could do our own research on that, once we got the green light."

If the Brown baby is normal and healthy, the medical world hopes that the Steptoe-Edwards team will publish details of the technique. That would enable other researchers to reproduce their methods.

24/9/78 Page 98

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s before its birth.
HER, a retired
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, has researched the
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OMBEE how the
as conceived

Sick miner set the old General going

On November 4 1886 Thomas Gray, a miner and the first patient in a raw-brick building that served as prison and "hospital," died.

Another patient had a leg amputated in full view of the prisoners.

It all started earlier that year, in February, when the gold outcrop was discovered on the Widow Oosthuizen's farm at Langlaagte. In September the goldfield was proclaimed, and on November 1 the prison was opened.

It also had to accommodate the sick.

The small raw-brick building with a thatched roof and enclosure of reeds was in Commissioner Street close to the present public library.

MISERABLE DEATHS

Thomas Gray was very sick with an infection of the stomach, and the nursing of the jailer, Barend Bruhn, did not help. So the first patient died three days after the prison/hospital was opened and was buried at government expense.

At this stage it seemed that early Johannesburg was going the same way as early Kimberley, where no provision had been made for the sick and men died miserable deaths with no hospital to care for them.

But during 1887 a few men, with Mr St John Carr as the leading figure, got moving to see that the same would not happen in Johannesburg. On March 16 1888 a meeting was held, and a hospital board was appointed with Mr St John Carr as chairman.

That meeting marked the beginning of the Johannesburg General Hospital.

It was attended by the first resident Catholic priest on the goldfields, the Rev Father O Mongineaux, who offered to provide a nursing staff. The people he found were religious sisters of the Order of the Holy Family of Bordeaux, who served the hospital for many years.

They were 14 trained nurses who served under the Rev Mother Adele. As the languages they spoke included English, French, Dutch, German and even some African languages, they were well equipped to serve early cosmopolitan Johannesburg.

SITE DONATED

Four-and-a-half months after the first meeting, on August 1, a temporary hospital was opened by Captain Carl von Brandis on a site donated by the Government. It could accommodate only 14 male patients, until March 1889, when an extension with 14 beds for women and children was opened by the Vice-President, General N J Smit.

He laid the foundation stone of the permanent hospital on the same day.

Dr G J M Melle, who had come from Bury Infirmary, Lancashire, was the first honorary secretary and treasurer of the temporary hospital. He resigned in August 1890, just more than two months before the first permanent hospital was opened in Smit Street.

130 PATIENTS

It could accommodate 130 patients and was officially opened on behalf of the state president by Mr J M A Wolmarans, on November 5 1890.

Dr John van Niekerk was the first official appointed to the permanent hospital, as resident surgeon and dispenser with effect from November 1. The Rev Mother Adele was matron and Mr F Evans the secretary.

Almost six years later Dr van Niekerk resigned and the post was advertised, the government insisting that applicants should have a knowledge of Dutch. Dr Henry Ireson Peirce was appointed from 28 applicants, and started on November 1 1896 as resident medical officer.

FIRST TIME

He was still in the post when he died at the age of 38 eight years later, on October 27 1904. An obituary appeared in The Star on the day of his death and a report on the funeral two days later.

The hospital board sent a cheque for £500 to his widow, in recognition of his services.

He was succeeded by Dr Ronald Pierson Mackenzie, who was head of the hospital for quarter of a century, from January 1 1905. His appointment was as medical superintendent, the first time that designation was used.

BREAST CANCER CLINICS FOR CITY

Mercury Bureau

PIETERMARITZBURG — New centres for the post-operative care of breast cancer sufferers will be established at the Addington and King Edward VIII hospitals in Durban.

Mr. Frank Martin, MEC in charge of hospitals, said yesterday that the establishment of the clinics had been approved by Exco.

The clinics, which will initially run for a two-year trial period, will be controlled by Dr. A. L. Brown, the chief radio-therapist at Addington Hospital.

The main object in establishing the clinics is to have a centre where post-operative breast cancer can be treated with chemotherapeutic treatment.

Patients of all race groups will be eligible and the costs will be borne by the administration.

However, private patients referred by their doctors, will be charged the full hospital fee.

The acting Director of Hospital Services for Natal, Dr. V. A. van der Hoven, said that the establishment of the clinics was an attempt to have a more rational basis for the treatment of post-operative breast cancer patients.

The project is being regarded as a "pilot study" to ascertain the best way to treat such patients.

Dr. van der Hoven said that at this stage it was impossible to estimate the number of patients likely to be involved.

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Call for clarity on hospital services

7/8/78 AA 98

GRAHAMSTOWN — The Cape congress of the Progressive Federal Party called on the Government to clarify its policy on hospital services for blacks in the Border region at the weekend.

The resolution was proposed by the Border Regional Council of the PFP.

Mr Jan van Gend of East London said because strong voices had been raised the Government had at the last minute decided not to close all services to blacks at Frere hospital immediately.

These services would continue until a day hospital was built to serve the residents of Duncan Village.

But, said Mr Van Gend, the Government had not even selected a site in East London for a day hospital.

He estimated it would not be ready for another two years.

The Government had shown a complete lack of foresight and had not consulted with the people whom such a hospital would serve.

Dr John Sonnenberg, the MPC for Greenpoint, told the congress: "This is a patent example of apartheid gone mad."

He said people in hospital services were trying to apply humanitarian principles in very difficult circumstances.

There should have been a day hospital at Duncan Village years ago said Dr Sonnenberg.

When the PFP had raised the matter about the closing of services for blacks at Frere hospital it had been accused by other parties of meddling in affairs that did not concern it.

"We are going to nag and pester them until the black people get what they deserve.

"We have no confidence in these public representatives and we shall continue." Dr Sonnenberg — DDR.

Day hospitals save the State 'lots' of money

98

The Argus Medical Reporter

BY SPENDING R4-million a year on the Peninsula's 16 day hospitals, the State is saving itself a vast sum of money on patients who would otherwise be admitted to the larger general hospitals run at many times the cost.

'Our budget is about four percent of the total hospitals' budget for the Peninsula,' said Dr J A Smith, senior superintendent of the Day Hospitals Organisation. 'This is saving the State a lot of money, as a small expenditure at the primary level saves millions of rands at a specialist level.

The average cost of treating a patient at a Day Hospital is R3 a visit. This covers a range of treatments from the removal of dressings to confinements, the setting of fractures and home visits.

More than 100 000 home visits are carried out to patients who might otherwise still be in hospital. The patient's own bed is always the cheapest, the hospital bed the most expensive.

CALCULATED

The patients themselves pay an amount calculated according to their income. Their fee is usually between 50c and R1 a visit.

In his annual report, Dr Smith pointed out that in a 10-year period the infant mortality rate among white and coloured babies in the Cape Town municipal area had been halved to 22 per 1 000 of the population. This is a tenth of the infant mortality rate in the rest of Africa.

'I'm not saying the Day Hospitals have accomplished this on their own,' said Dr Smith. 'But I am saying they have helped considerably in the nine years since their inception. We have been a catalyst in bringing this about.'

Dr Smith said with the advent of the Day Hospitals there was no need for any Peninsula woman to have her baby at home.

'They come to us for ante-natal care, and then have their babies here in sterile conditions.

'In an emergency, they can be transferred quickly to a general hospital. The ambulance and flying squad know where we are, and don't have to waste time searching for a shack in the bush.'

MR Rudolph looks at his X-ray plates, held for him by Miss Haj Ca, a radiographer at the Retreat Day Hospital.

'HE'S the most beautiful baby in the world,' says Mrs Ursula Flynn's smile, as she holds her two-hour-old son Colum, born at the Retreat Day Hospital.

EIGHT-YEAR-OLD Michelle Pieterse of Retreat looks on apprehensively as a nurse dresses the burn wound on her wrist at the Retreat Day Hospital.

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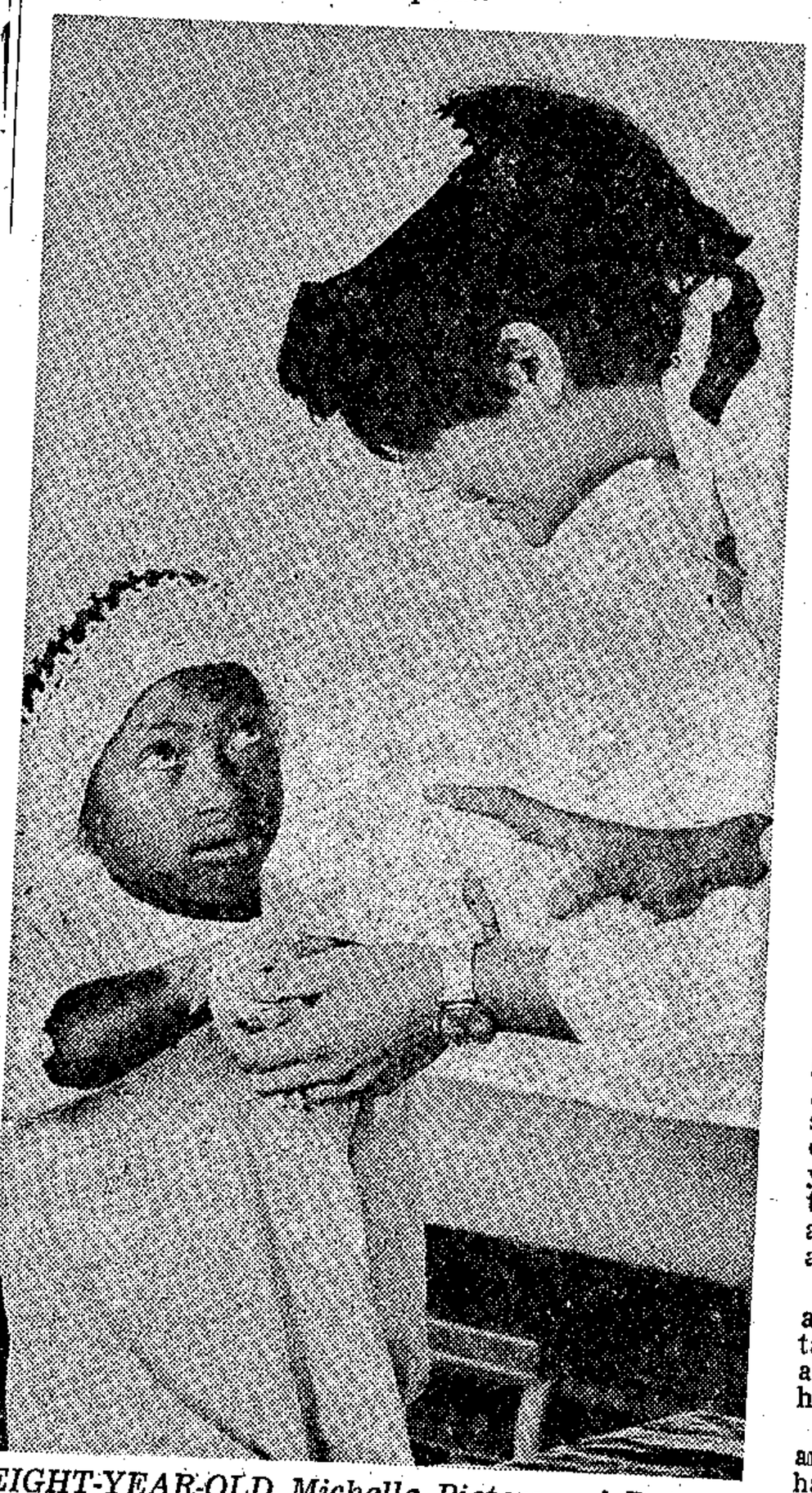
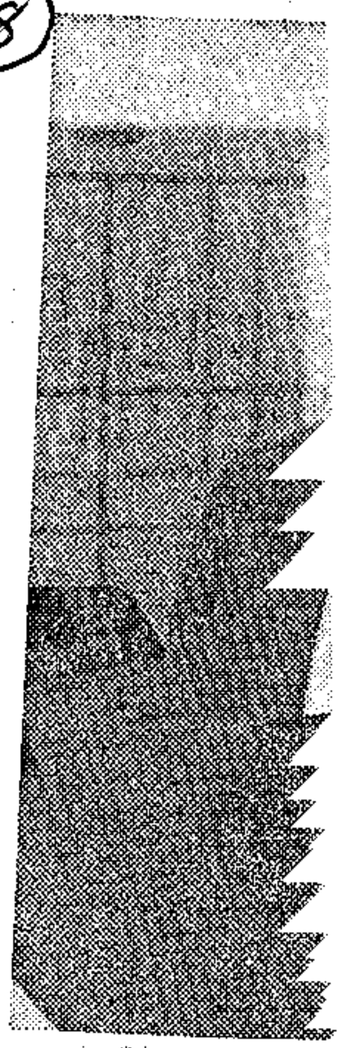
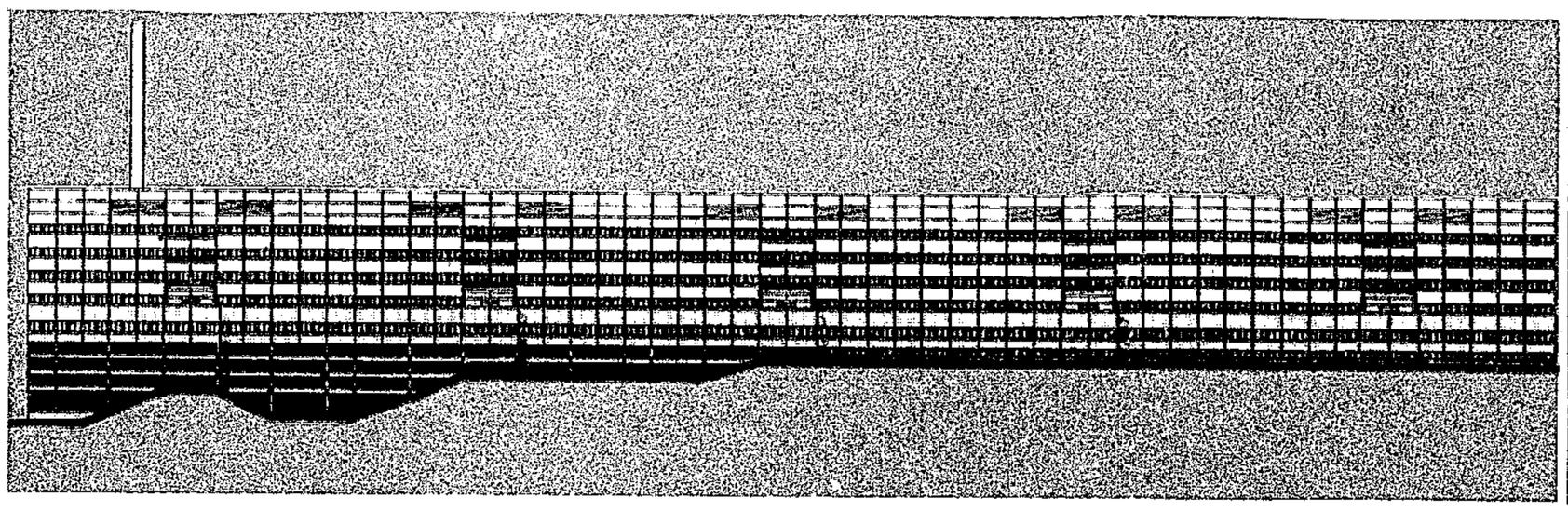


EIGHT-YEAR-OLD Michelle Pieterse of Retreat looks on apprehensively as a nurse dresses the burn wound on her wrist at the Retreat Day Hospital.



MR Rudolph Ba Cassier



JO
HOSPITAL

98

Supplement to Rand Daily Mail, Friday, August 18

It's bigger in volume than a pyramid

An entire medical town

THE new Johannesburg Hospital is one of the largest integrated hospitals in the world. It has been designed and constructed to serve three main areas of academic medicine; service to the patients, the training of medical personnel and research.

Situated in Parktown, one of Johannesburg's oldest and most beautiful suburbs, the Johannesburg Hospital had modest beginnings. Started in 1886 with 12 beds it was housed in the local jail. Now the hospital complex is bigger in volume than a pyramid.

At the cost of R156m, the hospital was built in record time for an academic hospital of its size and complexity.

The hospital is divided into five main sections or smaller hospitals, each with approximately 400 beds. They will be divided into the following disciplines:

Hospital 1 - obstetrics and gynaecology.

Hospital 2 - paediatrics.

Hospital 3 - surgical.

Hospital 4 - disciplines such as neurology, radiation therapy and urology.

Hospital 5 - internal medicine.

Hospital 1 and 2 were opened on July 3 this year.

Lecture theatres, seminar rooms and laboratories are situated within the hospital complex. Some academic departments such as paediatrics and medicine are housed entirely in the hospital complex while others will have facilities in the hospital as well as in the Medical School.

The Medical School will be completed within the next three years and will be linked to the hospital complex.

There are two major entrances to the hospital complex: There is the casualty or emergency entrance on the south side of the complex. It is well equipped with emergency rooms. This floor will contain the entire operating threatre complex of ths hospital.

The other main entrance is called "Hospital Street" and this is where outpatients and the public will enter the complex. It allows pedestrian traffic to move west east and joins all the smaller "hospitals" or blocks.

The hospital will accommodate a maximum of 2 000 beds, almost twice the amount presently used at the old General Hospital complex

It is estimated that the hospital will be served by 400 to 500 full time doctors ranging from heads of departments and professors to interns and 300 part time doctors.

The hospital will require between 2 500 to 3 000 nurses in different stages of training.

It will take between 700 to 800 administrative staff and approximately 2 000 domestic staff to run the hospital.

The hospital will be a training ground for up to 1 200 medical students as well as students from other disciplines such as physiotherapy, occupational therapy and social work.

The hospital has been equipped with two internal communications systems which are independent of the post office. One is for hospital staff, a PALX system and the other, a centralised nurse call system, is for the patients. A standard PABX system will be used for outside calls. This systems is not yet complete.

A computer has been installed to handle hospital administration. All the patient's medical information will be fed into the computer.

Modern technology is as good as those that work it and some hospital staff have had teething problems with these new systems. But it is primarily a question of adjustment. These systems have been built for the smooth running and efficiency of the hospital and will undoubtedly be of great advantage.

It is hoped that all five hospital blocks will be operational by the end of next year.

The move from the old "Gen" is by no means a simple one. The moving of expensive and sensitive hospital equipment is a complicated one.

The long delivery periods of the equipment has to be co-ordinated with installation and testing. Before any equipment is used at the new hospital is has to be checked and rechecked.

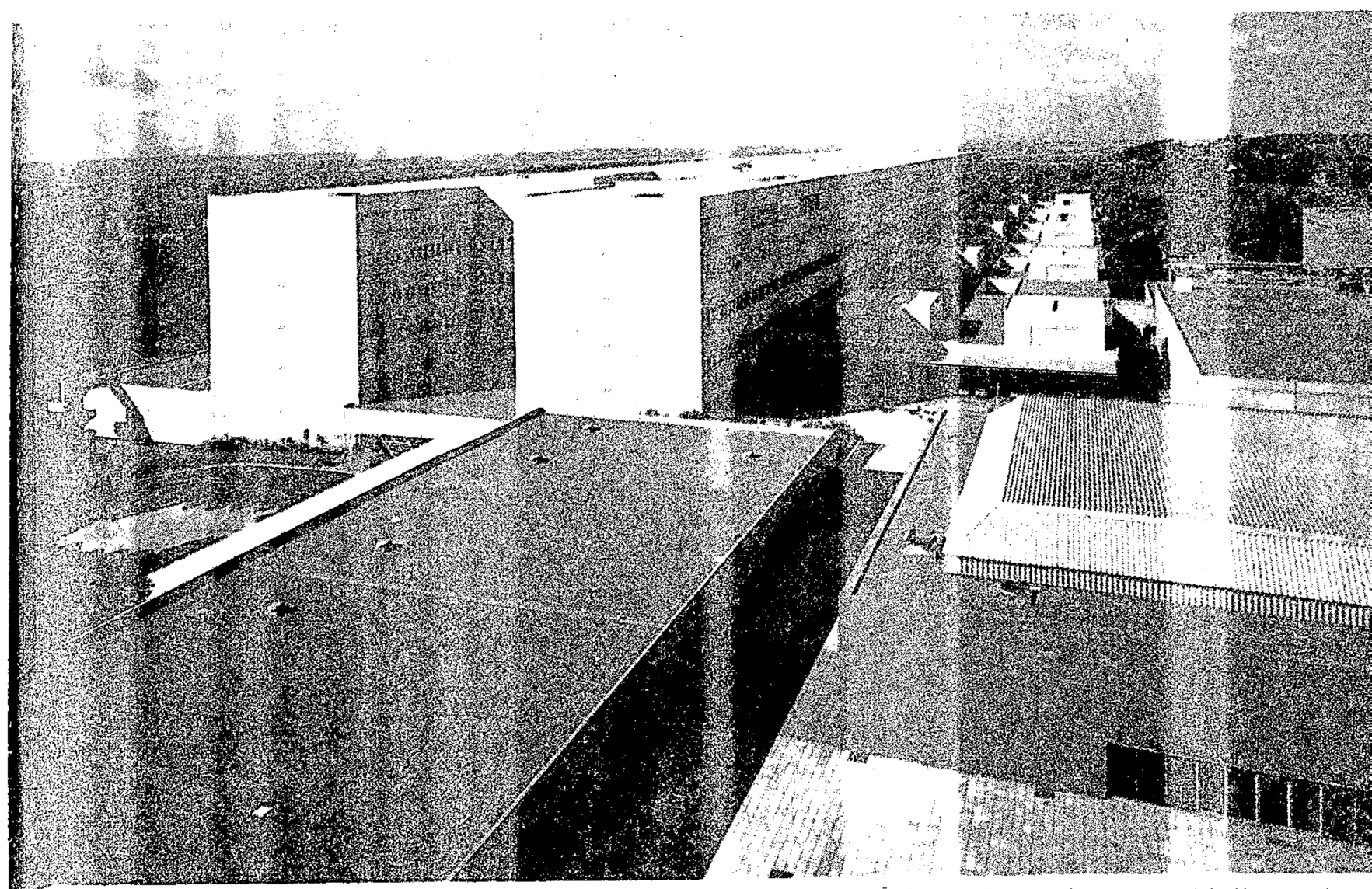
Add to this the annual updating and replacement of equipment, which will now have to be planned to slot in with the move.

Dr John McMurdo, the hospital's superintendent quips that it is a "complex game of draughts."

The smooth running of the new hospital will largely depend on Dr McMurdo who at the age of 37, is the youngest doctor to be appointed superintendent of a hospital in South Africa.

He believes that while no building has been built without mistakes, they have been kept to a bare minimum at the new hospital which he proudly refers to as "medical town".

"I have visited hospitals overseas and I have not seen a more exciting hospital in design. This is largely due to the fact that the architects have all along the line consulted doctors, nurses and academics.In addition the contracting team have surpassed expectations and finished the project ahead of schedule,which for an academic hospital of this complexity is unique".



In the foreground is the medical staff dining hall. On the left above it is the hospital proper with its nursing and one of the two main entrances to the complex. Next to the hospital, on the right, is the second main entr casualty, below the nursing levels. To the right of this podium is the administrative block. On the extreme ri the boiler house with its chimney. The Medical School will be between the boiler house and the administrative b

HOSPITAL CONTRACTORS

JOHANNESBURG

MAIN CONTRACTORS FOR THE JOHANNESBURG HOSPITAL

JOINT VENTURE BETWEEN:

Hochtief Aktiengesellschaft
für Hoch- und Tiefbauten
vorm. Gebr. Helfmann
Essen/West Germany
Sponsoring Company

Imprese Italiane
All'Estero
Impresit S.p.A.
Milan/Italy

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Rome
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South Africa (Pty) Ltd
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Combrink Construction
(Pty) Ltd
Randburg

Concor Construction
(Pty) Ltd
Johannesburg

Address: Cor. York and Jubilee Roads, Parktown, Johannesburg. P.O. Box 17536, Hillbrow 2038, Tvl. Cables: Hospicontra.
Telex: 8-6543 SA. **Telephone: 643-4967, Johannesburg.**

The patients can now look forward to their meals

MEALS will be something to look forward to at the new hospital and you will be able to enjoy them with members of the opposite sex.

A far cry from the days when patients were woken up at an unearthly hour and expected to eat lukewarm porridge wrapped up in bedsheets.

Meals are now served at normal hours and patients are encouraged to eat them in the ward's pleasant dayroom.

In addition there will be a choice of menu and trained dieticians will organise special diets for those in need of them.

Even meals make up part of the space age image of the hospital. A new frozen food system is being used.

It boils down to this. Most meals are prepared and prepacked in bulk at a factory in Pretoria and then reconstituted in the hospital.

The meals are delivered in special refrigerated trucks and then stored in deepfreeze chambers in the main hospital kitchen.

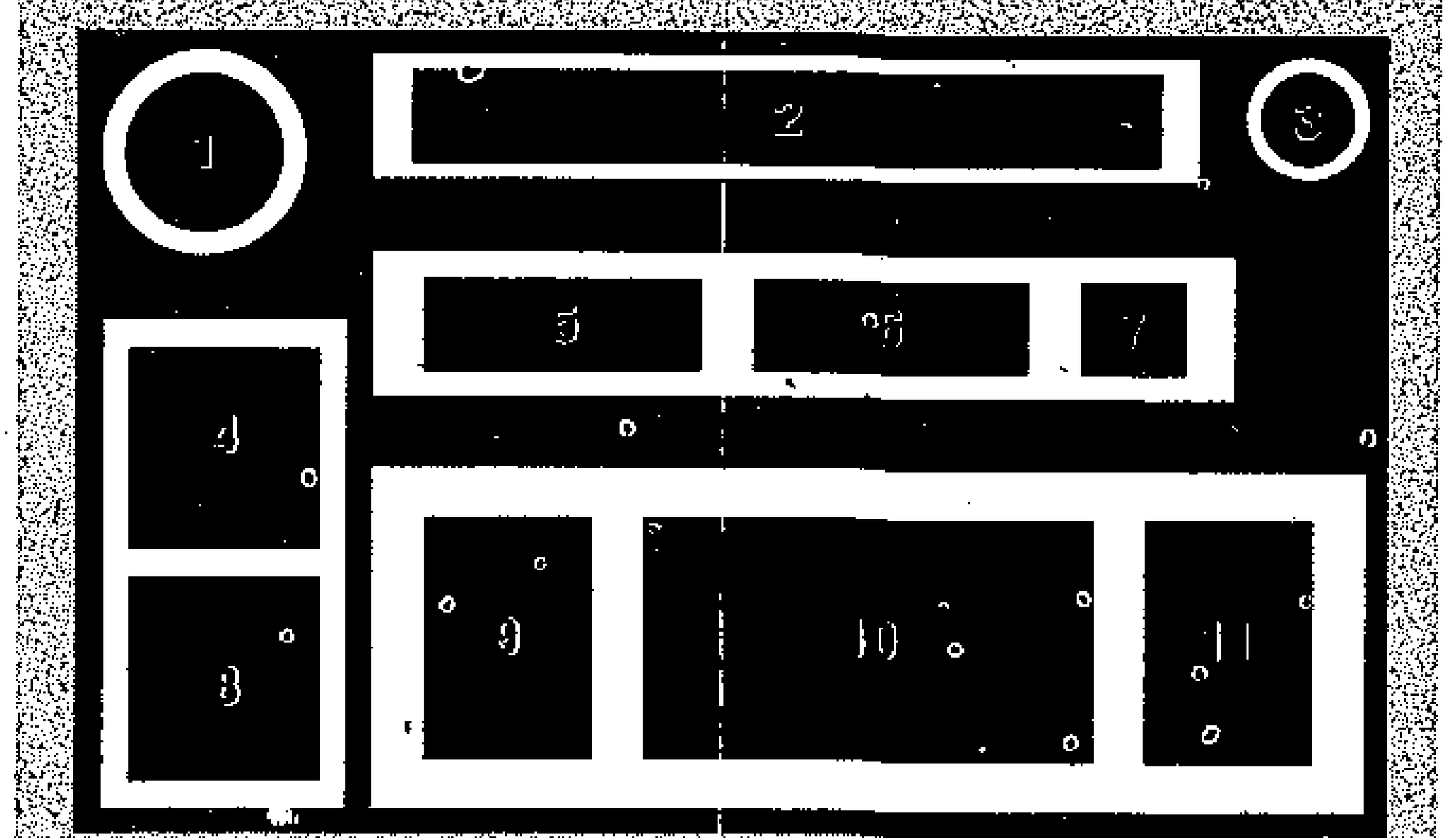
From there the meals are distributed to reconstitution kitchens. Items such as fresh salads, porridge, eggs and soups will be prepared in these kitchens.

Cooking meals in the normal way would take up to three hours. With the new system it will take about 30 minutes to prepare and serve them.

The food will be served on attractive trays much like the ones the airways use. Each individual dish is packed in a disposable cardboard container.

Still on the subject of meals, the paediatric section has a specially designed milk kitchen to cater for babies bottles.

UITLEG VAN SKINKBORD — LAY-OUT OF TRAY



ETENSTYE/MEAL-TIMES
TEETYE/TEA-TIMES

VROEË-OGGEND-DRANK	06h00	EARLY MORNING DRINK
ONTBYT	07h45	BREAKFAST
OGGENDTEE	09h30	MORNING TEA
MIDDAGETE	12h15 - 13h00	LUNCH
NAMIDDAGTEE	15h00	AFTERNOON TEA
AANDETE	18h15	SUPPER
LAAT-AANDDRANK	20h30	EVENING DRINK

BREAKFAST

11 Start with the porridge. Do not yet remove the lid off the main dish **10** - hot food is much nicer than cold food.

7 Here you will find the sugar for your porridge.

3 Fresh fruit juice/fruit.
OR

5 Stewed dried fruit.

6 Bread, butter, preserve.

8 Butter your bread here.

10 Now you can remove the lid from the main dish - start at the sharp corner. Place the lid out of the way underneath the container.

LUNCH

1 Start with the soup.

10 Remove the lid from the main dish,

9 vegetables and

11 starchy food by starting at the sharp corner. Place the lids out of the way underneath each container.

5 Fresh, crispy salad or a second portion of vegetables.

6 Pudding.

3 Pudding sauce.

SUPPER

1 Start with the soup.

3 Fresh fruit.

5 Salad.

6 Bread, butter and preserve.

8 Butter your bread here.

10 Remove the lid from the main dish and

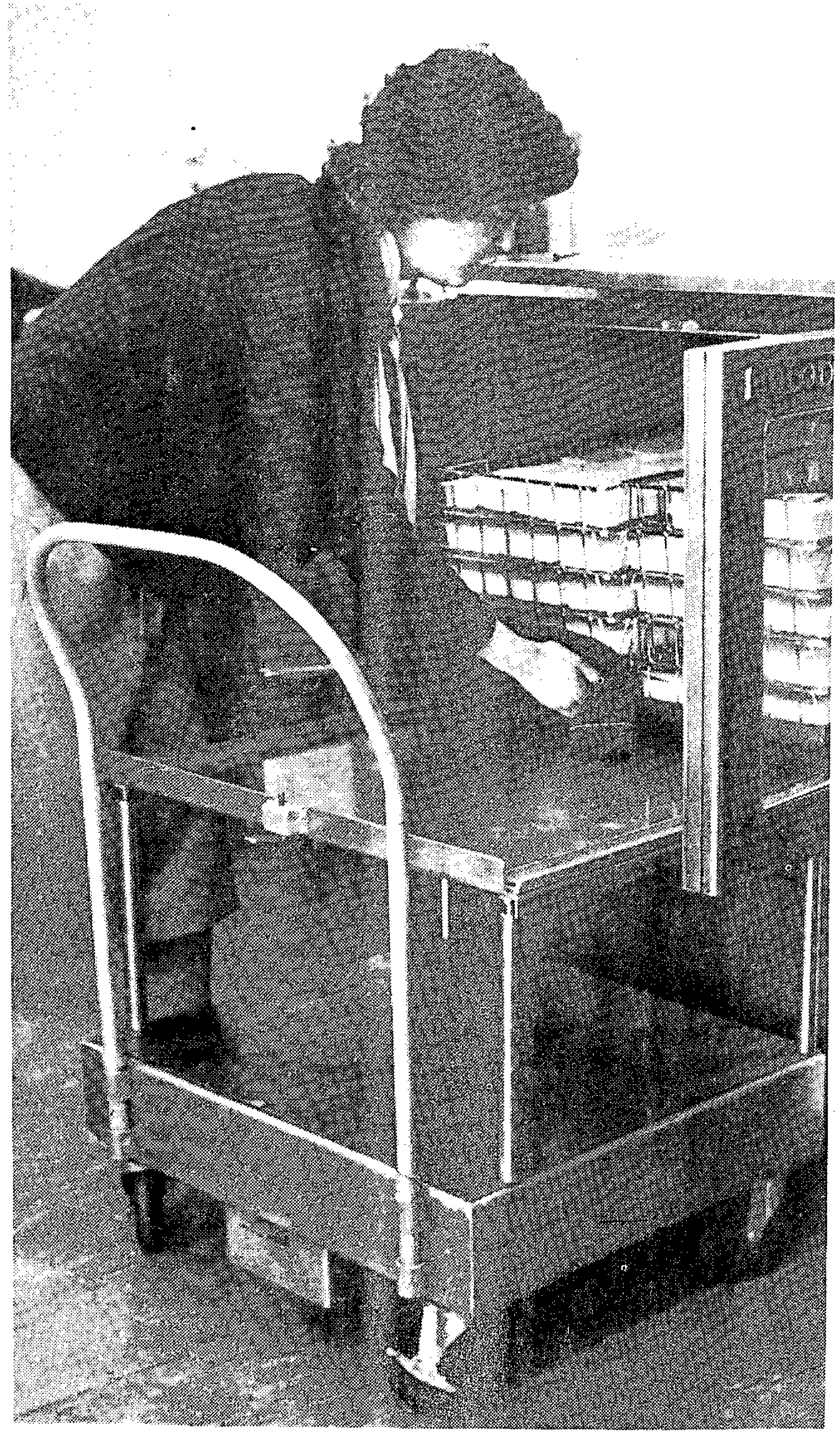
11 starchy food - start at the sharp corner. Place the lids out of the way underneath each container.

4 The menu on which you indicated your choice.
2 Cutlery with which you will enjoy your meal more. Do not forget the napkin.

Salt, pepper, Worcester sauce, tomato sauce, mustard, chutney and picalilli are available. If you would like some, kindly order it by indicating it on your menu.

ENJOY YOUR MEAL!

Not everbody has had a reconstituted frozen meal (see story) so the hospital has printed a simple set of intructions to tell you how to go about having one. This is part of the hospital menu. There is a limited choice of dishes for each meal. For example, for lunch there is mushroom soup but you can choose between goulash and grilled steak for the main course which is served with brown rice and a choice of either vegetables and or salad. There is a choice of desert, either banana loaf or trifle. The menu says the food is pre-cooked, hygienically packed and quick-frozen and has a high nutritional value.



Miss Anna Marie Joubert takes reconstituted meals out of a reconstitution oven in one of the ward kitchens at the new hospital.

It wo blow its to

THE boiler sy part of the la of its type yet in a hospital co rica.

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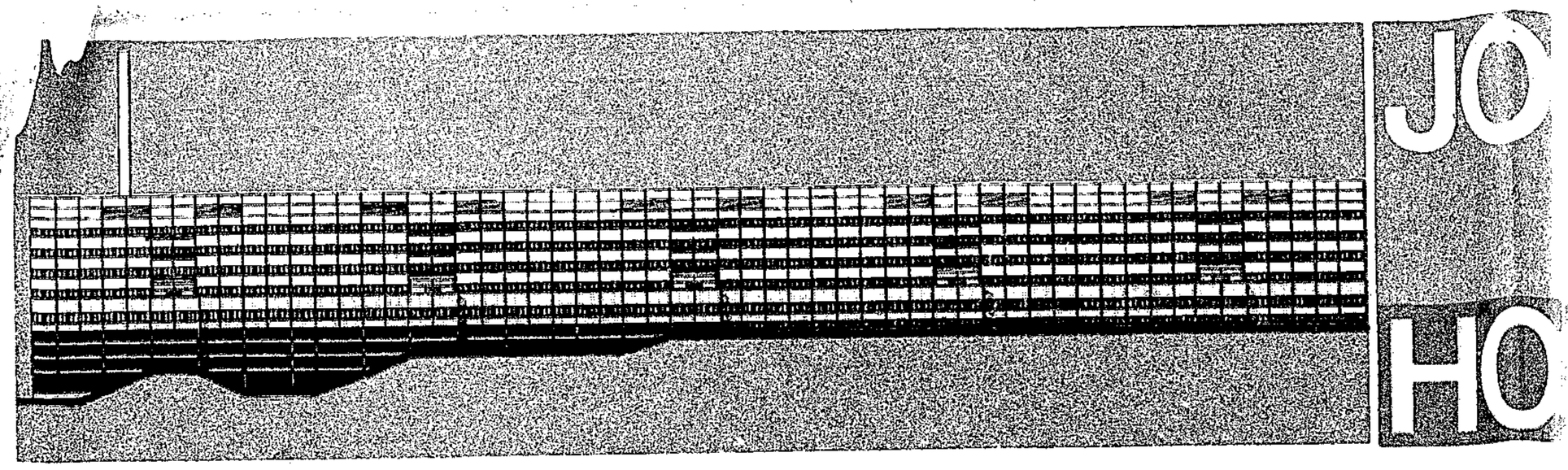
THE main ent hospital is call Street". It is mall that is th spine of the ho

This thorou have kiosks s snacks and b post office, a shops and a flo

It has sunny outpatients and eat their good newspaper or friends. There levels of car the mall.

In addition ea dayrooms whe and visitors c easy chairs to music. And for expecting a s there is a "r dresser" who w able to men and tients.



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Supplement to Rand Daily Mail, Friday, August 18

It's bigger in volume than a pyramid

An entire medical town

THE new Johannesburg Hospital is one of the largest integrated hospitals in the world. It has been designed and constructed to serve three main areas of academic medicine; service to the patients, the training of medical personnel and research.

Situated in Parktown, one of Johannesburg's oldest and most beautiful suburbs, the Johannesburg Hospital had modest beginnings. Started in 1886 with 12 beds it was housed in the local jail. Now the hospital complex is bigger in volume than a pyramid.

At the cost of R156m, the hospital was built in record time for an academic hospital of its size and complexity.

The hospital is divided into five main sections or smaller hospitals, each with approximately 400 beds. They will be divided into the following disciplines:

Hospital 1 - obstetrics and gynaecology.

Hospital 2 - paediatrics.

Hospital 3 - surgical.

Hospital 4 - disciplines such as neurology, radiation therapy and urology.

Hospital 5 - internal medicine.

Hospital 1 and 2 were opened on July 3 this year.

Lecture theatres, seminar rooms and laboratories are situated within the hospital complex. Some academic departments such as paediatrics and medicine are housed entirely in the hospital complex while others will have facilities in the hospital as well as in the Medical School.

The Medical School will be completed within the next three years and will be linked to the hospital complex.

There are two major entrances to the hospital complex: There is the casualty or emergency entrance on the south side of the complex. It is well equipped with emergency rooms. This floor will contain the entire operating threatre complex of ths hospital.

The other main entrance is called "Hospital Street" and this is where outpatients and the public will enter the complex. It allows pedestrian traffic to move west east and joins all the smaller "hospitals" or blocks.

The hospital will accommodate a maximum of 2 000 beds, almost twice the amount presently used at the old General Hospital complex

It is estimated that the hospital will be served by 400 to 500 full time doctors ranging from heads of departments and professors to interns and 300 part time doctors.

The hospital will require between 2 500 to 3 000 nurses in different stages of training.

It will take between 700 to 800 administrative staff and approximately 2 000 domestic staff to run the hospital.

The hospital will be a training ground for up to 1 200 medical students as well as students from other disciplines such as physiotherapy, occupational therapy and social work.

The hospital has been equipped with two internal communications systems which are independent of the post office. One is for hospital staff, a PALX system and the other, a centralised nurse call system, is for the patients. A standard PABX system will be used for outside calls. This systems is not yet complete.

A computer has been installed to handle hospital administration. All the patient's medical information will be fed into the computer.

Modern technology is as good as those that work it and some hospital staff have had teething problems with these new systems. But it is primarily a question of adjustment. These systems have been built for the smooth running and efficiency of the hospital and will undoubtedly be of great advantage.

It is hoped that all five hospital blocks will be operational by the end of next year.

The move from the old "Gen" is by no means a simple one. The moving of expensive and sensitive hospital equipment is a complicated one.

The long delivery periods of the equipment has to be co-ordinated with installation and testing. Before any equipment is used at the new hospital is has to be checked and rechecked.

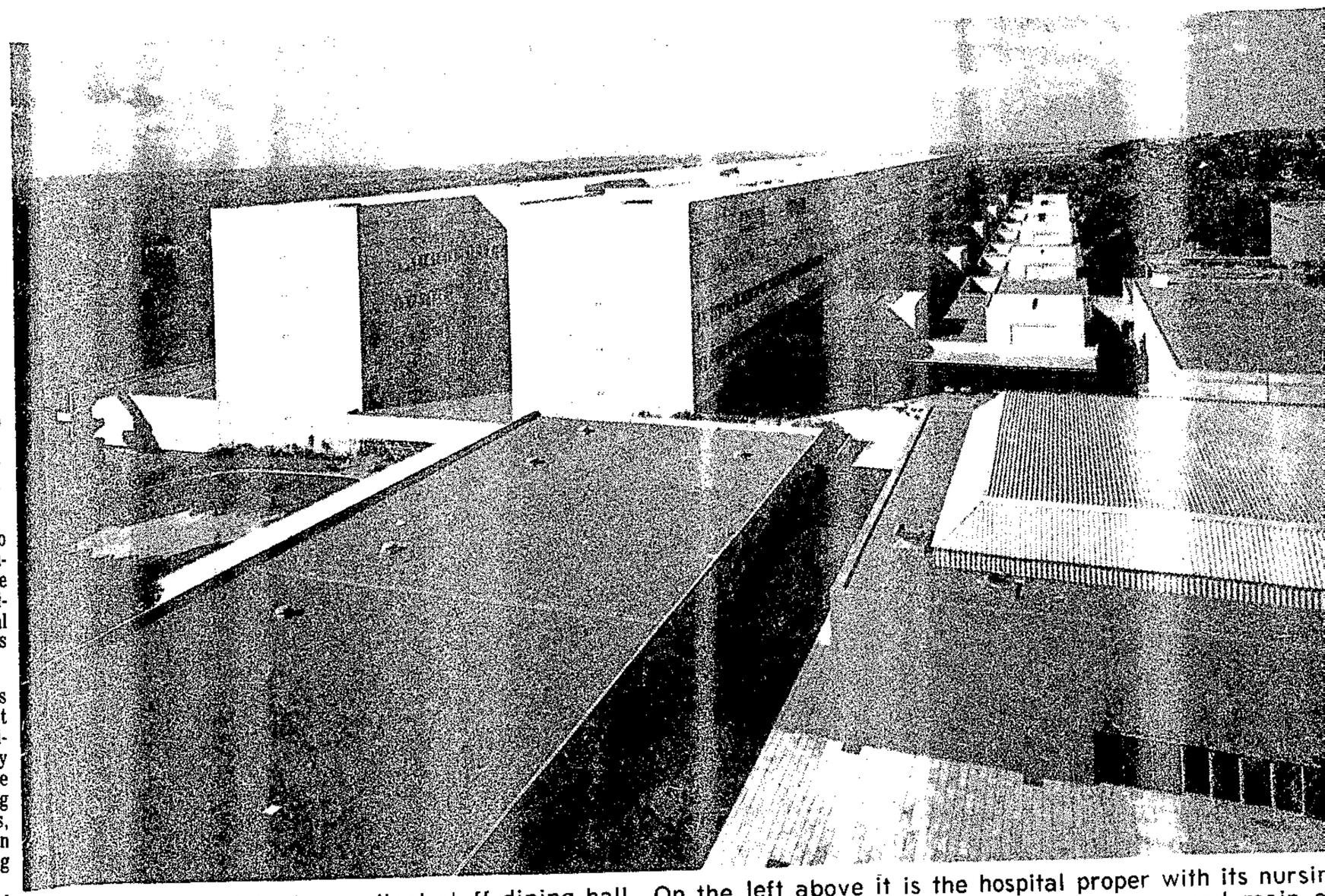
Add to this the annual updating and replacement of equipment, which will now have to be planned to slot in with the move.

Dr John McMurdo, the hospital's superintendent quips that it is a "complex game of draughts."

The smooth running of the new hospital will largely depend on Dr McMurdo who at the age of 37, is the youngest doctor to be appointed superintendent of a hospital in South Africa.

He believes that while no building has been built without mistakes, they have been kept to a bare minimum at the new hospital which he proudly refers to as "medical town".

"I have visited hospitals overseas and I have not seen a more exciting hospital in design. This is largely due to the fact that the architects have all along the line consulted doctors, nurses and academics.In addition the contracting team have surpassed expectations and finished the project ahead of schedule,which for an academic hospital of this complexity is unique".



In the foreground is the medical staff dining hall. On the left above it is the hospital proper with its nursin
and one of the two main entrances to the complex. Next to the hospital, on the right, is the second main e
casualty, below the nursing levels. To the right of this podium is the administrative block. On the extreme
the boiler house with its chimney. The Medical School will be between the boiler house and the administrativ

THE JOHANNESBURG HOSPITAL

HOSPITAL CONTRACTORS

JOHANNESBURG

MAIN CONTRACTORS FOR THE JOHANNESBURG HOSPITAL

JOINT VENTURE BETWEEN:

Hochtief Aktiengesellschaft
für Hoch- und Tiefbauten
vorm. Gebr. Helfmann
Essen/West Germany
Sponsoring Company

Imprese Italiane
All'Estero
Impresit S.p.A.
Milan/Italy

Impresa Ing. F. Federici
Rome
Italy

Prodilog Construction
South Africa (Pty) Ltd
Johannesburg

Combrink Construction
(Pty) Ltd
Randburg

Concor Construction
(Pty) Ltd
Johannesburg

Address: Cor. York and Jubilee Roads, Parktown, Johannesburg. P.O. Box 17536, Hillbrow 2038, Tvl. Cables: Hospicontra.
Telex: 8-6543 SA. **Telephone: 643-4967, Johannesburg.**

A large complex but no labyrinth

THE design team, Johannesburg Hospital Associated Architects, took three years to design the hospital. Their problem — how to design an academic hospital that would allow a maximum amount of flexibility.

To build and complete a teaching hospital before it is outdated is difficult enough.

As leader of the design team, Mr Gilbert Colyn, points out: "This hospital has to last at least 100 years. Medical science knows no boundaries. Its input is phenomenal and information is exchanged freely throughout the world."

Construction took six years and the project from its inception to its completion took nine years — a record time for a teaching hospital.

Space has been used profitably. Columns have been used 12.8m and 8.4m apart, allowing for maximum change without major structural changes.

An example of its flexibility can be seen in the design of the interfloor or interstitial "floor" areas.

Situated between each level, these "floors" carry 23 services in them, from air conditioning to hot and cold water pipes, and can be altered or removed without it affecting the normal running of the hospital.

During construction the system was a boon, saving approximately 80 weeks of construction time. Work in these "floors" could be done simultaneous with work done on the ordinary floor levels, without work in one area delaying work done in the other.

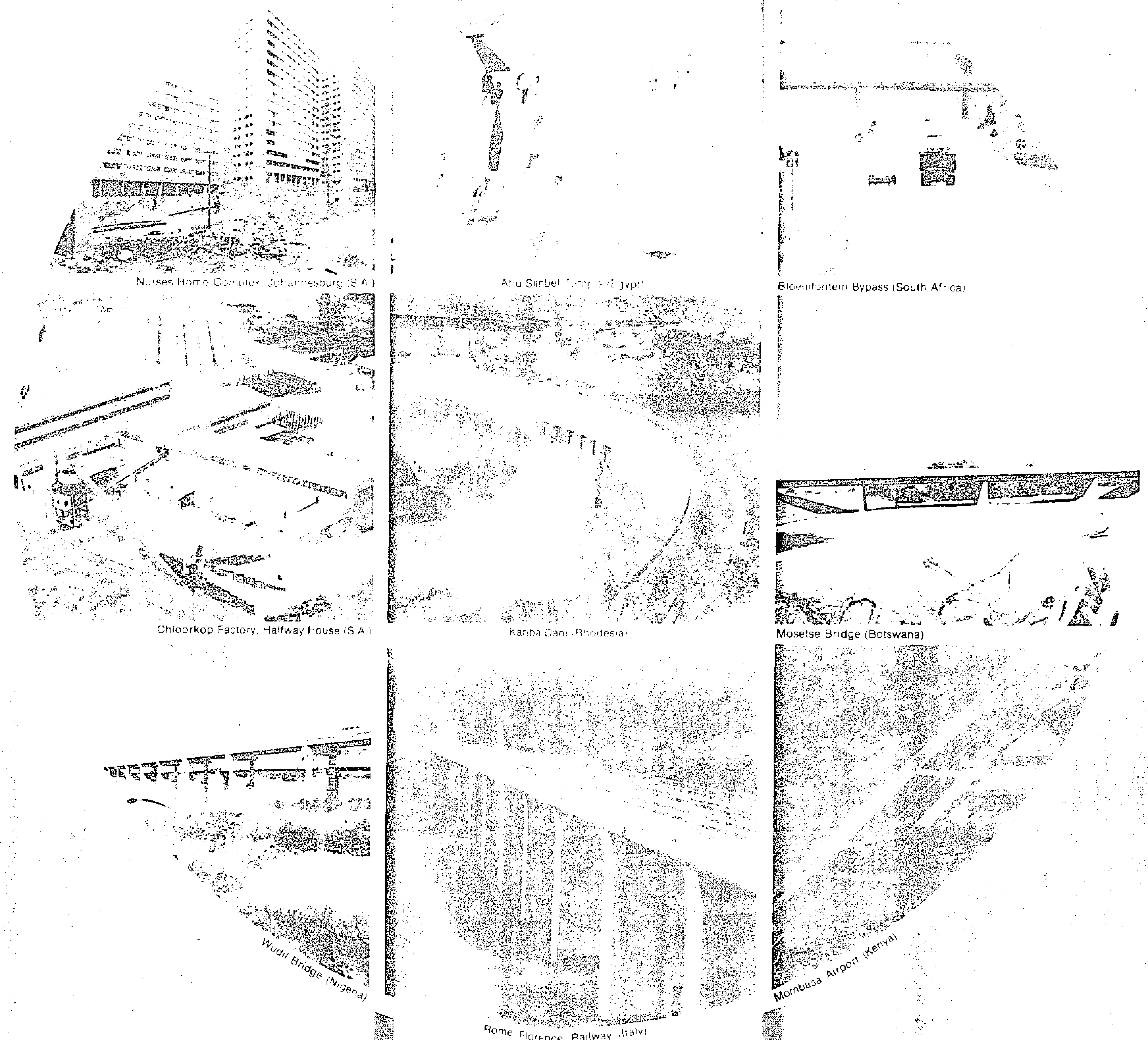
Another area that allows for change is in the hospital blocks themselves

The hospital blocks are strung together like a chain of Hs on their side and can flow into each other depending on their space requirements.

Mr Colyn says that while the complex is large there is no question of it being a labyrinth.

'Once you walk in through the main entrance it is easy to work out where to go. If you move to the right, you are in the teaching area, if you move to the left you are in the treatment area. Each of the five hospital blocks has been colour coded."

Dominating the Johannesburg skyline and built on a rocky ridge are the five residential blocks for medical staff. Built entirely of precast concrete the blocks will have bachelor as well as one, two and three-roomed flats. The complex will have its own recreational facilities, including a swimming pool. The photograph was taken from the main hospital entrance, "Hospital Street". The medical staff dining hall and escalator leading to the complex can be seen at left.



Nurses Home Complex, Johannesburg (S.A.)
Abu Simbel Temple (Egypt)
Bloemfontein Bypass (South Africa)
Chloorkop Factory, Halfway House (S.A.)
Kariba Dam (Rhodesia)
Mosetse Bridge (Botswana)
Wudil Bridge (Nigeria)
Rome Florence Railway (Italy)
Mombasa Airport (Kenya)

A concrete monument to co-operation

MONUMENTAL in size and concept, the new Johannesburg Hospital is the first major precast concrete building in Southern Africa.

Built on a quartzite ridge running east-west, the hospital is made up of approximately 30 000 precast concrete elements.

It is 360m long, 145m wide and is 58m tall at its highest point.

A highly co-ordinated example of design and construction, the building was started in August, 1972 and was completed in July this year — 15 months ahead of schedule.

During peak construction periods, the work force totalled 2 500 men.

Leading the contractors' team, Hospital Contractors Johannesburg, and service sub-contractors, Multiservice Engineering Consortium, was Hochtief, a West German company.

Apart from Hochtief, the contractor's team included two Italian companies — Impresit and Federici, and three South African companies, Prodilog, Concor and Combrink.

Hochtief's contribution to the R156-million project was considerable.

Intially designed with a steel frame, Hochtief proposed an "all concrete alternative" suggesting that the use of a precast concrete frame would be more practical for the project.

At the time steel was in short supply and the "all concrete alternative" meant a saving of R1 200 000.

In also overcame the then artisan shortage and its third benefit was speed of construction.

This was largely due to the fact that the precast concrete elements could be produced on site while other building work continued.

To achieve this, an on-site factory was established to manufacture precast concrete beams and columns for the frame.

Another precast concrete factory, 35 km north of Johannesburg in Chloorkop, was established to manufacture all other precast elements such as facades, internal walls, ceilings and floors.

These were mostly transported by flat bed trailers. Special trailers were designed to carry wall and facade elements.

Stored on site, the elements were then taken to the various cranes for erection.

Hochtief, as the main contractor, was responsible for the programming and management of construction. Most of the administrative and supervising staff came from that company.

The site management was responsible for communications between the client (the Transvaal Department of Works) and the architects (Johannesburg Hospital Associated Architects) and for communications with the various consulta tractors (for whom the main contrac responsibility).

In line with this there were no contractors, but bids were called jointly by the design team and mair

Hospital Contractors Johannes certain major service sub-contrac consortium, thus allowing considera of design.

The project was the first to ha clause built into the tender docum since become common practice wit industry.

The telelift — and good design — rule out collisions

EVER collided with a trolley in the corridors of the old "Gen" while visiting a patient? It's unlikely to happen at the new hospital.

The building has been carefully designed to keep patients, medical staff, visitors — and heavy trolleys — from getting entangled.

For a start all hospital supplies will be kept out of sight and mind, not to mention limb.

All supplies will be stored in the basement level, or tunnel, of the hospital. Food will be stored in the main hospital kitchen on the same level.

Food and supplies will be distributed throughout the hospital by special service lifts to the various service areas in the hospital, thus interfering as little as possible with pedestrian traffic.

Outpatients and visitors will mostly use "Hospital Street", the main pedestrian mall, running east-west on the ground level while inpatients will be confined to the three nursing levels above "Hospital Street".

In addition the movement of small goods will, to a large extent, be inconspicuous to the rest of the hospital because of a telelift system.

This computerised workhorse has, at present, 300 self-propelled containers that whizz around on 9km of track fetching and carrying goods to and from 125 stations throughout the hospital.

The containers can carry goods up to 5kg and are ideal for dispensing medicines, X-ray plates and documents such as laboratory results and bed letters.

About 10 tons of goods will be carried daily by the telelift system — a considerable saving of time and energy.

Each container is directed to its destination by a magnetic setting indicator located on its side.

Once a start button has been pushed it moves off on a track which runs vertically up and into the interfloor levels and on to the designated receiving station.

If it is mistakenly sent to a non station it will eventually find its way to a lost section depot from where it will be sent back to the station it came from.

And there is absolutely no chance of staff, patients or visitors falling over a lumbering electrician or plumber. All services are located in an interfloor or interstitial floor area. Between each level, services are carried by these service "floor" areas.

The "floors" are the height of an average man and work can be done in them without it being visible to the rest of the hospital or even heard by the rest of the hospital. So when there are men at work - YOU won't be disturbed.

Three telelifts wait in the main dispensary of the hos medical supplies to the rest of the hospital.

Mr Lionel Spies, the hospital PRO, using the PALX system. Next to it is the ordinary telephone for outside calls.

Communication systems for efficiency

A HOSPITAL, more than any other institution, needs to deal efficiently with emergencies. Communications are of major importance.

The new hospital has two new systems, both of them internal networks.

The first is a PALX system which functions as an intercom/telephone and is for staff use only. The device itself looks like a cross between a telephone and a calculator and will eventually be linked to a bleeper system.

It has several advantages. If a doctor wishes to communicate with several nurses, for example, the nifty device can be used as an intercom and is particularly useful for staff members busy examining patients.

If, however, the doctor wishes to have a private conversation with the matron, all she has to do is lift the receiver — what the doctor says can then only be heard by her.

The system leaves the ordinary telephone switchboard free for outside calls. This PABX system will be complete at the end of the year and will have about 1 500 extensions.

The second system — a centralised nurse call — is for the benefit of the patient and ensures that a patient in need of urgent attention gets it.

Once the patient rings a bell above her bed an operator working in front of a video screen will see the patient's name flicker on the screen.

By means of a two-way intercom the patient will be able to tell the operator what is wrong. The operator will then be able to bleep the patient's nurse — whoever she may be.

Basic details about the patients will appear on the screen. Their nurse care level will be given, the language in which they wish to be addressed, and their ward and bed numbers. Thus the operator will have some knowledge about the particular patient.

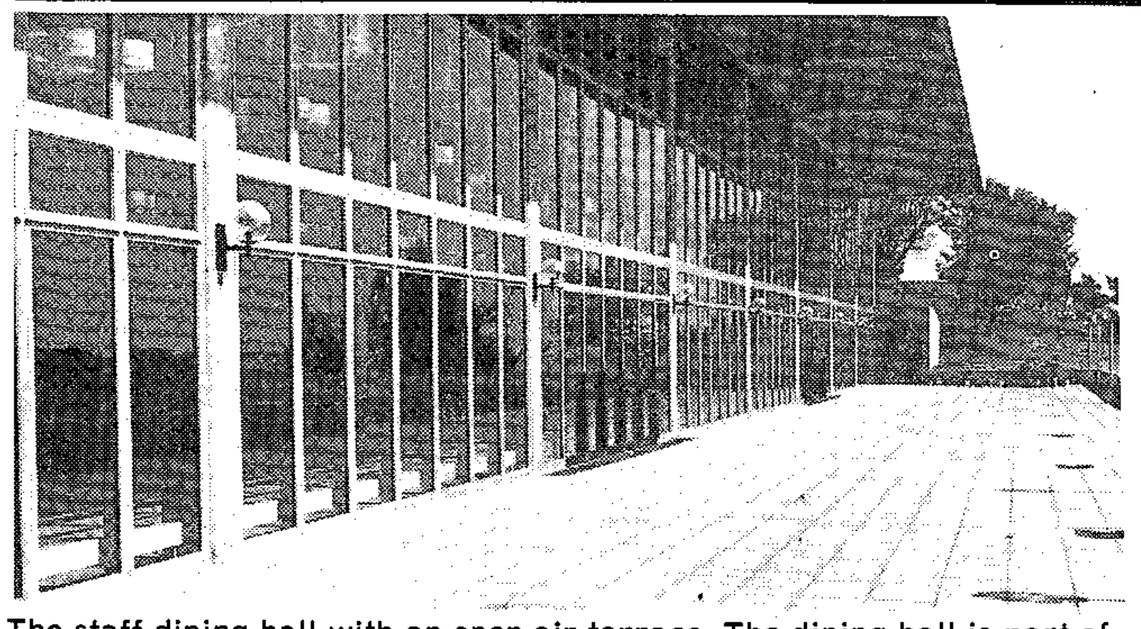
One main advantage of the system is that while it gives the patient a sense of security, it also saves nurses from making unnecessary trips.

If, for example, the patient needs a pain-killer the nurse will be able to pick it up on the way to the patient's bed.

If, on the other hand, the patient merely wants to know when the next meal will be served the operator can reply.

It has been estimated that this system can save up to 30% of nursing time. It has been designed to improve nursing — not to cut down on staff.

Each operator will be responsible for about 500 beds. The patient's name will continue to flicker on the screen until she has been attended to.



The staff dining hall with an open air terrace. The dining hall is part of a complex that includes a multi-purpose hall.

Staff at hom in the comp

FIVE residential blocks to the west of the hospital complex will accommodate doctors and nurses.

Built on a rocky ridge, the five blocks dominate Parktown ridge and will accommodate about 1 200 staff members.

Doctors, sisters and matrons will be housed in the two smaller blocks which have bachelor, one, two and three-bedroom flats.

Junior nurses housed in the th and central bloc blocks will acco 300 nurses in sing the type found in veristy residences

On the hospital residential compl staff dining hall purpose hall. Th hall opens onto a terrace which is the hospital by a escalator.

This computer makes you better

BHIS is out to make you better. "He" is not quite CP30 of "Star Wars" fame but he can cut down on your hospital stay and find you compatible bedfellows. "He" is the new hospital computer.

The Burroughs Hospitals Information System (BHIS) is one of the most sophisticated hospital computer systems in South Africa.

BHIS can tell how many beds are empty, who is in the ones next to them and whether they are smokers. It can tell which operating theatres are in use, which doctors booked them and when they will be vacant.

But BHIS has had some teething troubles. He is, after all, a computer and computers are only as good as the people using them.

Research done by Burroughs showed that the average stay in a hospital was eight days. One entire day could be saved with BHIS and one eighth of hospital costs.

The system is intended to speed up administrative work which alone takes up a considerable amount of time from the moment the

patients are admitted.

It is able to absorb a phenomenal amount of information from patients' medical records to laboratory tests and make them available within seconds.

With the help of the computer the hospital will be able to move away from the first-come, first-served system used in many of its clinics for outpatients.

The computer will be able to book appointments and keep track of changes, if any.

Video terminals have been situated at all key administrative areas throughout the hospital.

This will save both medical staff and outpatients from running to and fro. Medical staff will be able to call up any patient's file from many points in the hospital. And outpatients will be able to go directly to their clinics without first having to collect their files from Admission.

Print-outs can be made of any of the information in the data system should the medical staff wish to have a copy.

BHIS himself takes no chances once an inpatient has been registered. He immediately gets down to work and prints out labels with the patient's name and particulars.

And if a patient gives his name as "Jones" the computer will call up a list of "Jones" and names that SOUND like it.

The reason? The patient may have a speech defect. Patients will be able to see the video screen during admission and correct mistakes.

Quite a quantity

THE quantity of materials used on the hospital complex was no mean amount.

During excavation 165 000 cubic metres of soft ground was covered and 170 000 cubic metres of rock.

180 000 tons of precast concrete was used covering 75 000 cubic metres.

The length of prestressing wire was long enough to go all the way to Cape Town and half way back — 2 150 km.

503 000 sq m of gypsum board was used and approximately four and a half million screws were used on 475 000 m of metal runners.

Approximately 50 000 sq m of vynil asbestos sheeting was used and 250 000 litres of paint covered 500 000 sq m of ceilings and walls.

A move away from the Florence Nightingale type of institution ...

The days of endless, bleak wards are over

THE days of endless, bleak wards are over and so is the martial discipline patients were subjected to while occupying them.

A progressive approach to nursing care has been epitomised in the design of the nusring wards of the new hospital.

"We are moving away from the Florence Nightingale type of institution, a move away from the barren lonely clinical environment," says Dr John McMurdo, the hospital's superintendent.

For a start wards have been split up into smaller nursing units which are sunny and cheerful.

Each ward will be made up of about 24 to 30 beds which are subdivided into units of six, four and two. There are also private units with their own bathrooms.

The wards have been designed on a "race track" or double corridor plan with the nurses station at the centre of the double corridors.

The advantage of this design is that it allows for a minimum amount of distance between the nurses' station and the patients' units.

The private units and two-bed units look down on a patio or lightwell, while the six-bed units overlook the northern suburbs of the city.

Each ward has a day room for patients who are well enough to get up and there is every encouragement for patients to do so and spend a "normal" day.

The day rooms are carpeted and furnished with writing desks and easy chairs. Patients can relax and listen to background music, play bridge or read in a corner.

Mr and Mrs A Language play with their daughter, Marna, 10 years, in a playroom in the children's block.

The rooms also have tables and chairs where patients can serve their own meals and there is no ban on the sexes mixing. It is hoped that each day room will eventually have a television set.

Patients will be woken between 6 am and 7 am for breakfast and they will be able to go to sleep at midnight. Each bed has been provided with a dimmer so that patients can control the light intensity to suit their individual needs.

In addition, each patient will have his own nurse-call handset.

Special attention has been given to the children's block or hospital. Because children suffer from a "depri-vation syndrome" more easily than adults the children's ward has been made to look as much as possible like a nursery.

Animal-shaped pouffes are scattered cosily around the numerous playrooms in the children's section. There are games and toys to play with and the children's drawings have been stuck up on the playroom walls.

One attraction of the north-facing wards is that they look down on to the Johannesburg Zoo.

The Transvaal Education Department runs a school in the hospital and has two classrooms and a library-cum-staff room. It is staffed by nine full-timers and four part-timers.

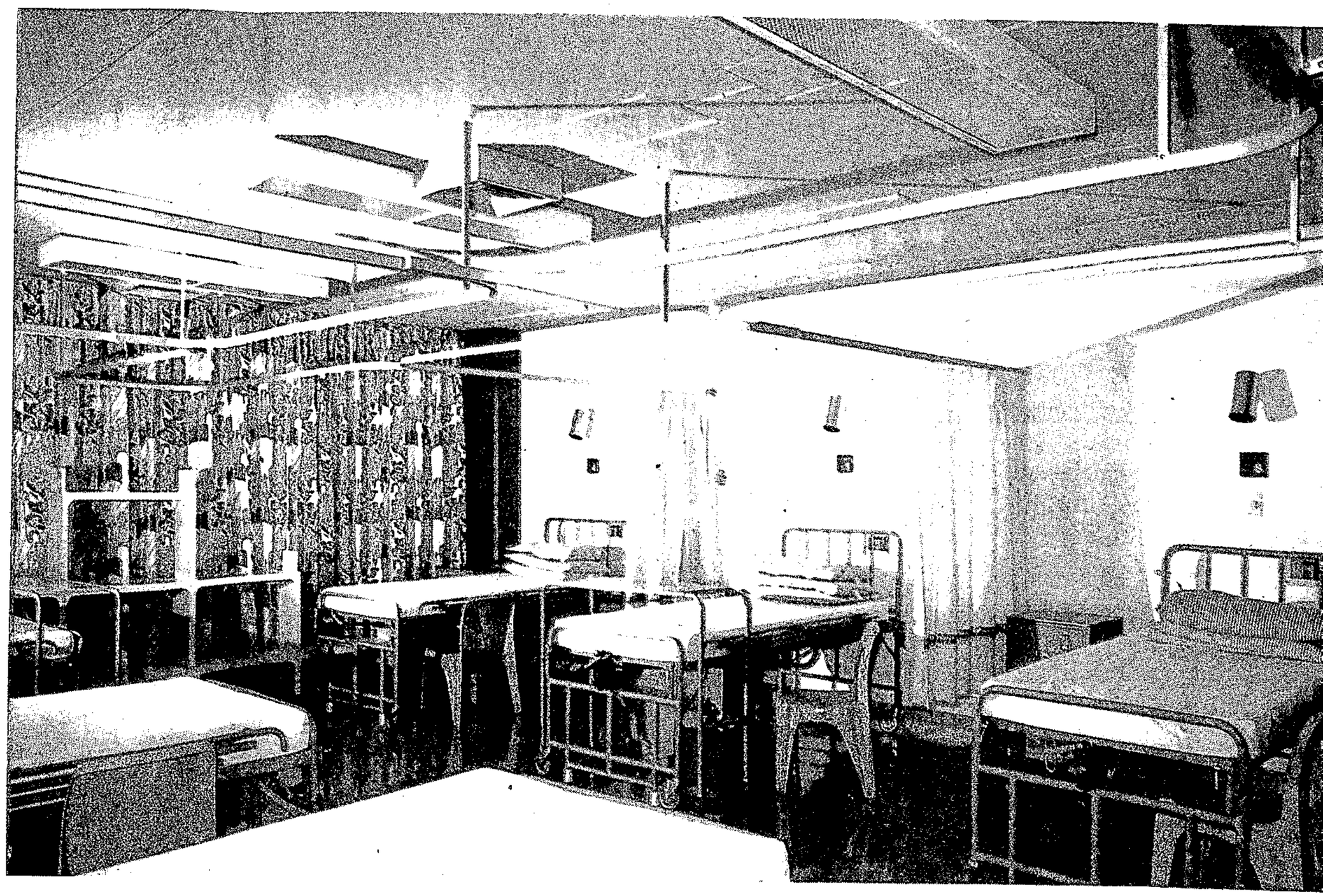
For pre-school children there are three full-time nursery school teachers.

Provision has been made for additional playroom facilities in the Occupational Therapy Department and children will also have the use of the physiotherapy pool.

A psychiatric ward has been provided for children. The old Children's Hospital did not have a psychiatric ward of its own.

The children's units are generally designed like the adult ones, except for glass windows between them, to make supervision easier. A nurse in one unit will be able to see what is happening in the ones next to it.

Parents will be encouraged to spend as much time as possible with their children. Special sleeping facilities have been provided for mothers in cases where the doctor feels that it is essential that she be with her child. This is restricted to special cases and is made available only at the doctor's discretion.



A typical six bed nursing unit. The colourful curtains with an exotic design match the red chairs in the unit. The six bed units look o northern suburbs or the city skyline.

GEOGRAPHY III STUDENTS - 1978 PROJECTS

TITLES OF PROJECTS SUBMITTED

Industrial Location : Lansdowne Area.

The National P.D. Plan and the Contract Labour System : Policies that restrict Black Migrant Worker Mobility with special reference to the Cape Peninsula.

The Social and Economic Development of Gamkaskloof.

Labour in the Textile Industry : A Case Study of S.A. Fine Worsteds.

Solar Radiation Patterns - Particular Case Study of Gobabeb in the Namib Desert.

Commuting Patterns from an Economic Housing Area - Sun Valley.

Nature of the Fishing Industry at Struisbaai and Agulhas.

Residential Location Theory in the Cape Town Metropolitan Area.

Plumstead Retail Trade Areas and Consumer Behaviour.

Language Variation in Residential Areas of Cape Town

Labour Bureaux - A Studv

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SPEECH AND DRAMA

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DOCTORS ANGER OVER SUPERGERM DELAY

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 and Fairwood 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 it has not.

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.

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.

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

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."

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."

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.

KARL BREMER BLY OOP — LOUBSER

MNR. P. J. LOUBSER, L.U.K. belas met hospitaaldienste, het gister ontken dat die Karl Bremer-Hospitaal in Bellville sy status as oop hospitaal ontneem en weer as opleidingshospitaal vir die Universiteit van Stellenbosch gebruik sal word.

Mnr. Loubser het gister in 'n onderhoud kommentaar gelewer op 'n berig wat Saterdag in Die Burger verskyn het. Hy het beklemtoon dat die vernaamste taak van die ad hoc-komitee, wat aangestel is om opleidingsgeriewe vir mediese studente van die Universiteit van Stellenbosch te ondersoek, nie die ondersoek nà die gebruik van die Karl Bremer-Hospitaal as opleidingshospitaal is nie.

Daar is geen sprake dat die hospitaal vir die publiek gesluit sal word nie. Die afleiding wat gemaak is dat die hospitaal sy oop status ontneem kan word en weer 'n opleidingshospitaal sal word, is 'n misverstand.

VOORSTELLE

Die ad hoc-komitee het gister vir die eerste keer vergader om ondersoek in te stel na die behoeftes wat nog by die fakulteit van geneeskunde van die Universiteit van Stellenbosch in die opleiding van studente bestaan. Die komitee moet moontlike oplossings voorstel. Een van die voorstelle kan wees die toekenning van 'n aantal beddens in die Karl Bremer-Hospitaal aan die fakulteit van geneeskunde, 'n ander oplossing kan wees die herverdeling van beddens in die Tygerberg-Hospitaal, wat tans as opleidingshospitaal dien.

PROBLEEM

Die universiteit ondervind tans by die Tygerberg-Hospitaal probleme deurdat studente in dié hospitaal nie genoeg gevalle van sekere siektes kan bestudeer nie. Die probleem kan opgelos word deur die toewysing van 'n aantal beddens in 'n ander hospitaal, of deur 'n daghospitaal.

PASIËNTE

As 'n deel van die Karl Bremer-Hospitaal as opleidingshospitaal gebruik word, sou verseker word dat pasiënte wat deur private dokters behandel word, in die toekenning van beddens voorkeur geniet. Die hospitaal word tans opgeknap en net sowat 'n kwart van die hospitaal se beddens en teaters is in gebruik.

Die ad hoc-komitee sal na verwagting vroeg aanstaande jaar sy werk afhandel. Die komitee is saamgestel uit verteenwoordigers van die universiteit, die Hospitaalraad van die noordelike stadsgebiede en die Kaaplandse Departement van Hospitaaldienste. Mnr. Loubser is die voorsitter. Die komitee se voorstelle sal aan die Administrateur en die Uitvoerende Komitee voorgelê word.

(98)

11/11/78

DIE BURGER, SATERDAG, 11 NOV

Kaap kry gebou vir belemmerde kinders

'N MODERNE gebou van tussen R400 000 en R500 000 word beplan op die plek waar die Rondebosse Hospitaal gestaan het. Dit sal deel wees van die Kindersentrum, waar belemmerde kinders behandel sal word. In 'n gedeelte van die ou gebou wat nie platgeslaan is nie, word belemmerde kinders reeds behandel.

Gister het dr. W. H. J. Greeff, eerste mediese superintendent van die Rooi Kruis-Kinderhospitaal in Rondebosch, die planne vir die nuwe gebou bekend gemaak. Die Rondebosse Kindersentrum is 'n afdeling van die Kinderhospitaal.

Planne vir die nuwe dubbelverdieping-gebou is reeds opgestel. Die Provinsiale Administrasie, die Universiteit van Kaapstad en die Skiereilandse Hospitaalraad sal genader word om geld hiervoor beskikbaar te stel.

HIPERAKTIEF

As genoeg geld nie gekry kan word nie, kan die bouwerk nogtans begin word omdat dit in fases afgehandel kan word. Altesame R35 000 is reeds hiervoor beskikbaar, het dr. Greeff gesê.

Gister het dr. Greeff en matrone D. M. McWilliams, hoofmatrone van die Kindersentrum, aan lede van die Skiereilandse Hospitaalraad en verslaggewers gewys wat reeds in die Kindersentrum gedoen word.

Kinders word van jongs af (in sommige gevalle van kort ná geboorte) daar behandel. Toe Die Burger die sentrum gister besoek het, is gesien hoe 'n drie maande oue baba fisioterapeutiese behandeling ontvang.

Blinde en dowe kinders word ook gehelp, en ook kinders met emosionele en verstandelike gebreke.

Sommige kinders wat na die Kindersentrum gebring word, is hiperaktief. Gelukkig is daar genoeg ruimte benewens 'n swembad en 'n tennisbaan vir sulke woelwaters. Ander kinders is aggressief en die ouers weet nie hoe om die kind te hanteer nie. Ander is kleptomanies. Dikwels moet die ouers en ander gesinslede ook aan die behandeling deelneem, omdat die simptome wat die kind openbaar, eintlik die gevolg is van 'n gesinsprobleem.

Ouers en gesinslede moet ook leer hoe om 'n moeilike of belemmerde kind te hanteer.

In sommige gevalle word die kind net een keer per week behandel en ouers kan die behandeling tuis voortsit. In ander gevalle moet die kinders elke dag na die Kindersentrum kom, en duur die behandeling tien maande of langer.

SPEELGOED

Die behandeling is gespesialiseerd en dikwels kan 'n personeellid net een kind op 'n keer behandel. Die nuwe gebou sal hoofsaaklik vir spraakterapie gebruik word. Daar sal ook 'n lesingsaal wees, want dit is dringend noodsaaklik dat meer mense opgelei word om belemmerde kinders te behandel. Opleiding sal die verantwoordelikheid van die Universiteit van Kaapstad wees.

'n Interessante afdeling in die Kindersentrum is die speelgoedbiblioteek. Die speelgoed word terapeuties gebruik en ouers kan speelgoed tot drie weke lank huis toeneem.

Dr. D. J. Power, senior lektor in die pediatrie aan die Universiteit van Kaapstad, het gesê dat baie nog gedoen moet word om belemmerde kinders te help. Ondervoeding is 'n geweldige probleem. In dele van die Skiereiland is tussen 20 en 30 persent van skoolgaande kinders ondervoed.

Te min word gedoen om ernstige siektes te voorkom. Hy het gesê dat masels, tering, maagdermontsteking en baie ongelukke voorkom kan word.

Veral in plattelandse gebiede is die geriewe onvoldoende. Ook die ouers van die belemmerde kind het hulp nodig. Hulle kan die las nie alleen dra nie.

In die Kinderhuis kan die belemmerde kind deur 'n span deskundiges behandel word. Dit is nie vir die ouer nodig om van die een departement na die ander in 'n hospitaal te gaan met 'n kind wat dikwels gedra moet word nie. Dit is ook nie nodig om na verskillende hospitale te gaan nie.

Probleme met die aanvaarding van 'n belemmerde kind ontstaan in die gesin, en gesinne moet hiermee gehelp word. Vir die toekoms van die belemmerde kind moet ook behoorlik beplan word, en die kind moet gehelp word sodat hy liggaamlik en geestelik kan ontwikkel.

estigation were that in
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cations and 27,3% required a
of ballot papers (57,1% of the
respondents).

liaison committees were
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hly committee meetings were
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a question as to why they had
majority of 147 (nearly 52%)
was an 'anti-polarisation' device
anagement and prompt solution
parties' interests and improving two-way communi-
cation. In a further 38 instances (about 13%) either the liaison committee

32. Ibid, p.20.

Goodwood weier losieshuis vir gestremdes

(98) 13/11/78 Burger 13/11/78

GOODWOOD.

'N AANSOEK deur 'n voormalige matrone van die Alexandra-Rehabilitasiesentrum in Maitland om 'n huis in Goodwood as losieshuis te gebruik vir gerehabiliteerde verstandelik gestremdes, is deur die stadsraad van Goodwood op een stem nå eenparig afgekeur.

Mev. G. J. A. Visser het geruime tyd gelede by die raad aansoek gedoen dat sy 'n huis in Townsendstraat as losieshuis inrig om ses mense, twee mans en vier vroue, wat by die Alexandrasentrum ontslaan is, te huisves. Dié mense is ten volle gerehabiliteer en opgelei om 'n normale bestaan in die samelewing te voer, maar het nasorg nodig om hulle ten volle by die samelewing te laat aanpas.

Die stadsraad het mev. Visser se aansoek na die belastingbetalersvereniging verwys vir ondersoek. Die belastingbetalersvereniging het die aansoek op 26 Oktober op 'n komiteevergadering bespreek. Mev. Visser is op haar versoek tot die vergadering toegelaat om haar saak te stel. Die vereniging het oplaas van die belastingbetalersvereniging aanvaar word.

Op die afgelope stadsraadsvergadering het die burgemeester, raadslid Joe Simon, voorgestel dat die aanbeveling van die belastingbetalersvereniging aanvaar word.

Raadslid S. M. Douglas wou weet of dit reg is dat die raad die betrokke saak in die hande van die belastingbetalersvereniging laat.

Hy het gevra of dit reg laat geskied teenoor die aansoeker. Hy hou nie daarvan dat die raad 'n saak doodeenvoudig aanvaar op 'n vereniging se aanbeveling nie.

Raadslid W. H. L. Faasen het gesê hy stem volkome met raadslid Douglas saam. Dit is vir hom 'n beginselsaak wat ter sprake is. Hy het gevra of soortgelyke sake voortaan ook na die belastingbetalersvereniging verwys gaan word vir 'n beslissing. Die raad loop die gevaar dat dit lyk of belangrike raadsake in die hande van die belastingbetalersvereniging gelaat word, in plaas daarvan dat die raad sulke sake self ondersoek. Hy het bygevoeg dat die betrokke saak met groot versigtigheid gehanteer moet word omdat hier sprake van 'n tehuis is.

Raadslid C. J. Bothma het gesê die raad gaan nie op die saak in nie, maar neem sommer net 'n besluit. Die saak word nie gedebatteer nie. As daar navraag gedoen word na die raad se redes vir 'n besluit, sit hy in die benarde posisie dat die saak nie bespreek is nie.

Raadslid Simon het gesê dit is nie waar dat die belastingbetalersvereniging die raad se beleid vir hom vorm nie. In die geval van mev. Visser se aansoek moet die belastingbetalersvereniging se wense egter eerbiedig word.

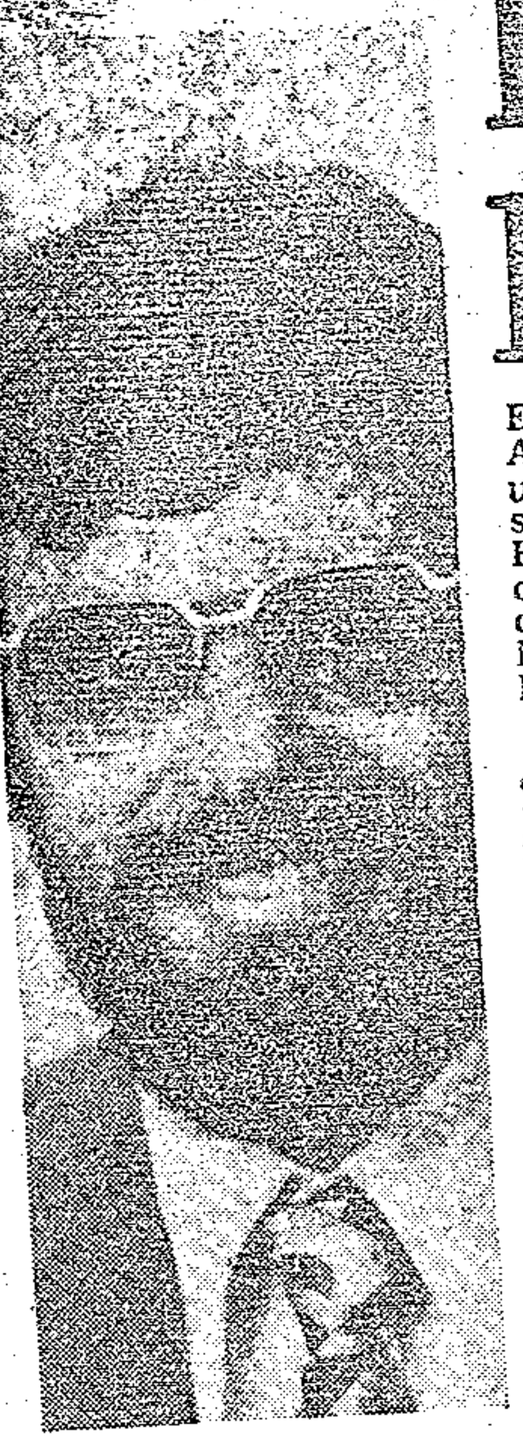
Die onderburgemeester, raadslid Louwtjie Rothman, het gesê mev. Visser se aansoek is die eerste in sy soort wat die stadsraad ontvang het.

Die saak is na die belastingbetalersvereniging verwys, want hulle verteenwoordig die stadsgebied se inwoners. Die vereniging het 'n onderhoud met mev. Visser gevoer en ná hul ondersoek 'n beslissing gegee. Daar is geen alternatief vir die stadsraad as om die aansoek te weier nie.

Die enigste raadslid wat teen die weiering gestem het, is raadslid dr. J. S. Smiedt. Hy het geen kommentaar oor die meriete van die saak gelewer nie.

M 29/12/75

De Pontes denies Frere black ban



MR DE PONTES . . . emergency cases will be treated.

EAST LONDON — Allegations that the urology and ophthalmology services for blacks at Frere Hospital are to close on December 31 are incorrect, according to the MPC for East London City, Mr Petro de Pontes.

He said emergency cases would still be treated at Frere after December 31 and only non-emergency "cold" cases would be transferred to the Cecilia Makiwane Hospital in Mdantsane when there was no possibility of any detriment to the patient's condition. Adequate transport would be provided.

Doctors do not view the retaining of emergency services as the retention of the services of the specialist departments, however, and, through the local branch of the Medical Association, they have expressed strong opposition to the coming closure.

In reply to queries from the Daily Dispatch in regard to the proposed closure, Mr De Pontes consulted with the Director of Hospital Services for the Cape, Dr L. Kotze, the Medical Superintendent at Frere, Dr F. Visser, the Ciskeian Secretary for Health, Dr J. Klopper, and other interested parties.

He was satisfied that as the services offered by these two departments were completely different to those which were to be provided by the proposed day hospital in Duncan Village, the transfer did not contradict the undertaking given to him by Dr M. Jooste in July this year that no more black services at Frere would close until the day hospital was built.

"The services provided by these two departments are of a very specialised nature and are not provided in all hospitals. Patients at other hospitals are referred to the central hospitals where such services are provided, as is the case with the Grey Hospital in King William's Town which refers patients to Frere," Mr De Pontes said.

He also denied allegations that the services in these two departments which were to be provided at Mdantsane were in any way inferior to those presently provided at Frere.

"At present Frere has the services of a full-time ophthalmologist, but only a part-time urologist, who has to look after all patients, white, Indian, Coloured and black.

"The Cecilia Makiwane Hospital has a full-time specialist in each of these departments who will now be able to concentrate on the treating of black patients only, which could only result in more effective services being provided for all patients," he said.

Allegations of inferiority at Mdantsane were, he said, "a malicious insult to the Ciskeian Health Services."

Mr De Pontes allayed fears about what was to happen to Transkeian blacks needing treatment in either of these specialist services. "Dr Klopper emphasised that though the Cecilia Makiwane Hospital was established primarily for Ciskeian citizens, there were no official directives to the effect that Transkeians, or any other group are to be excluded because of their nationality," Mr De Pontes said.

He appealed to anyone concerned to inform him of any practice by which he felt prejudiced. To date, he said, no black person had come forward in connection with the transfer of services from Frere to the Cecilia Makiwane. — DDR.

rare and one must remember
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over-all structure of the reserves continues to inhibit the
implementation of new systems, would-be-developers should realise
that "changes in consciousness" can occur but only up to a certain
stage.

Furthermore, one should not make the mistake of believing that
one can asses the way in which future systems would develop
from what is happening in the present, nor that people's present
aspirations would hold for all time.

realm.... In so many instances the introduction of marketing
co-operatives, in effect leaves the actual provision of local
marketing facilities on the ground to the same non-resource that
was to produce the instant harmony and consensus of interests
and leadership in the organisation of the co-operative itself."

In many cases the resources made available for projects benefit
the richer only and so in some cases entrench the differences
between classes. In the situation of poverty and, in some

Find out how your clinic can help you

MANY people do not know what a clinic can do for them. We hope to give them some idea of the clinic's functions.

Large areas will have one or more fixed clinics, while smaller towns may have a mobile clinic (a travelling van) which visits them on particular days of the week.

Some villagers in the country may have to travel to the clinic in a nearby village.

It is the duty of each person in the community to find out where the clinic is, when it is open, who works at the clinic and what services they supply.

Information about clinics can be obtained from the local authority and from the hospital in the area.

The clinics are usually run by nursing sisters, assistants and health-workers who make up the health team. This team is advised by a doctor who visits the clinic on particular days to see the patients whom the sister sends to him.

The clinic staff provides a "comprehensive service', that is, they help prevent disease, treat some illnesses and refer some patients to hospital. The staff also visit people in their homes to make sure that sick people are getting better and to remind them about the clinic.

An important service is the "mother-and-child" clinics. Pregnant women are cared for and taught about breast-feeding and child care. Young children are weighed and measured often to make sure that they are developing well, physically and mentally.

Immunisation (vaccination) protects the children from "killer" diseases like diphtheria, measles and TB.

Some clinics have maternity nurses who help with births at home. For those women who want to plan their families and have healthy, well-spaced children, the clinics provide advice on family planning.

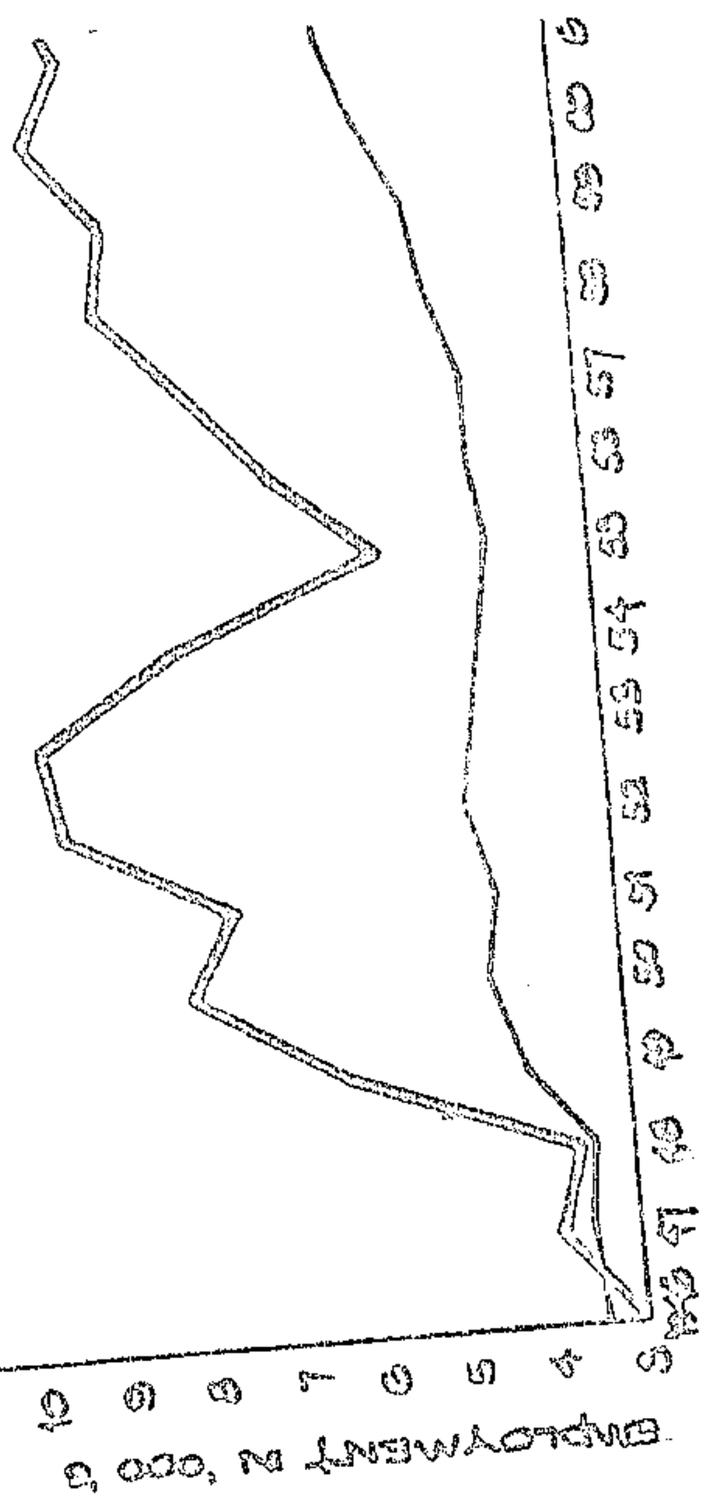
Clinics give treatment for minor ailments and injuries and treat, or follow up, patients with TB and venereal disease.

Some clinics give dental care and the nurse can give advice about other health problems. Many of the services are free.

WORD MEANINGS:

- Duty: What one should do.
- Minor: Not serious or less important.

A Department of Health mobile clinic. A nurse is questioning a patient



HEALTH & DISEASE - HOSPITALS & CLINICS

98

14-1-79 — 31-12-79

Health Year off to an all-White start

● Baragwanath Hospital, which has a reputation of being well-staffed, with simple but modern facilities, is becoming seriously overcrowded.

HEALTH YEAR seems to apply to Whites only. The first three hospitals being opened during the year are exclusively for Whites.

Promises for hospitals in Soweto and Mamelodi have been delayed but large modern hospitals have been built in Carltonville, Bloemfontein and Wynberg in the Cape — all for White use only.

Johannesburg city councillor and PFP health spokesman, Dr Selma Browde, told me: "The situation over hospitals for Blacks is critical. It is beyond comprehension how the building of a hospital in Soweto could have been neglected, while White hospital accommodation is being increased".

vaal last year — and both are for Whites only. They are the Kempton Park Hospital and the Pretoria West Hospital.

In interviews this week with hospital and health officials I was made to understand that White and Black medical needs

By ALISON GILLWALD

were considered independently.

The acting Director for Hospital Services, Dr Hennie van Wyk, said that it was hoped that hospitals for Blacks would be opened in Klerksdorp and Vereeniging by the end of the year.

Bloemfontein now has two hospitals for Whites, bedding a total of 1 020 patients, but only one for Blacks, the Palonomi Hosptial, wiith a maximum of 750 patients. Alterations are being done to the Palonomi Hospital as 150 patients with acute mental problems are being treated there at present.

The population of Bloemfontein, according to the 1976 census, is 183 000 people — 73 000 Whites and more than 93 000 Blacks.

"Population and area were important criteria in deciding where to establish the new hospital," Dr J H Kruger, Director for Hospital Services in the Orange Free State, said.

He added that White and Black accommodation was treated separately, but equally.

"After the old National Hospital became a Whites hospital only, in the 1960s, the Palonomi Hospital was built for Blacks.

"The new Universitas Hospital has now been built for Whites, but one of the reasons is that a teaching hospital was needed close to the medical faculty. The number of beds at the National Hospital has been reduced from 600 to 400 as a result," he said.

Carletonville has a population of 108 000 people of whom 28 000 are White and 80 000 are Black.

The Sybrand van Niekerk Hospital, which was opened on Friday, is the only provincial hospital in the Carletonville area, but it caters for Whites only. The hospital can take 350 people.

This means that Blacks who need treatment have to travel either to Vereeniging or Krugersdorp. The mine hospital at Blyvooruitzicht treats Blacks in emergencies.

Soweto, with its huge Black population, still relies on the over-crowded Baragwanath Hospital.

Dr Chris van der Heever, Superintendent of Baragwanath, said that although the hospital was overcrowded Blacks from the tribal homelands and even Zambia and Swaziland travelled to Baragwanth for treatment.

He felt sure Blacks in Soweto would welcome and support the much-needed hospital in Soweto. He said there would be trained Black nurses available as soon as the hospital opened.

The hospital planned for Mamelodi will only be a day-hospital and will bed only 60 patients.

Commandant J T Krynauw of the SADF said that no information on the Wynberg Military Hospital could be released until it was officially opened by the Minister of Defence on March 2.

New hospital to serve 500 a day

CAPE TOWN — The new day hospital in Duncan Village will cater for 400 to 500 patients a day and will include a midwife obstetric unit as well as accommodation for a local authority clinic.

Planning for the day hospital will be completed about March, and financial provision for its construction is to be made in this year's budget by the Cape Provincial Administration.

It is expected that the day hospital will open about two months after its completion.

This was disclosed by the MEC in charge of hospital services, Mr P. J. Loubser, in a reply to a series of questions by the Progressive Federal Party's acting leader in the Provincial Council, Mr Roger Hulley.

The questions were originally tabled in the council during the short session at the end of last year, but the answers were sent in a letter to Mr Hulley.

Yesterday Mr Hulley said although he was not satisfied with the date for the intended completion of the hospital, "I am nevertheless gratified that some practical steps appear to have been taken in the right direction."

He would pursue commitment to a target date for commissioning the proposed day hospital during the session in February.

"Whether the proposed facilities and arrangements will meet the needs of the local people is a matter which the PFP in the Provincial Council will monitor in the months ahead."

Mr Loubser said negotiations were in progress with the East London City Council for the acquisition of the site in Duncan Village for the day hospital.

"The city council's reply to the administration's formal application dated 27 September 1978 for the site is still awaited.

"Consultants have been appointed to undertake the final planning of the scheme which has been given high priority. In order to expedite planning, the design will be based on the completed plan of another day hospital, which will be adjusted to meet the requirements of the site.

"The services provided will be similar to those rendered in a fully-fledged day hospital.

"An efficient patient transportation system between the day hospital and the Cecilia Makiwane Hospital is also envisaged for patients who have to be hospitalised," Mr Loubser said. — PC.

and possibly in livestock ownership and management.

It illustrates the ability of two programmes to create favourable conditions for an upturn in economic activity in the countryside despite the initial difficulty of matching the income trasfers required through employment creation. An increase in economic employment and the ruling wage rate in the countryside should follow so that, after a few years, the level of transfers required would fall. As it fell, so the employment guarantee scheme would be able to match the need more completely. Delay for ten years or so would make the race more difficult to win.

The Report on Rural Development rightly stresses the need to develop a credit programme in Botswana. Botswana's present comfortable budgetary position suggests that the formation of a fund to support credit operations in the countryside would not be difficult. As the Report stresses, the difficulty is to implement credit programmes without too great a financial risk to government or to the banks. It is unlikely that Botswana, even under the most favourable conditions of finance and manpower, could develop an effective credit system that would reach the majority of rural households for at least the next ten to twenty years, largely because of the great difficulty in working with impoverished clients under conditions of high risk. Credit programmes are most likely to succeed when there is a modicum of economic security in the countryside and when the development of the physical and service infrastructure provides increasing opportunities for profitable activities. The adoption of the two proposals outlined above, an Employment Guarantee Scheme and the use of the company concept to manage grazing, would infuse P3,5 million to P9 million annually into the pockets of the poorer people. Of this, between P2,5 million and P5 million would be additional income in the countryside. In times of drought or other calamity the component under the employment guarantee would rise and would flow to households in all economic categories as they sought work.

Govt's R154m mental care plan

RDM 16/1/79 (98)

CAPE TOWN. — The Government is spending R154 000 000 on more psychiatric centres and services planned by the Department of Health.

The Minister of Health, Dr Schalk van der Merwe, disclosed the plans yesterday when he opened the third national congress of psychiatry at the University of Cape Town.

Dr Van der Merwe said new hospital buildings and services were in various stages of planning and building would start next year.

Facilities were being built to accommodate a further 1 700 beds at various institutions under the control of the department, at an estimated cost of R35 000 000.

Other projects in the R154 0000 000 plan include:

- A 2 400-bed hospital for coloured people at Mitchell's Plain near Cape Town and a 1 000-bed hospital for coloureds at Port Elizabeth.
- For blacks, two 1 000-bed hospitals near Soweto, a 1 000-bed hospital in the East Rand area, and a 700-bed hospital near Bloemfontein.
- A 500-bed hospital for Asiatics at Verulam in Natal and an 800-bed hospital for whites near Johannesburg.

Dr Van der Merwe said the medical schools were training as many psychiatrists as they could, but there was still a shortage of black, coloured and Indian psychiatrists.

"There are many reasons for this, among them the general shortage of black medical manpower and the fact that there has not been a tendency for blacks to specialise in any sphere of medicine.

"However, the department is actively encouraging recruiting and will establish as many posts as are necessary to meet its very considerable needs," he said.

Dr Van der Merwe paid tribute to South Africa's psychiatric nurses. "We are proud of the quality of our nurses today and are convinced that there are no finer anywhere," he said.

His department's policy was continually to improve the standards of nursing care. Special refresher and instructors' courses had been instituted over the years "and, in fact, promotion beyond certain grades cannot take place unless nurses have satisfactorily completed additional training", he told the congress. — Sapa.

Legalisation of S

Whereas the 1953 1973 Act legalised strikes in certa ion of a strike in the Industrial C Labour Relations Regulation Act ar , was grafted onto the latter. Thi the two instruments: the former embrac as it is generally understood, the l gely consultative machinery, and a

The followinq prc .can workers remain (as they do in mc he I.C. Act).

(a) wher nding and lan one

(b) duri , award or d ciliation Act,

(c) where the African workers are employed by a local authority;

(d) where the African workers are employed in essential services providing light, power, water, sanitation, passenger transportation or a fire extinguishing service, within the area of a local authority;

(e) where they are employed in the supply, distribution and canning of perishable foodstuffs, or the supply and distribution of petrol and other fuels to local authorities or others engaged in providing essential services, if the Minister has extended the prohibition on strikes to such industries;

(f) where the Central Bantu Labour Board has referred a proposed industrial council agreement which it finds unsatisfactory to the Minister for a Wage Board recommendation;

(g) where the Central Bantu Labour Board has reported an unresolved dispute to the Minister for a Wage Board recommendation.

In all other instances a dispute must be referred to the liaison committee, co-ordinating works committee or works committee, as the case may be, which exists in the plant concerned. If the committee is unable to settle the dispute, or where no committee exists, a report must be made to the Bantu Labour Officer for the area concerned. After thirty days from the date of such a report have elapsed a strike or lock-out may legally take place.

C.T. 18/1/79

R30 m to be spent on new hospital (98)

By TONY ROBINSON

A NEW psychiatric hospital which will accommodate 2 400 patients and cost well over R30 m is to be built at Mitchells Plain to serve the coloured population of the Western Cape.

The hospital, to be built by the Department of Health, is in the final stages of planning.

The site for the huge project is more than 70 ha in the extreme north-eastern section of Mitchells Plain, well away from the main residential area.

A spokesman for the department said provisional planning for the hospital started about 30 years ago and it was originally to have been built in the Kalksteenfontein area. With the development of Mitchells Plain, however, it had been decided to site the hospital near the new town.

Construction was to have started about three years ago but was postponed. At the time the cost was estimated at R31,87 m but since then building costs have escalated.

The hospital buildings will be spread out in spacious grounds and the layout will be more like that of a village with clusters of buildings than the conventional general hospital.

Provision will be made for occupational therapy and there will be sports fields and gardens but no farming. There will also be a nurses' home and an administration block.

The number of beds (2 400) will make the new hospital larger than the giant Tygerberg Hospital in Parow which has 1 500 beds. Like Tygerberg, it will be used for training in conjunction with either the University of Cape Town or Stellenbosch or with both universities.

The spokesman was unable to say when construction would start.

98

New clinic-hospital treats 600 a day

Mercury Reporter

THREE full-time and two part-time doctors treat 600 people, mainly from Clermont, every day at the new day hospital on the edge of the township near Pinetown.

Dr. G. M. Gregersen, the medical superintendent of the clinic - cum - hospital at KwaDabeka yesterday commented on complaints by some Clermont residents that the Clermont clinic had been closed in favour of one in the new township of KwaDabeka.

Residents at a meeting on Sunday said they were now forced to pay for bus fares to reach the new clinic.

Dr. Gregersen said State Health maintained an adequate ambulance service in Clermont and ran a mobile clinic in different parts of the town twice a week.

The new clinic, between Clermont and KwaDabeka, is less than three kilometres from Clermont's commercial centre.

It provided an excellent service with three full-time doctors, 20 trained nurses, a visiting psychiatrist, a drip bank and a preventive medicine unit.

Since opening in May 1977 the day hospital's maternity section had delivered about 120 babies a month while the clinic had treated about 600 patients a day.

Plea for health 'resource centre'

Poor liaison between hospital services and community care services was causing serious medical problems in South Africa, the superintendent of the Johannesburg Hospital told a symposium in the city today.

Patients received inadequate treatment Dr John McMurdo said at a symposium on care services in the community at the South African Institute for Medical Research in Johannesburg.

He was chairing a panel from the hospital, which discussed with the symposium delegates, ways of creating better liaison between hospital and community.

Johannesburg's mayor, Dr J Otto, opening the two-day conference, said: "It is essential that a central resource centre be established where people needing assistance can go for care, whether it is to request a wheelchair or get help on how to deal with an alcoholic parent."

Johannesburg hospital social worker Miss Sylvia Poss stated that although there were many resources available, there were severe limitations.

The symposium is part of Health Year. It was organised by the Southern Transvaal group of the South African Association of Occupational Therapists.

Asians			
Blacks	552	701	4,0
TOTAL	622	783	3,9

Note: The impression of rapid growth is compounded of course by having 1975 as base year - 1975 experienced the lowest level of employment in the mining sector since 1967.

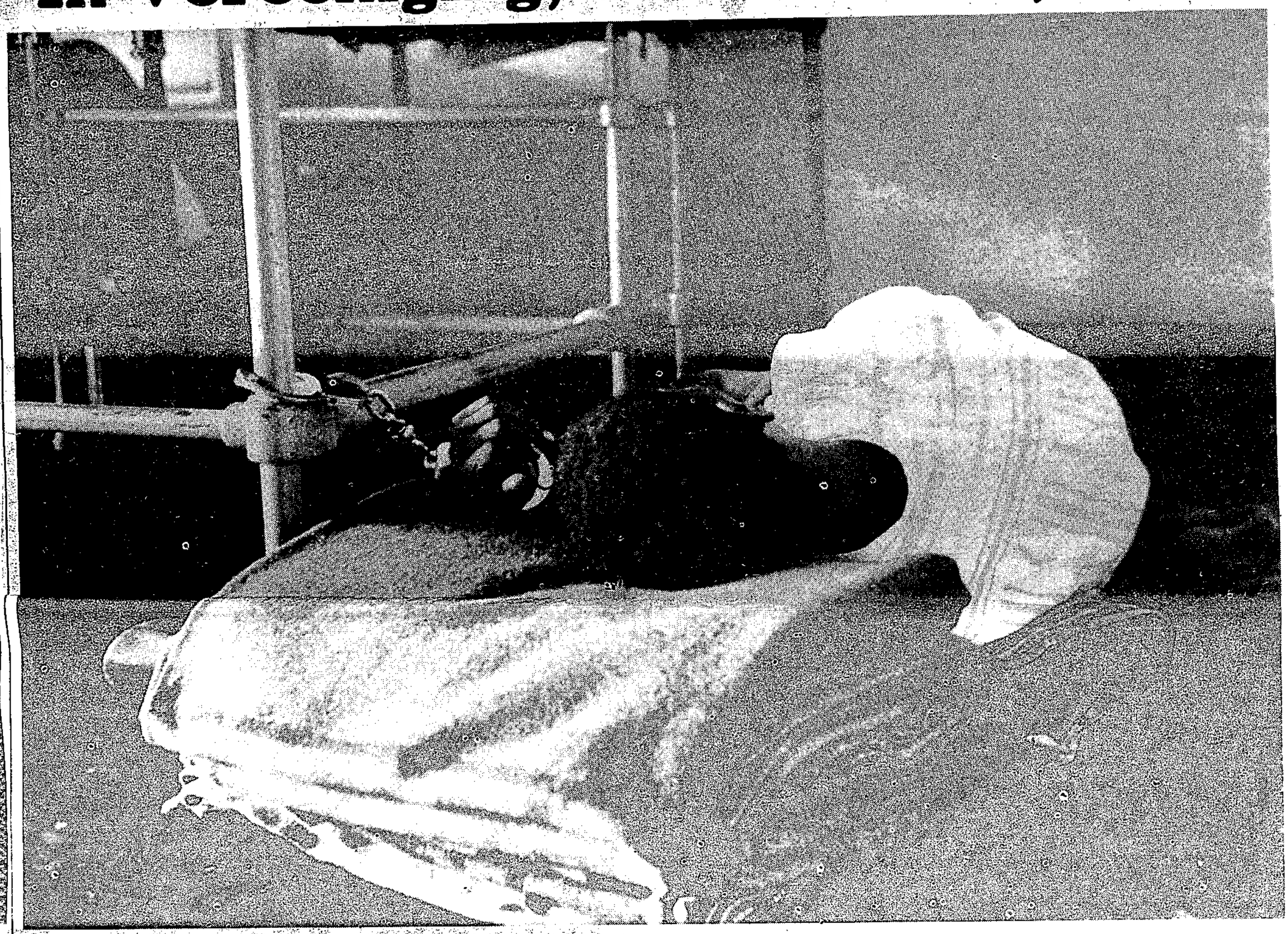
The comparison with Plewman's 1981 figures is as follows: his figures for 1980 are 761 000 (3 per cent rate of growth of domestic demand)and 775 000 (5 per cent rate of growth of domestic demand) which became 774 165 and 790 875, respectively, when projected for another year at the 1970's projected employment growth rates. The EDP figure (based on 5 per cent domestic GDP growth) of 783 000 falls into the middle of the range between Plewman's figures (however this is a little fictitious because the EDP is using in service and Plewman uses at work figures. The relevant projected range using in service figures would be 799 000 and 816 000 above the EDP figure).

Of course the EDP scenario for 1976-81 involves rates of growth far higher than those assumed by Plewman - who is interested in decade averages and assumes smoother progress. It is important to understand the grounds for the EDP's 'optimism' for the late 1970's. They report that the share of mining in real GDP dropped from an average of 11,3 per cent in 1961-65 to an average of 8,8 per cent in the 5 years 1971-75. They maintain that these are "strong indications, however, that it will rise over the programming period, at a rate of 5,8 per cent per annum. This growth should be concentrated mainly on entry into the export markets, particularly for iron ore and coal. The expected strengthening of the share of mining in the South African economy is mainly related to the development of the export projects at Saldanha Bay and Richard's Bay". (p.21, Economic Development Programme 1976-81, summary). In addition mention is made of energy problems which have created a renewed interest in South African coal

(98)

EXPRESS CLOSE-UP ON THE 'FLOOR CASES'

This is a picture of a mental patient. Handcuffed to a bed. In a public maternity ward. In Vereeniging, South Africa, 1979



Picture: ROBERT TSHABALALA

A SUNDAY EXPRESS team this week found a woman mental patient lying on the floor without a mattress and handcuffed to a bed in the maternity ward of the Vereeniging Hospital's Black section.

The woman was dressed in the usual hospital garment given to patients who come in without pyjamas, lying under an old, but clean, grey hospital blanket.

Her pregnancy was not apparent.

A nursing sister in the ward told the Sunday Express the woman was a mental patient and had been handcuffed there for "some days" — but would say no more.

The hospital superintendent, Dr J Erasmus, was unaware of the woman lying huddled next to the bed. "I have no knowledge of that patient," he said. He added he could not comment on police or prisons.

"We do not handcuff any patients, although at times, as in any hospital, a patient's hands are tied for their own safety. But we don't use handcuffs."

The unnamed woman was not the only one on the floor when we visited the hospital. In the same maternity ward five women lay on the floor of the eight-bed ward. One of them said the ward was for women who had given birth.

She added she had a bed after giving birth, but it had been taken to another ward for a woman about to have a baby. The woman said she had been on the floor for three days.

And in ward 10, for male surgical patients, 20 men — also without mattresses — lay under the 24 beds, while others sat waiting on rows of wooden benches for treatment by an overworked doctor.

The medical wards did not appear to be overcrowded.

They are called "floor cases".

Nursing staff send them out on the hospital lawns during the day, they come in for meals and treatment, then go out again.

One of the nursing sisters, who asked not to be identified, said: "The hospital cannot turn away patients if they need treatment. It's better for them to get hospital treatment than to miss it."

Problem

"But what can we do? We hope we will get well if we sleep on hard floors and without mattresses?"

Dr Erasmus said the hospital accomodated 20% more patients than it was meant to. No new wards had been been added for the past 10 years. "But what else can I do? I can't turn a patient away."

He said there was a shortage of doctors too — although he did not have details. Part of this problem was the two-year Army call-up.

Dr Erasmus said a new hospital was almost completed at nearby Sebokeng location, and would open in April.

With 900 beds, he said, it would ease overcrowding at the present hospital — and the Black patient section would then be closed down.

"There is no point in renovating the present building with a new hospital on the point of opening."

Dr Erasmus said the "floor cases" spent most of their time on the lawn because they liked playing sedentary games there to amuse themselves during the day. The hospital, with 416 beds and 12 wards, caters for the Black population of the Vaal triangle and neighbouring areas.

Patients interviewed asked not to be identified.

One male patient in a surgical ward said he had been at the hospital since November. He has never slept on a bed since being admitted. He said they were compelled to sleep on the floor as there was no accommodation. He described the blankets they were sleeping on as rough. The blankets in all wards seen by the Sunday Express were clean.

Another patient in the same ward said he was admitted at the hospital in December after a car accident, He claimed that at one time the ward was so congested with "floor cases" that there was no room to move.

But none of the nursing staff — who spoke freely to the Sunday Express — agreed with his claim.

The man said when he was admitted he slept on a bed, but as the time went on he was told to sleep on the floor. His bed was then given to a patient who appeared to have worse injuries than himself.

He said he doubted whether he was going to recover because of the pains he suffered by sleeping on the floor. He had not complained to hospital staff.

Painful

One of the patients sitting on a bench while awaiting treatment from a doctor said he had been in the hospital since November, and had slept on the floor since his admission.

After treatment the "floor cases" were returned to their "beds" on the floor underneath the other patients.

A middle-aged woman in the maternity section found sleeeping on the floor said she had a bed before she gave birth. But she was "transferred" to the floor a day after her child was born.

She said: "It is so painful to sleep on the hard floor without a mattress.

"If I had an alternative I would have left the hospital, but since I do not, I cannot. Even four-legged animals would feel uncomfortable in giving birth under such conditions," she continued.

Another patient said she was sleeping on a bed when she was admitted three days ago. She was compelled to forsake her bed and sleep on the floor when a patient who appeared to be in worse condition than her was was admitted.

She said the "floor cases" felt humiliated by such treatment. "But what can we do?" she asked.

One of the nursing sisters in the maternity ward said it was heartbreaking to see patients sleeping on the floors.

"There is nothing we can do about the matter. We are trying to do all we can to make the patients as comfortable as possible, but with such an acute shortage of accommodation there is no answer."

Another nursing sister said patients were compelled to "rest" on the lawn during the day because there was no space in the ward. She said they sat on benches inside the ward when it rained.

The nurse said she had seen patients sleeping on the floor since 1976 when she joined the hospital. If and when beds were available the "floor cases" were transferred to them.

'Not police action'

BRIGADIER I Slabbert, Divisional Commissioner of Police for the Vaal Triangle and West Rand, said he did not know about the woman, and added the police under his command would not treat a prisoner in that way.

A Department of Prisons spokesman in Pretoria said there was a woman prisoner at Vereeniging Hospital — "but she is not handcuffed".

"She has been there for about a month, and is visited daily by female prison staff. It is not the same woman."

Hospital move: Clash looms

7/2/79 98

Mercury Bureau

PIETERMARITZBURG — The City Council is heading for a confrontation with the Department of Health over the department's refusal to pay compensation for its take-over of the non-White infectious disease hospital here.

The hospital is to be taken over by the Natal Provincial Administration on April 1 and turned into a geriatric hospital for non-Whites.

The department has told the NPA it can take over the land and the hospital buildings for free, but now it has to persuade the city council not to press for compensation.

"I wish to confirm that the department is not prepared to compensate your council for the buildings or the land as the department will receive no compensation in return from the Natal Provincial Administration," the Secretary of Health, Dr. James Gilliland, said in a letter to the council.

He asked the council to reconsider its previous decision to press for compensation for the land and buildings.

The municipal valuation of the land alone is R30 800.

At a meeting yesterday the city council's Finance, Policy and General Services Committee recommended to the council that the take-over on April 1 be allowed, but without any prejudice to any claim the council might make for compensation.

ON FEMINISM - THE WOMEN'S MOVEMENT REPLY

As a group of U,C.T. Feminists we are appalled by the naivety of the S.S.D. editors' in including the pretentious study entitled "A Critique of Bourgeois Feminism"in their latest newsletter. We would like to point out some of the combined illogicalities, misconceptions and muddled thinking that appear in their article.

The description of what a Women's Movement should be confines itself to stating the obvious; "A Women's Movement is a political movement", "It must, therefore, identify the women's position within the structures of society". To assume that factors such as the "pass-laws, the reserves, squatter-camps and the role of women in these" have not been explored, even theoretically, by the U.C.T. Women's Movement indicates that the writer of this article has no direct knowledge of discussions and projects currently in progress among Women's Movement members. A notable difference being that members of the Movement are perhaps more aware of the discrepancy between "examining the institutions that continually produce and reproduce the structural position of women in South Africa" and developing what the writer idealistically refers to as "adequate political practice"from within the context of such an undeniably bourgeois establishment as a white university. To theorize around the projected "integrated struggle for liberation of all men and women" is mere utopianism, organisation must concern itself with specific oppression. Separatism in no way excludes the awareness of other oppressed groups.

In correlating such diverse statements as the"fundamental contradiction that exists between men and women" (which contradiction is never examined in detail) and saying that "the contradictions that exist between social classes then assumes secondary importance (if at all)" the writer fails to realise that he/she moves from stating a basic feminist tenet to attack one particular feminist stance - radical feminism (not to be confused with Marxist, Socialist, Liberal or Lesbian Feminism) which is only one of the numerous positions held by U.C.T. women within the 'umbrella' organization of the movement. This article is a misinformed attempt to stereotype the U.C.T. Women's Movement into an homogenous radical-feminist group and attack its policies accordingly.

By a process of flawed illogical reasoning several false conclusions are deduced, the most erroneous of which concerns "consciousness-raising". No feminist position in any Women's Movement would endorse a description of "consciousness-raising" as an involvement with

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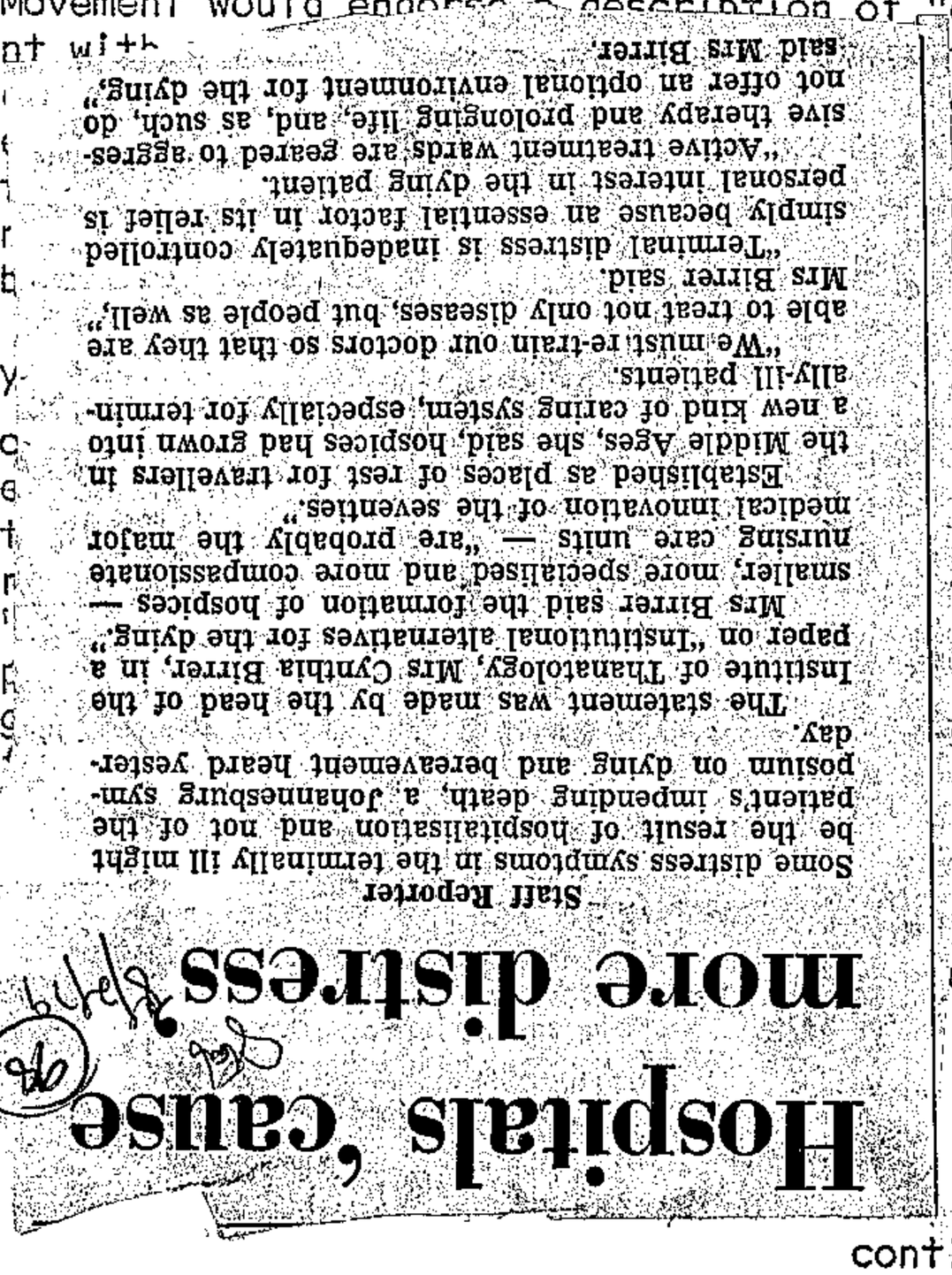


Hospitals 'cause more distress'

Staff Reporter

Some distress symptoms in the terminally ill might be the result of hospitalisation and not of the patient's impending death, a Johannesburg symposium on dying and bereavement heard yesterday.

The statement was made by the head of the Institute of Thanatology, Mrs Cynthia Birrer, in a paper on "Institutional alternatives for the dying."

Mrs Birrer said the formation of hospices — smaller, more specialised and more compassionate nursing care units — "are probably the major medical innovation of the seventies."

Established as places of rest for travellers in the Middle Ages, she said, hospices had grown into a new kind of caring system, especially for terminally-ill patients.

"We must re-train our doctors so that they are able to treat not only diseases, but people as well," Mrs Birrer said.

"Terminal distress is inadequately controlled simply because an essential factor in its relief is personal interest in the dying patient.

"Active treatment wards are geared to aggressive therapy and prolonging life, and, as such, do not offer an optional environment for the dying," said Mrs Birrer.

continues/...

EXPRESSCOPE — THE PAINFUL TRUTH

Sunday Express COMMENT

ONE SIMPLE POINT was missed in the angry attacks on the Sunday Express for its report last week on the handcuffed mentally disturbed patient.

The country's name would have been enhanced if the authorities had openly acknowledged the accuracy of the report — and promised to do something about it.

There are many things in our State medical services we can be proud of, not least of them the valiant efforts made by the medical staff at this hospital to minister to patients under inadequate conditions.

But there are wrong things too, and any newspaper that suppressed them — or withheld them until 1980 in the interests of "Health Year" — would be doing a disservice to the public.

What damages South Africa, therefore, is not the revelation but the attempt by the authorities to execute the bearer of the bad tidings. Good heavens, common humanity demands a warmer response than that.

As for the Minister of Justice's insinuation that the picture might have been posed by the Sunday Express, he now knows it to be incorrect.

We will accept an apology from him for his unwarranted comment. If, on the other hand, he wishes to stick to his guns we invite him to repeat the remark outside the House of Assembly.

Then we will sue him.

Picture the Ministers would not believe . . .

THE picture on the right caused a storm in Parliament this week — and three Cabinet Ministers angrily attacked the Sunday Express for publishing it.

The photograph is of a Black woman patient at Vereeniging Hospital lying on the floor of a public ward, handcuffed to the bottom of a bed.

Because of it Mr J T Kruger, Minister of Police, Dr Schalk van der Merwe, Minister of Health, and Mr Pik Botha, Minister of Foreign Affairs, all vehemently attacked the Sunday Express.

□□□

But not one of them could fault the picture or article on factual grounds.

In fact the details set out in the photograph and the article have been confirmed by authorities at the hospital.

What mistakes were made were in reality made by the Ministers Kruger and Botha.

Mr Kruger's attack was by far the strongest. He was also by far the worst offender when it came to inaccuracies.

On Monday he told the House that the photograph had been taken in one or other of the country's psychiatric institutions.

THIS WAS WRONG — the picture was taken in a public maternity ward at Vereeniging Hospital, as was clearly stated in the headline.

The Minister also said the woman had a chain round her neck.

THIS WAS WRONG — the woman was handcuffed, by the wrists, which again was stated in the report and was visible in the photograph.

The Minister also said he suspected the Sunday Express put the chain around the woman.

THIS WAS WRONG — it was done by a hospital security guard.

The Minister added that he wondered whether the Sunday Express did not also realise it would be in the public interest to inform everybody that one of its writers was a "stringer" for the "far-left" British newspaper The Guardian.

THIS WAS WRONG — no writer on the Sunday Express strings for The Guardian.

□□□

On Tuesday Dr van der Merwe issued a statement saying the picture was "grossly misleading" and a "reprehensible misrepresentation".

He said it conveyed the impression that Black mental patients were treated and detained in this manner in South African hospitals.

In fact nowhere in the article was it ever claimed that the picture was representative of how mental patients were treated.

It was meant to show the plight of this one woman patient, not to depict general conditions.

In fact this was a balanced article that gave sympathetic attention to the problems experienced by the hospital authorities.

The Minister also said: "It is not, and never has been, the policy of any hospital authority to incorporate the use of handcuffs in the treatment of patients."

The article, once again, did not state anywhere that the use of handcuffs was hospital policy, although the hospital superintendent, Dr Josef Erasmus, DID say afterwards that handcuffing, while not policy, had been resorted to before.

Dr van der Merwe said the woman had been put on the floor to prevent her falling out of bed and injuring herself.

□□□

Matron E Otto said this week the woman had no bed until after she had been handcuffed.

She was a "floor case", like various other patients at Vereeniging Hospital's black section.

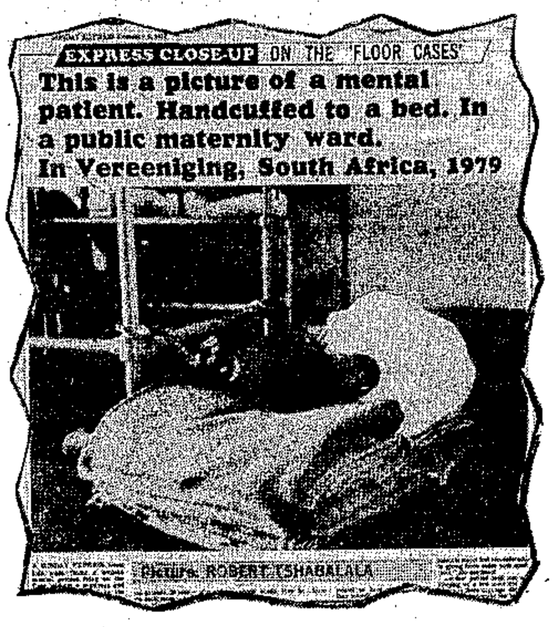
But she was given a bed after she had been handcuffed and sedated after suddenly attacking other patients and hitting a security guard with a brick.

The Minister alleged that one of two Sunday Express men had posed as a minister of religion and had been allowed into the ward on that basis.

This has been denied by both the newsmen who went to the ward.

On Friday Mr Pik Botha said the picture was "an absolute lie".

He said Black patients were not handcuffed to their beds in hospitals.



● The picture that started the row — the woman handcuffed to the bed. Ministers mentioned it in Parliament — but got their facts wrong.

Staff confirms Express story

By PETER WELLMAN

THE SUNDAY EXPRESS this week went back to the hospital where we photographed a Black woman patient handcuffed to the bottom of a bed in a public maternity ward on January 31.

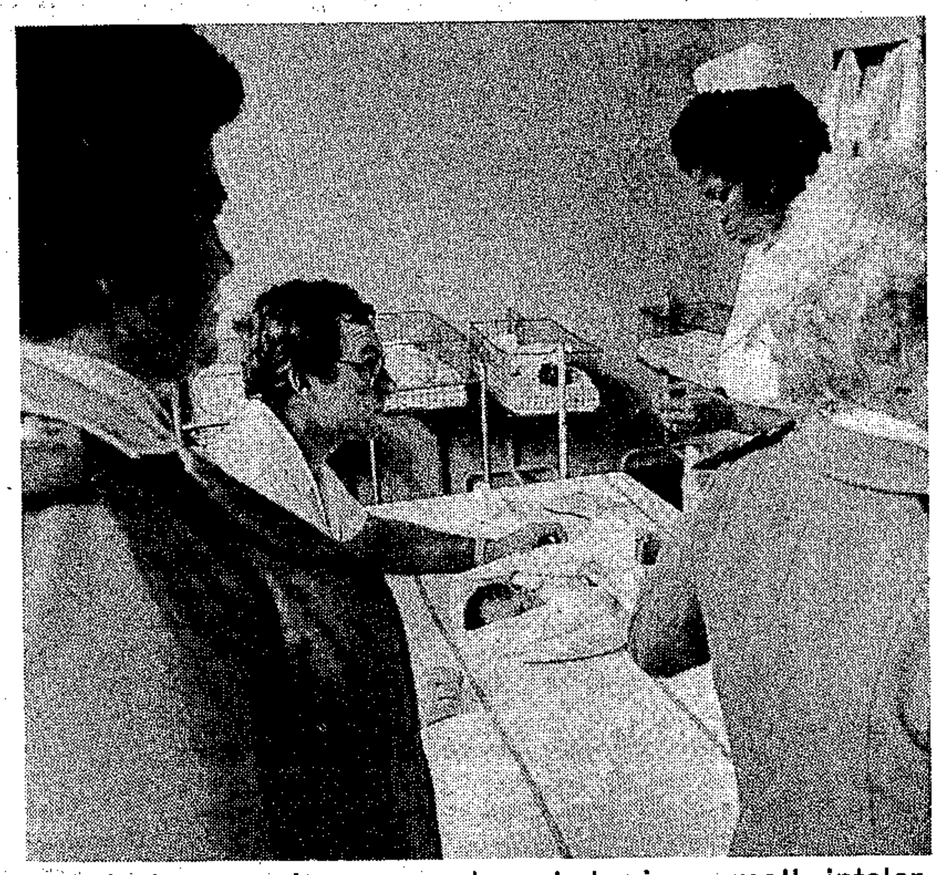
We returned to Vereeniging Hospital's Black section at the invitation of the superintendent, Dr Josef Erasmus, to have lunch with him and tour the hospital.

And we went to see the uncompleted new 870-bed hospital nearby, which Dr Erasmus can hardly wait to get his patients into.

He confirmed that not only had the woman been handcuffed, but she had stayed like that, on the floor on blankets, from just after 5 am on January 30 until the next day, when the handcuffs were removed.

We saw her again this week on Tuesday afternoon. She was sitting on a wooden bench in a hospital corridor, sedated and unattended.

Head Matron E van Staden and I tried to talk to her but she could not talk coherently. I asked Dr Erasmus later in the week why she was still being sedated and he said the sedation had been stopped on Tuesday.



● A doctor examines a new-born baby in a small, intolerably hot room with closed windows at the Vereeniging Hospital's Black section.

Picture by DOUG LEE

"She has now been given a bed. She is quite all right now," Matron Van Staden told me to give the Sunday Express details about the woman before publication of the picture last week, but this week he and Matron Van Staden did so.

She was admitted on December 28 for a leg ulcer. She is about 50.

She was kept on at the hospital because she required daily treatment and was "not in the mood to come to hospital daily".

The woman, who was a "floor case" without a bed, had family troubles which the matron said might have led to her sudden attack on other patients early on the morning of January 30.

The patients in her ward fled, except for one who had had a leg amputated and her strain her was hit with a [illegible] of a bed in a public eight-bed maternity ward, and she was sedated.

That was where the Sunday Express found her.

A reporter and photographer were investigating reports of gross overcrowding at the hospital.

They knew a patient at the hospital, and decided to pay the patient a visit and gauge, from the brief opportunity this provided, whether it was worth approaching the superintendent.

But they then saw the woman on the floor, and decided it was in the public interest to take the photograph.

Dr Erasmus estimates that the 416-bed hospital has a 20% patient overload. Whether patients get a bed depends on how sick they

His present theatre of op[illegible] from the spreading stains of rainwater in the ceiling, dirtied by its passage through the old, corrupted roof, to the chipped and smeared walls, and down to floors holding a generation of grime under ceaseless attack by cleaners whose diligence is ill rewarded, it's hopeless.

This hospital knows, more than any American Negro, what it means to suffer from benign neglect.

In a children's ward, for instance, more beds than provincial regulations allow are crammed in. The superintendent admitted it: "What can I do? I can't turn them away." The ward should have had six beds and six children. It had, instead, 10 beds and 15 toddlers, some two to a bed.

The patients were happy, and they would have [illegible] Parts of the building, like the ward where a sweating doctor checks on new-born babes, are intolerably hot.

I started sweating in that small room with high, closed windows, and heard the young doctor confess: "I do a few minutes at a time, get some fresh air, and go back in again."

But don't blame the super or the staff.

The surface shine on the floors might be as thin as a two-rand note, but it shows they are trying.

And, as human as anybody else, their attention is fixed on the number of tomorrows before they move into a hospital worth keeping clean.

In the meantime the superintendent stands with one foot in the grave of the old and one on the threshold of the new.

He is overworked, with a hopelessly overburdened job and a hopelessly inadequate staff.

Just about 1,85 m tall, with a suntan, a safari suit and a full head of greying hair, he is surprisingly informal for a man with such dedication to a profession that never has welcomed Press inquiries.

And while he hunched his shoulders in tension a few times during our 2½-hour visit when he spoke about the overcrowding problem, he hopes things will be better in the new building.

Due in April after what the superintendent described as contractual problems the new hospital has been 10 years in the building.

It cost R2-million and took two tenders.

Mr I du Plessis, Provincial Director of Works, said this week that the job was first given to the Vaal Triangle Administration Board in November, 1969.

In 1974 the agreement [illegible] it (the board) threw in the towel because it found it a big job to do" and "its progress was too slow".

The site was redocumented and handed over to a new tenderer in 1975.

It has faults, of course, like any new hospital with 23 wards, 11 operating theatres and seven nurses' homes.

Like the low-slung steam pipes across a corridor that an average-sized man can touch without stretching.

"Get a patient with a drip being wheeled under that and it'll be hit. Look — it's been dented already."

But he was more relaxed here, showing us around his new domain, than in his old one.

And why not. For the first time in years he's going to have something to boast about.

Shock over child deaths in hospital

Argus Correspondent

DURBAN. — Shock figures show that more than 1 600 children died in the paediatric wards of King Edward VIII Hospital last year and that 80 percent of the deaths occurred in children under two years of age.

Most of the deaths occurred from diseases — including measles — which are preventable and curable at relatively low cost at the primary health care stage.

The report submitted by Professor I W F Spencer, head of the Department of Community Health and Professor A Moosa, head of the Department of Paediatrics at the University of Natal Medical School, states that about 8 000 children are admitted annually to the hospital.

Of the 20 percent that die, most deaths occur within the first 48 hours of admission and nearly half the admissions have evidence of malnutrition.

Other facts included in the report — directed at a primary health care project for the underpriviledged child run in conjunction with State Health— Are that:

TUBERCULOSIS

● Of 525 well-nourished babies under one year admitted with gastro-enteritis, 121 (about 23 percent) died. The mortality rate and incidence of gastro-enteritis in malnourished babies was considerabl higher.

● Of approximately 600 cases of measles admitted annually 20 percent die.

Typhoid and tuberculosis are common conditions in the wards and about 80 new cases of tuberculosis in children are seen each year at King George V Tuberculosis Hospital. . . .

Day hospital land staked

21/2/79 DD

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EAST LONDON — Two portions of land in the proposed Braelyn Township Extension 3 have been set aside for the Duncan Village Day Hospital.

Both are being surveyed by the engineers and architects of the Provincial Administration and the East London City Council to determine which is best for the hospital and which fits best with a view to road access and the town planning scheme.

The chairman of the Frere Hospital Board, Mr David Lazarus, said the scheme to build the hospital would go ahead as soon as a final decision had been taken between the two sites. The transfer of the chosen site from the municipality to the administration would be a formality.

"It is expected that planning will be completed early next year. Construction should start about two months after the completion of planning," Mr Lazarus said.

The scheme was being given a high priority and there would be no delay which was not essential.

The day hospital will include a midwife obstetric unit and will serve between 400 and 500 patients a day. Acommodation for a local authority clinic is to be provided.

Patients who have to be hospitalised will be transferred to the Cecilia Makiwane Hospital in Mdantsane. — DDR.

LATIN I

	SETWORK				HISTORY	PAPER I	UNSEENS				PROSE	PAPER I
	25	25	25	75	25	%	20	20	20	60	40	%
Adhikari, M.	18	23	22	63	14	77	9	10	5	24	18	42
Ash, Miss C.	-	-	-	-	4	4	0	1	1	2	0	2
Bridges, R.C.	14	17	3	34	13	47	15	16	14	45	12	57
Barrows, C.C.	14	18	20	52	12	64	11	10	10	31	22	53
Blomson, D.M.	16	18	19	53	12	65	10	11	14	35	19	54
Brown, G.C.	18	13	10	41	13	54	10	10	5	25	13	38
Bruinders, T.J.	7	3	-	-	-	10	6	1	6	13	-	13
Chait, Miss G.E.	20	11	19	50	19	69	13	11	13	37	28	65
Chance, R.G.F.	14	16	20	50	14	64	14	7	12	33	23	56
Charnock, G.	23	23	24	70	16	86	18	18	18	54	22	76
Chiat, A.R.	10	9	12	31	0	31	6	9	3	18	20	38
Chicken, Miss D-M.	14	17	19	50	7	57	12	14	13	39	24	63
Cohen, M.Z.	1	1	4	6	5	11	9	1	-	10	10	20
Constantine, Miss D.L.	20	21	21	62	16	78	18	18	17	53	34	87
Darge, Miss E.M.	16	13	15	44	12	56	12	8	13	33	25	58
Dark, Miss J.E.	11	17	15	43	18	61	10	7	14	31	11	42
Dudlyke-Thomas, I.	13	9	12	34	12	46	6	3	14	23	9	32
Emmett, E.	13	16	16	45	13	58	15	15	13	43	18	61
Enraght-Moony, Miss P.A.	2	14	15	31	8	39	14	11	12	37	18	55
Erasmus, D.G.	-	-	5	5	4	9	Did not write					0
											5.6	11.4
											15	5

Casualty case

ONLY Transvaalers will appreciate the agonising that must have gone on behind the scenes of Pretoria's Opera House to have it declared open to all races. After years of argument good reason has prevailed and for that we should all be grateful.

And now hard on its heels, is a suggestion that the old Johannesburg General Hospital be turned over to blacks. At the moment, in keeping with the apartheid rules which the Province maintains, whites in Johannesburg now have two hospitals — the massive R156-million Johannesburg Hospital AND the General Hospital.

Mr J F Oberholzer, MPC, this week pointed out to the Provincial Council that it would be more in keeping with this region's real needs if it were turned into a black hospital. There are, he said, 785 000 blacks in this area (a very conservative estimate we think) served by only 2 725 beds. Many have to sleep in hospital corridors. Per capita, whites have twice as many beds. The imbalance is a direct result of an apartheid policy which, we seem to recall, the Foreign Minister told the world last year, was something of the past. When it comes to budget-breaking facilities of this magnitude it is wasteful as well as immoral for one group to hog it all. Let us hope that the Province's performance at the Opera House will permeate its other enterprises.

Star 23/2/79 (98)

Contents (continued)

Institutions for mental patients

*12. Mr. H. E. J. VAN RENSBURG asked the Minister of Health:

What progress has been made in the establishment of the new institutions for mental patients referred to by him in reply to Question No. 205 on 1 March 1978.

†The MINISTER OF HEALTH: Hansard 3 (63) 23/2/78

(1) The first phase of the Mitchells Plain Hospital, namely buildings for auxiliary services, is in the sketchplan stage and the tender date for this phase is set for 1979-'80.

(2) Verulam Hospital is in the planning stage and the tender date is set for 1983.

According to information received from the Department of Public Works, the following institutions are included in that Department's major works programme for 1983-'84:

(1) Soweto.

(2) Mamelodi.

(3) Vereeniging.

(4) Daveyton.

(5) Secunda.

MAJOR ROW ERUPTS AS ACCLAIMED BASHED BABY UNIT BECOMES A CASUALTY

Hospital boss McMurdo quits 'over administration problems'

SUNDAY EXPRESS INVESTIGATION

By JENNIFER HYMAN

THE chief superintendent of the Johannesburg General Hospital, Dr John McMurdo, has resigned and is to leave his post at the end of May — 6½ years after becoming the youngest superintendent in the hospital's history.

His surprise resignation comes at a time when the move to the new hospital complex on Parktown Ridge is still under way and fewer than 20 of its 70 wards are occupied.

The Sunday Express understands from hospital sources that Dr McMurdo, 38, has resigned because of increasing problems facing the hospital administration and general dissatisfaction with the Transvaal Hospital Services.

When we put this to Dr McMurdo this week he declined to comment, saying only that his reasons were personal. He is expected to take a post in the private sector.

The Director of Hospital Services in the Transvaal, Dr Hennie Grové, also refused to comment on Dr McMurdo's resignation.

Dr McMurdo has played an important part in the planning of the new 2 000-bed hospital, which, at a cost of R156-million, has been variously termed a white elephant and a disease palace.

When all the departments intended for the new hospital, including three or four wards located at the J G Strijdom Hospital because of pressure on space, have moved, there will still be at least 20 empty wards with about 600 unoccupied beds.

Yet chronic staffing problems, emigration of doctors, and the acute shortage of nurses do not improve the prospect of the hospital being filled in the near future.

The move itself is taking longer than expected. Only the paediatric and maternity sections — which formerly occupied the Transvaal Memorial Children's Hospital and the Queen Victoria Maternity Home — have moved to the new premises so far.

Some hospital sources say staffing is again the problem and that more staff is needed to man the new hospital.

Meanwhile, the provincial council was told this week that it was necessary for a greater number of hospital beds to be available for Whites because of the ever-present possibility that private hospitals might be forced by economic factors to close down.

Mr Kalie De Haas, MEC in charge of hospital services, said that if private nursing homes closed the provincial hospitals would be responsible for their patients.

He was replying to a statement by Mrs Irene Menell, PRP spokesman on hospitals, that there was a tremendous discrepancy between the number of hospital beds available to Whites and Blacks.

● Dr John McMurdo — At 32 he was the hospital's youngest superintendent.

Psychiatric section in 'alarming state'

THE highly acclaimed child-abuse unit at Johannesburg Children's Hospital has run into major problems.

And a Sunday Express investigation has triggered a row between the unit's founder and the General's medical superintendent.

Dr Claire Irwin, who founded the unit and who was South Africa's only children's psychiatrist before emigrating to Australia last month, described the state of the unit and the entire child and adolescent psychiatrict section at the hospital as "alarming".

She told the Sunday Express in a telephone interview that there was "no way" she would consider returning to South Africa unless drastic changes were made.

But Dr John McMurdo, the hospital's medical superintendent, claims that the chief problem confronting the unit is that Dr Irwin left without training a successor.

The unit was left without a head.

To which Dr Irwin responded angrily from Adelaide: "I was used, abused and taken advantage of while I and the rest of my team over-extended ourselves keeping that unit going. I am not going to be made a scapegoat for problems which I have been pointing out to the authorities for five years."

The Sunday Express probe of the child and adolescent psychiatric unit disclosed several disturbing facts.

● Battered babies may be going undetected — the child abuse unit is seeing only half the number of cases it handled previously, when all the signs are that the incidence of baby battering is increasing.

● The entire child and adolescent psychiatric unit also saw considerably fewer cases last year than in 1977.

● A main reason appears to be the move by the Children's Hospital — with the exception of the psychiatrict unit — from the old building in lower Braamfontein to the new hospital complex in Parktown.

● A new ward, designed by Dr Irwin and intended to be used by the unit at the new hospital, remains empty.

● Hospital authorities maintain that the new psychiatric ward is suffering the same fate as dozens of other wards at the new hospital, which remain empty because of an inability to staff them.

● Dr Irwin's position as head of the unit is still vacant because there are no trained children's psychiatrists in South Africa, while no psychiatrists from overseas are interested in coming to South Africa.

The unit has been headed, since Dr Irwin's departure last month, by Dr Marian Lundie, a psychiatrist who by her own admission is not trained or experienced in child psychiatry and who might leave at any time to return to her special field, which is mental health among Blacks.

In addition to Dr Lundie, there are two psychiatric registrars who have not completed their training, two clinical psychologists and two more in training, one full-time social worker and one who works part-time, a couple of psychiatric nurses, an occupational therapist and a part-time remedial teacher.

They rely heavily on the services of a few private psychiatrists, who act as consultants.

The unit asked for extra staff in 1973, but has received only two psychiatric nurses and a part-time social worker.

The unit's problems, say staff, are compounded by the fact that it falls under three separate authorities: the Province, which runs hospital services, Wits University, to which the Department of Psychiatry is attached, and the State, which has control over all psychiatric services.

The child psychiatry unit, which includes the battered-baby centre, saw 154 fewer cases last year than in 1977, while the number seen by the battered-baby unit dropped from 35 in the first half of the year to 16 in the second — after the move took place.

This week, Dr McMurdo confirmed the decline in cases seen by the child abuse centre, but said figures appeared to have improved in the first month of this year.

He denied that the psychiatric unit as a whole was seeing fewer patients, claiming that cases handled last year showed a marginal increase. The Sunday Express ascertained from another source that this was not so.

When it asked Dr McMurdo for the official figures, he said: "You will have to take my word for it."

Dr Irwin said this week she had battled unsuccessfully for years to put things right in the unit, to get additional staff and a "more positive orientation towards child psychiatry".

She had not trained any psychiatrists because there was no field of study for child psychiatry in South Africa.

She said that several years ago, when she returned from a two-month overseas trip, she was told by casualty staff that her return was not welcome.

"They told me, in explicit terms, that during my absence they had been able to simply patch the children up and send them home."

In her experience, and that of other members of the unit, unless psychiatrists are on hand when potential cases are seen at casualty or admitted to the wards, cases of child abuse might go undetected.

Dr McMurdo disputed that the drop in referrals was due to the distance of the unit from the new hospital. He said baby-battering cases might be going to other hospitals which had established or expanded paediatric sections.

"I was used, abused and taken advantage of," says Dr Claire Irwin, founder of the General Hospital's child-abuse unit.

RACISM TO GO IN YEAR OF CHILD?

Argus 2/3/79

THE outpatients section at the Red Cross Children's Hospital is to be scrapped and a new one without segregated facilities is being planned, according to Dr W H J Greeff, the hospital's superintendent.

Several people, including some hospital staff members, complained to The Argus this week of 'shocking differences' in reception facilities for black and white outpatients.

The people appealed to The Argus to highlight the 'inferior and degrading facilities,' for blacks, since this was the 'year of the child.'

Dr Greeff described the complaints as *'reasonable' but said new facilities were being planned.*

Although separate facilities for the different races would not be duplicated in the new complex, Dr Greeff said he could not say if the new area would be integrated or for blacks only.

TWO SECTIONS

An Argus team which inspected the facilities, found there were two outpatients' reception sections — one at the back of the hospital used by blacks and the other in front used by whites.

The blacks receive attention through a hatch in a window while the whites have a smart reception area in wood-panelling with glass sliding doors.

The hatch for the blacks is outside the hospital in an area covered with a canopy of fibre glass, while the whites' section is inside the main entrance to the hospital.

After being attended at the hatch where they have to present their hospital cards, the blacks wait in a big room inside the hospital building.

OVERCROWDING

Dr W H J Greeff, the hospital's superintendent, said that although Red Cross was a 'happy hospital,' there were things which were not the way he would like them to be.

Because of persistent complaints, the authorities had approved plans to build a new outpatients section.

The decision to integrate facilities could not be taken by the hospital, but by the Director of Hospital Services and the Provincial Administration.

Black outpatients, Dr Greeff said, were attended through a hatch outside the building for security reasons and because of their large numbers.

Initially, a hatch inside the building was used but because of the number of patients, the waiting room became too small and another hatch had to be made outside.

ROOF LEAKS

White outpatients were admitted in front because their outpatients' section was closer to the front of the hospital.

The area where the blacks were received was actually the front of the hospital's outpatients department, he said.

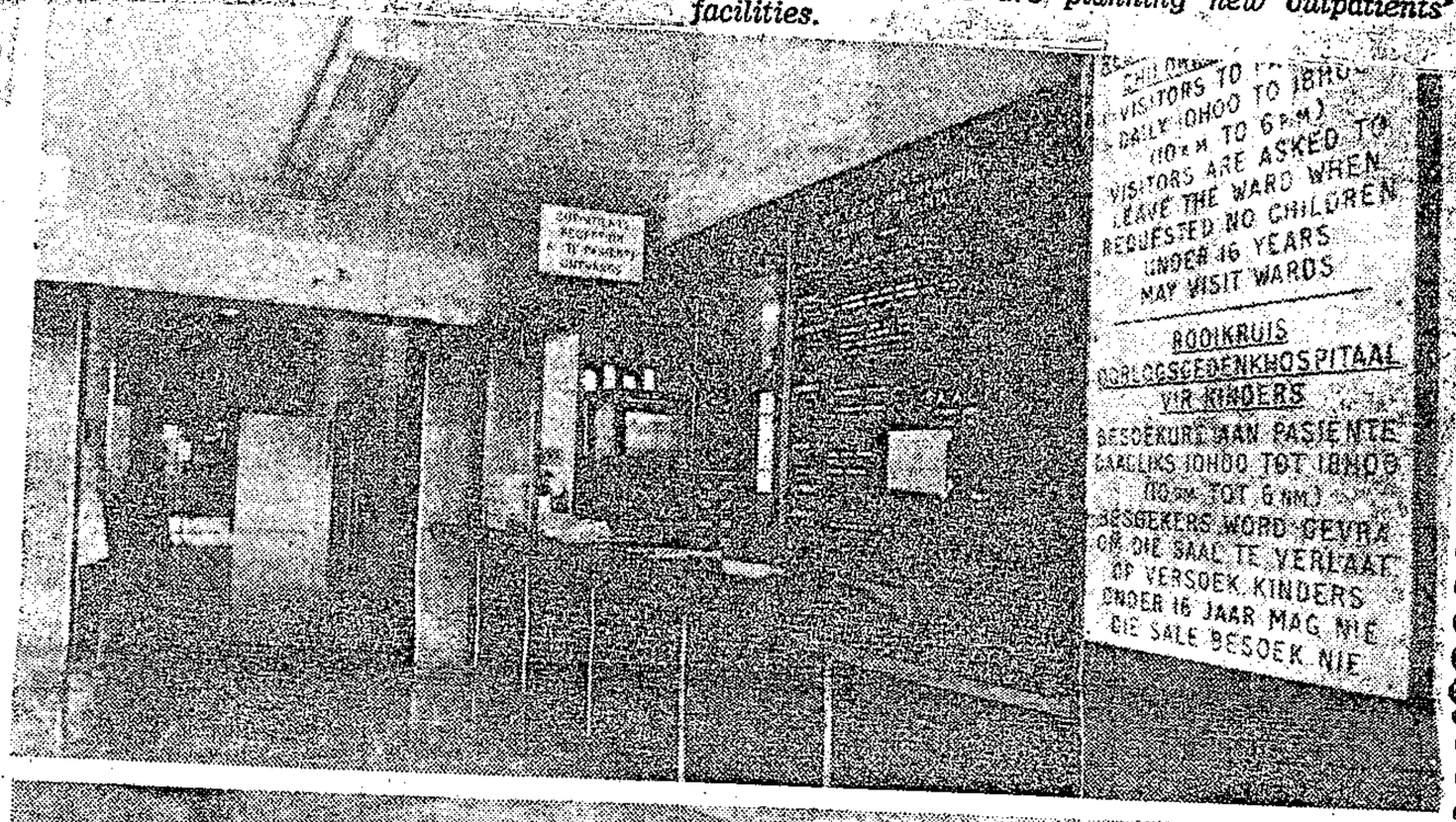
The blacks' area looked shabby because of leaks in the roof which had now been fixed. Maintenance staff were now waiting for damp patches to dry before painting.

The hospital treated *220 000 patients yearly* — between 600 to 800 every day — and 90 percent of them were blacks.

Because the white patients were few, their queues were shorter and they received attention more promptly. The whites had one doctor and the blacks 13.

Blacks had to wait much longer, some even longer than two hours, because of their large numbers and the thorough procedures of the

THE wood-panelled reception area with sliding windows (below) is where white outpatients have to report at the Red Cross Children's Hospital, while black patients have to present their hospital cards at a hatch (above) in a window outside the hospital building. The blacks' area is covered with a fibre-glass canopy. The hospital authorities are planning new outpatients' facilities.



PART of the blacks' waiting room showing the crowded facilities. The patients and their parents wait here to be called by the doctors. The waiting room is shabby and not very clean compared to the facilities for whites.

AFRICAN HISTORY.

in traditional ... from the north have come to ... Sudan originally.

2/...

Dental clinics

Hansard 5 (270) 5/3/79

170. Mr. N. B. WOOD asked the Minister of Health: (98)

(1)(a) How many dental clinics were established by his Department in co-operation with provincial administrations and local authorities in each province during 1978, (b) for which race groups were they established, (c) where are they situated and (d) what was the State's annual contribution to dental services for each province during 1978;

(2) how many persons were treated at such clinics in each province during the year ended 31 December 1978.

The MINISTER OF HEALTH:

(1) and (2) No dental clinics were established during 1978 in co-operation with provincial administrations and local authorities. According to the National Dental Health Policy the Department of Health will be responsible for all public dental services in the country and is at present in the process of taking over existing services from provincial administrations and local authorities.

KENNISGEWING 167 VAN 1979

DEPARTEMENT VAN GESONDHEID

AFKONDIGING VAN REGULASIES BETREFFENDE PRIVATE HOSPITALE EN LOSSTAANDE TEATEREENHEDE

Hierby word vir algemene inligting bekendgemaak dat die Minister van Gesondheid kragtens die bevoegdheid aan hom verleen by artikel 44 van die Wet op Gesondheid, 1977 (Wet 63 van 1977), voornemens is om die volgende regulasies betreffende private hospitale en losstaande teatereenhede uit te vaardig.

Belanghebbendes word hierby versoek om binne drie maande na die datum van hierdie kennisgewing gemotiveerde kommentaar in te dien by die Sekretaris van Gesondheid, Privaatsak X88, Pretoria, 0001 (vir aandag dr. K. H. Field).

Die Minister van Gesondheid het kragtens die bevoegdheid hom verleen by artikel 44 van die Wet op Gesondheid, 1977 (Wet 63 van 1977), die volgende regulasies uitgevaardig:

REGULASIES VIR PRIVATE HOSPITALE EN LOSSTAANDE OPERASIETEATEREENHEDE

WOORDOMSKRYWING

1. By die toepassing van hierdie regulasies, en tensy uit die samehang anders blyk, beteken—

"behandeling" 'n diagnostiese of terapeutiese prosedure wat uitgevoer word vir chirurgiese, mediese, verloskundige of tandheelkundige doeleindes, met inbegrip van die verskaffing van die nodige verpleegdienste, akkommodasie, toerusting en aanvullende fasiliteite, en het "behandel" 'n ooreenstemmende betekenis;

"Direkteur" 'n Direkteur van Hospitaaldienste van die provinsiale administrasie van 'n provinsie waarbinne 'n bepaalde private hospitaal of losstaande operasieteatereenheid geleë is of gaan wees;

"eienaar" die persoon, of, die benoemde in die geval van 'n maatskappy of vereniging van persone (met of sonder regspersoonlikheid), wat 'n private hospitaal of losstaande operasieteatereenheid instel, uitbrei, dryf of onderhou;

"geventileer", in verband met 'n vertrek, dat sodanige vertrek geventileer word deur 'n doeltreffende kunsmatige ventilasiestelsel of deur een of meer vensters wat regstreeks na die buitelug oop is en wat heeltemal of gedeeltelik oopgemaak kan word en so geplaas is dat dit 'n doeltreffende deurtrek of kruisventilasie bewerkstellig;

"inspekterende beampte" 'n beampte omskryf in artikel 1 van die Staatsdienswet 1957 (Wet 54 van 1957), wat deur die Sekretaris skriftelik daartoe gemagtig om 'n inspeksie uit te voer;

"herstelkamer of -ruimte" daardie gedeelte van 'n operasieteatereenheid wat spesiaal beskikbaar gestel word en ten volle toegerus is vir onmiddellike na-operatiewe herstel, resussitering, verpleging en spesiale versorging van pasiënte tot tyd en wyl sodanige pasiënte geag word genoegsaam te herstel het dat hulle met veiligheid vanuit voormelde gedeelte verwyder kan word;

NOTICE 167 OF 1979

DEPARTMENT OF HEALTH

PROMULGATION OF REGULATIONS REGARDING PRIVATE HOSPITALS AND UNATTACHED OPERATING THEATRE UNITS

It is hereby notified for general information that the Minister of Health, in the exercise of the powers vested in him by section 44 of the Health Act, 1977 (Act 63 of 1977), intends to promulgate the following regulations regarding private hospitals and unattached operating theatre units.

Interested parties are hereby invited to submit substantiated comments to the Secretary for Health, Private Bag X88, Pretoria, 0001 (for attention Dr K. H. Field), within three months of the date of this notice.

The Minister of Health has, by virtue of the powers vested in him by section 44 of the Health Act, 1977 (Act 63 of 1977), made the following regulations:

REGULATIONS GOVERNING PRIVATE HOSPITALS AND UNATTACHED OPERATING THEATRE UNITS

DEFINITIONS

1. For the purposes of these regulations, unless the context otherwise indicates—

"approved" means approved by the Secretary;

"central sterile supply department" means a room or rooms in which instruments, dressings, basins, containers, water and other items which are required to be sterile for the treatment of patients are sterilised, and are for this purpose received, cleaned, packed, sterilised and stored;

"Director" means the Director of Hospital Services of the provincial administration of a province within which a particular private hospital or unattached operating theatre unit is or is to be situated;

"inspecting officer" means a Government official as defined in section 1 of the Public Servants Act, 1957 (Act 54 of 1957), authorised in writing by the Secretary to carry out an inspection;

"lighted" in relation to any room means that such room is effectively lighted by an approved artificial lighting system or that the total unobstructed window area is equivalent to not less than 15 per cent of the floor area of such room;

"prescribed procedures" means surgical operations and medical procedures given in Annexure A;

"operating-theatre" means a room in which a registered medical practitioner or dentist carries out operations;

"operating-theatre unit" means a place where surgical activities are carried out and in which provision is made for those facilities as set forth in these regulations;

"overcrowded", in relation to any room or accommodation, means that there is less than 4 m^2 of floor area and less than 12 m^3 of air space for each person working or accommodated in such room or accommodation and less than half of this area and space for each such person under 10 years of age: Provided that the floor area and air space of a single room shall not be less than 10 m^2 and 30 m^3 respectively;

"losstaande operasieteatereenheid" 'n operasieteatereenheid wat nie in besit is van, of bestuur word deur, die Staat, 'n provinsiale administrasie, 'n plaaslike bestuur, 'n private hospitaalowerheid, 'n hospitaalraad of enige ander openbare liggaam nie, wat nie verbonde is aan 'n hospitaal of verpleeg- of kraaminrigting nie, en waar 'n pasiënt wat in sodanige operasie-eenheid geopereer word, hoogstens 12 uur mag vertoef, bereken vanaf die tydstip waarop hy die eenheid binnegaan onmiddellik voordat hy geopereer word;

"oorbewoon", in verband met 'n vertrek of akkommodasie, dat daar minder as 4 m^2 vloeroppervlakte en 12 m^3 lugruimte is vir elke persoon wat in sodanige vertrek of akkommodasie werk of gehuisves word, of dat daar minder as die helfte van hierdie oppervlakte en ruimte vir elke sodanige persoon van jonger as 10 jaar is: Met dien verstande dat die vloeroppervlakte en die lugruimte van 'n enkelkamer nie kleiner mag wees as onderskeidelik 10 m^2 en 30 m^3 nie;

"operasieteater" 'n vertrek waarin 'n geregistreerde mediese praktisyn of tandarts operasies uitvoer;

"operasieteatereenheid" 'n plek waar chirurgiese aktiwiteite uitgevoer word en waarin voorsiening gemaak is vir die fasiliteite soos in hierdie regulasies uiteengesit;

"private hospitaal" 'n hospitaal of 'n ander inrigting, gebou of plek waar voorsiening gemaak word vir die behandeling en versorging van gevalle wat geneeskundige of chirurgiese behandeling en verpleging nodig het, maar met uitsluiting van—

(a) 'n hospitaal of enige sodanige inrigting, gebou of plek wat bedryf word deur die Staat, 'n provinsiale administrasie, 'n plaaslike bestuur, 'n hospitaalraad of enige ander openbare liggaam;

(b) 'n spreekkamer, operasiekamer of apteek van 'n geneesheer of tandarts wat nie bedakkommodasie verskaf nie;

(c) 'n losstaande operasieteatereenheid;

(d) 'n gelisensieerde hospitaal of ander inrigting vir die opneming en aanhouding van geestesongestelde persone ingevolge artikel 46 van die Wet op Geestesgesondheid, 1973 (Wet 18 van 1973);

"sentrale sterielevoorraaddepartement" 'n vertrek of vertrekke waarin instrumente, verbande, komme, houers, water en ander items wat vir die behandeling van pasiënte steriel moet wees, gesteriliseer word, en vir hierdie doel ontvang, skoongemaak, verpak, gesteriliseer en geberg word;

"spoelkamer" 'n vertrek waar bedpanne, urienbakke, spoegbakke en soortgelyke houers geberg, geledig, uitgespoel en ontsmet word en waar vuil bedlinne, verbande en dergelike artikels geplaas kan word voor verwydering;

"verlig", in verband met 'n vertrek, dat sodanige vertrek verlig word deur 'n kunsmatige beligtingstelsel of dat die totale onversperde vensteroppervlakte gelykstaande is met minstens 15 persent van die vloeroppervlakte van sodanige vertrek;

"voorgeskrewe prosedures" die chirurgiese operasies en mediese prosedures wat in Aanhangsel A aangegee word.

Enige ander uitdrukking wat in hierdie regulasies gebruik word, het, tensy uit die samehang duidelik anders blyk, dieselfde betekenis as dié wat daaraan geheg word in die Wet op Gesondheid, 1977 (Wet 63 van 1977).

"private hospital" means any hospital or any other institution, building or place at which provision is made for the treatment and care of cases who need medical or surgical treatment and nursing care, but excluding—

(a) a hospital or any such institution, building or place conducted by the State, a provincial administration, local authority, private hospital authority, hospital board or any other public body;

(b) any consulting room, surgery or dispensary of a medical practitioner or dentist which does not provide any bed accommodation;

(c) an unattached operating-theatre unit; and

(d) a hospital or other institution licensed for the reception and detention of mentally ill persons in terms of section 46 of the Mental Health Act, 1973 (Act 18 of 1973);

"proprietor" means the person, or the nominee in the case of a company or an association of persons (whether corporate or incorporate), the nominee of such company or association who establishes, extends, conducts or maintains a private hospital or unattached operating-theatre unit;

"recovery room or area" means that section of an operating theatre unit specially set aside and fully equipped for the immediate post-operative recovery, resuscitation, nursing and special care of patients until such time as such patients are considered to have recovered sufficiently to be safely removed from the aforementioned section;

"sluice room" means a room where bed pans, urinals, sputum mugs and similar containers are kept and can be emptied, washed out, disinfected and stored, and where soiled linen, dressings and similar items can be deposited prior to removal;

"treatment" means any diagnostic or therapeutic procedure carried out for surgical, medical, obstetrical or dental purposes, and includes the provision of the necessary nursing services, accommodation, equipment and ancillary facilities, and "treat", "treating" and "treated" have corresponding meanings;

"unattached operating-theatre unit" means an operating-theatre unit not owned or managed by the State, a provincial administration, a local authority, a private hospital authority, a hospital board or any other public body and not attached to a hospital or nursing home or maternity home, and where a patient operated on in such operating-theatre unit may remain for a period not exceeding 12 hours, reckoned from the time he enters the unit immediately before being operated on; and

"ventilated", in relation to any room, means that such room is ventilated by an effective artificial ventilation system or by one or more windows opening direct to the outer air and capable of opening wholly or partly, and so placed as to make possible an effective through draught or cross-ventilation.

Any other expression in these regulations has the same meaning, unless the context clearly indicates otherwise, as that assigned to it in the Health Act, 1977 (Act 63 of 1977).

REGISTRASIE

2. Behoudens die bepalings van regulasie 8, mag niemand 'n private hospitaal of 'n losstaande operasieteatereenheid oprig, instel, uitbrei, bedryf, onderhou, bestuur of beheer of 'n diens daarin lewer of die verskaffing van behandeling daarin toelaat of reël nie, tensy sodanige private hospitaal of losstaande operasieteatereenheid of beoogde private hospitaal of losstaande operasieteatereenheid geregistreer is ooreenkomstig die bepalings van hierdie regulasies en in besit is van 'n geldige registrasiesertifikaat wat die Sekretaris ten opsigte daarvan aan die eienaar uitgereik het.

3. Elke sodanige registrasiesertifikaat wat ingevolge regulasie 14 (1) of 14 (3) uitgereik word, is van krag vanaf die datum van uitreiking tot en met die eersvolgende 31ste dag van Desember, wanneer dit verval, of vir sodanige gedeelte van bedoelde tydperk as wat in die registrasiesertifikaat vermeld word. 'n Aansoek om hernuwing van sodanige registrasiesertifikaat moet minstens 90 dae voor die vervaldatum en ooreenkomstig regulasie 11 gedoen word.

4. 'n Private hospitaal of losstaande operasieteatereenheid word nie as sodanig geregistreer nie en geen registrasiesertifikaat word ten opsigte daarvan uitgereik nie, tensy—

(1) die perseel waarin die private hospitaal of losstaande operasieteatereenheid bedryf word of gaan word en die toerusting wat in sodanige private hospitaal of losstaande operasieteatereenheid gebruik word of vir gebruik aldaar bestem is, geskik en toereikend is vir die doeleindes van genoemde private hospitaal of losstaande operasieteatereenheid;

(2) die private hospitaal of losstaande operasieteatereenheid nie bestuur word of bestuur sal word op 'n wyse wat vir die liggaamlike, geestelike of sedelike welsyn van die pasiënte of personeel daarvan nadelig is of sal wees nie;

(3) die personeel van die private hospitaal of losstaande operasieteatereenheid voldoen of sal voldoen aan aanvaarde norme vir die doeleindes van sodanige hospitaal of eenheid;

(4) die persoon in beheer van sodanige private hospitaal of losstaande operasieteatereenheid as 'n geneesheer of, in die geval van 'n uitsluitlike tandheelkundige diens, as 'n tandarts geregistreer is of sal wees ingevolge die bepalings van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsberoepe, 1974 (Wet 56 van 1974), of, in die geval van 'n algemene mediese verplegingsdiens of 'n verloskundige diens, as onderskeidelik 'n algemene verpleegster of 'n vroedvrou geregistreer is of sal wees ingevolge die bepalings van die Wet op Verpleging, 1957 (Wet 69 van 1957);

(5) die persoon in beheer 'n geregistreerde geneesheer of tandarts is soos in subregulasie (4) beskryf, daar 'n algemene verpleegster wat ingevolge die Wet op Verpleging, 1957 (Wet 69 van 1957), geregistreer is, in bevel van die verplegingsdiens is of sal wees; en

(6) sodanige registrasie in die openbare belang is.

5. (1) In sy aansoek moet die eienaar 'n beskrywing gee van die perseel; besonderhede verstrek aangaande die ligging daarvan, die aard van die behandeling wat daar verskaf sal word, die bevolkingsgroepe van die personeel wat aan die private hospitaal of losstaande operasieteatereenheid verbonde sal wees en die bevolkingsgroepe wat van die private hospitaal of losstaande operasieteatereenheid gebruik sal maak; en enige verdere verstrek wat die Sekretaris nodig ag om hom in staat te stel om die aansoek te oorweeg.

REGISTRATION

2. Subject to the provisions of regulation 8, no person shall establish, extend, conduct, maintain, manage, control or render any service in a private hospital or an unattached operating-theatre unit or allow or arrange for treatment to be provided therein unless such private hospital or unattached operating-theatre unit or proposed private hospital or unattached operating-theatre unit has been registered in accordance with the provisions of these regulations and is in possession of a valid registration certificate issued in respect thereof to the proprietor by the Secretary.

3. Each such registration certificate issued in terms of regulations 14 (1) or 14 (3) shall be effective from the date of issue up to and including the next succeeding 31st day of December, when it shall lapse, or for such portion of the said period as may be specified in the registration certificate. An application for the renewal of such certificate of registration shall be made in accordance with regulation 11, not less than 90 days before the date of expiry.

4. A private hospital or unattached operating-theatre unit shall not be registered as such and no certificate of registration shall be issued in respect thereof, unless—

(1) the premises in which the private hospital or unattached operating-theatre unit is or is to be conducted and the equipment which is used or is intended for use in such private hospital or unattached operating-theatre unit are suitable and adequate for the purposes of the said private hospital or unattached operating-theatre unit;

(2) the private hospital or unattached operating-theatre unit is not managed or will not be managed in a manner which will be detrimental to the physical, mental or moral welfare of the patients or staff thereof;

(3) the staff of the private hospital or unattached operating-theatre unit complies with, or will comply with, accepted standards for the purposes of such hospital or unit;

(4) that the person in charge of such private hospital or unattached operating-theatre unit is or will be registered as a medical practitioner or, in the case of an exclusively dental service, a dentist, in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), or in the case of a general medical nursing service or a midwifery service, is or will be registered in terms of the Nursing Act, 1957 (Act 69 of 1957), as a general nurse or a midwife, respectively;

(5) that if the person in charge is a registered medical practitioner or dentist as described in subregulation (4), a general nurse registered in terms of the Nursing Act, 1957 (Act 69 of 1957), is or will be in charge of the nursing service; and

(6) that such registration is in the public interest.

5. (1) In his application the proprietor shall give a description of the premises and also furnish particulars regarding the location thereof, the nature of the treatment to be rendered there, the population group of the staff attached to the private hospital or unattached operating-theatre unit and the population groups that will make use of the private hospital or unattached operating-theatre unit, and shall furnish any further information required by the Secretary in order to consider the application.

(2) Die eienaar moet elke verandering in die besonderhede wat hy ingevolge subregulasie (1) verstrek het, of wat aangedui word op die huidige sertifikaat van registrasie soos ooreenkomstig regulasie 12 van hierdie regulasies uitgereik, onmiddellik skriftelik aan die Sekretaris meedeel.

6. Die eienaar van 'n geregistreerde private hospitaal moet aan die Direkteur en aan die pasiënte en personeel van sodanige hospitaal ten minste drie maande kennis gee van die voorgenome sluiting daarvan: Met dien verstande dat in buitengewone omstandighede die Direkteur 'n korter tydperk van kennisgewing kan magtig.

OPRIGTING EN REGISTRASIE VAN PRIVATE HOSPITALE EN LOSSTAANDE OPERASIETEATEREENHEDE

7. (1) Niemand mag sonder die vooraf verkreë skriftelike toestemming van die Sekretaris 'n gebou oprig, verander, of toerus of op enige ander wyse gereedmaak vir gebruik as 'n private hospitaal of losstaande operasieteatereenheid nie.

(2) (i) Iemand wat voornemens is om 'n private hospitaal of losstaande operasieteatereenheid op te rig, moet vooraf skriftelike toestemming verkry van die Sekretaris, wat, in oorleg met die Direkteur, hom van die nodigheid of onnodigheid van so 'n private hospitaal of losstaande operasieteatereenheid moet oortuig alvorens hy toestemming verleen of te weier.

(2) Nadat die aansoeker sodanige toestemming verkry het, moet hy Aanhangsel B voltooi en planne tesame met die nodige inligting voorlê vir goedkeuring deur die Sekretaris en sodanige bykomende inligting verstrek as wat die Sekretaris verlang.

(3) Toestemming en goedkeuring ingevolge regulasie 7 is nie oordraagbaar nie.

8. In die geval van 'n private hospitaal of losstaande operasieteatereenheid waarvan die gebou nog opgerig of omgebou staan te word, moet 'n aansoek om registrasie vergesel gaan van planne van die gebou of beoogde gebou. Sodanige planne moet die aard en konstruksie van die gebou of beoogde gebou of die aard van die ombouings, na gelang van die geval, duidelik aantoon.

Die benamings van die kamers, afmetings en vierkante afmetings moet by die planne aangeheg word in die vorm van 'n skedule.

9. Indien die pasiënte gehuisves word in 'n meerverdiepinggebou, moet daar voorsiening gemaak word vir 'n genoegsame aantal hysers of opritte: Met dien verstande dat behoorlike voorsiening gemaak moet word vir hysers wat geskik is om 'n pasiëntbed of -trollie te neem en dat voorsiening gemaak moet word vir die afsonderlike verwydering van vuil linne, afval en vullis.

10. Alle planne op 'n skaal van 1:100 geteken word en in tweevoud ingedien word.

11. Die aansoeker moet aan die Sekretaris skriftelik bewys lewer dat nòg enige ander staatsdepartement nòg die betrokke plaaslike bestuur beswaar daarteen het dat die private hospitaal of losstaande operasieteatereenheid op die betrokke perseel bedryf word. In die geval van 'n gebou wat nog opgerig of omgebou staan te word, moet die aansoeker skriftelik bewys lewer dat die plan deur die betrokke plaaslike owerheid goedgekeur is.

(2) The proprietor shall immediately report to the Secretary in writing any change in the particulars furnished by him in terms of subregulation (1) or indicated on the current certificate of registration issued in terms of regulation 12 of these regulations.

6. The proprietor of a registered private hospital shall give not less than three months' notice in writing of the intended closure of such hospital, to the Director, patients and staff: Provided that, in exceptional circumstances, the Director may authorise a shorter period of notice.

ESTABLISHMENT AND REGISTRATION OF PRIVATE HOSPITALS AND UNATTACHED OPERATING-THEATRE UNITS

7. (1) No person shall erect, alter, equip or in any other way prepare any premises for use as a private hospital or unattached operating-theatre unit without the prior approval in writing of the Secretary.

(2) (1) Any person intending to establish a private hospital or an unattached operating-theatre unit shall first obtain permission in writing from the Secretary, who, in consultation with the Director, shall satisfy himself as to the necessity or otherwise for such a private hospital or unattached operating-theatre unit before granting or refusing permission.

(2) Having obtained such permission, the applicant shall complete Annexure B and submit plans for approval by the Secretary, together with the necessary information, and shall supply any additional information which the Secretary may require.

(3) Permission and approval in terms of regulation 7 are not transferable.

8. In the case of a private hospital or unattached operating-theatre unit of which the buildings are still to be erected or converted, plans of the buildings or proposed buildings shall accompany the application for registration. The plans should show clearly the nature and construction of the buildings or proposed buildings or the nature of the conversions, as the case may be. Room names, dimensions and square measurements shall be attached to the plans in the form of a schedule.

9. A sufficient number of lifts or ramps shall be provided where patients are housed in a multi-storey building: Provided that adequate provision shall be made for lifts suitable for taking a patient bed or trolley and for the separate removal of soiled linen, waste and refuse.

10. All plans shall be drawn to the scale of 1:100 and submitted in duplicate.

11. The applicant shall furnish the Secretary with proof, in writing, that neither any other Government department nor the local authority concerned has any objection to the private hospital or unattached operating-theatre unit being conducted on the premises concerned. In the case of a building still to be erected or to be converted, the applicant shall furnish proof, in writing, that the plan has been passed by the local authority concerned.

AANSOEK OM HERNUWING VAN REGISTRASIE

12. Minstens 90 dae voor die datum waarop 'n registrasiesertifikaat verval, moet die eienaar aansoek doen om die hernuwing van die registrasie.

13. Elke aansoek om hernuwing van registrasie word aan die Sekretaris gerig in wesenlik die vorm van Vorm I in Aanhangsel B vir private hospitale of losstaande operasieteaterecnhede.

AFHANDELING VAN AANSOEKE

14. By ontvangs van 'n aansoek besluit die Sekretaris in oorleg met die Direkteur—

(1) om die beoogde private hospitaal of losstaande operasieteatereenheid as 'n private hospitaal of losstaande operasieteatereenheid te registreer en 'n registrasiesertifikaat ten opsigte daarvan uit te reik behoudens sodanige voorwaardes as wat hy goeddink; of

(2) om registrasie te weier, in welke geval hy geen registrasiesertifikaat uitreik nie; of

(3) om die registrasie van die private hospitaal of losstaande operasieteatereenheid te hernieu en 'n registrasiesertifikaat ten opsigte daarvan uit te reik behoudens sodanige voorwaardes as wat hy goeddink; of

(4) om hernuwing van registrasie te weier, in welke geval hy geen registrasiesertifikaat uitreik nie.

15. Die Sekretaris kan vir die doel van regulasie 14 die perseel waarop die aansoek betrekking het, inspekteer of deur 'n inspekterende beampte laat inspekteer en die aansoeker moet, ten opsigte van sodanige inspeksie, aan die Ontvanger van Inkomste inspeksiegeld van R30 betaal, wat vervoergelde insluit.

HERAANSOEK OM REGISTRASIE

16. 'n Eienaar wat om die registrasie van 'n private hospitaal of losstaande operasieteatereenheid aansoek gedoen het en wie se aansoek geweier is, of 'n eienaar wie se aansoek om hernuwing van registrasie geweier is of wie se registrasiesertifikaat ingevolge regulasie 18 ingetrek is, of 'n eienaar wat versuim het om betyds om die hernuwing van registrasie aansoek te doen en wie se registrasiesertifikaat verval het, of 'n eienaar of voornemende eienaar wat ingevolge regulasie 56 appèl aangeteken het teen die weiering deur die Sekretaris van registrasie of hernuwing van registrasie of teen die intrekking deur die Sekretaris van 'n registrasiesertifikaat en wie se appèl nie geslaag het nie, kan te eniger tyd weer aansoek doen om die registrasie of hernuwing van registrasie van dieselfde private hospitaal of losstaande operasieteatereenheid: Met dien verstande dat indien registrasie of hernuwing van registrasie geweier is of die registrasiesertifikaat ingetrek is omrede versuim deur die aansoeker om aan die voorwaardes of die vereistes te voldoen wat die Sekretaris ingevolge regulasie 14 (1) of 14 (3) gestel het, sodanige verdere aansoek nie gedoen word voordat en tensy daar aan al sodanige voorwaardes of vereistes voldoen is nie.

VRYSTELLING VAN VEREISTES TEN OPSIGTE VAN REGISTRASIE

17. Die Sekretaris kan te eniger tyd, op dié voorwaardes en vir dié tydperk wat hy in oorleg met die Direkteur bepaal, aan 'n eienaar vrystelling verleen van enige vereistes ten opsigte van registrasie ingevolge hierdie regulasies.

APPLICATION FOR THE RENEWAL OF REGISTRATION

12. Not less than 90 days before the date on which a certificate of registration expires, the proprietor shall apply for the renewal of such registration.

13. Every application for the renewal of registration shall be made to the Secretary substantially in the form of Form I in Annexure B for private hospitals or unattached operating-theatre units.

HANDLING OF APPLICATIONS

14. Upon the receipt of an application the Secretary shall, in consultation with the Director, decide—

(1) to register the proposed private hospital or unattached operating-theatre unit and issue a certificate of registration in respect thereof, subject to such conditions as he may deem fit; or

(2) to refuse registration, in which event he shall not issue any certificate of registration; or

(3) to renew the registration of the private hospital or ununattached operating-theatre unit, subject to such conditions as he may deem fit; or

(4) to refuse the renewal of registration, in which event no certificate of registration shall be issued.

15. The Secretary may for the purposes of regulation 14 carry out or cause to be carried out by an inspecting officer an inspection of the premises in respect of which the application was made and the applicant shall pay to the Receiver of Revenue in respect of such inspection an inspection fee of R30, which shall include transport fees.

RE-APPLICATION FOR REGISTRATION

16. Any proprietor who has applied for the registration of a private hospital or unattached operating-theatre unit and whose application has been refused or any proprietor whose application for the renewal of registration has been refused or whose certificate of registration has been cancelled in terms of regulation 18 or any proprietor who failed to apply timeously for the renewal of registration and whose certificate of registration has expired or any proprietor or prospective proprietor who lodged an appeal in terms of regulation 56 against the refusal by the Secretary of registration or the renewal of registration or against the cancellation by the Secretary of a certificate of registration and whose appeal has been dismissed may at any time re-apply for the registration or the renewal of registration of the same private hospital or unattached operating-theatre unit: Provided that, if the registration or the renewal of registration has been refused or the certificate of registration has been cancelled because of failure by the applicant to comply with all the conditions or requirements imposed by the Secretary in terms of regulation 14 (1) or 14 (3), such further application shall not be made until and unless all such conditions and requirements have been complied with.

EXEMPTION FROM REQUIREMENTS IN RESPECT OF REGISTRATION

17. The Secretary may at any time, on such conditions and for such period as he may determine in consultation with the Director, grant a proprietor exemption from any requirements in respect of registration in terms of these regulations.

INTREKKING VAN REGISTRASIE-SERTIFIKAAT

18. 'n Registrasiesertifikaat kan te eniger tyd ingetrek word—

(1) deur die Sekretaris indien die eienaar—

(i) versuim om aan enige voorwaardes of vereistes te voldoen wat ingevolge regulasie 14 (1) of 14 (3) gestel is; of

(ii) versuim om die opgawes, besonderhede of inligting te verstrek wat hy ingevolge regulasie 28 moet verstrek; of

(iii) skuldig bevind word aan 'n misdryf ingevolge die bepalings van hierdie regulasies;

(2) deur die Sekretaris of die Minister indien hy dit in die openbare belang ag dat die private hospitaal of losstaande operasieteatereenheid ten opsigte waarvan sodanige registrasiesertifikaat uitgereik is, gesluit word.

19. Indien die Sekretaris of die Minister, na gelang van die geval, kragtens regulasie 18 'n registrasiesertifikaat intrek, gee hy aan die eienaar skriftelik kennis dat hy die registrasiesertifikaat aldus intrek, en dat die private hospitaal of losstaande operasieteatereenheid ten opsigte waarvan dit uitgereik is, gesluit moet word voor of op 'n datum in sodanige kennisgewing vermeld.

20. By die intrekking van 'n registrasiesertifikaat ingevolge regulasie 18 verval die registrasie van die private hospitaal of losstaande operasieteatereenheid ten opsigte waarvan sodanige registrasiesertifikaat uitgereik is, op die datum vermeld in die skriftelike kennisgewing bedoel in regulasie 19.

BOUVEREISTES VIR LOSSTAANDE OPERASIETEATEREENHEDE

21. Die vertrekke van 'n losstaande operasieteatereenheid moet aan die volgende vereistes voldoen:

(1) Behalwe waar daar in hierdie regulasies 'n ander vereiste gestel word, moet alle mure minstens 2,6 m hoog wees, gemeet van die vloer tot by die plafon, en gebou wees van baksteen, klip, beton of ander ondeurlatende materiaal en, tensy anders goedgekeur, moet die buitemure minstens 225 mm dik wees en die binnemure minstens 89 mm dik wees.

(2) In die operasieteater, die spoelkamer, die toilette en storthokkies moet die voeg tussen die muur en die vloer gerond wees.

(3) Alle gange wat pasiënttrollies neem, moet minstens 2 m wyd wees.

(4) Alle deure wat toegang verleen tot vertrekke waar pasiënte gehuisves sal word, moet minstens 2 m hoog en minstens 1 m wyd wees.

(5) Alle vertrekke moet geventileer en verlig wees en ruim genoeg om te verseker dat hulle nie oorbewoon is wanneer die maksimum getal persone wat gewoonlik op enige tydstip daarin sou wees, teenwoordig is nie.

(6) Alle vertrekke, gange en teaters moet voorsien wees van 'n gladde, stofdigte plafon.

(7) Die vloere van alle vertrekke en gange moet van materiaal wees en bedek wees met 'n wasbare, ondeurlatende materiaal: Behalwe dat waar vlambare materiaal gebruik, gehou of gebêre word, die vloer van die operasieteater en van die vertrekke waar sodanige vlambare materiaal gebruik, gehou of gebêre word, asook alle vloere binne 'n afstand van 1 m van die deure van die operasieteater en van sodanige vertrekke waar vlambare materiaal gebruik, gehou of gebêre

CANCELLATION OF CERTIFICATE OF REGISTRATION

18. A certificate of registration may at any time be cancelled—

(1) by the Secretary if the proprietor—

(i) fails to comply with any conditions or requirements imposed in terms of regulation 14 (1) or 14 (3); or

(ii) fails to furnish the returns, particulars or information which he is required to furnish in terms of regulation 28; or

(iii) is found guilty of an offence in terms of the provisions of these regulations;

(2) by the Secretary or the Minister if he deems it to be in the public interest that the private hospital or unattached operating-theatre unit in respect of which such certificate of registration has been issued be closed.

19. Whenever the Secretary or the Minister, as the case may be, cancels a certificate of registration in terms of regulation 18 he shall give notice in writing to the proprietor that he is so cancelling the certificate of registration and that the private hospital or unattached operating-theatre unit in respect of which it was issued shall be closed down on or before a date specified in such notice.

20. Upon the cancellation of a certificate of registration in terms of regulation 18, the registration of the private hospital or unattached operating-theatre unit in respect of which it was issued shall lapse on the date specified in the written notice referred to in regulation 19.

BUILDING REQUIREMENTS FOR UNATTACHED OPERATING-THEATRE UNITS

21. The rooms of an unattached operating-theatre unit shall comply with the following requirements:

(1) Save where otherwise required in these regulations, all walls shall be not less than 2,6 m high, measured from the floor to the ceiling, and shall be constructed of burnt brick, stone, concrete or some other impervious material and, unless otherwise approved, the external walls shall be not less than 225 mm thick and the internal walls not less than 89 mm thick.

(2) In the operating-theatre, sluice room, toilets and shower cubicles, the joint between the walls and the floor shall be rounded to the satisfaction of the Secretary.

(3) All corridors taking patient trolleys shall be not less than 2 m wide.

(4) All doors giving access to rooms in which patients are to be accommodated shall be not less than 2 m high and 1 m wide.

(5) All rooms shall be satisfactorily ventilated and lighted and spacious enough to ensure that they are not overcrowded when the maximum number of persons that would normally be in them at any time are present.

(6) All rooms, corridors and theatres shall be provided with a smooth, dustproof ceiling.

(7) The floors of all rooms and corridors shall be of approved material and covered with impervious washable material: Save that where flammable materials are used, kept or stored, the floor of the operating-theatre and the rooms where such flammable materials are used, kept or stored, as well as all floors within a distance of 1 m of the doors of the operating-theatre and of such rooms where flammable materials

word, bedek moet wees met 'n ondeurlatende, wasbare, antistatiese tipe materiaal en dat 'n opvallende waarskuwingskennisgewing 'n vereiste is ingeval die vloer nie antistaties is nie.

(8) Die oppervlakke van die mure moet glad gepleister wees en moet, behalwe waar hierdie regulasie anders bepaal, met 'n ligkleurige wasbare verf afgewerk wees of met 'n wasbare, ondeurlatende materiaal bedek wees: Met dien verstande dat in die geval van spoelkamers, toilette, storthokkies, operasieteaters 'n sentrale sterielevoorraaddepartement en steriliseerkamers die mure tot 'n hoogte van minstens 2,1 m van die vloer af, in plaas daarvan om met 'n ligkleurige wasbare verf geverf te word, bedek kan word met wit of ligkleurige glasuurteëls of met 'n ander wasbare, ondeurlatende materiaal: Met dien verstande, verder, dat die mure agter alle handewasbakke tot 'n hoogte van 500 mm bokant en 500 mm aan weerskante van sodanige handewasbakke bedek moet word met wit of ligkleurige glasuurteëls of ander wasbare, ondeurlatende materiaal.

(9) Korrek geplaaste en toereikende brandkrane, brandslange, brandblussers, branduitgange en nooduitgange moet verskaf word en behoorlik in stand gehou word.

(10) Indien die operasieteatereenheid nie op die grondverdieping van 'n meerverdiepinggebou is nie, moet die gebou voorsien wees sowel van 'n brandtrap as van 'n hyser wat groot genoeg is om 'n pasiëntedraagbaar te neem.

(11) Genoegsame water moet aangelê word na alle krane, storte, spoelapparaat en sanitêre geriewe in die operasieteatereenheid en alle vuilwater van die handewasbakke, spoelkamers, spoelbakke en toiletpanne moet doeltreffend dreineer in 'n goedgekeurde rioolstelsel.

(12) 'n Goedgekeurde verbrandingsoond of ander geskikte stelsel moet verskaf word vir die doeltreffende verbranding of wegdoen van vuil verbande en chirurgies verwyderde weefsels sonder om enige oorlas te veroorsaak.

VERTREKKE WAT NODIG IS

22. 'n Losstaande operasieteatereenheid moet bedryf word in akkommodasie waar voorsiening gemaak is vir—

(1) 'n operasieteater met nabygeleë steriliseerkamer, herstelruimte en saalakkommodasie wat so beplan of bedryf moet word dat die manlike en die vroulike pasiënte geskei sal wees: Met dien verstande dat indien sodanige herstelruimte so ingerig is dat dit voldoende is om die saalakkommodasie te vervang, geen sodanige afsonderlike saalakkommodasie vereis word nie;

(2) 'n skropruimte buite die operasieteater: Met dien verstande dat indien die operasieteater ruim genoeg daarvoor is, sodanige skropruimte verskaf kan word op enige geskikte plek binne die operasieteater, en

(3) 'n spoelkamer, spoelfasiliteite, dienskamerfasiliteite vir verpleegsters, 'n linnekamer of kas vir skoon linnegoed, opbergruimte vir vlambare materiaal, voldoende kleedkamer- en toiletfasiliteite vir personeel en pasiënte afsonderlik (toilette kan afsonderlik van kleedkamers vir mans en vroue afsonderlik verskaf word), 'n wagkamer vir pasiënte en hulle besoekers, kantoorruimte en, waar toepaslik, 'n spreekkamer.

are used, kept or stored, shall be covered with antistatic material of a washable impervious type and that a conspicious cautionary notice is a requirement if the floor is not antistatic.

(8) The surfaces of the walls shall be smoothly plastered and, save where otherwise provided in these regulations, be painted with washable paint of a light colour or clad with a washable impervious, material: Provided that in the case of sluice rooms, toilets, shower cubicles, operating-theatres, central sterile supply departments or sterilising rooms, the walls up to a height of not less than 2,1 m from the floor may, instead of being painted with washable paint of a light colour, be covered with white or light-coloured glazed tiles or other washable, impervious material: Provided further that the walls behind all wash-hand basins shall, up to a height of 500 mm above and on either side of such wash-hand basins, be covered with white or light-coloured glazed tiles or other washable, impervious material.

(9) Properly placed and adequate fire-hydrants, fire-hoses, fire-extinguishers, fire-excapes and emergency exits shall be provided and satisfactorily maintained.

(10) If the operating-theatre unit is in a multi-storeyed building and not on the ground floor, the building shall be equipped with fire-excape stairs as well as a lift of sufficient size to take a patient stretcher.

(11) Sufficient water shall be laid on to all taps, showers, sluicing apparatus and sanitary conveniences in the operating-theatre unit and all waste water from wash-hand basins, sluice rooms, sluice pans and toilet pans shall effectively drain into an approved sewerage system.

(12) An incinerator or other suitable system shall be provided for the effective incineration or disposal of soiled dressings and surgically removed tissues, without causing any nuisance.

ROOMS REQUIRED

22. An unattached operating-theatre unit shall be conducted in accommodation in which provision is made for—

(1) an operating-theatre with adjoining sterilising room and recovery area and ward accommodation so planned or conducted that male and female patients shall be effectively separated: Provided that if such recovery area is so arranged as to provide adequate substitute ward accommodation, no such separate ward accommodation shall be required;

(2) a scrubbing-up area outside the operating-theatre: Provided that if the operating-theatre is sufficiently spacious for the purpose, such scrubbing-up area may be provided at a suitable place within the operating-theatre; and

(3) a sluice room, sluicing facilities, nurses' duty-room facilities, a linen room or cupboard for clean linen, storage space for flammable material, adequate change-room and toilet facilities for staff and patients separately (toilets, independent from change-rooms may be provided, for males and females separately), a waiting-room for patients and their visitors, office space and, where applicable, a consulting room.

AKKOMMODASIE

23. Die vertrekke wat in regulasie 22 bedoel word, moet aan die volgende vereistes voldoen:

(1) Die wagkamer moet 'n vloeroppervlakte hê van minstens 12 m², met 'n minimum muurlengte van 3 m: Met dien verstande dat indien daar binne die wagkamer voorsiening ook vir die kantoorruimte gemaak word, die vloer van die wagkamer 'n oppervlakte moet hê van minstens 18 m², met 'n minimum muurlengte van 3,6 m.

(2) Die kantoorruimte moet—

(i) minstens 6 m² vloeroppervlakte beslaan indien 'n gedeelte van die wagkamer vir hierdie doel ingeruim is; of

(ii) verskaf word in die vorm van 'n afsonderlike vertrek met vloeroppervlakte van minstens 10 m² en met 'n minimum muurlengte van 2,4 m.

(3) Die spreekkamer moet, indien dit verskaf word, buite die operasieteater-area wees en moet 'n vloeroppervlakte hê van minstens 12 m², met 'n minimum muurlengte van 3 m, en moet toegerus wees met minstens een handewasbak met warm en koue water aangelê.

(4) Die operasieteater moet 'n vloeroppervlakte hê van minstens 20 m², met 'n minimum muurlengte van 3,6 m. Die mure moet minstens 2,6 m hoog wees, gemeet van die vloer tot by die plafon; en moet 'n aaneenlopende gladde oppervlak hê wat bedek is met harde glans-epoksieharpuis of 'n soortgelyke verf of met 'n ander geskikte wasbare, ondeurlatende materiaal; die plafon moet met 'n ligkleurige emaljeverf geverf wees. Die mure, die vloer en die plafon moet bestand wees teen herhaalde reiniging en ontsmetting.

(5) Warm en koue water moet aangelê word na elmboogkrane in die skropruimte bokant twee handewasbakke of trôe.

(6) Die operasieteater moet doeltreffend geventileer en verlig wees: Met dien verstande dat vensters, as daar is, stofdig moet wees. Die minimum vereiste vir lugreëling is dat 'n kantoortipe lugreëlaar met 'n 10-mikron-stoffilter geïnstalleer moet word.

(7) Die operasieteater moet van elektriese krag voorsien wees, met minstens drie vonkvrye muurproppe, 'n geskikte elektriese operasieteaterlamp wat van die plafon of van 'n vrydraende balk aan die muur hang, fasiliteite vir noodverligting in geval van 'n kragonderbreking, operasietafel wat die pasiënt minstens in die Trendelenburg-posisie kan plaas en, waar toepaslik, ook in ander posisies, na gelang van die operasies wat uitgevoer word.

(8) Die operasieteater moet toegerus wees met 'n geskikte suigapparaat (vir gebruik deur die chirurg en die narkotiseur afsonderlik) wat minstens twee suigpunte het en wat in staat is om slym en bloed tegelykertyd te verwyder. Daar moet ook voorsiening gemaak word vir noodfasiliteite van hierdie aard wat gebruik kan word ingeval die apparaat wat gewoonlik gebruik word, buite werking raak.

(9) Die operasieteater moet voorsien wees van geskikte pypleidings om suurstof en laggas vanaf 'n gasbank te lei, tensy sodanige gasse in silinders verskaf word. 'n Boyle-apparaat of 'n ander geskikte tipe narkoseapparaat met volledige aansluitings vir die pasiënt se asemweë moet verskaf word.

(10) Die steriliseerkamer moet 'n vloeroppervlakte van minstens 9 m² hê, met 'n minimum muurlengte van 3,0 m: Behalwe dat waar 'n losstaande operasieteatereenheid voor die afkondiging van hierdie regulasies op dieselfde perseel bedryf is en 'n steriliseerkamer

ACCOMMODATION

23. The rooms referred to in regulation 22 shall comply with the following requirements:

(1) The waiting-room shall have a floor area of not less than 12 m², with a minimum wall length of 3 m: Provided that if the office space is to be provided within the waiting-room the floor of the waiting-room shall have an area of not less than 18 m² and a minimum wall length of 3,6 m.

(2) The office space shall—

(i) have a floor area of not less than 6 m² if a portion of the waiting-room is set aside for this purpose; or

(ii) be provided in the form of a separate room, with a floor area of not less than 10 m² and a minimum wall length of 2,4 m.

(3) The consulting room, if provided, shall be outside the operating-theatre area and shall have a floor area of not less than 12 m² and a minimum wall lenght of 3 m and shall be fitted with at least one wash-hand basin with sufficient hot and cold water laid on.

(4) The operating-theatre shall have a floor area of not less than 20 m², and a minimum wall length of 3,6 m. The walls shall be not less than 2,6 m high, measured from the floor to the ceiling, and shall have a continuous, smooth surface and be painted with hard glossy epoxy resin or a similar paint or covered with any other washable impervious material; the ceiling shall be painted with a light-coloured enamel paint. The walls, the floor and the ceiling shall be capable of withstanding repeated cleansing and disinfection.

(5) In the scrubbing-up area, hot and cold water shall be laid on to elbow-operated taps over two wash-hand basins or troughs.

(6) The operating-theatre shall be effectively ventilated and lighted: Provided that windows if any, shall be dustproof. The minimum requirement for air conditioning shall be the installation of an office type conditioning unit with a 10 micron dust filter.

(7) The operating-theatre shall be provided with electric power to at least three flashproof wall plugs, a suitable electric operating-theatre lamp suspended from the ceiling or cantilevered from the wall, approved facilities for emergency lighting in the event of a power failure and an approved operating table capable of placing the patient at least in the Trendelenburg position and, where applicable, in other position as well, depending on the operations to be carried out.

(8) The operating-theatre shall be provided with suitable suction apparatus (for use by the Surgeon and the anaesthetist separately) with at least two suction points capable of effectively removing blood and mucus simultaneously. Provision shall also be made for emergency facilities of this kind which can be used if the apparatus that is normally used fails.

(9) The operating-theatre shall be provided with suitable piping for leading oxygen and nitrous oxide from a gas bank, unless such gases are supplied in cylinders. A Boyle's apparatus or other suitable type of anaesthetic apparatus with all the necessary connections for the patient's airways shall be provided.

(10) The sterilising room shall have a floor area of not less than 9 m² and a minimum wall length of 3,0 m. Save that where an unattached operating-theatre unit was conducted on the same premises prior to the promulgation of these regulations and a sterilising

wat 'n kleiner vloeroppervlakte het alreeds vir hierdie doel gebruik is, sodanige steriliseerkamer verder gebruik kan word.

(11) Die instrumente, komme, verbande, verbandtrommels/pakke, houers, water, ens., moet in die steriliseerkamer gesteriliseer word in 'n steriliseerapparaat, wat van een of meer van die volgende metodes gebruik kan maak:

(i) Stoom onder druk;
(ii) kookwater;
(iii) droë hitte;
(iv) 'n steriliseergas;
(v) enige ander metode:

Met dien verstande dat indien 'n stoomoutoklaaf gebruik word, die apparaat gemonteer moet word in 'n toereikend geventileerde masjienkamer buite, maar direk langsaan, die steriliseerkamer en die outoklaaf in die steriliseerkamer moet inwys: Met dien verstande, verder, dat indien gebruik gemaak word van 'n proses wat stoom, waterdamp of ander gasse voortbring, 'n geskikte apparaat vir die verwydering daarvan verskaf moet word.

(12) In plaas van 'n ingeboude steriliseerapparaat kan reëlings getref word dat die sentrale sterielevoorraaddepartement voldoende steriele verbande, doeke, komme, bakke, instrumente, spuite en steriele water verskaf vir alle operasies.

(13) (1) Die herstelkamer of -ruimte moet binne die afgebakende area wees, met 'n vloeroppervlakte van minstens 12 m² en 'n minimum muurlengte van 3 m. Dit moet toegerus wees met minstens een handewasbak met warm en koue water na elmboogkrane oor die handewasbak aangelê; minstens een vonkvrye muurprop; 'n draagbare lig wat na elke bed geneem kan word; 'n suigapparaat wat bloed en slym kan suig en wat elke bed kan bereik; 'n suurstoftoevoer, wat op so 'n wyse aangelê is dat daar by elke bed suurstof gelewer kan word; en geskikte resussiteer-apparaat. Verder moet daar fasiliteite wees om, indien nodig, die pasiënte af te skerm.

(2) 'n Storttregter en opwasbak moet in 'n geskikte area verskaf word.

(14) Die kleedkamer moet 'n vloeroppervlakte hê van minstens 7 m², met 'n minimum muurlengte van 2,1 m, met vonkvrye muurproppe en met minstens een handewasbak, met warm en koue water aangelê. Behalwe waar dit buite die kleedkamer verskaf is soos in regulasie 23 (3) bepaal, moet daar in elke kleedkamer spoeltoilette verskaf word op die grondslag van een vir elke agt persone, en sodanige spoellatrines moet afgeskort wees van die res van sodanige kleedkamer. Sodanige kleedkamer moet oor voldoende fasiliteite beskik waar klere en skoon en vuil teaterdrag afsonderlik gehou kan word. Sodanige kleedkamer moet een deur hê wat binne die rooilynarea oopmaak en moet 'n aparte ingang van buite die rooilynarea hê.

(15) Die saal moet 'n vloeroppervlakte hê van minstens 8 m² vir elke bed. Dit moet toegerus wees met minstens een vonkvrye muurprop en met 'n handewasbak, met warm en koue water aangelê na elmboogkrane.

(16) Die spoelkamer moet 'n vloeroppervlakte hê van minstens 5 m², met 'n minimum muurlengte van 2,1 m. Daar moet genoegsaam koue water aangelê wees na 'n spoelpan. Die spoelkamer moet toegerus wees met geskikte rakke van ondeurlatende materiaal vir skoon en ontsmette bedpanne en urinehouers, asook met houers van ondeurlatende materiaal met digsluitende deksels vir vuil linnegoed.

room with a smaller floor area was used for this purpose, such room may continue to be so used.

(11) The instruments, basins, dressings, dressing drums/packs, containers, water, etc., shall be sterilised in the sterilising room in an approved sterilising apparatus which may use one or more of the following methods:

(i) Steam under pressure;
(ii) boiling water;
(iii) dry heat;
(iv) a sterilising gas;
(v) any other approved method:

Provided that if a steam autoclave is used, the apparatus shall be mounted in an adequately ventilated machine room outside but immediately next to the sterilising room, with the autoclave facing into the sterilising room: Provided further that if the process used involves the production of steam, water vapour or other gases, a suitable apparatus for the effective removal thereof shall be provided.

(12) Instead of built-in sterilising apparatus, suitable arrangements may be made for an approved central sterile supply department to provide sufficient sterile dressings, towels, bowls, basins, instruments, syringes and sterile water for all operations.

(13) (1) The recovery room or area shall be in the demarcated area and shall have a floor area of not less than 12 m² and a minimum wall length of 3 m. It shall be fitted with at least one wash-hand basin to which hot and cold water shall be laid on to elbow-operated taps over the wash-hand basin, at least one flashproof wall plug, a portable lamp that can be taken to every bed, a suction apparatus which can effectively draw off blood and mucus and can reach every bed, a supply of oxygen so laid on that oxygen can be supplied to every bed and suitable resuscitation apparatus. In addition, facilities shall be provided for the screening-off of patients if inecessary.

(2) A slop hopper and sink shall be provided in a suitable area.

(14) The change room shall have a floor area of not less than 7 m² and a minimum wall length of 2,1 m and shall be fitted with flashproof wall plugs and at least one wash-hand basin to which hot and cold water is laid on. Unless provided outside the change room as provided in regulation 23 (3), flush toilets shall be provided in each change room on the basis of one for every eight persons, and such flush toilets shall be partitioned off from the rest of the change room. Such change room shall have adequate facilities where clothes and clean and soiled theatre clothing may be kept separately. Such change room shall have one door which opens inside the red line area and a separate entrance from outside the red line area.

(15) The ward shall have a floor area of not less than 8 m² for every bed. It shall be fitted with at least one flashproof wall plug and a wash-hand basin to which hot and cold water is laid on to elbow-operated taps.

(16) The sluice room shall have a floor area of not less than 5 m² and a minimum wall length of 2,1 m. Sufficient cold water shall be laid on to a sluice pan. The sluice room shall be fitted with suitable shelves of impervious material for clean and disinfected bed pans and urine containers, as well as receptacles of impervious material, with tight-fitting lids, for soiled linen.

(17) (i) Die opbergruimte vir vlambare materiaal moet 'n vloer hê wat met 'n wasbare, ondeurlatende materiaal bedek is; en

(ii) voorsiening moet gemaak word vir 'n geskikte linnekamer of linnekas vir skoon linnegoed; en

(iii) fasiliteite vir steriele opberging moet verskaf word.

(18) Die dienskamer moet 'n vloeroppervlakte hê van minstens 10 m², met 'n minimum muurlengte van 2,4 m. Dit moet langsaan die herstelkamer of -ruimte wees en tussen laasgenoemde en die saal (as daar 'n saal is), met 'n venster in die muur tussen die dienskamer en die herstelkamer of -ruimte en 'n venster in die muur tussen die dienskamer en die saal. Dit moet toegerus wees met warm en koue water aangelê na elmboogkrane oor 'n handewasbak, asook met 'n tafel met 'n blad van ondeurlatende materiaal, 'n koelkas en, tensy dit elders in die gebou verskaf word, ook 'n spoeltoilet en genoegsame rakke en kaste sodat klere, skoene en vuil oorklere afsonderlik gebêre kan word: Met dien verstande dat in plaas van 'n dienskamer daar binne die herstelkamer of -ruimte of die saal 'n diensstasie vir die verpleegster verskaf kan word, welke diensstasie toegerus moet wees met sodanige fasiliteite as wat vir hierdie doel nodig is.

MEUBELS EN TOERUSTING

24. In akkommodasie waar 'n losstaande operasieteatereenheid bedryf word, moet daar meubels en toerusting verskaf word, met inbegrip van fasiliteite vir die toediening van binneaarse vog en bloed, bloeddrukmeters, 'n stetoskoop, spuite en naalde, 'n sluitkas vir gewoontevormende medisyne, vergifte, ens., en 'n instrumentekas vir die operasieteater. Verder moet die operasieteatereenheid apparaat en instrumente bevat, met inbegrip van minstens twee laringoskope, McGill-tipe klemme vir volwassenes en kinders, geskikte endotragneale buise met die nodige verbindings, tongklemme, lugweë, 'n tragneostomiestel, 'n hartmasseringstel en defibrillator, asook middels om die pasiënt te ventileer ingeval die suurstoftoevoer onklaar raak, en ander toerusting en middels wat by 'n noodtoestand nodig mag wees.

PLIGTE VAN EIENAAR

25. Die eienaar van 'n losstaande operasieteatereenheid moet sorg dat—

(1) die akkommodasie waarin hy sy losstaande operasieteatereenheid bedryf, altyd in 'n skoon en netjiese toestand is;

(2) alle toerusting en instrumente altyd skoon en in 'n goeie en veilige werkende toestand is en, wanneer dit nie in gebruik is nie, netjies in die toepaslike bêreplek of kas gehou word;

(3) die steriliseerapparaat of -toerusting vir geen ander doel as sterilisering gebruik word nie, dat sodanige ander gebruik daarvan ook nie toegelaat word nie, en dat sodanige apparaat of toerusting gereeld getoets word vir doeltreffendheid en die bevinding aangeteken word in 'n register wat hy vir hierdie doel moet byhou;

(4) die operasieteater vir geen ander doel as dié van 'n operasieteater gebruik word en dat sodanige ander gebruik daarvan ook nie toegelaat word nie;

(5) 'n register bygehou word van alle kleinere chirurgiese ingrepe wat uitgevoer word en van alle monsters wat vir patologiese ondersoek weggestuur word;

(17) (i) The storage area for flammable material shall have a floor covered with a washable, impervious material;

(ii) a suitable linen room or cupboard for clean linen shall be provided; and

(iii) facilities for sterile storage shall be provided.

(18) The duty room shall have a floor area of not less than 10 m² and a minimum wall length of 2,4 m. It shall be next to the recovery room or area and between the latter and the ward, if any, with a window in the wall between the duty room and the recovery room or area and one in the wall between the duty room and the ward. It shall be equipped with hot and cold water laid on to elbow-operated taps over a washhand basin and a table with a top of impervious material, a refrigerator, and, unless provided elsewhere in the building, a flush toilet and sufficient shelves and lockers for keeping clothes, shoes and soiled gowns separately: Provided that instead of a duty room, a duty station may be provided for the nurse within the recovery room or area or the ward, and such station shall be equipped with such facilities as may be necessary for this purpose.

FURNITURE AND EQUIPMENT

24. In accommodation in which an unattached operating-theatre unit is being conducted, furniture and equipment shall be provided and shall include facilities for the administration of intravenous fluids and blood, sphygmomanometers, a stethoscope, syringes and needles, a lockable cupboard for habit-forming drugs, poisons, etc., and an instrument cupboard for the operating-theatre. In addition the operating-theatre unit shall contain sufficient suitable apparatus and instruments, including not less than two laryngoscopes, McGill-type forceps for adults and children, suitable endoctracheal tubes with the necessary connections, tongue forceps, airways, a tracheostomy set, a cardiac massage set and defibrillator, as well as means to ventilate the patient if the oxygen supply fails, and other equipment and materials that may be required for emergencies.

DUTIES OF PROPRIETOR

25. The proprietor of an unattached operating-theatre unit shall ensure that—

(1) the accommodation in which he conducts his unattached operating-theatre unit is always in a clean and tidy condition;

(2) all equipment and instruments are always clean and in good and safe working order, and are kept tidily in the appropriate storage place or cupboard when not in use;

(3) any sterilising apparatus or equipment is not used or permitted to be used for any other purpose than sterilisation and that it is regularly tested for effectiveness and the results recorded in a register which he shall maintain for this purpose;

(4) the operating-theatre is not used or permitted to be used for any other purpose than as an operating-theatre;

(5) a register is kept of all minor surgical operations performed and all specimens forwarded for pathological examination;

(6) 'n gelyste stof ingevolge die Wet op die Beheer van Medisyne en Verwante Stowwe, 1965 (Wet 101 van 1965), en 'n gevaarhoudende stof ingevolge die Wet op Gevaarhoudende Stowwe, 1973 (Wet 15 van 1973), gebêre word slegs in sluitkaste wat vir die doel aangehou word;

(7) daar geen gordyne in die operasieteater of steriliseerkamer hang of opgehang word nie;

(8) daar geen tapyte of enige los bedekkingsmateriaal op die vloer van die operasieteater of die steriliseerkamer, of 'n saal of dienskamer of pasiënteruimte is of geplaas word, en dat geen plakpapier teen mure van pasiënt- of behandelingsruimtes gebruik word nie; en verder dat sodanige mure vry bly van aangeplakte kennisgewings, papier en soortgelyke materiaal wat skoonmaak belemmer;

(9) 'n kamer waarvan die mure, vloer of plafon tekens van klammigheid toon, nie as pasiëntakkommodasie gebruik word nie;

(10) instrumente en toerusting te alle tye skoon, netjies en in goeie en veilige werkende toestand is en, wanneer dit in die behandeling van pasiënte gebruik word, vóór gebruik behoorlik, soos wat nodig is, ontsmet of gesteriliseer word;

(11) solank daar 'n pasiënt in die operasieteatereenheid is, geen deure wat toegang tot die eenheid verleen, gesluit word nie;

(12) die spoelkamer nie gebruik word of die gebruik daarvan toegelaat word vir enige doel nie, behalwe die bewaring en skoonmaak van bedpanne, urinebottels en soortgelyke houers, en die uitspoel en opberging van vuil linnegoed, verbande en ander afval, totdat dit verwyder word; dat geen ander plek behalwe die spoelkamer vir die opberging en skoonmaak van sodanige artikels gebruik word nie, en dat die gebruik van geen sodanige ander plek vir sodanige doel toegelaat word nie;

(13) daar in elke spoelkamer altyd behoorlike houers van ondeurlatende materiaal en met digsluitende deksels beskikbaar is vir vuil linnegoed, verbande en ander afval;

(14) die inhoud van houers vir vuil verbande en afvalweefsels minstens twee keer per dag verwyder en doeltreffend weggedoen word;

(15) alle bedpanne en urinehouers, nadat dit gebruik is, sonder versuim geledig, skoon uitgespoel en dan ontsmet word;

(16) 'n toereikende aantal vuilgoedhouers van ondeurlatende materiaal en met digsluitende deksels in goeie toestand beskikbaar is; dat hulle nooit oopstaan nie; dat die inhoud van sodanige houers minstens een keer per dag doeltreffend en sonder om 'n oorlas te veroorsaak, weggedoen word; en dat sodanige houers nadat hulle leeggemaak is, behoorlik gewas en ontsmet word;

(17) die vloere van die vertrekke wat vir die losstaande operasieteatereenheid gebruik word, minstens een keer per dag skoongemaak word en dat alle vuilgoed in vuilgoedhouers geplaas word;

(18) ingeval die vloere nie antistaties is nie, 'n toepaslike waarskuwing op 'n opvallende plek geplaas word;

(19) benodigdhede, byvoorbeeld seep, 'n geskikte naelborsel en handedroogmaakfasiliteite, altyd beskikbaar is by elke handewasbak in die losstaande operasieteatereenheid;

(20) 'n geregistreerde verpleegster of geneesheer of tandarts altyd teenwoordig is (afgesien van die geregistreerde verpleegsters of geneeshere in die operasieteater) solank daar in die herstelkamer of -ruimte 'n pasiënt is wat nie by sy volle bewussyn is nie;

(6) any scheduled substance in terms of the Medicines and Related Substances Control Act, 1965 (Act 101 of 1965), and any hazardous substance in terms of the Hazardous Substances Act, 1973 (Act 15 of 1973), shall be stored only in lockers kept for the purpose;

(7) no curtains hang or are hung in the operating-theatre or the sterilising room;

(8) no carpets or any loose covering materials are on or are laid on the floor of the operating-theatre or the sterilising room or any ward or duty room or patient area; that there is no wall paper against the walls of patient or treatment areas and further that all walls are kept free from affixed notices and paper or similar material which impede cleaning;

(9) any room showing dampness in the walls, floor or ceiling is not used for patient accommodation;

(10) instruments and equipment shall at all times be kept clean, tidy and in good and safe working condition and, if used in the treatment of patients, shall be effectively disinfected or sterilised, as may be required, prior to such use;

(11) while there is a patient in the operating-theatre unit, no doors affording admission to the unit are locked;

(12) the sluice room is not used for any purpose other than the storage and cleansing of bed pans, urine bottles and similar containers, and the rinsing and depositing of soiled linen, dressings and other waste, until their removal, and that no place other than the sluice room is used for the storage and cleansing of such items;

(13) in each sluice room proper receptacles of impervious material, and with tight-fitting lids, are always available for soiled linen, dressings and other waste;

(14) the contents of receptacles for soiled dressings and waste tissues are removed at least twice a day and effectively disposed of;

(15) after use all bed pans and urine containers, are immediately emptied, rinsed clean and then disinfected;

(16) an adequate number of refuse receptacles of impervious material, with tight-fitting lids in good condition, are available; that they are never left open; that the contents of such containers are effectively disposed of at least once daily, without causing a nuisance, and that such containers are properly washed and disinfected after they have been emptied;

(17) the floors of the rooms used for the unattached operating-theatre unit are cleaned at least once a day and that all refuse is emptied into refuse receptacles;

(18) in the event of the floors not being antistatic, an appropriate warning is prominently displayed;

(19) requisites such as soap, a suitable nail brush and hand-drying facilities are always available at every wash-hand basin in the unattached operating-theatre unit;

(20) A registered nurse or medical practitioner or dentist (apart from the registered nurses in the operating-theatre) is always present as long as there is a patient not fully conscious in the recovery room or area;

(21) solank daar 'n bedpasiënt binne die gebied van die losstaande operasieteatereenheid is, die dienste van ten minste 'n ingeskrewe verpleegster geredelik beskikbaar is;

(22) dat die onderskeie kamers en ruimtes gebruik word slegs vir die doeleindes waarvoor hulle goedgekeur is;

(23) dat alle dienste en maatreëls wat oor die algemeen vir die genoegsame sorg en die veiligheid van die pasiënte nodig is, gehandhaaf en nagekom word;

(24) aseptiese beginsels ten volle nagekom word in die behandeling van pasiënte;

(25) alle handewasbakke vir pasiënte, personeel en besoekers bevredigend toegerus is met skoonmaakmateriaal en droogmaakfasiliteite;

(26) doeltreffende plaagbeheer toegepas word;

(27) die rioleerstelsel en die stormwaterdreineerstelsel onderhou word in ooreenstemming met die vereistes van die betrokke plaaslike bestuur;

(28) die kosware op die perseel gehanteer, gehou, opgeberg en voorberei word in ooreenstemming met openbare gesondheidstandaarde en die regulasies van die betrokke plaaslike bestuur;

(29) genoegsame noodfasiliteite vir verligting en vir die instandhouding van essensiële toerusting en dienste verskaf en onderhou word;

(30) geen ongemagtigde persone toegang het tot die pasiënterekords nie en dat die privaatheid en belange van die pasiënte beveilig word;

(31) daar by die operasieteatereenheid 'n "Geen toegang"-teken aangebring word; en

(32) 'n afskrif van hierdie regulasies in 'n leesbare toestand, en behoorlik bygehou, op die perseel beskikbaar gehou word.

26. Die eienaar moet ondergenoemde afsonderlike registers, waar toepaslik, byhou of laat byhou:

(a) 'n Register, wesentlik in die vorm van Aanhangsel D, van die algemene mediese en chirurgiese pasiënte wat toegelaat word;

(b) 'n register, wesentlik in die vorm van Aanhangsel E, van die bevallingspasiënte wat toegelaat word en van die geboortes;

(c) 'n register, wesentlik in die vorm van Aanhangsel F, van alle pasiënte wat in 'n operasieteater behandel word;

(d) 'n register, wesentlik in die vorm van Aanhangsel G, van alle buitepasiënte of ongevallepasiënte wat behandel word;

(e) 'n register, soos die Sekretaris verlang, van alle pasiënte met aansteeklike siektes en van enige ander spesiale klas pasiënt; en

(f) 'n register, wesentlik in die vorm van Aanhangsel H, van die verpleegpersoneel.

27. Geen eienaar mag in 'n private hospitaal meer pasiënte opneem of behandel of die opneming of behandeling aldaar toelaat van meer pasiënte as die getal waartoe daar in die registrasiesertifikaat magtiging verleen word nie. Die Sekretaris mag toestemming verleen om meer pasiënte op te neem of te behandel in gevalle van nood of waar hy daarvan oortuig is dat ander hospitaalfasiliteite nie beskikbaar is nie.

28. Elke eienaar moet binne 15 dae na die einde van elke maand aan die Sekretaris 'n opgawe verstrek of laat verstrek waarin aangedui word met welke getal pasiënte die getal waartoe daar in die registrasiesertifikaat magtiging verleen word, daagliks gedurende die maand oorskry is en wat, in elke geval, die redes vir sodanige oorskryding is.

(21) whenever there is a bedpatient on the premises of an unattached operating-theatre unit the services of at least an enrolled nurse are readily available;

(22) the various rooms or areas are used only for the purposes for which they have been approved;

(23) all services and measures generally necessary for adequate care and safety of patients are maintained and observed;

(24) aseptic principles are fully observed in the treatment of patients;

(25) all wash-hand basins for patients, staff and visitors are satisfactorily provided with cleansing materials and drying facilities;

(26) effective pest control is exercised;

(27) sewerage and storm-water drainage systems are maintained in conformity with the requirements of the local authority concerned;

(28) foodstuffs are handled, kept, stored and prepared on the premises in conformity with public health standards and the regulations of the local authority concerned;

(29) adequate stand-by facilities for lighting and for the maintenance of vital equipment and services are provided and maintained;

(30) no unauthorised person has access to patient records and that the privacy and interests of patients are safeguarded;

(31) a "No Entry" sign is affixed to the operating-theatre unit; and

(32) a copy of these regulations, in a legible condition and up to date, is kept available on the premises.

26. The proprietor shall keep or cause to be kept the following separate registers, where applicable:

(a) A register of general medical and surgical patients admitted, substantially in the form of Annexure D;

(b) a register of maternity patients admitted and of deliveries, substantially in the form of Annexure E;

(c) a register of all patients treated in any operating theatre, substantially in the form of Annexure F;

(d) a register of outpatients or casualty patients treated, substantially in the form of Annexure G;

(e) a register as required by the Secretary, of patients with infections diseases, or any other special class of patient; and

(f) a register of the nursing staff, substantially in the form of Annexure H.

27. No proprietor shall admit to or treat in or allow to be admitted to or treated in any private hospital more patients than the number authorised by the certificate of registration. The Secretary may give permission for more patients to be admitted or treated in emergencies or if he is satisfied that no other hospital facilities are available.

28. Every proprietor shall within 15 days of the end of each month furnish or cause to be furnished to the Secretary a return showing the number of patients exceeding daily during the month the number authorised by the certificate of registration and the reasons for such excess in each case.

29. Elke eienaar moet sonder versuim aan die Sekretaris sodanige opgawes en inligting verstrek as wat die Sekretaris van tyd tot tyd vereis met betrekking tot die beheer oor en bestuur van die betrokke private hospitaal, die geriewe, voorrade of personeel waaroor dit beskik, die dienste wat daarin gelewer word en die pasiënte wat daarin behandel of verpleeg word.

PRIVATE HOSPITALE

30. *Akkommodasie en fasiliteite.*

'n Privatehospitaal moet bedryf word op 'n perseel waar daar genoegsame en bevredigende voorsiening vir die volgende gemaak is:

(a) Een of meer verpleegeenhede, met inbegrip van—

(i) beddens in sale of kamers vir die behandeling van pasiënte;

(ii) 'n dienskamer of verpleegsterskantoor wat so geleë is dat die fisiese toegang tot geen sorgbehoewende pasiënt verhinder of vertraag word nie;

(iii) bad- en toiletfasiliteite vir pasiënte;

(iv) 'n behandelings- of verbandkamer;

(v) afsonderlike opbergplek vir linne, farmaseutiese benodigdhede, saaltoerusting, die besittings van die pasiënte en sodanige diverse items as wat nodig is vir die bestuur van die verpleegeenheid;

(vi) 'n spoelkamer;

(vii) fasiliteite vir die skoonmaak en opberg van skoonmaaktoerusting en -materiaal;

(viii) saalkombuis; en

(ix) aansluitende gange;

(b) 'n kamer of kamers wat toereikend vir administratiewe beheer, navrae, die toelating van pasiënte en die opberging van rekords is, wat afsonderlik is van die dienskamer van 'n verpleegeenheid en wat aan die personeel toegang bied sonder dat hulle deur die pasiënteruimtes beweeg;

(c) 'n hoofkombuis;

(d) pakkamers vir massa-opberging;

(e) ruskamer- en toiletfasiliteite vir die personeel;

(f) wagkamer- en toiletfasiliteite vir die besoekers;

(g) steriele voorrade;

(h) 'n apteek of farmaseutiese diens, of die onmiddellike beskikbaarstelling van alle benodigde farmaseutiese produkte;

(i) 'n wassery of die verskaffing van skoon linne;

(j) 'n lykshuis of die onmiddellike verwydering van 'n lyk; en

(k) 'n verbrandingsoond of ander geskikte stelsel vir die doeltreffende en onskadelike wegdoen van besoedelde verbandmateriaal en van chirurgies verwyderde weefsels.

31. *Addisionele fasiliteite.*

Een of almal van ondergenoemde fasiliteite kan, na gelang van die behoeftes van die pasiënte wat by sodanige hospitaal toegelaat of opgeneem word, ooreenkomstig hierdie regulasies verskaf word en moet aldus verskaf word indien dit as onontbeerlik beskou word of deur die Sekretaris vereis word:

(a) 'n Operasieteatereenheid;

(b) 'n afsonderlike verloskundige eenheid;

(c) ontvangs- en behandelingsfasiliteite vir buitepasiënte en/of ongevalle;

(d) sentrale steriliseerfasiliteite;

(e) akkommodasie en fasiliteite vir werknemers;

(f) fasiliteite vir—

(i) radiologie en verwante diagnostiese doeleindes;

(ii) fisioterapie;

(iii) arbeidsterapie;

(iv) elektrokonvulsiewe eenheid;

29. Every proprietor shall without delay furnish to the Secretary such returns and information as the Secretary may from time to time require in relation to the control and management of the private hospital concerned, the facilities, stores or staff at its disposal, the services rendered therein and the patients receiving treatment or nursing care therein.

PRIVATE HOSPITALS

30. *Accommodation and facilities.*

A private hospital shall be conducted on premises where adequate and satisfactory provision has been made for—

(a) one or more nursing units, including—

(i) beds in wards or rooms for the treatment of patients;

(ii) a duty room or nurses' station so placed that physical access to any patient requiring care is not impeded or delayed;

(iii) bath and toilet facilities for patients;

(iv) a treatment or dressings room;

(v) separate storage space for linen, pharmaceuticals, ward equipment, patients' belongings and such sundry items as may be necessary for the management of the nursing unit;

(vi) a sluice room;

(vii) facilities for the cleansing and storage of cleaning equipment and materials;

(viii) a ward kitchen; and

(ix) connecting corridors;

(b) a room or rooms, adequate for administrative control, enquiries, admission of patients and storage of records, which shall be separate from the duty room of a nursing unit and accessible to the staff without their having to pass through patient areas;

(c) a main kitchen;

(d) stores for bulk storage;

(e) a rest-room and toilet facilities for staff;

(f) a waiting area and toilet facilities for visitors;

(g) sterile supplies;

(h) a dispensary, or a pharmacy service, or facilities for making all necessary pharmaceutical products available without delay;

(i) a laundry or a supply of clean linen;

(j) a mortuary or provision for the immediate removal of any dead body; and

(k) an approved incinerator or other suitable system for the effective and innocuous disposal of soiled dressings and surgically removed tissues.

31. *Additional facilities.*

Depending on the requirements of patients admitted or treated at such hospital, any or all of the following facilities may be provided, in accordance with these regulations, and, where deemed indispensable or required by the Secretary, shall be thus provided:

(a) An operating-theatre unit;

(b) a separate maternity unit;

(c) reception and treatment facilities for outpatients and/or casualties;

(d) central sterilising facilities;

(e) accommodation and facilities for employees;

(f) facilities for—

(i) radiology and allied diagnostic purposes;

(ii) physiotherapy;

(iii) occupational therapy;

(iv) electro-convulsive treatment;

(v) psigoterapie;

(vi) enige spesiale ondersoek of behandeling;

(vii) die opleiding van verpleegsters, mediese praktisyns en lede van aanvullende mediese gesondheidsdienste;

(viii) die mediese ondersoek van werknemers;

(ix) die opleiding van werknemers in noodhulp;

(g) enige ander fasiliteite.

32. *Algemene bouvereistes.*

Behalwe waar hierdie regulasies 'n ander vereiste stel, is die volgende bouvereistes van toepassing op alle private hospitale:

(1) Die mure van die operasieteatereenheid en van die verloskundige eenheid moet minstens 2,6 meter hoog wees, gemeet van die vloer tot by die plafon, en moet gebou word van ondeurlatende materiaal.

(2) Die voeg tussen die vloer en die mure moet in die operasieteatereenheid, in die verloskundige eenheid, en in alle toilette, badkamers en spoelkamers, asook orals anders waar nodig, sodanig gerond wees dat doeltreffende skoonmaak moontlik is.

(3) Elke gang of deurgang wat vir pasiënte gebruik word moet minstens 2 meter wyd wees en waar pasiënte binne die operasieteatereenheid of verloskundige eenheid geskuif word, moet die gang minstens 2,5 meter wyd wees.

(4) Al die vertrekke moet voldoende verlig en geventileer word.

(5) Stofdigte plafonne van 'n gladde, ondeurlatende materiaal en geverf met 'n wit of ligkleurige wasbare verf moet aangebring word in alle pasiënteakkommodasie- en pasiëntebehandelingsruimtes.

(6) Die vloere van al die kamers en gange moet van beton of soortgelyke ondeurlatende materiaal wees, met 'n gladde afwerking, en, tensy hierdie regulasies anders bepaal, bedek word met 'n wasbare, ondeurlatende materiaal.

(7) Al die binnemuuroppervlakke moet bedek word met 'n gladde, harde pleisterafwerking met ronde hoeke en moet geverf word met 'n ligkleurige, duursame, wasbare verf of, so nie, bevredigend bedek word met 'n soortgelyke wasbare, ondeurlatende materiaal: Met dien verstande dat waar die mure geverf is, die mure agter die handewasbakke spesiaal met glasuurdeteëls of 'n spesiale wasbare, ondeurlatende materiaal bedek moet word tot 'n hoogte van ten minste 500 mm bo, en 'n afstand van ten minste 500 mm verby, die kante van sodanige handewasbakke sodat op hierdie wyse ondeurlatende afwerking verkry word wat met die verfwerk aaneenloop.

(8) Doeltreffend geplaaste en toereikende brandkrane, brandslange, brandblussers, brandtrappe en nooduitgange moet verskaf word en bevredigend onderhou word.

(9) Handewasbakke moet in die onmiddellike nabyheid van elke toilet, urinaal en spoelfasiliteit verskaf word.

33. *Pasiënte-akkommodasie.*

(1) In hierdie regulasie word elke vaste toebehoorsel vir die doeleindes van die bepaling van die minimum afmetings, geag as 'n muur of gedeelte van 'n muur of 'n kamer waarbinne 'n pasiënt geakkommodeer word.

(2) Geen pasiënt mag gehuisves word in 'n vertrek met 'n vloerruimte van minder as 10 m^2 per pasiënt nie of in 'n enkelvertrek waar daar nie die volgende minimum ruimte is nie:

(a) 0,9 m tussen elke sykant van die bed en die naaste muur aan sodanige sykant; en

(v) psychotherapy;

(vi) any special investigation or treatment;

(vii) training of nurses, medical practitioners and members of supplementary health service professions;

(viii) medical examination of employees;

(ix) training of employees in first aid;

(g) any other approved facilities.

32. *General structural requirements.*

Save where otherwise required in these regulations, the following structural requirements shall apply to all private hospitals:

(1) The walls of the operating-theatre unit and of the labour unit shall be not less than 3 m high, measured from the floor to the ceiling and constructed of impervious material.

(2) The joint between the floor and the walls shall be so rounded throughout the operating-theatre unit, labour unit, in all toilets, bathrooms and sluice rooms, and wherever else required, as to allow for effective cleaning.

(3) No corridor or passageway used for patients shall be less than 2 m wide and where patients are moved within the operating theatre unit or labour unit the corridor shall be at least 2,5 m wide.

(4) All rooms shall be satisfactorily lighted and ventilated.

(5) Dustproof ceilings of smooth, impervious material, painted with a white or light-coloured suitable washable paint, shall be provided throughout all patient accommodation and treatment areas.

(6) The floors of all rooms and corridors shall be of concrete or a similar impervious material brought to a smooth finish and, except where otherwise provided in these regulations, covered with a washable, impervious material.

(7) All interior wall surfaces shall be of a smooth, hard plaster finish with rounded corners, painted with a light-coloured durable washable paint or alternatively satisfactorily covered with a similar washable, impervious material: Provided that, where walls have been painted, the walls behind wash-hand basins shall be specially clad to a height of at least 500 mm above, and to a distance of at least 500 mm beyond the sides of, such wash-hand basins in glazed tiling or a special washable, impervious material so as to form an impervious finish continuous with the paintwork.

(8) Effectively placed and adequate fire-hydrants, fire-hoses, fire-extinguishers, fire-escapes and emergency exits shall be provided and satisfactorily maintained.

(9) Wash-hand basins shall be provided in the immediate vicinity of all toilets, urinals and sluices.

33. *Patient accommodation.*

(1) In this regulation any fixture shall, for purposes of determining minimum measurements, be regarded as a wall or part of a wall of a room in which a patient is accommodated.

(2) No patient shall be accommodated in any room with a floor area of less than 10 m^2 or in a single room where there is not a minimum space of—

(a) 0,9 m between any side of the bed and the nearest wall on that side; and

(b) 1,2 m tussen die voetenent van die bed en die teenoorgestelde muur.

(3) Geen pasiënt mag gehuisves word in 'n kamer met meer as een bed nie, tensy voorsiening gemaak is vir 'n minimum ruimte van—

(a) 0,75 m tussen elke sykant van elke bed en die naaste muur;
(b) 0,9 m tussen die sykante van elke twee aangrensende beddens nie; en
(c) 1,2 m tussen die voetenent van elke bed en die teenoorgestelde muur of 'n minimum van 1,5 m tussen die voetenent van 'n bed en die teenoorgestelde bed nie.

(4) Geen kind mag in 'n kinderkamer gehuisves word nie, tensy daar 'n minimum ruimte van—

(a) 0,75 m tussen elke twee aangrensende bababedjies is;
(b) 0,6 m tussen elke sykant van elke bababedjie en die naaste muur is; en
(c) 0,9 m tussen die voetenent van elke bababedjie en die teenoorgestelde muur is.

(5) Geen pasiëntekamer mag gebruik word vir die akkommodasie van sowel manlike as vroulike pasiënte nie, tensy al die pasiënte kinders is van 'n leeftyd van hoogstens tien jaar: Met dien verstande dat 'n pasiëntekamer gebruik kan word vir die gelyktydige akkommodasie van 'n man en sy vrou.

(6) Uitgesonderd die geval van 'n moeder en kind, moet kinders en volwassenes altyd in afsonderlike kamers geakkommodeer word: Met dien verstande dat in die gevalle waar afsonderlike akkommodasie van volwassenes en kinders onder tien jaar onprakties is met die oog op behandeling, daar voldoende tussenskotfasiliteite beskikbaar moet wees.

34. *Pasiëntekamers.*

(1) Elke pasiëntekamer in 'n private hospitaal moet direk verbind wees met 'n gang of deurgang.

(2) Deure wat toegang verleen tot kamers waarin pasiënte gehuisves is of sal word, moet ten minste 1,2 m wyd wees.

(3) Elke pasiëntekamer moet toegerûs wees met 'n handewasbak toegerus met elmboogkrane waarnatoe daar warm en koue water aangelê is.

(4) Elke pasiëntekamer moet geïdentifiseer word deur die volgende by die ingang aan te bring:

(a) Die nommer van die pasiëntekamer; en
(b) die getal beddens daarin.

35. *Bykomende fasiliteite.*

(1) (a) Waar twee of meer pasiëntekamers toiletfasiliteite deel of waar 'n pasiëntekamer met sy eie fasiliteite meer as agt beddens bevat, moet die volgende verskaf word:

(i) Ten minste een bad of stort per 12 pasiënte of gedeelte van sodanige getal: Met dien verstande dat die getalsverhouding van die baddens tot die storte in ooreenstemming moet wees met die funksie van die verpleegeenheid;
(ii) ten minste een toilet per 8 pasiënte of gedeelte van sodanige getal, maar in mansale kan elke derde toilet vervang word deur een urinaal; en
(iii) ten minste een handewasbak per 8 pasiënte of gedeelte van sodanige getal.

(b) Vir babas moet toereikende spesiale badfasiliteite verskaf word in direkte aansluiting met die kinderkamers.

(b) 1,2 m between the foot of the bed and the opposite wall.

(3) No patient shall be accommodated in a room with more that one bed unless provision is made for a minimum space of—

(a) 0,75 m between any side of any bed and the nearest wall;
(b) 0,9 m between the sides of any adjacent beds; and
(c) 1,2 m between the foot of any bed and the opposite wall or a minimum of 1,5 m between the foot of any bed and the opposite bed.

(4) No infant shall be accommodated in a nursery unless there is a minimum space of—

(a) 0,75 m between adjacent cots;
(b) 0,6 m between the side of any cot and the nearest wall; and
(c) 0,9 m between the foot of any cot and the opposite wall.

(5) No patient room shall be used for accommodation of both male and female patients, except when all patients are children not older than 10 years: Provided that a patient room may be used for the simultaneous accommodation of a husband and wife.

(6) Except in the case of a mother and child, children and adults shall always be accommodated in separate rooms: Provided that, where separate accommodation for adults and children under the age of 10 years is impractical for reasons of treatment, proper screening facilities shall be available.

34. *Patient rooms.*

(1) Each patient room in a private hospital shall communicate directly with a corridor or passageway.

(2) Doors giving access to rooms in which patients are or are to be accommodated shall be at least 1,2 m wide.

(3) Each patient room shall be provided with a wash-hand basin fitted with elbow-operated taps to which hot and cold water is laid on.

(4) Each patient room shall be identified by displaying at the entrance—

(a) the number of the patient room; and
(b) the approved number of beds therein.

35. *Ancillary facilities.*

(1) (a) Where several patient rooms share toilet facilities or where a patient room with its own facilities contains more than 8 beds, the following shall be provided:

(i) At least one bath or shower per 12 patients or part of such number, the proportion of baths to showers corresponding to the function of the nursing unit;

(ii) at least one toilet per 8 patients or part of such number, but in male wards a urinal may be substituted for every third toilet; and

(iii) at least one wash-hand basin per 8 patients or part of such number.

(b) Adequate special bathing facilities for babies shall be provided in direct conjuction with nurseries,

(2) (a) Die grootte en toerusting van die afdelingskombuis moet voldoende wees vir die grootte en funksie van die verpleegeenheid en vir die wyse waarop voedsel verskaf word.

(b) Die afdelingskombuis moet so geplaas wees dat dit geen oorlas veroorsaak nie.

(3) (a) Na gelang van die wyse waarop voedsel verskaf word, moet voldoende voorsiening vir die volgende gemaak word:

(i) Fasiliteite vir die ontvangs van aflewerings, opberging, voorbereiding en bediening van warm en koue voedsel aan pasiënte en personeel;

(ii) fasiliteite vir die verwydering, opwas en opberging van breekgoed en messegoed; en

(iii) fasiliteite vir die effektiewe uitlaat van stoom, rook, damp en hitte.

(b) Voldoende en behoorlike voorsiening moet vir die volgende gemaak word:

(i) Vullisdromme wat behoorlik leeg en skoongemaak kan word en toegerus is met 'n digsluitende deksel; en

(ii) handewasbakke vir kombuispersoneel.

(4) Geskikte kleedkamer-, ruskamer- en toiletfasiliteite moet vir die werknemers verskaf word en sodanige fasiliteite moet minstens van die standaard wees wat voorgeskryf word by die Wet op Fabrieke, Masjinerie en Bouwerk, 1941 (Wet 22 van 1941).

(5) Geskikte en doeltreffende wagkamers en toilet- en handewasbakke moet vir besoekers ingerig word.

OPERASIETEATEREENHEID IN 'N PRIVATE HOSPITAAL

36. *Algemene vereistes.*

'n Operasieteater moet die volgende insluit:

(a) Een of meer operasieteaters met toegang slegs deur een kamer, area, deurgang of gang, wat duidelik binne die rooilyn area is, en wat so beplan en ingerig is dat toereikende beheer uitgeoefen kan word oor alle persone en materiaal wat sodanige kamer, area, deurgang of gang binnegaan;

(b) en verder binne die rooilyn area—

(i) toereikende steriele-pakkamers en stelkamers;

(ii) 'n skroparea buitekant die operasieteater maar aangrensend daarby en met bevredigende toegang daartoe: Met dien verstande dat, behoudens die aanbeveling van die Direkteur met betrekking tot spesiale dienste in die teater aangebied, die Sekretaris verlof kan verleen dat sodanige skroparea binne die teater geleë mag wees;

(iii) 'n herstelkamer of -ruimte waar pasiënte toereikend geakkommodeer kan word vir naoperatiewe verpleegwaarneming, wat onmiddellik toeganklik is vir 'n mediese praktisyn en wat beskik oor voldoendo resussiteer- en noodfasiliteite;

(iv) 'n steriele verskaffingseenheid: Met dien verstande dat 'n gedeelte van die fasiliteite van sodanige eenheid so afgeskort kan word dat dit buite die afgemerkte area is;

(v) 'n spoelkamer wat slegs die teater of teaters bedien: Met dien verstande dat, indien 'n spesiale pomp benodig is waarvandaan die operasieteater of teaters skoongemaak kan word, sodanige spoelkamer nie binne die afgemerkte area mag wees nie maar so geleë moet wees dat dit 'n toegangsdeur slegs vanaf sodanige gang het;

(2) (a) The size and equipment of the ward kitchen shall be adequate for the size and function of the nursing unit and for the mode of food supply.

(b) The ward kitchen shall be placed so as not to cause a nuisance.

(3) (a) Depending on the mode of food supply, adequate provision shall be made for—

(i) facilities for taking delivery, storing and preparing hot and cold food, and serving such food to patients and staff;

(ii) facilities for the removal, washing-up and storage of crockery and cutlery;

(iii) facilities for the effective extraction of steam, smoke, vapour and heat.

(b) Adequate and suitable provision shall be made for—

(i) garbage bins which can be properly emptied and cleaned and which are provided with close-fitting lids; and

(ii) wash-hand basins for kitchen staff.

(4) Suitable change room, rest room and toilet facilities for the various categories of staff shall be provided and such facilities shall be of a standard no lower than that laid down in the Factories, Machinery and Building Work Act, 1941 (Act 22 of 1941), as amended.

(5) Suitable and adequate waiting rooms, toilets and wash-hand basins shall be provided for visitors.

OPERATING-THEATRE UNIT IN A PRIVATE HOSPITAL

36. *General requirements.*

An operating-theatre unit shall include the following:

(a) One or more operating-theatres with access only through a room, area, passageway or corridor which is clearly demarcated and so planned and fitted that adequate control can be exercised over all persons and materials which enter such room, area, passageway or corridor;

(b) and further within the demarcated area—

(i) adequate sterile pack and setting rooms;

(ii) a scrubbing-up area outside, adjacent and with satisfactory access to the operating-theatre: Provided that, subject to the recommendation of the Director with regard to any special purposes to be served by the operating theatre, the Secretary may permit such scrubbing-up area to be situated within the operating theatre;

(iii) a recovery room or area where patients can be adequately accommodated for post-operative nursing surveillance, which is immediately accessible to a medical practitioner and which has sufficient resuscitation and emergency facilities;

(iv) a sterile supply unit: Provided that a portion of the facilities of such unit may be screened off so as to fall outside the demarcated area;

(v) a sluice room to serve the theatre or theatres only: Provided that, where a special corridor is provided from which cleaning of the operating theatre or theatres can be effected, such sluice room shall not be situated within the demarcated area, but shall be so placed as to have an access door from such corridor only;

(vi) voldoende kleedkamerfasiliteite, met direkte toegang tot die afgemerkte area, vir mediese praktisyns, verpleegsters en huishoudelike personeel: Met dien verstande dat daar vir pasiënte wat nie gebruik maak van saalakkommodasie nie, bykomende verkleefasiliteite verskaf moet word;

(vii) 'n oorplaasarea, vir die oorplasing van pasiënte van saaltrollies of na teatertrollies toe, by die pasiënte-ingang van die afgemerkte area;

(viii) 'n verpleegstersdienskamer of -stasie wat so geleë, gebou en toegerus is dat dit vir die verpleegpersoneel moontlik is om die pasiënte regstreeks en doeltreffend waar te neem en om, waar nodig, bystand aan die pasiënte te verleen;

(ix) indien ligte verversings voorgesit gaan word, moet voldoende fasiliteite verskaf word vir die opberging, voorbereiding en bediening van sodanige verversings;

(x) skoonmakerfasiliteite; en

(xi) afsonderlike opbergkamers, of voldoende geskikte bergingskaste in die plek daarvan, vir die opberging van skoon linne, medisyne, toerusting en diverse items.

37. *Afmetings.*

'n Operasieteater moet oor die volgende beskik:

(a) 'n vloeroppervlakte van minstens 30 m²;

(b) 'n muurhoogte van minstens 3 m;

(c) 'n wydte van minstens 5,1 m; en

(d) 'n area, direk by die operasieteater, waar die instrumente gestel kan word.

38. *Vloer.*

(1) Die vloer van 'n operasieteater moet van 'n ondeurlatende materiaal wees, gelê sonder oop gedeeltes en met alle lasplekke opgevul ten einde 'n aaneenlopende ondeurlatende bedekking te verskaf en so afgewerk dat die muurbedekking en vloerbedekking saamgevoeg is in 'n aaneenlopende gladde oppervlak sonder openinge.

(2) In 'n operasieteater, tensy daar 'n antistatiese vloerbedekking gelê is, moet daar by die ingang van sodanige teater 'n waarskuwende kennisgewing aangebring word en op 'n opvallende plek vertoon word ten effekte dat die vloer van sodanige teater nie antistaties is nie en dat plofbare narkosemiddels, gasse of skoonmaakmiddels nie binne sodanige teater gebruik mag word nie.

39. *Installasies.*

By elke teater moet die volgende verskaf word:

(a) 'n Toereikende pypleidingtoevoer van suurstof en distikstofoksied;

(b) 'n toereikende beligtingstelsel;

(c) 'n lugreëlingstelsel toegerus met filters wat doeltreffend is vir deeltjies met 'n grootte van vyf mikron en wat 'n genoegsame vermoë het om 'n temparatuur van tussen 20° C en 22° C asook 'n relatiewe voggehalte van tussen 45 en 55 persent, te handhaaf;

(d) 'n toereikende en bevredigende meganiese suigstelsel met ten minste twee suigpunte;

(e) toereikende fasiliteite vir 'n noodtoevoer van suurstof en distikstofoksied, noodbeligting en noodsuiging in die geval van meganiese, elektriese of ander onderbreking tydens 'n operasie;

(f) elektriese krag by ten minste drie vonkvrye muurproppe;

(g) 'n operasietafel waarop 'n pasiënt geposisioneer kan word na gelang van die vereistes van die operasie wat gedoen moet word.

(vi) suitable change-room facilities with direct access to the demarcated area, for medical practitioners, nursing and domestic staff: Provided that additional change facilities shall be provided for patients not utilising ward accommodation;

(vii) a transfer area for the transfer of patients from ward trolleys to theatre trolleys across the demarcated area;

(viii) a nurses' duty room or station which is so situated, constructed and fitted that it is possible for the nursing staff to observe patients directly and render assistance to patients where necessary;

(ix) if light refreshments are to be served, suitable facilities for storing, preparing and serving such refreshments;

(x) cleaners' facilities; and

(xi) separate store rooms, or sufficient suitable storage cupboards in lieu thereof, for the storage of clean linen, medicines, equipment and sundry items.

37. *Dimensions.*

Any operating-theatre shall have—

(a) a floor area of not less than 30 m²;

(b) a wall height of not less than 3 m;

(c) a width of not less than 5,1 m; and

(d) an instrument setting area immediately off the operating-theatre.

38. *Floor.*

(1) The floor of any operating-theatre shall be of impervious material, laid without open interstices and with jointing filled in so as to provide a continuous impervious covering, and so finished that the wall covering and the floor covering are joined in a continuous smooth surface without interstices.

(2) In an operating-theatre, unless anti-static flooring has been laid and maintained in conformity with the specifications of the South African Bureau of Standards, there shall be affixed and prominently displayed at the entrance to such theatre a cautionary notice to the effect that the floor of such theatre is not anti-static and that explosive anaesthetic agents, gases or cleaning agents are not to be used within such theatre.

39. *Installations.*

At every theatre there shall be provided—

(a) an adequate piped-gas supply of oxygen and nitrous oxide;

(b) an adequate lighting system;

(c) an air-conditioning system fitted with filters effective for five micron size particles and with sufficient capacity to maintain a temperature of between 20 °C and 22 °C and a relative humidity of between 45 and 55 per cent;

(d) an adequate and satisfactory mechanical suction system, with at least two suction points;

(e) satisfactory facilities for an emergency supply of oxygen and nitrous oxide, emergency lighting and emergency suction in the event of mechanical, electrical or other failure during an operation;

(f) electric power to at least three flash-proof wall plugs; and

(g) an approved operating table on which the patient can be positioned according to the requirements of the operation to be performed.

40. *Gange binne operasieteatereenhede.*

'n Onbelemmerde wydte van minstens 2,5 m moet vir die pasiëntetrollies gehandhaaf word in die gange en deurgange van 'n operasieteatereenheid.

41. *Skroparea binne operasieteatereenheid.*

(1) 'n Skroparea moet 'n wydte van minstens 2,1 m hê en moet so toegerus wees dat dit drie persone in staat stel om, voordat hulle die teater binnegaan, tegelykertyd onbelemmerd en afsonderlik te skrop onder warm en koue water uit elmboogkrane oor goedgekeurde spatvrye bakke of 'n goedgekeurde dreineertrog, en om teaterdrag aan te trek.

(2) Waar die gebruik van die operasieteater beperk word tot die prosedures in Bylae A opgeneem, word bevredigende voorsiening vir die gelyktydige afsonderlike skrop van slegs twee persone beskou as voldoende vir die doel van hierdie regulasie.

42. *Herstelarea binne operasieteatereenhede.*

(1) Die herstelkamer of -ruimte moet binne die afgemerkte area wees en 'n vloeroppervlak van minstens 12 m² hê en 'n muurlengte van minstens 3 m en moet voldoende spasie verskaf vir ten minste een pasiënt uit elke operasieteater wat bedien word, bereken op 'n basis van 9 m² onbelemmerde vloeroppervlak per pasiënt.

(2) Die herstelkamer of -ruimte moet met die volgende toegerus wees:

(a) 'n Goedgekeurde handewasbak voorsien van warm en koue water, beheer met 'n elmboogkraan;

(b) 'n voldoende suurstoftoevoer vir elke pasiënt wat geakkommodeer word;

(c) 'n genoegsaam verstelbare vasstaande of draagbare lamp vir elke herstelbed of hersteltrollie;

(d) 'n toereikende en bevredigende meganiese suigstelsel met een suigpunt vir elke herstelbed of hersteltrollie;

(e) twee vonkvrye elektriese kragpunte vir elke herstelbed of hersteltrollie; en

(f) fasiliteite om afskortings tussen pasiënte op te rig.

43. *Sterielevoorraadeenheid.*

(1) Die sterielevoorraadeenheid moet 'n vloeroppervlakte hê van minstens 12 m² en 'n muurlengte van minstens 3,0 m asook 'n toereikende vrye vloeroppervlak.

(2) Die sterielevoorraadeenheid moet toereikend toegerus wees om die instrumente, materiale, verbandpakke, bakke, houers, water en diverse items vir gebruik in verband met die behandeling wat verskaf word, afsonderlik te ontvang, skoon te maak, te verpak, te steriliseer en op te berg.

(3) Indien 'n stoomoutoklaaf gebruik word, moet dit gemonteer word in 'n toereikend geventileerde en toeganklike masjienkamer buitekant die steriliseer-area en onmiddellik aangrensend daarby en moet die outoklaaf in sodanige area oopmaak: Met dien verstande dat indien 'n steriliseerproses wat gebruik word, die voortbrenging van stoom, waterdamp of ander gasse behels, 'n geskikte metode verskaf moet word vir die doeltreffende verwydering daarvan.

(4) Die bepalings van hierdie regulasie belet nie die eienaar om, met toestemming van die Sekretaris en behoudens sodanige voorwaardes as wat die Sekretaris vasstel, 'n goedgekeurde sentrale sterielevoorraaddepartement op te rig en te onderhou nie, om sodoende steriele voorrade aan alle pasiënte-akkommodasie- en behandelingsareas van die hospitaal te verskaf.

40. *Corridors within operating-theatre units.*

An unobstructed width of not less than 2,5 m shall be maintained for patient trolleys in corridors and passageways within any operating-theatre unit.

41. *Scrubbing-up areas within operating-theatre units.*

(1) Any scrubbing-up area shall have a width of not less than 2,1 m and shall be so fitted as to permit both unhindered separate simultaneous scrubbing-up by three persons under hot and cold running water from elbow-operated taps over splash-limiting basins or a drainage trough and gowning prior to entering the operating-theatre.

(2) Where the use of the operating theatre is limited to the procedures listed in Annexure A, satisfactory provision for simultaneous separate scrubbing-up by two persons only will be deemed sufficient for the purposes of this regulation.

42. *Recovery areas within operating-theatre units.*

(1) The recovery room or area shall be inside the demarcated area and shall have a floor area of not less that 12 m² and a wall length of not less than 3 m, and shall provide sufficient space for a least one patient from each operating-theatre which it serves, calculated on a basis of 9 m² of unobstructed floor area per patient.

(2) The recovery room or area shall be fitted with—

(a) a wash-hand basin to which hot and cold water is laid on to elbow-operated taps;

(b) a sufficient supply of oxygen for each patient to be accommodated;

(c) a sufficiently adjustable fixed or portable lamp for every recovery bed or trolley;

(d) an adequate and satisfactory mechanical suction system with one suction point for every recovery bed or trolley;

(e) two flash-proof electric power outlets for every recovery bed or trolley; and

(f) facilities for screening off patients.

43. *Sterile supply unit.*

(1) The sterile supply unit shall have a floor area of not less than 12 m², a wall length of not less than 3,0 m and adequate free floor area.

(2) The sterile supply unit shall be adequately equipped separately to receive, clean, pack, sterilise and store instruments, materials, dressings, basins, containers, water and sundry items used in connection with the treatment provided.

(3) If a steam autoclave is used, it shall be mounted in an adequately ventilated and accessible machine room outside and immediately adjacent to the sterilising area, with the autoclave opening into such area: Provided that, if any sterilising process used involves the production of steam, water vapour or any other gases, a suitable means for the effective removal thereof shall be provided.

(4) The provisions of this regulation shall not preclude any proprietor from establishing and maintaining, with the consent of the Secretary, and subject to such conditions as the Secretary may impose, an approved central sterile supply department in order to provide adequate sterile supplies to all patient accommodation and treatment areas of the hospital.

44. *Dienskamer binne operasieteatereenhede.*

(1) Die teaterdienskamer moet 'n vloeroppervlakte hê van minstens 10 m² en 'n minimum muurlengte van 2,4 m en moet so geleë en gebou wees dat die doeltreffende bewaking van die pasiënte moontlik is: Met dien verstande dat in plaas van 'n dienskamer 'n toereikende diensstasie verskaf kan word.

(2) Die teaterdienskamer of -stasie moet toegerus wees met sodanige fasiliteite as wat nodig is vir die doel waarvoor sodanige dienskamer of -stasie gebruik word.

45. *Spoelkamer van operasieteatereenhede.*

'n Teaterspoelkamer moet 'n vloeroppervlakte hê van minstens 5 m² en 'n muurlengte van minstens 2,1 m² en moet met die volgende toegerus wees:

(a) 'n Spoelpan;
(b) toereikende rakke vir die opberging van skoon houers;
(c) 'n vlekvrystaal-opwasbak met warm en koue water; en
(d) 'n handewasbak met warm en koue water.

46. *Kleedkamers van operasieteatereenhede.*

'n Teaterkleedkamer moet 'n toereikende grootte hê, moet 'n vloeroppervlakte van minstens 9 m² 'n muurlengte van minstens 2,1 m² hê en moet met die volgende toegerus wees:

(a) 'n Handewasbak met warm en koue water;
(b) geskik afgeskorte toilette op die basis van een toilet vir elke agt lede van die teaterpersoneel of gedeelte van sodanige getal;
(c) toereikende fasiliteite vir die afsonderlike bewaring van persoonlike klere en besittings, skoon teaterdrag en gebruikte teaterdrag; en
(d) 'n storthokkie met 'n droë aantrekarea.

VERLOSKUNDIGE EENHEID

47. *Algemene vereistes.*

'n Verloskundige eenheid sluit in—

(a) een of meer verpleegeenhede ooreenkomstig hierdie regulasies;
(b) toereikende verplegingfasiliteite;
(c) 'n melkkombuis, indien meer as 15 beddens vir moeders verskaf word;
(d) 'n pasiëntevoorbereidingskamer, indien meer as 15 beddens vir moeders verskaf word;
(e) 'n kraamkamer bestaande uit—

(i) 'n bevallingskamer of -kamers op die basis van een bevallingskamer vir elke 10 beddens vir moeders, of een bevallingskamer plus 'n kamer vir pasiënte in die eerste stadium van bevalling vir elke 15 beddens vir moeders;
(ii) bykomende dienste met inbegrip van—

(aa) 'n spoelkamer met voorsiening vir die bewaring, ondersoek en wegdoen van plasentas; en
(bb) afsonderlike opbergfasiliteite vir steriele pakke en instrumente, linne, medisyne en diverse toerusting.

(f) waar meer as 15 beddens vir moeders verskaf word en geen operasieteaterfasiliteite geredelik beskikbaar is nie, moet daar voorsiening gemaak word vir 'n operasieteatereenheid wat geskikte teaterfasiliteite bied.

48. *Bevallingskamer.*

(1) 'n Bevallingskamer moet 'n vloeroppervlakte hê van minstens 16 m² en 'n wydte van minstens 3,7 m.

44. *Duty rooms within operating-theatre units.*

(1) The theatre duty room shall have a floor area of not less than 10 m² and a minimum wall length of 2,4 m and shall be so situated and constructed as to make effective patient surveillance possible: Provided that an adequate duty station may be provided instead of a duty room.

(2) The theatre duty room or station shall be equipped with such facilities as may be necessary for the purpose, for which such theatre duty room or station is used.

45. *Sluice rooms of operating-teatre units.*

A theatre sluice room shall have a floor area of not less than 5 m² and a minimum wall length of 2,1 m, and shall be fitted with—

(a) a sluice pan;
(b) adequate shelving for storing clean containers;
(c) a stainless steel wash-up basin with hot and cold water; and
(d) a wash-hand basin with hot and cold water.

46. *Change rooms of operating-theatre units.*

Any theatre change room shall be of adequate size and shall have a floor area of not less than 9 m² and a minimum wall length of 2,1 m, and shall be provided with—

(a) a wash-hand basin to which hot and cold water is laid on;
(b) suitably partitioned off toilets on the basis of one toilet for every eight members of the theatre staff or part of such number;
(c) adequate facilities for the separate keeping of personal clothes and effects, clean theatre clothing and used theatre clothing; and
(d) a shower cubicle with a dry change area.

MATERNITY UNIT

47. *General requirements.*

A maternity unit shall include—

(a) one or more nursing units, in accordance with these regulations;
(b) adequate nursery facilities;
(c) a milk kitchen, if more than 15 mother beds are provided;
(d) a patients' preparation room, if more than 15 mother beds are provided;
(e) a labour unit consisting of—

(i) a delivery room or rooms on the basis of one delivery room for every 10 mother beds, or one delivery room plus a room for patients in the first stage of labour for every 15 mother beds;

(ii) ancillary services, including—

(aa) a sluice room with provision for storing, examining and disposing of placentas; and
(bb) separate storage facilities for sterile packs and instruments, linen, medicines and sundry equipment;

(f) where more than 15 mother beds are provided and no operating-theatre facilities are readily available, provision shall be made for an operating-theatre unit with sufficient suitable theatre facilities.

48. *Delivery rooms.*

(1) Any delivery room shall have a floor area of not less than 16 m² and a minimum width of 3,7 m.

(2) 'n Bevallingskamer moet ook oor die volgende beskik:

(a) Toereikende skropfasiliteite;
(b) 'n toereikende, verstelbare lamp, vasstaande of draagbaar;
(c) 'n antistatiese vloer indien plofbare verdowingsgasse gebruik word;
(d) voldoende voorsiening vir suurstof; en
(e) toereikende fasiliteite vir die resussiteer van babas.

ALGEMEEN

49. Geen gebou van 'n private hospitaal of losstaande operasieteatereenheid of gedeelte van sodanige gebou mag uitgebrei, gesloop of andersins struktureel of funksioneel verander word sonder die skriftelike goedkeuring van die Sekretaris nie. 'n Eienaar wat sodanige goedkeuring verlang, moet skriftelik daarom aansoek doen en elke sodanige aansoek moet—

(1) vergesel gaan van gedetailleerde planne en spesifikasies; en

(2) die redes vir die beoogde uitbreiding, sloping of verandering volledig uiteensit.

VERANDERINGS

50. Die houer van 'n registrasiesertifikaat moet toesien dat daar tydens die geldigheidsduur van die registrasiesertifikaat wat aan hom uitgereik is, geen strukturele of ander veranderings wat met die goedgekeurde planne strydig is, sonder die vooraf verkreë skriftelike goedkeuring van die Sekretaris, verleen in oorleg met die Direkteur, aangebring word nie.

VERTONING VAN REGULASIES BY PRIVATE HOSPITALE EN LOSSTAANDE OPERASIETEATEREENHEDE

51. Die houer van 'n registrasiesertifikaat moet die registrasiesertifikaat in regulasie 14 (1) en 14 (3) vermeld, asook 'n eksemplaar van hierdie regulasies, op 'n ooglopende plek op die perseel waarop dit betrekking het, aanbring en onderhou of laat aanbring en laat onderhou. Die eksemplaar van die regulasies moet altyd leesbaar en op datum wees.

INSPEKSIES

52. Die Sekretaris kan 'n private hospitaal of losstaande operasieteatereenheid te eniger tyd en so dikwels as wat hy dit nodig ag, inspekteer of deur 'n inspekterende beampte laat inspekteer.

53. Die eienaar van 'n private hospitaal of losstaande operasieteatereenheid of 'n ander persoon wat vir die bestuur daarvan of beheer daaroor verantwoordelik is of wat in bevel van die verplegingsdienste daarvan is, moet aan die persoon wat ingevolge hierdie regulasie as inspekterende beampte optree, alle inligting verstrek wat sodanige beampte verlang betreffende die organisasie en bestuur van sodanige private hospitaal of losstaande operasieteatereenheid en betreffende die akkommodasie, verpleging en behandeling van pasiënte. Al die registers, kliniese rekords, en ander rekords in verband met pasiënte en personeel moet vir die doel van sodanige inspeksie beskikbaar gestel word.

54. Niemand mag 'n inspekterende beampte in enige opsig in die uitvoering van sy inspeksie strem nie; of weier om inligting wat deur sodanige beampte gevra word, na sy beste wete te verstrek nie; of weier om enige apparaat of plek of ding te wys of om enige kas oop te sluit nie.

(2) Any delivery room shall also contain the following:

(a) Adequate scrubbing-up facilities;
(b) an adequate adjustable lamp, fixed or mobile;
(c) an anti-static floor if explosive anaesthetic gases are to be used;
(d) adequate provision for oxygen; and
(e) adequate baby resucitation facilities.

GENERAL

49. No building of any private hospital or unattached operating-theatre unit or any portion of such building shall be extended, demolished or otherwise structurally or functionally altered without the written approval of the Secretary. Any proprietor wishing to obtain such approval shall apply therefor in writing and every such application shall—

(1) be accompanied by detailed plans and specifications; and

(2) set out in full the reasons for the proposed extension, demolition or alteration.

ALTERATIONS

50. The holder of a certificate of registration shall ensure that, during the currency of any certificate of registration issued to him, no structural or other alterations not in accordance with the approved plans are made without the prior written approval of the Secretary, granted in consultation with the Director.

DISPLAYING OF REGULATIONS AT PRIVATE HOSPITALS AND UNATTACHED OPERATING-THEATRES

51. The holder of a certificate of registration shall display and maintain or cause to be displayed and maintained in a conspicuous place on the premises to which such certificate relates, the registration certificate mentioned in regulation 14 (1) and 14 (3) as well as a copy of these regulations. Such copy of these regulations shall always be in a legible condition and shall be up to date.

INSPECTIONS

52. The Secretary may at any time, and as often as he may deem necessary, inspect or have inspected by an inspecting officer any private hospital or unattached operating-theatre unit or order such inspection.

53. The proprietor of a private hospital or unattached operating-theatre unit or any other person responsible for the management or control thereof or who is in charge of the nursing services thereof shall render to the inspecting officer in terms of these regulations all or any information the said officer may require in regard to the organisation and management of such private hospital or unattached operating-theatre unit and the accommodation, nursing and treatment of the patients. All registers, clinical records and any other records in connection with patients and staff shall also be available for inspection.

54. No person shall in any way obstruct any inspecting officer carrying out his inspection or refuse to furnish to the best of his knowledge any information requested by such officer or to show any apparatus or place or thing or to unlock any cupboard.

55. Die Sekretaris kan te eniger tyd die eienaar van sodanige hospitaal of losstaande operasieteatereenheid by skriftelike kennisgewing aansê om, binne 'n redelike tyd wat in die kennisgewing vermeld word, sodanige strukturele veranderings of sodanige verbeterings in verband met die organisasie of bestuur van voornoemde private hospitaal of losstaande operasieteatereenheid aan te bring of sodanige toerusting aan te skaf of te vervang of sodanige gebreke reg te stel as wat in bedoelde kennisgewing vermeld word.

APPÈL

56. Die eienaar of voornemende eienaar van 'n private hospitaal of losstaande operasieteatereenheid kan skriftelik by die Minister appelleer teen enige besluit wat die Sekretaris ingevolge 'n bepaling van hierdie regulasies geneem het met betrekking tot sodanige eienaar of voornemende eienaar, na gelang van die geval, van 'n private hospitaal of losstaande operasieteatereenheid.

57. 'n Appèl ingevolge regulasie 56 moet aangeteken word binne sewe dae nadat die besluit waarteen geappelleer word onder die aandag van die eienaar of voornemende eienaar, na gelang van die geval, gekom het en moet duidelik vermeld—

(1) teen watter besluit sodanige appèl aangeteken word; en

(2) op watter gronde sodanige appèl aangeteken word.

58. 'n Appèl ingevolge hierdie regulasies word ingelewer by die Sekretaris, wat dit, tesame met sy redes vir die besluit waarteen daar geappelleer word, aan die Minister voorlê.

59. Die Minister kan die besluit wat die Sekretaris ingevolge die bepalings van hierdie regulasie geneem het, bekragtig, wysig of herroep, en die eienaar of voornemende eienaar van 'n private hospitaal of losstaande operasieteatereenheid skriftelik van sy besluit in kennis stel.

MISDRYWE EN STRAFBEPALINGS

60. 'n Persoon wat—

(1) 'n private hospitaal of losstaande operasieteatereenheid instel, uitbrei, bedryf, onderhou, bestuur of beheer of 'n diens daarin lewer terwyl sodanige private hospitaal of losstaande operasieteatereenheid nie ingevolge die bepalings van hierdie regulasies geregistreer is nie; of

(2) die bestaande geboue van 'n private hospitaal of losstaande operasieteatereenheid of 'n gedeelte van sodanige geboue uitbrei, sloop of struktureel verander of die gebruik daarvan wysig sonder die vooraf verkreë skriftelike goedkeuring van die Sekretaris; of

(3) die eienaar is van, of in diens is by, 'n private hospitaal of losstaande operasieteatereenheid en wat—

(i) versuim of weier om aan die Sekretaris, of aan 'n persoon wat namens hom handel, toegang tot sodanige hospitaal of losstaande operasieteatereenheid te verleen vir die doel van 'n inspeksie ingevolge regulasie 54; of

(ii) versuim om aan die bepalings van regulasie 55 te voldoen; of

(iii) die Sekretaris, of 'n persoon wat namens hom handel, in die uitvoering van sy pligte ingevolge regulasie 54 verhinder of belemmer.

55. The Secretary may at any time direct the proprietor of such hospital or unattached operating-theatre unit by notice in writing to effect within a reasonable period stated in the notice such structural alterations or such improvements in regard to the organisation or management of the said private hospital or unattached operating-theatre unit or to acquire or replace such equipment or to remedy such defects as may be specified in the said notice.

APPEALS

56. The proprietor or prospective proprietor of a private hospital or unattached operating-theatre unit may appeal in writing to the Minister against any decision made by the Secretary in terms of any provision of these regulations in respect of such proprietor or prospective proprietor, as the case may be, of a private hospital or unattached operating-theatre unit.

57. An appeal in terms of regulation 56 shall be lodged within seven days of the decision against which the appeal is made having come to the knowledge of the proprietor or prospective proprietor, as the case may be, and shall clearly state—

(1) against which decision such appeal is made; and

(2) the grounds on which such appeal is made.

58. Any appeal in terms of these regulations shall be lodged with the Secretary, who shall submit it to the Minister together with his reasons for the decision against which the appeal is being lodged.

59. The Minister may confirm, amend or rescind a decision taken by the Secretary in terms of the provisions of these regulations and inform the owner or prospective owner of a private hospital or unattached operating-theatre unit in writing of his decision.

OFFENCES AND PENALTIES

60. Any person who—

(1) establishes, extends, conducts, maintains, manages, controls or renders a service in any private hospital or unattached operating-theatre unit which is not registered as a private hospital or unattached operating-theatre unit in terms of the provisions of these regulations; or

(2) extends, demolishes or makes structural alterations to the existing buildings of a private hospital or unattached operating-theatre unit, or any portion or part of such buildings without the prior approval in writing of the Secretary; or

(3) is the proprietor of or is employed at a private hospital or unattached operating-theatre unit and who—

(i) fails or refuses to allow the Secretary, or any person acting on his behalf, access to such hospital for the purpose of an inspection in terms of regulation 54; or

(ii) fails to comply with the provisions of regulation 55; or

(iii) obstructs or hinders the Secretary or any person acting on his behalf in the performance of his duties in terms of regulation 54,

61. Iemand wat die bepalings van regulasie 60 oortree of versuim om daaraan te voldoen, is aan 'n misdryf skuldig en strafbaar—

(a) by 'n eerste skuldigbevinding, met 'n boete van hoogstens R500 of met 'n gevangenisstraf vir 'n tydperk van hoogsténs ses maande of met sowel daardie boete as daardie gevangenisstraf;

(b) by 'n tweede skuldigbevinding aan 'n soortgelyke misdryf, met 'n boete van hoogstens R1 000 of met 'n gevangenisstraf vir 'n tydperk van hoogstens een jaar of met sowel daardie boete as daardie gevangenisstraf; en

(c) by 'n derde of daaropvolgende skuldigbevinding aan 'n soortgelyke misdryf, met 'n boete van hoogstens R1 500 of met 'n gevangenisstraf vir 'n tydperk van hoogstens twee jaar of met sowel daardie boete as daardie gevangenisstraf.

62. *Vorms.*

Vir doeleindes van die Wet op Gesondheid, 1977 (Wet 63 van 1977), en die regulasies uitgevaardig, moet gebruik gemaak word van vorms wesenlik daarkragtens soos in die aanhangsels hiervan gespesifiseer.

HERROEPING VAN REGULASIE R. 1071 VAN 25 JUNIE 1971

63. Die bepalings van die regulasies vir losstaande operasieteatereenhede (Regulasie R. 1071 van 25 Junie 1971) word hierby herroep vir sover dit van toepassing is op losstaande operasieteatereenhede of daarop betrekking het.

(1) 'n Kennisgewing, bevel, besluit, goedkeuring, toestemming, magtiging, inligting of dokument uitgereik, geneem, verleen of verstrek en 'n ander handeling wat ingevolge 'n bepaling van hierdie regulasies uitgevoer is of by hierdie regulasies herroep is, geag word, indien dit nie onbestaanbaar is met die bepalings van hierdie regulasies nie, uitgereik, geneem, verleen, verstrek of uitgevoer te geword het ingevolge die ooreenstemmende bepalings van hierdie regulasies.

AANHANGSELS

Aanhangsel	Vorm	Onderwerp
A	—	Omvang van chirurgiese ingrepe uitgevoer in losstaande operasieteatereenhede
B	I	Aansoek om registrasie van 'n private hospitaal/losstaande operasieteatereenheid
C	II	Sertifikaat van registrasie van 'n private hospitaal/losstaande operasieteatereenheid
D	III	Register van pasiënte
E	IV	Bevallingsregister
F	V	Operasieteaterregister
G	VI	Ongevalle-en-buitepasiënteregister
H	VII	Register van verpleegpersoneel

Aanhangsel A

OMVANG VAN VOORGESKREWE PROSEDURES UITGEVOER IN LOSSTAANDE OPERASIETEATEREENHEDE

In losstaande operasieteatereenhede mag geen ingreep uitgevoer word nie tensy die nodige fasiliteite, toerusting en assistensie vir die ingreep, vir resussitasie en vir naoperatiewe sorg beskikbaar is nie.

Alle weefsel wat verwyder word, moet vir patologiese ondersoek gestuur word.

A. TANDHEELKUNDE

(1) Herstellende tandheelkunde.
(2) Verwydering van tande.
(3) Geringe mondchirurgie.

61. Any person who contravenes the provisions of regulation 60 or fails to comply with such provisions shall be guilty of an offence and liable—

(a) upon a first conviction, to a fine not exceeding R500 or to a term of imprisonment not exceeding six months or to both such fine and such term of imprisonment;

(b) upon a second conviction for a similar offence, to a fine not exceeding R1 000 or to a term of imprisonment not exceeding one year or to both such fine and such term of imprisonment; and

(c) upon a third or subsequent conviction for a similar offence, to a fine not exceeding R1 500 or to a term of imprisonment not exceeding two years or to both such fine and such term of imprisonment.

62. *Forms.*

The forms essentially as specified in the Annexures hereto shall be used for the purposes of the Health Act, 1977 (Act 63 of 1977), and the regulations made under the Act.

REPEAL OF REGULATION R. 1071 OF 25 JUNE 1971

63. The provisions of the regulations in respect of unattached operating-theatre units (Regulation R. 1071 of 25 June 1971) are hereby repealed in so far as they apply or relate to unattached operating-theatre units.

(1) Any notice, order, decision, approval, permission, authority, information or document issued, made, granted or furnished and any other action taken under any provision of these regulations or repealed by these regulations shall, if not inconsistent with the provisions of these regulations, be deemed to have been issued, made, granted, furnished or taken under the corresponding provisions of these regulations.

ANNEXURES

Annexure	Form	Subject
A	—	Scope of prescribed procedures carried out in unattached operating theatres
B	I	Application for registration as a private hospital/unattached operating-theatre unit
C	II	Certificate of registration in terms of Regulations No. of
D	III	Register of patients admitted
E	IV	Maternity register
F	V	Operating-theatre register
G	VI	Casualty and out-patients register
H	VII	Register of nursing staff

Annexure A

SCOPE OF PRESCRIBED PROCEDURES CARRIED OUT IN UNATTACHED OPERATING-THEATRES

In unattached operating-theatres no procedure shall be carried out unless the necessary facilities, equipment and assistance are available for such procedure, for resuscitation and for post-operative care.

All tissues removed shall be submitted for pathological analysis.

A. DENTISTRY

(1) Restorative dentistry.
(2) Removal of teeth.
(3) Minor oral procedures.

B. ALGEMENE CHIRURGIE

(1) Vratte.
(2) Besnyding.
(3) Hegting van wonde en pese.
(4) Insnyding van oppervlakkige absesse.
(5) Lediging van hematoom.
(6) Verwydering van vingernaels en toonnaels.
(7) Verwydering van oppervlakkige voorwerpe, maar slegs waar metodes van akkurate lokalisasie beskikbaar is.
(8) Sigmoïdoskopie en kolonoskopie.
(9) Verwydering van eenvoudige oppervlakkige tumors.
(10) Inspuiting hemoroïede en spatare.
(11) Abdominale parasentese.
(12) Rektale dilatasie (Lord).
(13) Spierbiopsie.

C. PSIGIATRIE

(1) Elektrokonvulsiewe terapie.
(2) Narkoanalise.
(3) Elektrostimulasie.
(4) Lumbaal- en sisternepunksie.

D. OPTOPEDIE

(1) Reduksie van eenvoudige frakture.
(2) Reduksie van eenvoudige dislokasies.
(3) Manipulasies.
(4) Aspirasie van gewrigte.
(5) Inspuitings in gewrigte.
(6) Artrografie.

E. OOR, NEUS EN KEEL

(1) Laringoskopie.
(2) Proefpunksie en sinusspoeling.
(3) Parasentese, met inbegrip van installering van plastiekbuisies en skoonmaak van ore onder algemene narkose.
(4) Kouterisering.
(5) Verwydering van vreemde voorwerpe en poliepe.
(6) Neusfraktuur.
(7) Tonsillektomie en adenoïdektomie.

F. GINEKOLOGIE EN OBSTETRIE

(1) Ondersoek onder narkose.
(2) Insnyding van Bartholin-sist.
(3) Uitwendige kering.
(4) Insit van intra-uteriene voorbehoedmiddel.
(5) Kouterisering van serviks.
(6) Endometriumbiopsie.
(7) Histerosalpingogram.
(8) Verwydering van servikale poliep.
(9) Vulvabiopsie.
(10) Hormooninplanting.
(11) Himenektomie.
(12) Dilatasie en kurettering.
(13) Diagnostiese laparoskopie.
(14) Sterilisering.

G. OOGHEELKUNDE

(1) Ondersoek van kinders onder narkose.
(2) Verwydering van vreemde voorwerpe in kornea.
(3) Sondering van traanbuise.
(4) Insnyding van Meibom-siste.
(5) Pterigium.

H. VELSIEKTES

(1) Diatermie en kurettering van vratte.
(2) Diatermie en kurettering van soolvratte.
(3) Diatermie en kurettering van verrucae acuminatae.
(4) Biopsie van vel of slymvlies deur middel van 'n insnyding of met behulp van 'n pons.
(5) Verwydering van goedaardige letsels deur middel van diatermie en kurettering of eksisie.
(6) Verwydering van kwaadaardige letsels deur middel van diatermie en kurettering of eksisie.
(7) Insnyding en dreineer van oppervlakkige abses.

I. UROLOGIE

(1) Sistoskopie.
(2) Uretradilatasie.
(3) Vasektomie.
(4) Testisbiopsie.
(5) Meatotomie.
(6) Besnydenis.
(7) Uretrakarunkels.
(8) Spermatokeel.

J. TORAKSCHIRURGIE

(1) Pleura-aspirasie en naaldbiopsie van pleura of long.
(2) Interkostale blok.
(3) Verwydering van oppervlakkige gewasse.
(4) Brongoskopie } met of sonder verwydering van vreemde
(5) Esofagoskopie } voorwerpe.
(6) Dilatasie van esofagus.

B. GENERAL SURGERY

(1) Warts.
(2) Circumcision.
(3) Stitching of wounds and tendons.
(4) Incision of superficial abscesses.
(5) Evacuation of haematoma.
(6) Removal of finger-nails and toe-nails.
(7) Removal of superficial foreign bodies, but only where methods for accurate localisation are available.
(8) Sigmoidoscopy and colonoscopy.
(9) Removal of simple superficial tumours.
(10) Injection of haemorrhoids and varicose veins.
(11) Abdominal paracentesis.
(12) Rectal dilations (Lord's).
(13) Muscle biopsy.

C. PSYCHIATRY

(1) Electroconvulsive therapy.
(2) Narcoanalysis.
(3) Electrostimulation.
(4) Lumbar and cisternal puncture.

D. ORTHOPAEDICS

(1) Reduction of simple fractures.
(2) Reduction of simple dislocations.
(3) Manipulations.
(4) Aspiration of joints.
(5) Injections into joints.
(6) Arthography.

E. EAR, NOSE AND THROAT

(1) Laryngoscopy.
(2) Proof puncture and sinus irrigation.
(3) Paracentesis, including insertion of grommets and toilet of ears under general anaesthetic.
(4) Cauterisation.
(5) Removal of foreign bodies and polyps.
(6) Fractured nose.
(7) Tonsillectomy and adenoidectomy.

F. GYNAECOLOGY AND OBSTETRICS

(1) Examination under anaesthetic
(2) Incision of Bartholin's cyst.
(3) External version.
(4) Insertion of intra-uterine contraceptive device.
(5) Cauterisation of cervix.
(6) Endometrial biopsy.
(7) Hysterosalpingogram.
(8) Excision of cervical polyp.
(9) Vulva biopsy.
(10) Hormone implantation.
(11) Hymenectomy.
(12) Dilatation and curettage.
(13) Diagnostic laparoscopy.
(14) Sterilisation.

G. OPTHALMOLOGY

(1) Examination of children under anaesthetic.
(2) Removal of corneal foreign bodies.
(3) Probing of tear ducts.
(4) Incision of Meibomian cysts.
(5) Pterygium

H. DERMATOLOGY

(1) Diathermy and curettage of warts.
(2) Diathermy and curettage of plantar warts.
(3) Diathermy and curettage of verrucae acuminatae.
(4) Biopsy of skin or mucous membrane by means of incision or punch.
(5) Removal of benign liesions by means of diathermy and curettage or excision.
(6) Removal of malignant lesions by means of diathermy and curettage or excision.
(7) Incision and drainage of superficial abscess.

I. UROLOGY

(1) Cystoscopy.
(2) Urethral dilatation.
(3) Vasectomy.
(4) Testis biopsy.
(5) Meatotomy.
(6) Circumcision.
(7) Urethal caruncles.
(8) Spermatocele.

J. THORACIC SURGERY

(1) Pleural aspiration and needle biopsy of pleura and lung.
(2) Intercostal block.
(3) Removal of superficial tumours.
(4) Bronchoscopy } with or without removal of foreign bodies.
(5) Oesophagoscopy }
(6) Dilatation of oesophagus.

K. NEUROCHIRURGIE

Soos by B, plus:

(1) Ondersoek onder narkose.
(2) Lumbaalpunksie en gepaardgaande prosedures soos intratekale fenol- of alkoholtoediening, spinale wortelblokkering, lugenkefalogram, miëlogram, medisynetoediening, spinale dreinering.
(3) Senuweeblokkering soos van ganglion Gasseri, oksipitale senuwee, ens.
(4) Angiografie deur middel van naald of kateter.
(5) Trageotomie.
(6) Aftap van ventrikels deur bestaande beengat (boorgat) of fontanelle of beenpunksie vir doel van dreinering of toediening van kontrasmedia of geneesmiddel.

L. PLASTIESE CHIRURGIE

Soos by B, plus:

(1) Plastiese reparasie van klein wonde.
(2) Manipulasie van neusfraktuur (onder plaaslike verdowing).
(3) Klein veltransplantate.
(4) Uitsny en herrangskikking van littekens (onder plaaslike verdowing).

M. INTERNE GENEESKUNDE

(1) Gastroskopie en duodenoskopie.
(2) Sigmoïdoskopie.
(3) Rektale biopsie.
(4) Sternale punksie.
(5) Diagnostiese parasentese van pleura en peritoneum.
(6) Inspuiting in senuweewortels en ganglia.
(7) Lumbaalpunksie.

Aanhangsel B
Vorm I

Departement van Gesondheid

Aansoek om registrasie as 'n *private hospitaal/losstaande operasieteatereenheid ingevolge Regulasie No. ..... van..... operasie van.

Die Sekretaris van Gesondheid
Privaatsak X88
PRETORIA
0001

Hiermee word aansoek gedoen om die registrasie van 'n *private hospitaal/*losstaande operasieteatereenheid, ten opsigte waarvan besonderhede vir die jaar eindigende op 31 Desember 19....., hieronder verstrek word.

1. Naam van *hospitaal/losstaande operasieteatereenheid .....

2. Ligging van die terrein (straat, lokaliteit, dorp).....

3. Naam en posadres van geregistreerde eienaar van die eiendom (perseel).....

4. Naam en adres van eienaar (in die geval van 'n maatskappy of assosiasie, sy benoemde verteenwoordiger) wat die *private hospitaal/losstaande teatereenheid sal bestuur.....

5. Naam en adres van die mediese praktisyn of geregistreerde verpleegster en verloskundige wat in beheer sal wees.....

6. Indien 'n mediese praktisyn in beheer sal wees, vermeld die naam en kwalifikasies van die geregistreerde verpleegster en verloskundige in beheer van die verpleegdiens.....

7. Hoeveelheid en toewysing van die beskikbare beddens vir pasiënte (sien aantekeninge hieronder):

K. NEUROSURGERY

As under B, plus, where applicable:

(1) Examination under an anaesthetic.
(2) Lumbar puncture and similar procedures such as intrathecal phenol or alcohol administration, spinal root block, air encephalogram, myelogram, drug administration and spinal drainage.
(3) Nerve block, e.g. Gasserian ganglion, occipital nerve, etc.
(4) Angiography—needle or catheter.
(5) Tracheotomy.
(6) Drainage of ventricles through existing burr hole or fontanelle or bone biopsy, for purposes of drainage or administration of contrast media or drugs.

L. PLASTIC SURGERY

As under B, plus, where applicable:

(1) Plastic repair of small wounds.
(2) Manipulation of nasal fracture (under local anaesthetic).
(3) Small skin transplants.
(4) Excision and repair of scars (under local anaesthetic).

M. MEDICINE

(1) Gastroscopy and duodenoscopy.
(2) Signoidoscopy.
(3) Rectal biopsy.
(4) Sternal puncture.
(5) Diagnostic paracentesis of pleura and peritoneum.
(6) Injection into nerve roots and ganglia.
(7) Lumbar puncture.

Annexure B
Form 1

Department of Health

Application for registration as a *private hospital/unattached operating-theatre unit in terms of Regulations No..... ..... of.....

The Secretary for Health
Private Bag X88
PRETORIA
0001

Application is hereby made for the registration of the followirg *private hospital/unattached operating-theatre unit, details of which are supplied below for the year ending 31 December 19.....

1. Name of *private hospital/unattached operating-theatre unit .....

2. Situation of premises (street, locality, town).....

3. Name and postal address of registered owner of the property (premises).....

4. Name and address of proprietor (in the case of a company or association, it's nominee) who will be conducting the *private hospital/*unattached operating-theatre unit.....

5. Name and address of the medical practitioner or registered nurse and midwife who will be in charge.....

6. If a medical practitioner will be in charge, name and qualifications of the registered nurse and midwife who will be in charge of the nursing services.....

7. Number and allocation of beds available for patients (see notes below).....

	Algemeen		Verloskunde		Aansteeklike siektes	Ander, spesifiseer	Totaal
	Volwassenes	Kinders	Moeders	Suigelinge			
Blankes.....							
Nie-Blankes.....							

	General		Maternity		Infectious diseases	Other (specify)	Total
	Adults	Children	Mothers	Babies			
Whites.....							
Non-Whites.....							

8. Hoeveelheid (a) Operasieteaters.....
(b) Bevallingskamers.....

9. Verandering (as daar is) van pasiënte-akkommodasie/-beddens gedurende die huidige jaar (spesifiseer).....

10. Hoeveelheid geregistreerde personeel *in diens op datum van aansoek/*wat in diens sal wees op datum van nuwe registrasie waarom aansoek gedoen word.....

8. Number of (a) operating-theatres.....
(b) delivery rooms.....

9. Changes in the patient accommodation/beds available during the current year, if any (specify).....

10. Numbers of registered staff *employed at date of application/*to be employed at date of new registration applied for:

		Praktisyns		Verpleegsters	
		Medies	Tandheelkundig	Geregistreer	Studente
Voltyds.....	Blank.....				
	Nie-Blank.....				
Deeltyds.....	Blank.....				
	Nie-Blank.....				

		Practitioners		Nurses	
		Medical	Dental	Registered	Student
Full-time.....	White.....				
	Non-White.....				
Part-time.....	White.....				
	Non-White.....				

11. Hoeveelheid voltydse ingeskrewe verpleegpersoneel *in diens op datum van aansoek/*wat in diens sal wees op datum van nuwe registrasie waarom aansoek gedoen word.

11. Number of full-time enrolled nurses *employed at date of application/*to be employed at date of new registration applied for:

		Ingeskrewe verpleegsters	Ingeskrewe student-verpleegsters	Ingeskrewe verpleegassistente	Ingeskrewe leerlingverpleegassistente
Voltyds.....	Blank.....				
	Nie-Blank.....				

		Enrolled nurses	Enrolled pupil nurses	Enrolled nursing assistants	Enrolled pupil nursing assistants
Full-time.....	White.....				
	Non-White.....				

12. Ander voltydse geregistreerde personeel in diens (as daar is) (spesifiseer).....

13. Ander deeltydse geregistreerde personeel in diens (as daar is) (spesifiseer).....

12. Other full-time registered staff employed (if any) (specify).....

13. Other part-time registered staff employed (if any) (specify).....

14. Indien die Verpleegstersraad die hospitaal erken as 'n opleidingsentrum vir verpleegsters, verloskundiges of ingeskrewe verpleegsters of ingeskrewe verpleegassistente-raad erken word—

(a)

Algemene verpleegster	Verloskundiges	Ingeskrewe verpleegsters	Ingeskrewe verpleegassistente
.....	.....	.....	.....

14. If the hospital is recognised by the Nursing Council as a training school for nurses, midwives or enrolled nurses or enrolled nursing assistants—

(a)

General nurses	Midwives	Enrolled nurses	Enrolled nursing assistants
.....	.....	.....	.....

(b) Indien die hospitaal erken word as 'n opleidingsentrum vir een of meer van die kategorieë van personeel in (a) hierbo vermeld, moet ondergenoemde inligting ook verstrek word:

Kategorie	Nommer van registrasie- of inskrywingssertifikaat deur die S.A.V.R. uitgereik	Datum van uitreiking
(i) Student- algemene-verpleegsters.....	.....	.....
(ii) Studentvroedvroue.....	.....	.....
(iii) Leerlingverpleegsters...	.....	.....
(iv) Verpleegassistente.....	.....	.....

Registrasie by die S.A.V.R. Meld:

	Nommer van oorspronklike sertifikaat	Datum van uitreiking	Jaarlikse registrasie	
			Kwitansienommer	Datum
Algemeen.....	.....	.....	.....	.....
Verloskundig.....	.....	.....	.....	.....
Ander.....	.....	.....	.....	.....

(c) Ander opgeleide personeel, met uitsluiting van die persoon in beheer.

(i) Geregistreerde verpleegsters/verloskundiges:

Naam	Kwalifikasies	Nommer van oorspronklike sertifikaat	Datum van uitreiking	Jaarlikse registrasie	
				Kwitansienommer	Datum
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....

(ii) Ingeskrewe verpleegsters:

....

Totaal..... .....

(ii) Ingeskrewe verpleegassistente:

....

Totaal..... .....

(b) If the hospital is recognised as a training school for one or more of the categories of nursing staff referred to in subsection (a), the following information should also be given:

Category	Number of registration or enrolment certificate issued by the S.A.N.C.	Date of issue
(i) Student general nurses.	.....	.....
(ii) Student midwives.....	.....	.....
(iii) Pupil nurses.....	.....	.....
(iv) Pupil nursing assistants	.....	.....

Registration with the S.A. Nursing Council (specify):

	Number of original certificate	Date of issue	Annual registration	
			Receipt number	Date
General.....	.....	.....	.....	.....
Midwifery.....	.....	.....	.....	.....
Other.....	.....	.....	.....	.....

(c) Other trained staff, excluding person in control.

(i) registered nurses/midwives.

Name	Qualifications	Number of original certificate	Date of issue	Annual registration	
				Receipt No.	Date
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....

(ii) Enrolled nurses:

....

Total..... .....

(iii) Enrolled nursing assistants:

....

Total..... .....

15. Reëlings vir die opleiding en onderrig van elk van ondergenoemde kategorieë, soos toepaslik:

(i) Studentverpleegsters.
(ii) Studentvroedvroue.
(iii) Leerlingverpleegsters.
(iv) Verpleegassistente.

Ek verklaar hierby dat bostaande gegewens waar en korrek is.

Plek.....
Datum.....

.....
Handtekening van eienaar

L.W.—Indien die beskikbare ruimte onvoldoende is, heg 'n aparte skedule aan.

Notas:

(a) *Woorde wat met 'n sterretjie aangedui word, moet deurgehaal word indien hulle nie van toepassing is nie.
(b) Hierdie vorm moet gebruik word vir die eerste en elke daaropvolgende aansoek om registrasie.
(c) Item 7: Die getalle beddens, bababedjies en wiegies wat werklik beskikbaar is om pasiënte te akkommodeer moet vermeld word, maar sluit die volgende uit:

Alle trollies;
alle wag-, voorbereidings, eerste-stadium- en bevallingskamerbeddens en bababedjies in die verloskundige eenheid;
die hersteltrollies en herstelbeddens van 'n operasieteatereenheid of 'n private hospitaal maar nie dié van 'n losstaande operasieteatereenheid nie, tensy die hersteltrollies of herstelbeddens gebruik word vir pasiënte-akkommodasie.

Aanhangsel C
Vorm 2

Sertifikaat No.....
Verwysing No.....

DEPARTEMENT VAN GESONDHEID

SERTIFIKAAT VAN REGISTRASIE INGEVOLGE REGULASIE No..... VAN.....

Hierby word gesertifiseer dat die.....
.....
.....
.....
geleë te.....
geregistreer is as 'n private hospitaal/losstaande operasieteatereenheid ingevolge die bepalings van Regulasie No.....
van..... vir 'n tydperk van.....maande eindigende.....
Naam van eienaar of besturende liggaam.....
.....
Adres van eienaar of besturende liggaam.....
.....
Naam van persoon aan die hoof.....
Maksimum getal pasiënte wat tegelykertyd opgeneem kan word
.....

Pasiënte wat tegelyk geakkommodeer word	Maksimum getal toegelaat	
	Blank	Nie-Blank
*Medies en chirurgies (a) Volwassenes.....	.....	.....
(b) Kinders....	.....	.....
Bevallings (a) Moeders.....	.....	.....
(b) Babas.....	.....	.....
Aansteeklike siektes.....	.....	.....
Ander (spesifiseer).....	.....	.....

Met uitsluiting van bogenoemde aktiwiteite word die werksaamhede van bogenoemde private hospitaal/losstaande operasieteatereenheid soos volg beperk:
Geteken te.....op hede die.....dag van..... 19.....

.....
Sekretaris van Gesondheid

Hierdie sertifikaat is nie oordraagbaar nie en moet jaarliks hernieu word.

* Skrap indien nie van toepassing nie.

15. Arrangements for the training and teaching of each of the following categories, as applicable:

(i) Student nurses.
(ii) Student midwives.
(iii) Pupil nurses.
(iv) Nursing assistants.

I hereby certify that the above particulars are true and correct.

Place.....
Date.....

.....
Signature of proprietor

**N.B.*—If available space is insufficient, attach separate schedule.

Notes:

(a) *Words designated by an asterisk to be deleted if not applicable.
(b) This form is to be used for the first and every subsequent application for registration.
(c) Item 7: The number of beds, cribs/cots actually available for accommodating patients are to be stated, but these exclude:

All trolleys;

All waiting, preparation, first stage and labour room beds and cots in maternity units;
The recovery trolleys and recovery beds of an operating-theatre unit of a private hospital, but not those of an unattached operating-theatre unit unless the recovery trolleys or beds are used for patient accommodation.

Annexure C
Form 2

Certificate No.....
Reference No.....

DEPARTMENT OF HEALTH

CERTIFICATE OF REGISTRATION IN TERMS OF REGULATIONS No..... OF.....

It is hereby certified that the.....
.....
situated at.....
is registered as a private hospital/unattached operating-theatre unit in terms of Regulations No.....of.....
for a period of..... months, ending.....
Name of proprietor or managing body.....
Address of proprietor or Managing Body.....
Name of person in charge .....
Maximum number of patients who may be admitted at the same time:

Patients to be accommodated simultaneously	Maximum number permitted	
	White	Non-White
*Medical and *surgical (a) Adults....	.....	.....
(b) Children..	.....	.....
*Maternity (a) Mothers.....	.....	.....
(b) Babies.....	.....	.....
Infectious diseases.....	.....	.....
Other (specify).....	.....	.....

With the exception of the above-mentioned activities, the activities of the above-mentioned *private hospital/*unattached operating-theatre unit are restricted as follows:
.....
.....
.....
Signed at.....this.....day of.....19.....

.....
Secretary for Health

This certificate is not transferable and must be renewed annually.

* Delete if not applicable.

Aanhangsel D
Vorm III

REGISTER VAN PASIENTE OPGENEEM

Reeksnommer	Pasiënt-registrasie-nommer	Datum opgeneem	Volle naam van pasiënt	Ouderdom	Geslag	Woon-adres	Diagnose/ Rede vir toelating	Naam van mediese praktisyn wat die pasiënt behandel	Finale diagnose	Datum		In geval van dood	
										Dood	Ontslag	Gesertifiseerde oorsaak	Deur wie gesertifiseer

Annexure D
Form III

REGISTER OF PATIENTS ADMITTED

Serial No.	Patient registration No.	Date admitted	Full name of patient	Age	Sex	Residential address	Diagnosis/ reason for admission	Name of Medical practitioner treating the patient	Final diagnosis	Date of		In case of death	
										Discharge	Death	Certified cause of death	By whom certified

Aanhangsel E
Vorm IV

BEVALLINGSREGISTER

Reeksnommer van geval .....
Datum opgeneem.....
Naam van pasiënt.....
Ouderdom.....
Ras.....
Adres.....
.....
.....
.....
(a) Getal vorige bevallings.....
(b) Getal vorige miskrame.....
(a) Datum van bevalling.....
(b) Datum van miskraam.....

Volle termyn, vroeggebore of miskraam? Indien miskraam, vermeld benaderde getal maande.....
Ligging.....
Duur van bevalling.....
Geslag van suigeling.....
Dood of lewend by geboorte.....
Komplikasies (as daar is) gedurende of na die bevalling.....
Mediese praktisyn (hoofletters).....
Handtekening.....
Vroedvrou (as daar is).....
Datum van vroedvrou se laaste besoek of datum van ontslag.....
.....
Toestand van moeder op daardie tydstip.....
Toestand van kind op daardie tydstip.....
Opmerkings.....
.....

Handtekening

Annexure E
Form IV

MATERNITY REGISTER

Serial number of case.....
Date admitted.....
Name of patient.....
Age.....
Race.....
Address.....
.....
.....
.....
(a) Number of previous confinements.....
(b) Number of previous miscarriages.....
(a) Date of confinement.....
(b) Date of miscarriage.....

Full-term, premature of miscarriage? If miscarriage, state approximate number of months.....
Presentation.....
Duration of labour.....
Sex of infant.....
Born alive or dead.....
Complications (if any) during or after labour.....
Name of medical practitioner (block letters).....
Signature.....
Midwife (if any).....
Date of midwife's last visit or date of discharge.....
.....
Condition of mother then.....
Condition of child then.....
Remarks.....
.....

Signature

Aanhangsel F
Vorm V

OPERASIETEATERREGISTER

Reeksnommer.....
Datum.....
Naam.....
Toelatingsregister No.....
Geslag.....
Ouderdom.....
Saal.....
Verdowingsmiddels.....
Narkotiseur.....
Chirurg.....
Assistent-chirurg.....
Operasie.....
Tyd van operasie: Van.....tot.....
Duur van operasie.....
Dreinering, ens.....
Teater.....
Handtekening van verpleegster by operasie.....
Handtekening van nasiener.....
Opmerkings (komplikasies, ongelukke, ens.).....

Annexure F
Form V

OPERATING-THEATRE REGISTER

Serial number.....
Date.....
Name.....
Admission reg. No.....
Sex.....
Age.....
Ward.....
Anaesthetics.....
Anaesthetist.....
Surgeon.....
Assistant surgeon.....
Operation.....
Time of operation: From.....to.....
Duration of operation.....
Drains etc.....
Theatre.....
Signature of nurse taking operation.....
Signature of co-checker.....
Remarks (complications, accidents, etc.).....

Reeks No.

Serial No.

Volle na
Nooiens
Identite
Geslag:
Ras...

Graa

Kwi
pleegst
Datun
No.

Kwi
vereni
Datun
No.
Datun
Datut
(9 Ma

Aanhangsel G
Vorm VI

ONGEVALLE-EN-BUITEPASIËNTEREGISTER

Reeks No.	Register No.	Datum	Tyd	Naam	Ouderdom	Geslag	Adres	Klagte/ Besering	Ontslag	Mediese praktisyn

Annexure G
Form VI

CASUALTY AND OUT-PATIENTS REGISTER

Serial No.	Register No.	Date	Time	Name	Age	Sex	Address	Complaint /Injury	Disposal	Medical practitioner

Aanhangsel H
Vorm VII

REGISTER VAN VERPLEEGPERSONEEL

Volle naam.....
Nooiensvan (indien toepaslik).....
Identiteitsnommer.....
Geslag..... Geboortedatum.....
Ras..... Nasionaliteit.....

PROFESSIONELE KWALIFIKASIES

Graad/Diploma/Sertifikaat	Registrasiesertifikaat	
	Datum	Nommer

Kwitansie van lopende registrasie/inskrywing by S.A. Verpleegstersraad.
Datum.....
No.....

Kwitansie van lopende lidmaatskap van S.A. Verpleegstersvereniging.
Datum.....
No.....
Datum van aanstelling.....
Datum van diensbeëindiging.....
(9 Maart 1979)

Annexure H
Form VII

REGISTER OF NURSING STAFF

Full name.....
Maiden name (if applicable).....
Identity number.....
Sex..... Date of birth.....
Race..... Nationality.....

PROFESSIONAL QUALIFICATIONS

Degree/Diploma/Certificate	Registration certificate	
	Date	Number

Receipt of current registration/enrolment with S.A. Nursing Council:
Date.....
Number.....

Receipt of current membership of S.A. Nursing Association:
Date.....
Number.....
Date of appointment.....
Date of termination of service.....
(9 March 1979)

KENNISGEWING 168 VAN 1979—NOTICE 168 OF 1979

DEPARTEMENT VAN DOEANE EN AKSYNS—DEPARTMENT OF CUSTOMS AND EXCISE

P. 5.01

VOORLOPIGE OPGAWE VAN HANDELSTATISTIEK VAN DIE REPUBLIEK VAN SUID-AFRIKA
PRELIMINARY STATEMENT OF TRADE STATISTICS OF THE REPUBLIC OF SOUTH AFRICA

Opmerking.—Syfers i.v.m. fisiese beweging van staafgoud is nie by die handelstatistiek ingesluit nie.
Remark.—Figures relating to the physical movement of gold bullion are not included in the trade statistics.

TYDPERK: JANUARIE 1979/PERIOD: JANUARY 1979

TABEL A.—TOTALE IN MILJOEN RAND VOLGENS WÊRELDSTREKE, SKEEPS- EN VLIEGTUIGVOORRADE EN ONGEKLASSIFISEERDE GOEDERE
TABLE A.—TOTALS IN MILLION RAND ACCORDING TO WORLD ZONES, SHIPS' AND AIRCRAFT STORES AND UNCLASSIFIED GOODS

Wêreldstreke—World zones	Invoere—Imports		Uitvoere—Exports	
	1979	1978	1979	1978
Afrika—Africa	14,3	18,5	41,0	35,0
Europa—Europe	333,3	289,8	328,5	270,1
Amerika—America	124,6	94,2	86,2	109,0
Asië—Asia	90,6	75,3	129,4	84,2
Oseanië—Oceania	4,0	5,3	3,5	5,8
Ander ongeklassifiseerde goedere—Other unclassified goods	0,5	1,5	0,3	0,1
Skeeps-/Vliegtuigvoorrade—Ships'/Aircraft stores	—	—	3,1	3,3
GROOTTOTAAL—GRAND TOTAL	567,3	484,6	592,0	507,5

TABEL B.—TOTALE IN MILJOEN RAND VOLGENS AFDELINGS VAN DIE BTN
TABLE B.—TOTALS IN MILLION RAND ACCORDING TO SECTIONS OF THE BTN

Afdelings/Sections	Invoere—Imports		Uitvoere—Exports	
	1979	1978	1979	1978
I. Lewende diere; dierlike produkte Live animals; animal products	2,2	1,6	14,1	10,9
II. Plantaardige produkte Vegetable products	14,5	13,8	43,1	36,3
III. Dierlike en plantaardige vette en olies en splitsprodukte daarvan; voorbereide spysvette; dierlike en plantaardige wasse Animal and vegetable fats and oils and their cleavage products; prepared edible fats; animal and vegetable waxes	3,6	4,4	3,9	1,9
IV. Voorbereide voedsel; dranke, spiritus en asyn; tabak Prepared foodstuffs; beverages, spirits and vinegar; tobacco	9,0	9,2	17,5	22,3
V. Mineraalprodukte Mineral products	9,4	9,2	93,4	85,1
VI. Produkte van die chemiese en verwante nywerhede Products of the chemical and allied industries	70,0	53,7	25,4	23,9
VII. Kunsharse en -plastiekstowwe, sellulose-esters en -eters, en artikels daarvan; rubber, sintetiese rubber, faktis, en artikels daarvan Artificial resins and plastic materials, cellulose esters and ethers, and articles thereof; rubber, synthetic rubber, factice, and articles thereof	24,2	20,9	2,9	1,9
VIII. Ongelooide huide en velle, leer, pelsvelle en artikels daarvan; saal- en tuiemakersware; reisartikels, handsakke en dergelike houers; artikels van derm (uitgesonderd sywurmsnaar) Raw hides and skins, leather, furskins and articles thereof; saddlery and harness; travel goods, handbags and the like; articles of gut (other than silk-worm gut)	2,7	1,9	11,3	6,5
IX. Hout en artikels van hout; houtskool; kurk en artikels van kurk; fabrikate van strooi, van esparto en van ander vlegwerkstowwe; mandjiewerk en vlegwerk Wood and articles of wood; wood charcoal; cork and articles of cork; manufactures of straw, of esparto and of other plating materials; basketware and wickerwork	5,1	4,1	2,0	1,2
X. Stowwe vir die vervaardiging van papier; paper en papierbord en artikels daarvan Paper-making material; paper and paperboard and articles thereof	17,5	17,1	7,1	6,8

Afdelings/Sections	Invoere—Imports		Uitvoere—Exports	
	1979	1978	1979	1978
XI. Tekstiele en tekstielartikels Textiles and textile articles	36,4	29,6	19,6	18,7
XII. Skoeisel, hoofdeksels, sambrele, sonsambrele, swepe, ryswepe en onderdele daarvan; bereide vere en artikels daarvan gemaak; kunsblomme; artikels van mensehaar; waaiers Footwear, headgear, umbrellas, sunshades, whips, riding-crops and parts thereof; prepared feathers and articles made therewith; artificial flowers; articles of human hair; fans	2,2	1,9	0,7	0,4
XIII. Artikels van klip, van gips, van sement, van asbes, van mika en van dergelike stowwe; keramiese produkte; glas en glasware Articles of stone, of plaster, of cement, of asbestos, of mica and of similar materials; ceramic products; glass and glassware	7,2	5,6	3,3	2,2
XIV. Pêrels, edel- en halfedelstene, edelmetale, gewalste edelmetale, en artikels daarvan; nagemaakte juweliersware; muntstukke Pearls, precious and semi-precious stones, precious metals, rolled precious metals, and articles thereof; imitation jewellery; coin	3,0	1,1	160,4	165,2
XV. Onedelmetale en artikels daarvan Base metals and articles of base metal	33,5	33,2	116,4	77,2
XVI. Masjinerie en meganiese toestelle; elektriese toerusting; onderdele daarvan Machinery and mechanical appliances; electrical equipment; parts thereof	205,7	180,5	12,3	10,2
XVII. Voertuie, vliegtuie en onderdele daarvan; vaartuie en sekere verwante vervoertoerusting Vehicles, aircraft, and parts thereof; vessels and certain associated transport equipment	91,9	72,7	7,7	3,8
XVIII. Optiese, fotografiese, kinematografiese, meet-, kontrole-, presisie-, mediese en chirurgiese instrumente en apparaat; uurwerke en horlosies; musiekinstrumente; televisiebeeld- en klankopnemers en -weergewers, magneties; onderdele daarvan Optical, photographic, cinematographic, measuring, checking, precision, medical and surgical instruments and apparatus; clocks and watches; musical instruments, television image and sound recorders and reproducers; parts thereof	23,6	17,5	0,9	1,3
XX. Diverse vervaardigde artikels Miscellaneous manufactured articles	3,8	3,4	0,6	0,3
XXI. Kunswerke, versamelaarsstukke en antieke Works of art, collectors' pieces, and antiques	1,0	0,3	2,7	0,3
Ander ongeklassifiseerde goedere Other unclassified goods	0,8	2,9	46,7	31,3
GROOTTOTAAL—GRAND TOTAL	567,3	484,6	592.0	507,5

(9 Maart 1979)/(9 March 1979)

Frere Hospital is big industry

9/8/79 DD 98

Health Year was ushered in on January 1 this year. All population groups are to be drawn into a gigantic programme which is being planned by Provincial Administrations, Local Authorities and private concerns.

South Africa is doing much more than many other countries.

Recently the Minister of Health announced that new propects which were being planned would cost R154 million. This was for further beds for Coloureds, blacks, Asiatics and whites in various parts of the Republic.

This is quite apart from what the Hospital's Departments in the provinces are doing.

As far as the Cape Province is concerned, its system of hospitalisation compares with the finest in the world.

Hospital Boards fulfil an essential function. They serve as a link between the community served by the hospital in question and the hospital authorities.

The goodwill and understanding brought about in this way are of inestimable value, and it greatly contributes to the high quality of hospital services for which the Cape is known.

It has been my experience for many years that the relationship among members of the Board has always been one of whole-hearted cooperation, characterised by dedication to the interests of the hospital, with individual or group interests always in the background.

I sincerely hope that courtesy and goodwill will always prevail.

As far as our medical profession is concerned, East London can be justly proud of the calibre of our doctors.

It is not inapposite to mention that in this Health Year provision has been made in Frere Hospital estimates for 1979-80 for R562 000 in respect of equipment and replacements. This includes highly sophisticated equipment which would come under the heading of nuclear medicine at a cost of R152 000.

A diagnostic x-ray ultrasonic unit at a cost of R70 000 has already been authorised.

The cost of running Frere Hospital, and its associated services for the financial year 1979-80 is estimated to be R12 740 000.

The total revenue received by Frere last year amounted to R1 390 000.

Shortly the pathology laboratory will be controlled by State Health who will take over on April 1.

Hitherto the cost of running this department was in the neighbourhood of R600 000 a year and paid for by province.

Frere is certainly one of our largest industries, and its contribution to our economy and to the municipal coffers, is considerable, for its employs more than 2 700 people.

The dry bones of figures nevertheless speak eloquently of the activities of Frere and of its ramifications — generally unknown and understandably so. It is, in the nature of things, unostentatious, its virtues taken for granted.

Last year over 28 000 patients were admitted, of which over 17 000 were Coloureds and blacks.

Mr David Lazarus (left) long-serving chairman of the Frere Hospital Board — a ward block in the hospital is named in his honour — writes on some of the little-known facts of what he describes as one of East London's largest industries.

Out-patients numbered over 677 000 of which whites accounted for 80 000.

Specialised departments dealt with over 208 000 cases, of which Coloured, black and Asiatics totalled over 166 000.

The average monthly expenditure for drugs and medicines dispensed totals over R78 000.

The number of investigations carried out in the pathology laboratory during 1978 numbered 3 508 000 units.

The orthopaedic workshop issued 8 708 appliances.

The Hospital Board itself, out of its own funds, paid for major items last year alone, a total of R12 148.

An important amenity of Frere is the cobalt bomb unit installed a few years ago at a cost of R76 000.

Another valuable amenity is the telephone transmitter designed for the transmission of electro-cardiograms from patients with permanent pacemakers.

It is fitting that in this Health Year an important function should be the official handing over ceremony of the two haemodialysis machines donated by the Rotary Club of Gately.

I want to express our deepest gratitude to them for their public spirited action. There are many causes which flourish in our midst, and always, find a ready response from Rotary. Much that is done by the voluntary worker, fills the needs that cannot be met by other means.

Frere Hospital has carried out peritoneal dialysis for many years. Until recent years, however, it had no artificial kidney machines. Consequently patients with their families had to move to other centres such as Cape Town, or Port Elizabeth for this type of treatment.

Four years ago it was decided that Frere Hospital should be able to provide artificial kidney machine treatment and careful planning was begun.

A suitable site for the renal unit was selected, specialised equipment was purchased, and most importantly, a nursing sister was given suitable training.

The new renal unit was opened in 1976.

Frere Hospital is a regional hospital, and caters for a population covering a wide area, serving about 125 000 whites and 2,8 million blacks.

Various surveys estimated that 25-75 persons per million of population were potential candidates for long-term haemodialysis.

It is, therefore, abundantly evident that facilities need to be increased to cope with the present demand, and these additional two machines will provide the optimum number in the renal unit.

Renal dialysis, the artificial kidney system, is a method employed for the treatment of renal failure. It is an expensive process, for the cost is in the region of R10 000 per patient per year for dialysis materials alone.

Dialysis machines normally cost between six and seven thousand rands each. The Rotary Club of Gately raised R5 200 for a dialysis machine.

We advised the hospitals department of this generous contribution, and to our delight were told this would provide two machines for that amount in place of only one which we had contemplated purchasing. So the Rotary Club of Gately has exceeded its own expectations!

At present there are six patients on the machines for chronic dialysis. These attend three times per week, each for a period of six hours commencing just after 7 am and finishing about 2 pm.

We can be proud of our system of hospitalisation, which caters for the needs of the lower income group and the underprivileged, while retaining the autonomy and independence of the medical profession.

May we in this Health Year, witness the amelioration of suffering, to which humanity is heir, and see even greater advances in medical science.

HOSPITALS (49) Tm 16/3/79

From white to black?

Will the old white Johannesburg General Hospital be opened for blacks? The city's management committee chairman, Francois Oberholzer, is confident it will be.

He tells the *FM* the question is under consideration by the Transvaal Provincial Council, to which he made a plea last month. "The council will not reject the plea," says Oberholzer, adding that the 233 beds at the Johannesburg Non-European Hospital (NEH) are not enough for the 100 000 blacks working in the city area.

NEH, he says, can be made available to Indians, thereby relieving the overcrowding at Coronation Hospital, which can then be used exclusively for coloured people.

Referring to the new R156m white Johannesburg hospital, Oberholzer says "we should not duplicate facilities for whites."

But Transvaal provincial executive Dawid van der Merwe Brink says Oberholzer is making "wild statements." The old general hospital will remain as it is, he says — for whites. Nevertheless, Kallie de Haas, who is in charge of the province's hospital services tells the *FM*: "There is no finality on the matter. We are considering it."

Baragwanath

While Johannesburg has at least 15 private nursing homes and three provincial hospitals for whites, Baragwanath and the West Rand's Leratong Hospital cannot cope with Soweto's million-plus population.

Plans for a new Soweto hospital — at New Canada, on the township's outskirts — have been in the pipeline for a decade.

Says one Soweto resident: "Can't the council forget ideology and face reality? Let them give us the general hospital."

Cargus 20/3/79 (98)

Hospital services hit at 'pathetic' handling charge

Medical Reporter

THE Cape's department of hospital services are equal to the best in the world and that is why locally trained doctors are so sought after overseas, the Director of Hospital Services, Dr R L M Kotze, said yesterday.

Dr Kotze was reacting to allegations of 'pathetic' handling of hospital affairs in the Cape made by a former member of the famous Groote Schuur cardiac team, Dr Allan Wolpowitz.

Dr Wolpowitz, who left South Africa last week, has been appointed associate professor of surgery and head of cardiothoracic surgery at the Wayne State University of Michigan in Detroit.

Dr Wolpowitz was reported as saying it was only due to the conscientiousness of the medical staff that South Africa still offered a fine medical service.

SALARY SCALES

He said hospitals should be run by trained business consultants, not doctors; that hospitals were being run to satisfy the Provincial Administration, not the staff, and referred to unnecessary wastage and inefficiency at provincial hospitals.

Dr Wolpowitz said conditions of service here compared badly with those overseas and salary scales were fixed and did not keep pace with the cost of living.

He said: 'I have reached a very senior position, but now there is no possibility of any further promotion for me.' He is reported to have added: 'As I see it, the humiliation caused by apartheid cannot go on forever.'

GUARD AGAINST

Dr Kotze said his department was worried about wastage and inefficiency and were doing all they could to combat it.

He added that people such as Dr Wolpowitz were in the best position to guard against this, as they were the senior people who were supposed to look to wastage. In this light Dr Kotze saw this as a cowardly allegation.

Dr Kotze said Dr Wolpowitz, in discussing hospital administration, was treading on ice as thin as Dr Kotze would be treading on if he presumed to discuss heart transplants.

'I find him guilty of an unethical remark and ask him in his wisdom to restrict himself to his own specialisation rather than criticise others on their terrain,' said Dr Kotze.

DEAL BLOWS

The member of the Executive Committee in charge of Hospital Services, Mr P J Loubser, said Dr Wolpowitz had reached such heights because of the facilities and opportunities made available to him by the Provincial Administration.

'Since he is leaving the country, on his own admission, for reasons of personal gain, it is difficult to understand why he is left and right dealing out blows based on vague generalities.

'He must decide for himself on the ethics of his allegation that sound health services in South Africa are due to the conscientiousness of the medical personnel only, while in the same breath alleging that his colleagues concerned with hospital administration are incompetent.'

APARTHEID

On Dr Wolpowitz's reference to apartheid, Mr Loubser commented: 'To gain popularity in many circles and possibly to silence your own conscience, if for selfish reasons you leave the country which has been good to you, it is only necessary to criticise South Africa's internal affairs and to drag in the word "apartheid."'

Clinic bid at Kidd's Beach

DA 9/4/79

EAST LONDON — An application to the Department of Health for a clinic in the Kidd's Beach area to provide a comprehensive out-patient service is to be made by the Divisional Council of Kaffraria.

This was resolved at a meeting of the Council. — DDR.

(98) 19/4/79 DD

Talks on hospital problems

EAST LONDON — Hospital problems here, and in particular the demands the large black population are making on outpatient facilities and the difficulty of obtaining suitably qualified staff for Border hospitals, will be the subject of a conference of senior provincial and local hospital officials at the Frere Hospital here today.

The MPC for East London City, Mr P. de Pontes, said the conference was the outcome of representations by himself and the MPC for Queenstown, Dr T. G. Schlebusch, at the recent provincial council session.

The meeting will be chaired by the MEC for Hospital Services, Mr P. J. Loubser and attended by the Director of Hospital Services in the Cape, Dr R. L. Kotze.

Senior officials of his department, the Regional Medical Superintendent for Border hospitals, Dr F. Visser and superintendents and matrons from all Border hospitals as well as the chairmen of the hospital committees and representatives of medical committees will attend.

All Border MPC's have also been invited.

Mr Du Pontes said problems peculiar to this area would be discussed in detail and ways formulated to solve them.

Visits to the various hospitals by senior members of the Provincial Hospital Department to implement the solutions will be organised. — DDR.

Day hospital should open by December

(98 00)

19/4/79.

EAST LONDON — The day hospital in Duncan Village will be in operation by December if everything goes according to plan.

This was announced by the MPC for East London City, Mr Petro de Pontes, yesterday.

Mr De Pontes said he had spoken to provincial hospital authorities in Cape Town about the day hospital during the recent provincial council session.

Ground had already been made available and advertisements placed for objections to the scheme. Once this phase was finalised, by about the end of June, the Administrator's final consent could be obtained for the transfer of the property from the municipality to Province.

"Due to the urgent need for the hospital the Department of Works was instructed not to go out to tender, but to negotiate a contract, and a contract has already been concluded with Murray and Stewart," Mr De Pontes said.

Frere Hospital here has been given instructions to investigate what equipment will be necessary at the day hospital and this is to be made available from surplus equipment at Frere or bought before the new hospital is completed.

"If nothing untoward happens the hospital will probably be operative by December," Mr De Pontes said. — DDR.

Outpatients are major problem

EAST LONDON — The still increasing flood of black patients, some from neighbouring states, to the outpatient sections of Provincial hospitals and clinics emerged as the major problem confronting hospital services in this area during a conference of Border hospital and administrative personnel here yesterday.

In a press release after the conference issued through the MPC for East London, Mr P. de Pontes, the MEC for hospital services, Mr P. J. Loubser, said the flood of patients was placing a great load on facilities and ambulance services.

"Various solutions were discussed, of which the most important is that primary services must be extended, among these the use of specially trained nurses to treat patients with less serious illnesses," he said. Only more serious cases will be referred to doctors.

Better co-ordination of health services and community involvement are also to be sought.

This includes the combined use of facilities and personnel of the Provincial Administration, municipalities and divisional councils at a local level wherever possible.

As a first step in this direction, hospital boards must take the initiative and arrange meetings of the concerned bodies to establish problems and find solutions for them. — DDR.

Attacks on nurses

By Syd Moses

UMTATA — Transkei nurses worked under the most trying circumstances and some become victims of violence and brutal cold-blooded attacks.

This was said in the National Assembly when the Minister of Health, Mr T. Vika, said nurses were also the victims of acrimonious anonymous letters.

He said interference by the public in the administration of hospitals was strongly deprecated.

Area health boards existed for the voicing of grievances.

If there were genuine reasons for complaint against any nursing staff, they would be taken up by responsible bodies in the community, with the hospital management or with the department.

"Let us demonstrate to our detractors that Transkei, having attained independence peacefully, will continue to pursue its objectives by quiet, peaceful negotiation," he said, We reject confrontation and violence.

Mr Vika said district health boards and the local area committees continued to do good work.

BYLAE

I Item	II Tariefpos en Beskrywing	III Mate van Korting
312.01	Deur tariefpos No. 40.08 deur die volgende te vervang: „40.08 Soolrand- en kantstroke, van rubber	Volle reg"
312.04	Deur na item 312.03 die volgende in te voeg: „312.04 **Nywerheid: Kunsblomme, -loof of -vrugte en onderdele daarvan** 51.04 Weefstowwe van gefabriseerde vesels (kontinu)	Volle reg"

Opmerkings.—1. Die voorsiening vir 'n korting op reg op plate, velle en reep van skuimrubber, vir die vervaardiging van skoeisel, word ingetrek.

2. Voorsiening word gemaak vir 'n volle korting op reg op weefstowwe van gefabriseerde vesels (kontinu), vir die vervaardiging van kunsblomme, -loof of -vrugte en onderdele daarvan.

DEPARTMENT OF HEALTH

No. R. 954 4 May 1979

MEDICAL SCHEMES ACT, 1967

In terms of section 30 (3) of the Medical Schemes Act, 1967 (Act 72 of 1967), as amended, I, Joseph Petrus Hermanus Steyn, Registrar of Medical Schemes, hereby publish the tariff of fees referred to in section 1 (1) of the said Act, as follows:

TARIFF OF FEES IN RESPECT OF PRIVATE HOSPITALS

1. The tariff set out in Annexure A hereto shall apply in respect of private hospitals with no more than 70 registered beds for Whites.

2. The tariff set out in Annexure B hereto shall apply in respect of private hospitals with more than 70 registered beds for Whites.

3. The tariff set out in Annexure C hereto shall apply in respect of both categories of such hospitals.

4. The tariff shall include general sales tax except on items in relation to medicines, drugs and dressings.

5. A committee of five members shall be established, and shall consist of three members nominated by the Representative Association of Medical Schemes and two members nominated by the Representative Association of Private Hospitals, to consider any applications from private hospitals having no fewer than 61 registered beds for Whites to be regarded for the purposes of the tariff in Annexure B as if they were hospitals with more than 70 such beds. The procedure for hearing such applications shall be laid down by the said committee and the decision of the said committee shall be final.

6. The tariff shall come into effect on the first day of the month following publication hereof.

ANNEXURE A

Ward fees

Hospitals shall indicate the exact times of admission and discharge on all accounts.

Ward fees shall be charged at the full daily rate if admission takes place before 12h00 and at half the daily rate if admission takes place after 12h00. Ward fees shall be charged at half the daily rate if discharge takes place before 12h00 and at the full daily rate if discharge takes place after 12h00. Provided that the minimum amount charged shall be equal to the tariff for one full day.

General ward

		R
57001	Surgical cases, per day	19,00
57002	Thoracic cases (surgical), per day	20,00
57003	Neurosurgical cases, per day	20,00
57004	Medical and neurological cases, per day	20,00

DEPARTEMENT VAN GESONDHEID

No. R. 954 4 Mei 1979

WET OP MEDIESE SKEMAS, 1967

Kragtens artikel 30 (3) van die Wet op Mediese Skemas, 1967 (Wet 72 van 1967), soos gewysig, kondig ek, Joseph Petrus Hermanus Steyn, Registrateur van Mediese Skemas, hierby die geldetarief in artikel 1 (1) van genoemde Wet bedoel, soos volg af:

GELDETARIEF TEN OPSIGTE VAN PRIVATE HOSPITALE

1. Die tarief wat in Bylae A hiervan uiteengesit is, geld ten opsigte van private hospitale vir Blankes met hoogstens 70 geregistreerde beddens.

2. Die tarief wat in Bylae B hiervan uiteengesit is, geld ten opsigte van private hospitale vir Blankes met meer as 70 geregistreerde beddens.

3. Die tarief wat in Bylae C hiervan uiteengesit is, geld vir beide sodanige kategorieë hospitale.

4. Die tarief sluit algemene verkoopbelasting in, behalwe op items met betrekking tot medisyne, verdowingsmiddels en verbandgoed.

5. 'n Komitee van vyf lede, van wie die Verteenwoordigende Vereniging van Mediese Skemas drie benoem en die Verteenwoordigende Vereniging van Private Hospitale twee benoem, word saamgestel om aansoeke van private hospitale met minstens 61 geregistreerde beddens vir Blankes, om by die toepassing van die tarief in Bylae B geag te word hospitale te wees wat meer as 70 sodanige beddens het, te oorweeg. Bedoelde komitee bepaal die prosedure wat by die aanhoor van sodanige aansoeke gevolg moet word, en die beslissing van bedoelde komitee is afdoende.

6. Die tarief tree in werking op die eerste dag van die maand wat volg op publikasie hiervan.

BYLAE A

Saalgelde

Hospitale moet die presiese tyd van toelating en ontslag op alle rekenings aandui.

Saalgelde word gehef teen die volle daaglikse tarief indien toelating vóór 12h00 geskied en teen die helfte van die daaglikse tarief indien toelating ná 12h00 geskied. Saalgelde word gehef teen die helfte van die daaglikse tarief indien ontslag voor 12h00 geskied en teen die volle daaglikse tarief indien ontslag ná 12h00 geskied: Met dien verstande dat die minimum bedrag wat gevra word, gelyk is aan die tarief vir een volle dag.

	Algemene saal	R
57001	Chirurgiese gevalle, per dag	19,00
57002	Toraks-chirurgiese gevalle, per dag	20,00
57003	Neurochirurgiese gevalle, per dag	20,00
57004	Mediese en neurologiese gevalle, per dag	20,00

57020 *Private ward*

If accommodation in a private ward has been prescribed by a medical practitioner for medical reasons, fees for such accommodation shall be charged at the prevailing private ward rate, which shall in no case exceed R30,00 per day, less a discount of 10%: Provided that the relevant scheme has guaranteed payment for accommodation in a private ward.

Hospitals shall obtain a detailed certificate as to the necessity for accommodation in a private ward from the attendant practitioner and such certificate shall be forwarded to the relevant scheme together with the account.

57021 *Private ward at request of member*

Where a scheme undertakes to guarantee payment for accommodation in a private ward, supplied *at the specific request of the member*, the scheme shall be entitled to a 10% discount on the *prevailing private ward rate*.

57045 *Drugs (ward)*

Drugs supplied by the ward as per Standard Drug and Materials Tariff (Annexure C)

	Fixed fee procedures	R
57051	Air encephalograms	21,00
57052	Hysterosalpingograms	21,00
57053	Angiograms	21,00
57054	Cardiac catheterisation	21,00
57055	Electroconvulsive therapy (E.C.T.)	5,00

Theatre fees

Out-patients (patients that are not warded)

57071 *Time in theatre:*

The exact time of admission to and discharge from theatre shall be stated. T

The theatre charge shall be calculated as follows:

	R
1–15 minutes	13,00
each subsequent 15 minutes or part thereof	6,50

In-patients

Operations—general

57081 *Time:*

The exact time of admission to and discharge from theatre shall be stated. T

The theatre charge shall be calculated as follows:

	R
1–15 minutes	33,50
16–30 minutes	39,00
31–45 minutes	44,50
46–60 minutes	50,00
each subsequent 15 minutes or part thereof	12,50

Operations—neurosurgery

57091 Preparation fee per operation (only chargeable where the duration of the operation exceeds 60 minutes) 49,00

57092 *Time:*

The exact time of admission to and discharge from theatre, and the exact operating time, shall be stated. T

The theatre charge shall be calculated as follows:

	R
1–60 minutes	52,00
each subsequent 15 minutes of part thereof	12,50

Operations—thoracic surgery

57101 *Time:*

The exact time of admission to and discharge from theatre shall be stated. T

The theatre charge shall be calculated as follows:

	R
1–30 minutes	39,00
31–60 minutes	52,00
each subsequent 15 minutes or part thereof	12,50

Operations—open heart

57121 Open heart surgery—rates by arrangement

Drugs and materials—theatre

57131 Theatre drugs—as per Standard Drug and Materials Tariff (Annexure C)

57020 *Privaatsaal*

Indien 'n geneesheer verblyf in 'n privaatsaal om mediese redes voorskryf, word gelde vir sodanige verblyf gehef teen die heersende privaatsaaltarief, wat in geen geval R30,00 per dag mag oorskry nie, min 10 persent korting: Met dien verstande dat die betrokke skema die betaling vir verblyf in 'n privaatsaal gewaarborg het.

Hospitale moet 'n gedetailleerde sertifikaat aangaande die noodsaaklikheid vir privaatsaalverblyf van die behandelende dokter verkry en sodanige sertifikaat saam met die rekening aan die betrokke skema stuur.

57021 *Privaatsaal op lid se versoek*

Waar 'n skema onderneem om betaling vir privaatsaalverblyf *wat op die uitdruklike versoek van die lid verskaf word*, te waarborg, is die skema geregtig op 'n 10 persent korting op die *heersende privaatsaaltarief*.

57045 *Verdowingsmiddels (saal)*

Verdowingsmiddels deur die saal verskaf—per Standaardtarief vir Verdowingsmiddels en Materiaal (Bylae C).

	Gelde vir vaste prosedures	R
57051	Lugenkefalogramme	21,00
57052	Histerosalpingogramme	21,00
57053	Angiogramme	21,00
57054	Hartkateterisasies	21,00
57055	Elektrokonvulsiewe terapie (E.K.T.)	5,00

Teatergelde

Buitepasiënte (pasiënte wat nie in 'n saal opgeneem word nie).

57071 *Tyd in teater:*

Die presiese tyd van toelating tot en ontslag uit teater moet aangetoon word. T

Die teatergelde word soos volg bereken:

	R
1–15 minute	13,00
elke daaropvolgende 15 minute of deel daarvan	6,50

Binnepasiënte

Operasies—algemeen

57081 *Tyd:*

Die presiese tyd van toelating tot en ontslag uit teater moet aangetoon word. T

Die teatergelde word soos volg bereken:

	R
1–15 minute	33,50
16–30 minute	39,00
31–45 minute	44,50
46–60 minute	50,00
elke daaropvolgende 15 minute of deel daarvan	12,50

Operasies—neurochirurgie

57091 Voorbereidingsgelde per operasie (slegs van toepassing wanneer die duur van die operasie 60 minute oorskry) 49,00

57092 *Tyd:*

Die presiese tyd van toelating tot en ontslag uit teater sowel as die presiese tydsduur van die operasie moet aangetoon word. T

Die teatergelde word soos volg bereken:

	R
1–60 minute	52,00
elke daaropvolgende 15 minute of deel daarvan	12,50

Operasies—toraks-chirurgie

57101 *Tyd:*

Die presiese tyd van toelating tot en ontslag uit teater moet aangetoon word. T

Die teatergelde word soos volg bereken:

	R
1–30 minute	39,00
31–60 minute	52,00
elke daaropvolgende 15 minute of deel daarvan	12,50

Operasies—opehart

57121 Opehartchirurgie—tarief volgens ooreenkoms.

Verdowingsmiddels en materiaal—teater

57131 Verdowingsmiddels deur die teater verskaf—per Standaardtarief vir Verdowingsmiddels en Materiaal (Bylae C).

Additional items

		R
57151	Fulguration, diathermy, cautery—first hour.....	2,00
	each additional hour or part thereof.....	1,00
57152	Recovery room, per operation.....	3,00
57153	After hours: per case, for cases admitted to theatre from 19h00 to 07h00 on weekdays, from 13h00 on Saturdays to 07h00 on Mondays and on public holidays.....	10,00
57181	*Non-chargeable theatre items*	
	White methylated spirits Aqueous solutions, e.g. Cetavlon, Savlon or any other proprietary name Biniodide Dettol Mercuric oxycyanide Instrument Dettol Formalin and saline Acetone Gill soap Liquid soap Use of surgical instruments and blades Use of laparoscope, gastroscope and microscope E.C.G.s and paper Disposable cautery/diathermy leads and pads Va.uum trays Operative trays (for anaesthetist) Linen savers Preptic swabs	
57182	*Non-chargeable items (in ward and in theatre)*	
	I.D. bands Disposable gloves Face masks Collection charges (Blood Bank) Labstix/Multistix	

Intensive care units

57201	I.C.U.: per day.....	45,00
	inclusive of all equipment *except:*	
57202	Angstrom or Bennett M.A.1.B. respirator, per day or part thereof, plus the charge for oxygen.....	30,00

All admissions to this unit shall be confirmed for each 72 hours.

Hospitals shall obtain a certificate as to the necessity for intensive care from the attendant practitioner and such certificate shall be forwarded to the relevant scheme together with the account.

N.B. No charge for special nursing may be made while a patient is accommodated in an intensive care unit.

57203 *Consumable materials*—as per Standard Drug and Materials Tariff (Annexure C)'

57215	*Post-operative high care ward:* per day.....	30,00

All admissions to this unit shall be confirmed for for each 72 hours. Hospitals shall obtain a certificate as to the necessity for high care from the attendant practitioner and such certificate shall be forwarded to the relevant scheme together with the account.

N.B. No charge for special nursing may be made while a patient is accommodated in a high care ward.

Standard charges for equipment

57231	Monitors (outside I.C.U.), per day or part thereof	10,00
57232	Respirators, e.g. Bennett PR2 or Bird (outside I.C.U.) (excluding oxygen), per day or part thereof	7,50
57233	Croupettes (excluding oxygen), per day or part thereof.....	2,00
57234	Incubators (excluding oxygen), per day or part thereof.....	4,00
57235	Oxygen tents (excluding oxygen), per day or part thereof.....	3,50
57236	Angstrom or Bennett M.A.1.B. respirator (excluding oxygen), per day or part thereof.....	30,00

Dressing trays

57251	Sterile trays—per tray.....	1,40
	Non-sterile trays:	
57253	Preparation trays—per tray.....	0,55
57255	E.N.T. trays—per tray.....	0,55
57257	Swabbing trays—per tray.....	0,55

Addisionele items

		R
57151	Fulgurasie, diatermie, branding—eerste uur.....	2,00
	elke addisionele uur of deel daarvan.....	1,00
57152	Herstelkamer—per operasie.....	3,00
57153	Na-ure: per geval, vir gevalle tot teater toegelaat tussen 19h00 en 07h00 op weeksdae, tussen 13h00 op Saterdae en 07h00 op Maandae en op openbare vakansiedae.....	10,00
57181	*Gratis teateritems*	
	Wit brandspiritus. Wateragtige oplossings, byvoorbeeld Cetavlon, Savlon of enige ander handelsnaam. Bijodied. Dettol. Merkurioksisianied. Instrument-Dettol Formalien en soutoplossing Asetoon Gill-seep Vloeibare seep Gebruik van chirurgiese instrumente en lemmetjies Gebruik van laparoskoop, gastroskoop en mikroskoop E.K.G.'s en E.K.G.-papier Wegdoenbare branding-/diatermie- geleidrade en -kussinkies Vakuumblaaie Blaaie vir operasies (narkotiseurs) Linnebesparingsdekkings Preptic-deppers	
57182	*Gratis items (in saal en teater)*	
	Identifikasiestroke Wegdoenbare handskoene Gesigmaskers Afhaalkoste (Bloedbank) Labstix/Multistix	

Intensiewe-sorgeenhede

57201	I.S.E.: per dag.....	45,00
	alle toerusting ingesluit *behalwe:*	
57202	Angstrom- of Bennett M.A.1.B.-respirator, per dag of deel daarvan, plus die koste van suurstof	30,00

Iedere toelating tot sodanige eenheid moet bevestig word vir elke 72 uur.

Hospitale moet 'n sertifikaat aangaande die noodsaaklikheid van intensiewe sorg van die behandelende dokter verkry en sodanige sertifikaat saam met die rekening aan die betrokke skema stuur.

L.W.—Geen gelde ten opsigte van spesiale verpleging mag gehef word tydens verblyf in 'n intensiewe-sorgeenheid nie.

57203 *Verbruikbare materiaal*—per Standaardtarief vir Verdowingsmiddels en Materiaal (Bylae C)

57215	*Na-operatiewe hoësorgsaal:* per dag.....	30,00

Iedere toelating tot sodanige eenheid moet bevestig word vir elke 72 uur. Hospitale moet 'n sertifikaat aangaande die noodsaaklikheid van hoë sorg van die behandelende dokter verkry en sodanige sertifikaat saam met die rekening aan die betrokke skema stuur.

L.W.—Geen gelde ten opsigte van spesiale verpleging mag gehef word tydens verblyf in 'n hoësorgsaal nie.

Standaardheffings vir toerusting

57231	Monitors (buite I.S.E.), per dag of deel daarvan	10,00
57232	Respirators, bv. Bennett PR2 of Bird (sonder suurstof) (buite I.S.E.), per dag of deel daarvan.....	7,50
57233	Croupettes (sonder suurstof), per dag of deel daarvan.....	2,00
57234	Broeikaste (sonder suurstof), per dag of deel daarvan.....	4,00
57235	Suurstoftente (sonder suurstof), per dag of deel daarvan.....	3,50
57236	Bennett M.A.1.B.- of Angstrom-respirator (sonder suurstof), per dag of deel daarvan.....	30,00

Bewerkingsblaaie

57251	Steriele blaaie—per blad.....	1,40
	Nie-steriele blaaie:	
57253	Voorbereidingsblaaie—per blad.....	0,55
57255	O.N.K.-blaaie—per blad.....	0,55
57257	Depperblaaie—per blad.....	0,55

ANNEXURE B

Ward fees

Hospitals shall indicate the exact time of admission and discharge on all accounts.

Ward fees shall be charged at the full daily rate if admission takes place before 12h00 and at half the daily rate if admission takes place after 12h00. Ward fees shall be charged at half the daily rate if discharge takes place before 12h00 and at the full daily rate if discharge takes place after 12h00: Provided that the minimum amount charged shall be equal to the tariff for one full day.

General ward

		R
58001	Surgical cases, per day	21,50
58002	Thoracic cases (surgical), per day	22,50
58003	Neurosurgical cases, per day	22,50
58004	Medical and neurological cases, per day	22,50

58020 *Private ward*

If accommodation in a private ward has been prescribed by a medical practitioner for medical reasons, fees for such accommodation shall be charged at the prevailing private ward rate, which shall in no case exceed R33,00 per day, less a discount of 10%: Provided that the relevant scheme has guaranteed payment for accommodation in a private ward.

Hospitals shall obtain a detailed certificate as to the necessity for accommodation in a private ward from the attandant practitioner and such certificate shall be forwarded to the relevant scheme together with the account.

58021 *Private ward at request of member*

Where a scheme undertakes to guarantee payment for accommodation in a private ward *at the specific request of the member*, the scheme shall be entitled to a 10% discount on the *prevailing private ward rate*.

Drugs (ward)

58045 Drugs supplied by ward—as per Standard Drug and Material Tariff (Annexure C)

Fixed fee procedures

58051	Air encephalograms	23,00
58052	Hysterosalpingograms	23,00
58053	Angiograms	23,00
58054	Cardiac catheterisation	23,00
58055	Electroconvulsive therapy (E.C.T.)	5,50

Theatre fees

Out-patients (Patients that are not warded)

58071 *Time in theatre:*

The exact time of admission to and discharge from theatre shall be stated. T

The theatre charge shall be calculated as follows:

	R
1–15 minutes	14,50
each subsequent 15 minutes or part thereof	7,20

In-patients

Operations—general

58081 *Time:*

The exact time of admission to and discharge from theatre shall be stated. T

The theatre charge shall be calculated as follows:

	R
1–15 minutes	37,00
16–30 minutes	43,00
31–45 minutes	50,00
46–60 minutes	56,00
each subsequent 15 minutes or part thereof	14,00

Operations—neurosurgery

58091	Preparation fee per operation only chargeable where the duration of the operation exceeds 60 minutes	54,00

58092 *Time:*

The exact time of admission to and discharge from theatre, and the exact operating time, shall be stated. T

The theatre charge shall be calculated as follows: R

1–60 minutes	57,00
each subsequent 15 minutes or part thereof	14,00

BYLAE B

Saalgelde

Hospitale moet die presiese tyd van toelating en ontslag op alle rekenings aandui.

Saalgelde word gehef teen die volle daaglikse tarief indien toelating vóór 12h00 geskied en teen die helfte van die daaglikse tarief indien toelating ná 12h00 geskied. Saalgelde word gehef teen die helfte van die daaglikse tarief indien ontslag vóór 12h00 geskied en teen die volle daaglikse tarief indien ontslag ná 12h00 geskied: Met dien verstande dat die minimum bedrag wat gevra word, gelyk is aan die tarief vir een volle dag.

Algemene saal

		R
58001	Chirurgiese gevalle, per dag	21,50
58002	Toraks-chirurgiese gevalle, per dag	22,50
58003	Neurochirurgiese gevalle, per dag	22,50
58004	Mediese en neurologiese gevalle, per dag	22,50

58020 *Privaatsaal*

Indien 'n geneesheer verblyf in 'n privaatsaal om mediese redes voorskryf, word gelde vir sodanige verblyf gehef teen die heersende privaatsaaltarief, wat in geen geval R33,00 per dag mag oorskry nie, min 10 persent korting: Met dien verstande dat die betrokke skema die betaling vir verblyf in 'n privaatsaal gewaarborg het.

Hospitale moet 'n gedetailleerde sertifikaat aangaande die noodsaaklikheid van privaatsaalverblyf van die behandelende dokter verkry en sodanige sertifikaat saam met die rekening aan die betrokke skema stuur.

58021 *Privaatsaal op lid se versoek*

Waar 'n skema onderneem om betaling vir privaatsaalverblyf *wat op die uitdruklike versoek van die lid verskaf word*, te waarborg, is die skema geregtig op 'n 10 persent korting op die *heersende privaatsaaltarief*.

Verdowingsmiddels (saal)

58045 Verdowingsmiddels deur die saal verskaf—per Standaardtarief vir Verdowingsmiddels en Materiaal (Bylae C).

Gelde vir vaste prosedures

58051	Lugenkefalogramme	23,00
58052	Histerosalpingogramme	23,00
58053	Angiogramme	23,00
58054	Hartkateterisasies	23,00
58055	Elektrokonvulsiewe terapie (E.K.T.)	5,50

Teatergelde

Buitepasiënte (Pasiënte wat nie in 'n saal opgeneem word nie).

58071 *Tyd in teater:*

Die presiese tyd van toelating tot en ontslag uit teater moet aangetoon word. T

Die teatergelde word soos volg bereken:

	R
1–15 minute	14,50
elke daaropvolgende 15 minute of deel daarvan	7,20

Binnepasiënte

Operasies—algemeen

58081 *Tyd:*

Die presiese tyd van toelating tot en onstlag uit teater moet aangetoon word. T

Die teatergelde word soos volg bereken:

	R
1–15 minute	37,00
16–30 minute	43,00
31–45 minute	50,00
46–60 minute	56,00
elke daaropvolgende 15 minute of deel daarvan	14,00

Operasies—neurochirurgie

58091	Voorbereidingsgelde per operasie slegs van toepassing wanneer die duur van die operasie 60 minute oorskry	54,00

58092 *Tyd:*

Die presiese tyd van toelating tot en ontslag uit teater sowel as die presiese tydsduur van die operasie moet aangetoon word. T

Die teatergelde word soos volg bereken:

1–60 minute	57,00
elke daaropvolgende 15 minute of deel daarvan	14,00

Operations—thoracic surgery

58101 *Time:*

The exact time of admission to and discharge from theatre shall be stated. T

The theatre charge shall be calculated as follows:

	R
1–30 minutes	43,00
31–60 minutes	57,00
each subsequent 15 minutes or part thereof	14,00

Operations—open heart

58121 Open heart surgery—rates by arrangement

Drugs and materials (theatre)

58131 Theatre drugs—as per Standard Drug and Materials, Tariff (Annexure C).

Additional items

58151	Fulguration, diathermy, cautery	
	first hour	2,00
	thereafter each additional hour or part thereof	1,00
58152	Recovery room—per operation	3,00
58153	After hours—per case, for cases admitted to theatre from 19h00 to 07h00 on weekdays, from 13h00 on Saturdays to 07h00 on Mondays and on public holidays	11,00

58181 *Non-chargeable theatre items*

White methylated spirits
Aqueous solutions, e.g. Cetavlon, Savlon or any other proprietary name
Biniodide
Dettol
Mercuric oxycyanide
Instrument Dettol
Formalin and saline
Acetone
Gill soap
Liquid soap
Use of surgical instruments and blades
Use of laparoscope, gastroscope and microscope
E.C.G.s and paper
Disposable cautery/diathermy leads and pads
Vacuum trays
Operative trays (for anaesthetist)
Linen savers
Preptic swabs

58182 *Non-chargeable items (in ward and in theatre)*

I.D. bands
Disposable gloves
Face masks
Collection charges (Blood Bank)
Labstix/Multistix

Intensive care units

58201	I.C.U., per day	50,00
	inclusive of all equipment *except:*	
58202	Angstrom or Bennet M.A.1.B. respirator, per day or part thereof, plus the charge for oxygen	30,00

All admissions to this unit shall be confirmed for each 72 hours.

Hospitals shall obtain a certificate as to the necessity for intensive care from the attendant practitioner and such certificate shall be forwarded to the relevant scheme together with the account.

N.B. No charge for special nursing may be made while a patient is accommodated in an intensive care unit.

58203 *Consumable materials*—as per Standard Drug and Materials, Tariff (Annexure C)

58215	*Post-operative high care ward*, per day	33,00

All admissions to this unit shall be confirmed for each 72 hours.

Hospitals must obtain a certificate as to the necessity for high care from the attendant practitioner and such certificate shall be forwarded to the scheme together with the account.

N.B. No charge for special nursing may be made while a patient is accommodated in a high care ward.

Operasies—toraks-chirurgie

58101 *Tyd:*

Die presiese tyd van toelating tot en ontslag uit teater moet aangetoon word. T

Die teatergelde word soos volg bereken: R

1–30 minute	43,(
31–60 minute	57,(
elke daaropvolgende 15 minute of deel daarvan	14,(

Operasies—opehart

58121 Opehartchirurgie—tarief volgens ooreenkoms.

Verdowingsmiddels en materiaal (teater)

58131 Verdowingsmiddels deur die teater verskaf per Standaardtarief vir Verdowingsmiddels en Materiaal (Bylae C).

Addisionele items

58151	Fulgurasie, diatermie, branding—eerste uur	2,(
	elke addisionele uur of deel daarvan	1,(
58152	Herstelkamer—per operasie	3,
58153	Na-ure—per geval, vir gevalle tot teater toegelaat tussen 19h00 en 07h00 op weeksdae, tussen 13h00 op Saterdae en 07h00 op Maandae en op openbare vakansiedae	11,

58181 *Gratis teateritems*

Wit brandspiritus
Wateragtige oplossings, bv. Cetavlon, Savlon of enige ander handelsnaam
Bijodied
Dettol
Merkurioksisianied
Instrument-Dettol
Formalien en soutoplossing
Asetoon
Gill-seep
Vloeibare seep
Gebruik van chirurgiese instrumente en lemmetjies
Gebruik van laparoskoop, gastroskoop en mikroskoop
E.K.G.'s en E.K.G.-papier
Wegdoenbare branding-/diatermie- geleidrade en -kussinkies
Vakuumblaaie
Blaaie vir operasies (narkotiseurs)
Linnebesparingsdekkings
Preptic-deppers

58182 *Gratis items (in saal en teater)*

Identifikasiestroke
Wegdoenbare handskoene
Gesigmaskers
Afhaalkoste (Bloedbank)
Labstix/Multistix

Intensiewe-sorgeenhede

58201	I.S.E., per dag	50
	alle toerusting ingesluit *behalwe:*	
58202	Angstrom- of Bennett M.A.1.B.-respirator, per dag of deel daarvan, plus die koste van suurstof	30

Iedere toelating tot sodanige eenheid moet bevestig word vir elke 72 uur.

Hospitale moet 'n sertifikaat aangaande die noodsaaklikheid van intensiewe sorg van die behandelende dokter verkry en sodanige sertifikaat saam met die rekening aan die betrokke skema stuur.

L.W.—Geen gelde ten opsigte van spesiale verpleging mag gehef word tydens verblyf in 'n intensiewe-sorgeenheid nie.

58203 *Verbruikbare materiaal*—per Standaardtarief vir Verdowingsmiddels en Materiaal (Bylae C).

58215	*Na-operatiewe hoësorgsaal*, per dag	33

Iedere toelating tot sodanige eenheid moet bevestig word vir elke 72 uur.

Hospitale moet 'n sertifikaat aangaande die noodsaaklikheid van hoë sorg van die behandelende dokter verkry en sodanige sertifikaat saam met die rekening aan die betrokke skema stuur.

L.W.—Geen gelde ten opsigte van spesiale verpleging mag gehef word tydens verblyf in 'n hoësorgsaal nie.

Standard charges for equipment, etc.

		R
58231	Monitors (outside I.C.U.), per day or part thereof	10,00
58232	Respirators, e.g. Bennett PR2 or Bird (outside I.C.U.) (excluding oxygen), per day or part thereof	7,50
58233	Croupettes (excluding oxygen), per day or part thereof	2,00
58234	Incubators (excluding oxygen), per day or part thereof	4,00
58235	Oxygen tents (excluding oxygen), per day or part thereof	3,50
58236	Angstrom or Bennett M.A.I.B. respirator (excluding oxygen), per day or part thereof	30,00
	Dressing trays	
58251	Sterile trays—per tray	1,40
	Non-sterile trays:	
58253	Preparation trays—per tray	0,55
58255	E.N.T. trays—per tray	0,55
58257	Swabbing trays—per tray	0,55

ANNEXURE C

STANDARD DRUG AND MATERIALS TARIFF: JUNE 1978

1. *Over-the-counter and proprietary items*

As per suggested retail prices—Pharmaceutical Society of South Africa.

2. *All dispensed items*

As per the official schedules and tables of the Pharmaceutical Society of South Africa.

3. *Ampoules ex broken bulk*

In proportion to the retail price. No dispensing fee shall be added, whether ampoules are obtained from the ward, the dispensary or the theatre.

4. *Schedule 7 ampoules*

Where such ampoules are obtained from the ward, the dispensary or the theatre, the Schedule 7 fee (20c) shall be levied on the *total* number of ampoules, irrespective of how many ampoules are supplied.

If more than one Schedule 7 commodity appears on an invoice, the Schedule 7 fee shall be charged separately for each commodity.

5. *Price of tables and capsules ex-ward*

The price per tablet or capsule shall incorporate a *pro rata* dispensing fee, i.e. the price charged shall be the retail price of the smallest pack plus the dispensing fee of the Pharmaceutical Society of South Africa divided by the number of tablets or capsules in the smallest pack.

In the case of tablets or capsules that fall under Schedule 7 the formula shall be the retail price of the smallest pack plus the dispensing fee of the Pharmaceutical Society of South Africa plus the Schedule 7 fee, divided by the number of tablets or capsules in the smallest pack.

6. *Syringes*

Manufacturer's list price plus 50 per cent. The same should apply to all surgical items such as catheters, etc.

7. *Gas (oxygen and nitrous oxide)*

R1,50 per 15 minutes—for both gases together. Ward fee for oxygen—60 cents per hour or part thereof. (In areas where railage or the manufacturer's supply price is much higher than average, these rates may be increased to cover such higher cost.)

8. *Halothane* (Fluothane)

R1,50 per 15 minutes or part thereof.

9. *Sutures*

Synthetic absorbable sutures e.g. Vicryl and polypropylene e.g. Prolene—R3,75 each.

Common atraumatic sutures—R2,25 each. Ophthalmic or special sutures at list price plus 50 per cent.

10. *Prosthesis*

Vitallium or equivalent:

Up to R120—gross cost plus 50 per cent; over R120—gross cost plus 25 per cent; and over R1 000—by arrangement.

11. *Electronic supplies*

By arrangement.

12. *Railage*

An additional charge may be made to cover the cost of railage paid on items sent to areas outside the supplier's free delivery area.

Standaardheffings vir toerusting, ens.

		R
58231	Monitors (buite I.S.E.), per dag of deel daarvan	10,00
58232	Respirators, bv. Bennett PR2 of Bird (sonder suurstof) (buite I.S.E.), per dag of deel daarvan	7,50
58233	Croupettes (sonder suurstof), per dag of deel daarvan	2,00
58234	Broeikaste (sonder suurstof), per dag of deel daarvan	4,00
58235	Suurstoftente (sonder suurstof), per dag of deel daarvan	3,50
58236	Bennett M.A.I.B.- of Angstrom-respirator (sonder suurstof), per dag of deel daarvan	30,00
	Bewerkingsblaaie	
58251	Steriele blaaie—per blad	1,40
	Nie-steriele blaaie:	
58253	Voorbereidingsblaaie—per blad	0,55
58255	O.N.K.-blaaie—per blad	0,55
58257	Depperblaaie—per blad	0,55

BYLAE C

STANDAARDTARIEF VIR VERDOWINGSMIDDELS EN MATERIAAL: JUNIE 1978

1. *Toonbank- en patentitems*

Per voorgestelde kleinhandelprys—Aptekersvereniging van Suid-Afrika.

2. *Alle toebereide items*

Per die amptelike skedules en tabelle van die Aptekersvereniging van Suid-Afrika.

3. *Ampules uit gebroke grootmaat*

Pro rata die kleinhandelprys. Toebereidingskoste moet nie bygereken word nie, ongeag of die ampules van die saal of apteek of teater verkry is.

4. *Skedule 7-ampules*

Waar sodanige ampules van die saal of die apteek of die teater verkry is, moet die Skedule 7-heffing van 20c gevra word op die *totale* aantal ampules, ongeag hoeveel ampules verskaf is.

Indien meer as een Skedule 7-middel op die faktuur verskyn, moet die Skedule 7-heffing vir elke afsonderlike middel gevra word.

5. *Prys van tablette en kapsules uit die saal*

Die prys per tablet of kapsule moet 'n *pro rata*-toebereidingsgeld insluit; byvoorbeeld: Die prys wat gevra word, is die kleinhandelprys van die kleinste verpakking plus die Aptekersvereniging van Suid-Afrika se toebereidingsgeld, gedeel deur die getal tablette of kapsules in die kleinste verpakking.

Waar die tablet of kapsule onder Skedule 7 ressorteer, is die formule: Die kleinhandelprys van die kleinste verpakking plus die toebereidingsgeld volgens die Aptekersvereniging van Suid-Afrika plus die Skedule 7-heffing, gedeel deur die getal tablette of kapsules in die kleinste verpakking.

6. *Spuite*

Die vervaardiger se gelyste prys plus 50 persent. Insgelyks geld die gelyste prys ook vir alle chirurgiese items soos kateters, ens.

7. *Gas (suurstof en laggas)*

R1,50 vir 15 minute—vir albei gasse saam. Suurstof, in die saal—60c per uur of gedeelte van 'n uur. (In gebiede waar die spoorvrag of die vervaardiger se prys aansienlik hoër as die gemiddelde is, kan die tarief verhoog word om die hoër koste te dek.)

8. *Halotaan* (Fluothane)

R1,50 per 15 minute of deel daarvan.

9. *Hegmateriaal*

Sintetiese oplosbare hegmateriaal, bv. Vicryl, en polipropileen, bv. Prolene, R3,75 elk.

Gewone nie-traumatiese hegmateriaal R2,25 per stuk. Oogkundige of spesiale hegmateriaal teen die gelyste prys plus 50 persent.

10. *Prostese*

Vitallium of ekwivalent:

Tot R120—brutokoste plus 50 persent; meer as R120—brutokoste plus 25 persent; en meer as R1 000—volgens ooreenkoms.

11. *Elektroniese benodigdhede*

Volgens ooreenkoms.

12. *Spoorvrag*

'n Bykomende heffing kan op items wat na gebiede gestuur word wat buite die verskaffer se gratis afleweringsgebied is, geplaas word om die uitgawe wat aan spoorvrag betaal is, te dek.

13. *Price increases*

Should there be an increase in the supplier's price of any item which is not listed in the official price list, e.g. gas, the new price shall be based on the additional cost plus 50 per cent added on to the existing price.

13. *Prysstygings*

Indien daar 'n styging is in die verskaffer se prys vir 'n item wa nie op die amptelike pryslys is nie, bv. gas, word die nuwe pry gebaseer op die bykomende koste plus 50 persent, wat by d bestaande prys getel word.

New fees for private hospitals

Argus 8/5/79

(98)

NEW fees for private hospitals, to come into effect on June 1, have been announced in the Government Gazette.

General ward fees at private hospitals with up to 70 registered beds for whites will be R20 a day, and in larger hospitals R23 a day.

Private wards in small hospitals — whether prescribed or on request — will be R30 a day with a 10 percent discount if the medical scheme concerned guarantees payment for a private ward. In larger hospitals the fee will be R33 a day with the same discount facility.

Full daily ward rates will be charged if patients are admitted before noon or discharged after noon.

THEATRE

Theatre fees for outpatients in small hospitals will be R13 for the first 15 minutes, plus R6,50 for each additional 15 minutes. Comparative fees in the larger hospitals will be R14,50 and R7,20.

In patients theatre fees in small hospitals will be R33,50 for the first 15 minutes, increasing at R6 a time to R50 for an hour. For each 15 minutes over the hour an additional R12,50 will be charged.

Fees in the larger hospitals average about R5 more.

Fees for intensive care units will cost R45 a day (small hospitals) and R50 a day (large hospitals). Both categories will charge R30 a day for post-operative high care wards.

Four new hospitals for blacks planned

Star 1/1/1979 (98)

Pretoria Bureau

Four new hospitals for the Transvaal's black people are on Provincial drawing boards.

Millions of rands will be pumped into improvements of facilities for this section of the community over the next few years.

Two new hospitals are being planned for the Johannesburg area — for Soweto's population and for Indian residents of Lenasia.

Plans are also being drafted for black hospitals in Volksrust and Pholosong.

Nursing colleges will also be built in Soweto and at Natalspruit, on the outskirts of Germiston.

New schools and improvements to existing facilities, which are now being planned by the Province, will push another R35-million into education in the Transvaal.

Pretoria's education requirements are particularly spotlighted, with two new Afrikaans primary schools, an art, music and ballet school and boarding houses at the Onderwys College and the Afrikaans Technical School planned.

The province will spend R13,4-million on construction of the Pretoria State Theatre over the next 12 months.

To date nearly R29-million has been spent on the development of the theatre which will eventually cost R52,4-million.

98

Whites only is nursing rule at Jo'burg clinic

Star 14/5/79

Black and coloured nurses will not be employed in the Park Lane Clinic Johannesburg. The clinic's management has knuckled down to political pressure despite the Minister of Health's assurance that there is no law against employing these nurses.

The manager of the prestige Johannesburg clinic, Mr Harry Fisher, said today he was abiding by the Director of Hospital Services, Dr Hennie Grove's ruling that black or coloured nurses could not be employed in the clinic.

Although the Minister of Health, Dr Schalk van der Merwe, was not available for comment today, he was quoted in a morning newspaper as saying there was no law against employing the nurses.

The dispute about the

To Page 3, Col 7

'Whites only' nurses

Continued.

From page 1

employment of the nurses started recently when 12 highly qualified coloured nurses at the clinic were banned from working as nurses and transferred to other "menial work."

Mr Fisher said he would not personally make any representations to Dr van der Merwe.

"Action is being taken in other spheres," he said.

A Department of Health official said that several years ago it became apparent private nursing homes were employing black nurses at lower pay. There were complaints that they preferred black staff because it was cheaper to employ them.

Now, however, qualified black staff may be employed provided vacant posts have been widely advertised, but must not be paid lower wages than whites.

Coloured man heads Peninsula hospital

Argus 16/5/79

(98)

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.

In an interview, Dr Gamieldien said there was no discrimination whatsoever at the hospital, and white and coloured nurses, doctors and staff used the same facilities.

The hospital, which caters for just under 1 000 coloured and Indian mental and tuberculosis patients, got its new name two years ago when the Westlake Institution, Dr Stals Hospital and D P Marais TB centre were amalgamated.

Dr Ahmed Fouad Gamieldien.

BORN IN CAIRO

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 completely and he had had no problems since he assumed 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.

'The only discrimination was in the pay but this has been removed as from last month.

Having been born overseas where he spent most of his life, he would have felt 'strongly' if there was an apartheid incident at the hospital, he said.

NURSES

Most of the nurses living at the centre were coloured and they had their own quarters.

The only coloured matron lived in a flat and the white matrons lived in married-quarter homes.

Besides having a coloured superintendent, the hospital board also had all coloured members for the first time, he said.

Dr Gamieldien said his parents moved from District Six to Cairo in 1930 after deciding to give his two elder brothers a religious 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.

In Cape Town he started as medical school inspector and in 1972 joined Valkenberg Hospital as a medical officer becoming assistant medical superintendent in 1977.

He took up his position as medical superintendent at the Dr Stals Centre at the beginning of this month.

Nursing home permits may be 'streamlined'

Political Reporter

THE ASSEMBLY — The Government is trying to streamline the procedure which black, Indian and coloured people have to follow when applying for a permit for treatment at a private nursing home in white areas.

This has emerged from a reply by the Minister of Community Development, Mr Marais Steyn, to a question tabled in Parliament by Mr Horace van Rensburg (PFP Bryanston).

Mr Steyn said that in terms of the Group Areas Act a "disqualified person," could only be admitted to a private hospital after obtaining a permit.

"However, an investigation is in progress to streamline the procedure to obtain permit authority."

In an interview later, the Secretary for Community Development, Mr L Fouche, declined to give further details about the investigation, beyond saying that it should not take long to complete.

Hospital opens up to Indians

Staff Reporter

THE GENERAL Hospital in Johannesburg will open its doors to Indian patients once the move to the new Johannesburg Hospital on Parktown Ridge is complete.

Mr Kallie de Haas, MEC in charge of hospitals for the Transvaal, said 114 beds in the Julius Jeppe block would be available to Indians until extensions were finished at the Coronation and New Lenasia Hospitals.

The superintendent of the Coronation Hospital, Dr C Kniep, said while extra accommodation was necessary, he would be unable to run the two hospitals on existing staff.

The Coronation Hospital staff complement of 501 coloured and 136 Indian nurses would not be able to cope with an extra 114 beds.

Mr De Haas said the present outpatient and administration centre at the old General Hospital would provide dental, psychiatric, outpatient, theatre and post-operative facilities.

Funds curb Ciskei hospital take-over

105
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DD
18/5/79

KING WILLIAM'S TOWN — The Ciskei Department of Health was keen to take over the McVicar and Victoria Hospitals at Lovedale on condition the necessary funds were available, the Ciskei Minister of Health, Dr B. R. Maku, said yesterday.

He was delivering his policy speech on the health budget vote at the Ciskei Legislative Assembly.

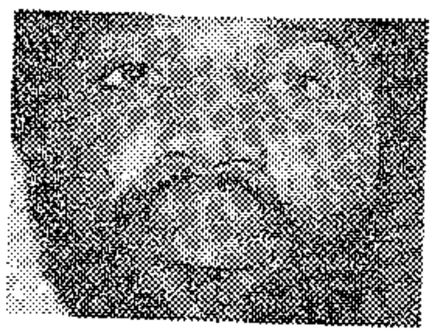
"It will not be feasible for my department to assume responsibility for these hospitals without the necessary funds to run them," Dr Maku said.

He said the Cecilia Makiwane Hospital at Mdantsane was expanding. More beds were commissioned and more wards were opened at the hospital to receive the patients who formerly received treatment at Frere Hospital.

From

CHARLES NQAKULA

in the CLA



"The Cape Provincial hospital administration authorities have curtailed certain services at Frere and these services are being transferred to the Cecilia Makiwane Hospital," he said.

Two departments, paediatrics and gynaecology, had been taken over and another takeover was envisaged soon of the departments of urology and ophthamology.

"In addition to these extra services at Cecilia Makiwane, two wards have been opened to accommodate patients who suffer from cancer and who received radiotherapy."

He said the patients were housed formerly at the old age home in Duncan Village, East London, but conditions there were unsatisfactory.

"A large number of tuberculosis patients are accommodated in other parts of the country which is unsatisfactory because we don't have adequate medical control over these patients," Dr Maku said.

It was necessary to arrange to accommodate 400 to 500 TB patients because he had been advised the Woodbrook Chest Hospital would probably be closed.

"There is also a need for institutional care of our own patients who suffer from psychiatric disorders. They currently are accommodated at Fort Beaufort and at Komani Hospital in Queenstown."

His department planned to build a hospital for such institutional care on a site near the Cecilia Makiwane Hospital.

The lack of funds had restricted the possibility of erecting a hospital at Whittlesea and the department's efforts had been concentrated on the establishment of as many clinics as possible.

'Close pay gap for black Tvl doctors'

By AMEEN AKHALWAYA
Political Reporter

SALARY discrimination against black doctors employed by the Transvaal has come under fire in the Transvaal Provincial Council.

Mr Schalk Visser (PFP Sandton) said on Thursday that "nowhere in this income and expense account called the budget" was provision made for equal pay for equal work.

"The situation today demands that equal pay be brought in for doctors employed by this Province. They are paid a lower salary purely and simply because they are not white," Mr Visser said.

He dismissed any suggestion that the Province could not afford to pay equal salaries.

The Government, he said, had spent a lot of money to influence the thinking of English-speaking South Africans and a few people outside the country through its backing of To The Point magazine.

"How about influencing the thinking of the black intelligensia by paying them what they deserve?" Mr Visser said.

On the question of employers illegally employing blacks, Mr Visser said the position could become appreciably worse because of the Riekert Commission recommendations.

Employers of "illegal" workers would be subject to heavy fines.

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Medical profession shocked by complaint

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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.

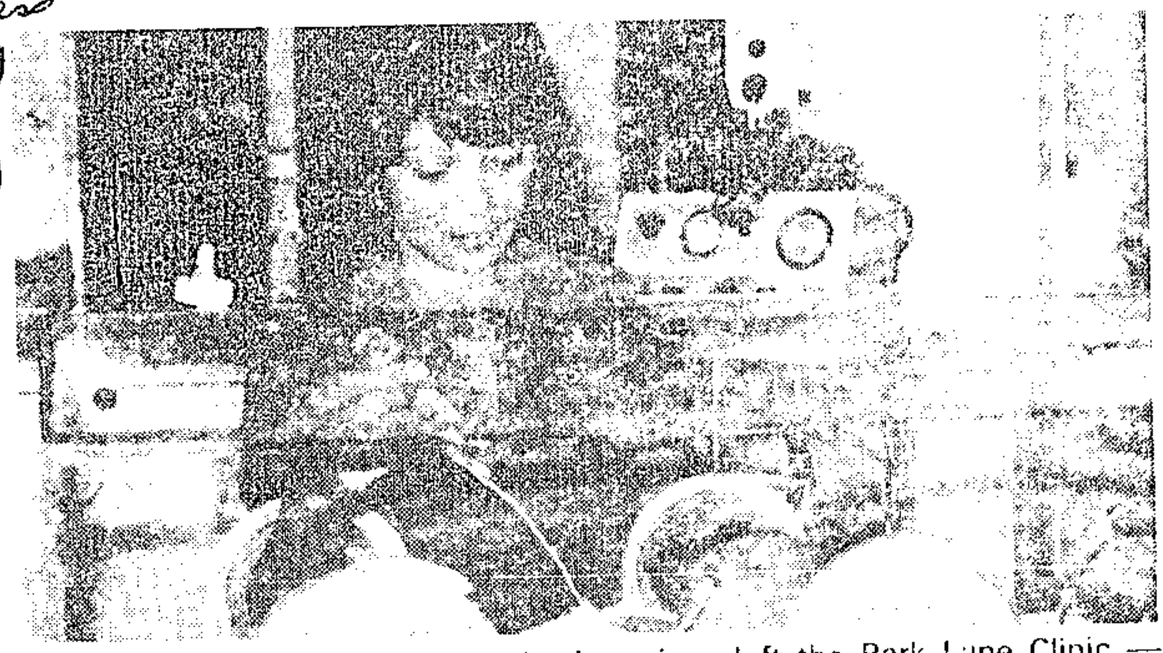
"I glanced at some headlines about nurses but I don't know anything about the situation," Mr Barnard said.

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.

The love that kept baby



● A young Coloured sister — who has since left the Park Lane Clinic — feeds Louise in her incubator.

Louise alive

DR PIET TO GET MUM'S CLINIC PLEA

By PADDI CLAY

FOR Mrs Felicity McBride the ban on Coloured nurses at the Park Lane Clinic, Johannesburg, is a personal outrage. Had it not been for them, she says, her baby daughter Louise would have died.

Mrs McBride wrote this week to Dr Piet Koornhof, Minister of Co-operation and Development, protesting against the ban.

She begged Dr Koornhof to use his influence to try to change the attitude of the Transvaal Provincial Administration, and allow the Coloured nurses to continue nursing premature and ill babies.

Mrs McBride told Dr Koornhof that had it not been for the sisters in the neo-natal unit at the clinic, her baby Louise would have died.

Louise was born weighing only 1.5 kg and had hyaline membrane. She was given a 50% chance of survival.

Mrs McBride is convinced it was the love and dedication of the sisters at the Park Lane Clinic that saved her little girl.

But now, in terms of a 21-year-old regulation of the provincial administration, the clinic has been told that Coloured sisters cannot nurse White patients.

Mrs McBride called the ban a tragic happening in the history of the country's nursing.

"And especially at a time when we South Africans look to the leaders of the National Party to help strive to eliminate petty apartheid . . ."

Mrs McBride told Dr Koornhof of the wonderful help and support she had received from the Coloured sisters who cared for tiny Louise, who had to spend the first five weeks of her life in an incubator.

Louise had to remain in the clinic after her mother was discharged.

Mrs McBride and her husband David were only able to see their incubator baby in the evenings.

Coloured sisters were on night duty in the neo-natal unit, and were the sisters the McBrides came to know best.

"It was those sisters who taught my husand and me, over the long weeks that we waited for our daughter to be allowed home, how to hold Louise, bath her, feed her and make her feel secure.

"Because Louise was such a tiny baby she had to be handled with extra care, caution and confidence."

Mrs McBride told the Minister the sisters inspired her to cope with the tiny, premature baby and be a competent mother.

The sisters even changed Louise's feeding time to fit in with the visits of Mrs McBride and her husband.

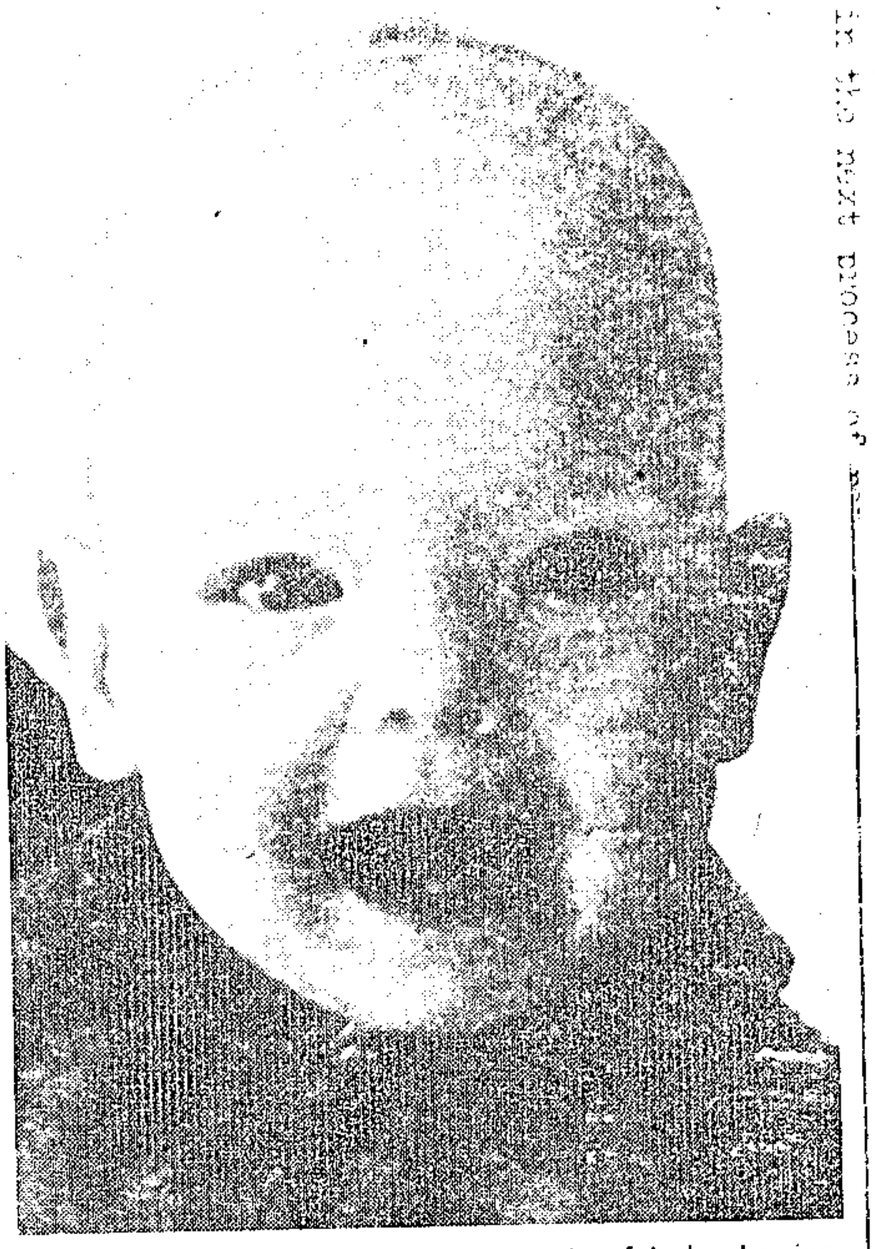
"All of us regret that the sisters are now unable to continue the work that everyone, except the Department of Health, believes they are best at," Mrs McBride said.

Mrs McBride ended her letter to Dr Koornhof:

"Can we as Christians ever hold our heads up to God again after depriving not only the sisters of their work but dying and sick babies of the professional and loving care that some have been fortunate enough to have?"

"I don't know if Dr Koornhof will even get my letter personally, but I felt I had to support the sisters in some way," Mrs McBride told me.

"There is a shortage of nurses. The policy should be to use the best ones for the job — regardless of race."



● Very much alive — a photograph of baby Louise McBride as she is today.

Picture by DENIS FARRELL

A sick business

argus 21/5/79

98

ANOTHER tawdry little triumph for the indefatigable forces of verkramptheid has been chalked up — this time at the expense of black nurses. A dozen, fully qualified black nurses, one of whom has lectured at London's Guy's Hospital, have been prevented by the Transvaal Provincial Administration from serving at a private clinic in Johannesburg. The MEC for hospital affairs, Mr Kalie de Haas, said it was 'undesirable' for black nurses to tend to white patients.

The sentiment is unacceptable, whatever the hospital. But it is outrageous that it be imposed on a private clinic, which should have the right to pick its own staff on the basis of competence, not colour. The Minister of Health says there is no law against blacks nursing at white hospitals. The clinic should stick to its guns and keep the black nurses.

i) "Self" Delusion : the sublime realization of the truths of Anicca and Anatta.

ii) Doubt and Skepticism : the dispelling of any misgivings about the Dhamma through the personal verification of all its tenets, and the direct experience of its truth.

iii) Dependence on Rites : the eradication of all superstitions and notions regarding the efficacy of rituals, ceremonies, invocations, worship and prayer and the knowledge that the simple adherence to ascetic practices and rules of conduct alone cannot, by themselves, bring liberation.

The Stream Enterer can no longer be deviated from his final goal : the state of Araha. At the most, he will require seven more incarnations during which he will eradicate the remaining seven Fetters.

The second stage of Sainthood : SAKADAGAMI - the "Once Returner". The next two Fetters, those of Sensual Desire and Aversion, are extremely stubborn defilements. Their outward manifestation (vitikkama) and even their subconscious presence (pariyutthana) may be sublimated but their latent potentialities (anusaya) are so basic to mundane existence, and have for so long been part of our psychological make-up, that their utter abolition is, in fact, the hallmark of true enlightenment. A Sakadagami never completely overcomes these two Fetters. This is finally only accomplished in the next stage of Sainthood. But his dominion over Sense Desires and Aversion is so advanced that he needs to be born only once more to overcome them completely.

The third stage of Sainthood : ANAGAMI - the "Non-Returner." The Anagami has totally uprooted all traces of Sensual Desire and Aversion. He has therefore destroyed all the motivations and seeds of attachment that give rise to phenomenal expression, namely :

iv) Sensual Desire. These are the longings and cravings for desirable
down to the

v) Aversion,
It is the
all those
one's wish

With the abolition of the
existence have become sev
as an Araha during his la
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The fourth stage of Saint
five Fetters have been ov
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These will have to be el
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vi) Attachmen
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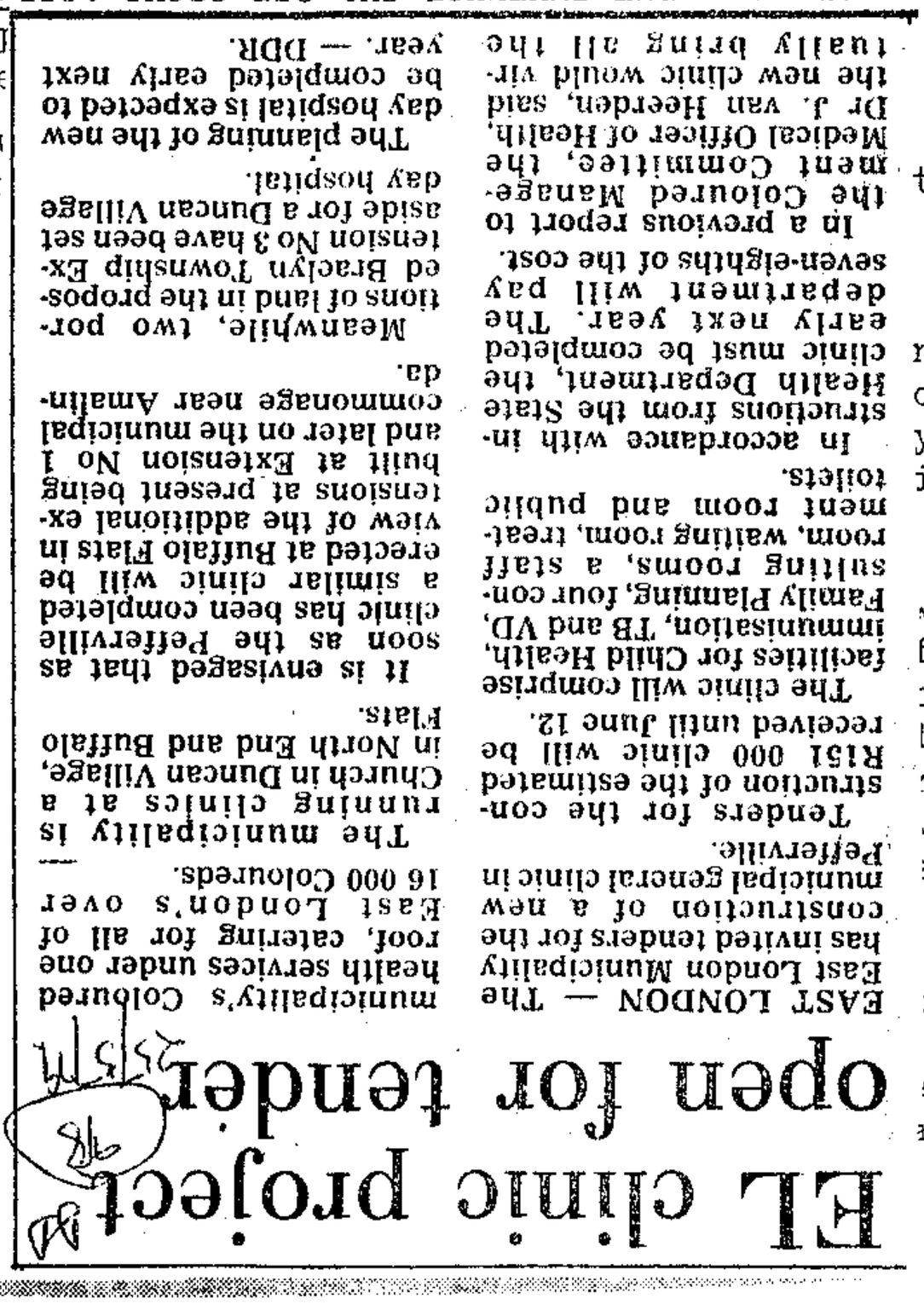


EL clinic project open for tender

EAST LONDON — The East London Municipality has invited tenders for the construction of a new municipal General clinic in Pefferville.

Tenders for the construction of the estimated R151 000 clinic will be received until June 12.

The clinic will comprise facilities for Child Health, immunisation, TB and VD, Family Planning, four consulting rooms, a staff room, waiting room, treatment room and public toilets.

In accordance with instructions from the State Health Department, the clinic must be completed early next year. The department will pay seven-eighths of the cost.

In a previous report to the Coloured Management Committee, the Medical Officer of Health, Dr J. van Heerden, said the new clinic would virtually bring all the

The planning of the new day hospital is expected to be completed early next year. — DDR.

Meanwhile, two portions of land in the proposed Bracyn Township Extension No 3 have been set aside for a Duncan Village day hospital.

It is envisaged that as soon as the Pefferville clinic has been completed a similar clinic will be erected at Buffalo Flats in view of the additional extensions at present being built at Extension No 1 and later on the municipal commonage near Amalinda.

The municipality is running clinics at a Church in Duncan Village, in North End and Buffalo Flats.

municipality's Coloured health services under one roof, catering for all of East London's over 16 000 Coloureds.

Hospital rules: Don't feed the patients

98
5/6/79
Sunday Express

By ZANDI SIKWEBU

VISITORS are not allowed to take home-cooked food into Tembisa Hospital, near Kempton Park, since a patient was allegedly poisoned.

Three nursing sisters told me a patient died after eating poisoned food brought in by somebody from outside.

After this incident, they said, people were barred from giving food to patients. Now only fruit or mineral drinks can be brought in.

The hospital superintendent, Dr H G van den Hooven, confirmed that this rule was in force.

He said some of the patients were on strict diet. "If they are given other food, they can go into a coma, which might be difficult to control, and could even die."

A reliable source at the hospital, who asked not to be identified, claimed that a patient collapsed and died earlier this year after eating food brought into the hospital.

She could not recall what the patient was suffering from when admitted.

Dr Van den Hooven said he was not aware of this case.

And police at Tembisa said they had not been asked to investigate the death of a patient at the hospital.

To prevent food being taken into the wards, visitors are searched by security guards as they enter the hospital.

Any food they are carrying must be left at the gate and collected on their way out.

None of the visitors I spoke to seemed upset by this arrangement.

But one visitor, from Springs, appealed to the hospital authorities to put up a notice in a conspicuous place informing the public about what they should not take into the wards for patients.

A security guard said they sometimes found bottles of liquor in visitors' bags. The liquor was apparently intended for patients.

When that happened they would take it into safekeeping and return it to the owner on his way out.

PFP attacked over EL hospital

7/6/79 98 BD

CAPE TOWN — The new day hospital in Duncan Village will cost R786 000, of which R500 000 will be spent this year, the MPC for East London City, Mr Petro de Pontes, disclosed in the Provincial Council yesterday.

Mr De Pontes attacked the Progressive Federal Party and the Daily Dispatch for what he called blatant distortion of the truth about hospital services in the East London area.

Mr De Pontes thanked the Cape Provincial health services for "ensuring that the people living there will at all times have complete medical services".

The department had regarded the interests of patients above any other consideration and ensured that changes in the services could only be carried out where there were no damaging consequences on such a patient.

In this spirit, the day hospital had been planned in Duncan Village and this planning would be completed at the end of the year.

"The department's view that as long as a community needs its services these should be available, deserves our greatest praise," he said.

In a plural society such as South Africa's "where this service to the whole society is controlled by one group, it is an area of potential friction, or goodwill between the various groups and an area easily accessible to those who wish to serve their own political ideals, rather than the well-being of the community."

He said that due to the tremendous population growth in the area, the Cecilia Makiwane Hospital had been built at Mdantsane.

"Services to blacks at Frere Hospital were, when it could be done without harm to the community, transferred to the new hospital.

"The whole process was conducted under the supervision of a committee established for this purpose, and carried out in the most co-ordinated and efficient way possible.

"Despite all possible being done to ensure the black patients suffered no prejudice — and I can assure you the utmost care was taken — the member for Constantia (Mr Roger Hulley), saw fit to attack the department about this.

"His attacks, as pointed out then, were baseless and demonstrated his party's ignorance more than its supposed concern for East London's blacks.

"But his party's elements in East London went even further. Aided and abetted by its local newspaper — or possibly led by it as the PFP have this tendency to follow rather than lead its newspapers — they published report after report, distributed pamphlets in which it was alleged certain services at Frere had been closed to blacks completely — and black people in need of immediate medical attention were turned away.

"This, while in fact Frere Hospital had always, and still does, immediately treat anyone — regardless of colour or creed —where such treatment was medically necessary.

"The only persons referred to Mdantsane were those referred to in medical terms as "cold cases", where medical attention was not immediately necessary, where this could be done without prejudice to such a person.

"Not satisfied with blatantly distorting the truth, they went further and published photographs of black women with their children in their arms, sitting destitutely on the sidewalk, allegedly lamenting that they had been turned away by the Frere Hospital and had to carry their desperately ill children all the way to Mdantsane — and that such children may die on the way.

"They published this in the full knowledge that, as I have said, Frere would at any time have afforded a needy child treatment — and, what is more, knowing that some of these women were not only resident in Mdantsane, but had actually passed the Cecilia Makiwane on their way to the Frere Hospital.

"I publicly invited anyone who felt aggrieved by anything done at the Frere Hospital to come and tell me about it so that I could have this complaint investigated — and I received no complaints.

"This groundless and scandalous agitation about this situation will cause the PFP everlasting damage.

"And was it not for the purposeful, service oriented actions by the MEC and the department, it could have developed into a nasty incident, which could have irreparably damaged race relations," Mr De Pontes said.

Phased out

These are some of the facts leading to Mr De Pontes' statement in the Provincial Council yesterday:

In May last year, the black obstetrics and gynaecology services at Frere Hospital were phased out.

The black children outpatients section and the nutrition clinic for blacks were closed in June last year.

In the same month, the Cape director of Hospital Services, Dr L. Kotze, postponed closure of black paediatric services at the hospital until transport between Duncan Village and Cecilia Makiwane Hospital was adequate.

In July last year, Mr De Pontes said none of the facilities for blacks then available at Frere Hospital, would be closed until a day hospital had been opened at Duncan Village or an alternative site to render these services had been found.

In December last year, Mr De Pontes said the urology and opthamology departments would treat emergency black cases only after December 31.

Non-emergency services would be transferred to Cecilia Makiwane Hospital and adequate transport would be provided.

The Border Medical Association, city councillors, the Progressive Federal Party and the Joint Locations Advisory Board have protested the phasing out of black services at Frere Hospital. — DDR.

Pressure kept services at Frere — Sparg

EAST LONDON — The National Party MPC for East London City was "patting the government on the back" for operating hospital services for blacks here that might have been taken away if various groups had not protested, the Border Regional chairman of the Progressive Federal Party, Mr Ivor Sparg, said yesterday.

Mr Sparg was commenting on an attack in the provincial council by the MPC, Mr Petro De Pontes, on the PFP and the Daily Dispatch for what he called blatant distortion of the truth about hospital services in the East London area.

In his speech Mr De Pontes thanked the Cape Provincial Services for "ensuring that the people living there will at all times have complete medical services".

Mr Sparg said it was a result of the objections of such groups as the PFP, the city council and others that the government decided not to discontinue certain services for blacks at Frere Hospital.

"I have no doubt the pressure brought to bear did have some results although these may not be totally satisfactory.

"We did not take part in the issue to make political capital or to make it a political issue. We acted on it as a moral issue," Mr Sparg said.

He said there were so many black people living in East London that hospital services had to be provided for them here and they could not be transported to Mdantsane.

The Senior Medical Superintendent at Frere, Dr G. L. Bracken, said the only black facilities that had been transferred from Frere to Cecilia Makiwane Hospital in Mdantsane were the booked beds in the gynaecology, urology and opthalmology wards. There were between five and eight beds in each of these wards.

Dr Bracken said in the average male and female wards there were 40-50 beds.

There were still emergency services in all these units and there were out-patients where necessary. Patients who had minor conditions and had been dealt with before were still treated at Frere.

Patients who booked operations in the gynaecology, urology and opthalmology section were referred to the Cecilia Makiwane Hospital.

It was untrue that the black obsetrics services had been phased out at Frere.

"There are full obstetric and ante-natal services and a full orthopaedic service," Dr Bracken said.

There was a day family planning service operating from 8 am to 5 pm.

Frere has a full ear, nose and throat service and a radiotherapy service for blacks.

A 24-hour casualty service operates.

Dr Bracken said there was a general out-patient service for adults which dealt with about 200 cases a day.

She emphasised that there was a full paediatric service operating at Frere for blacks.

This included a general section, a special section, a nutritional clinic, an immunisation clinic and an emergency operation room.

There was a dermatology section for blacks.

Dr Bracken said she felt news reports about services being discontinued for blacks were unjustifiably giving the Hospital a bad name.

(News by P. Kenny, 33 Caxton Street, East London.)

More patients than beds

THE ASSEMBLY — Four black and one white state-run mental hospitals have an average occupancy more than the number of beds available, the Minister of Health, Dr Schalk van der Merwe, said yesterday.

They are the Tower Hospital in the Cape, the Komani Hospital in the Cape, the Oranje Hospital in the Free State and the Witrand Hospital in the Transvaal.

The Tower Hospital at Fort Beaufort has 967 beds but an average occupancy of 1 181, at a cost of R3,10 per patient; Weskoppies has 641 beds for blacks but an average occupancy of 983 at a cost of R5,80 per patient; Komani Hospital in Queenstown has a capacity for 526 blacks but an average occupancy of 595 at a cost of R6,26 per patient; and the Oranje Hospital has 230 beds for blacks but an average occupancy of 308 at a cost of R7,12 per patient.

The white section of the Witrand Hospital has a capacity of 1 580 beds but an average occupancy of 1 627 at a cost of R4,93 per patient.

A number of other hospitals have high occupancy rates, including the black Randmore Hospital which has complete occupancy of its 390 beds, but no other state or private mental hospitals exceed their capacity.

The lowest cost per patient in state-run hospitals is R3,07 per patient at the Kowie Hospital in Port Alfred and the Tower Hospital at R3,10. The remainder range from R4,95 per patient to R9,65 per patient, but two — the Elizabeth Donkin Hospital in Port Elizabeth and the King George V Hospital in Natal — are R18,17 and R20,10 per patient.

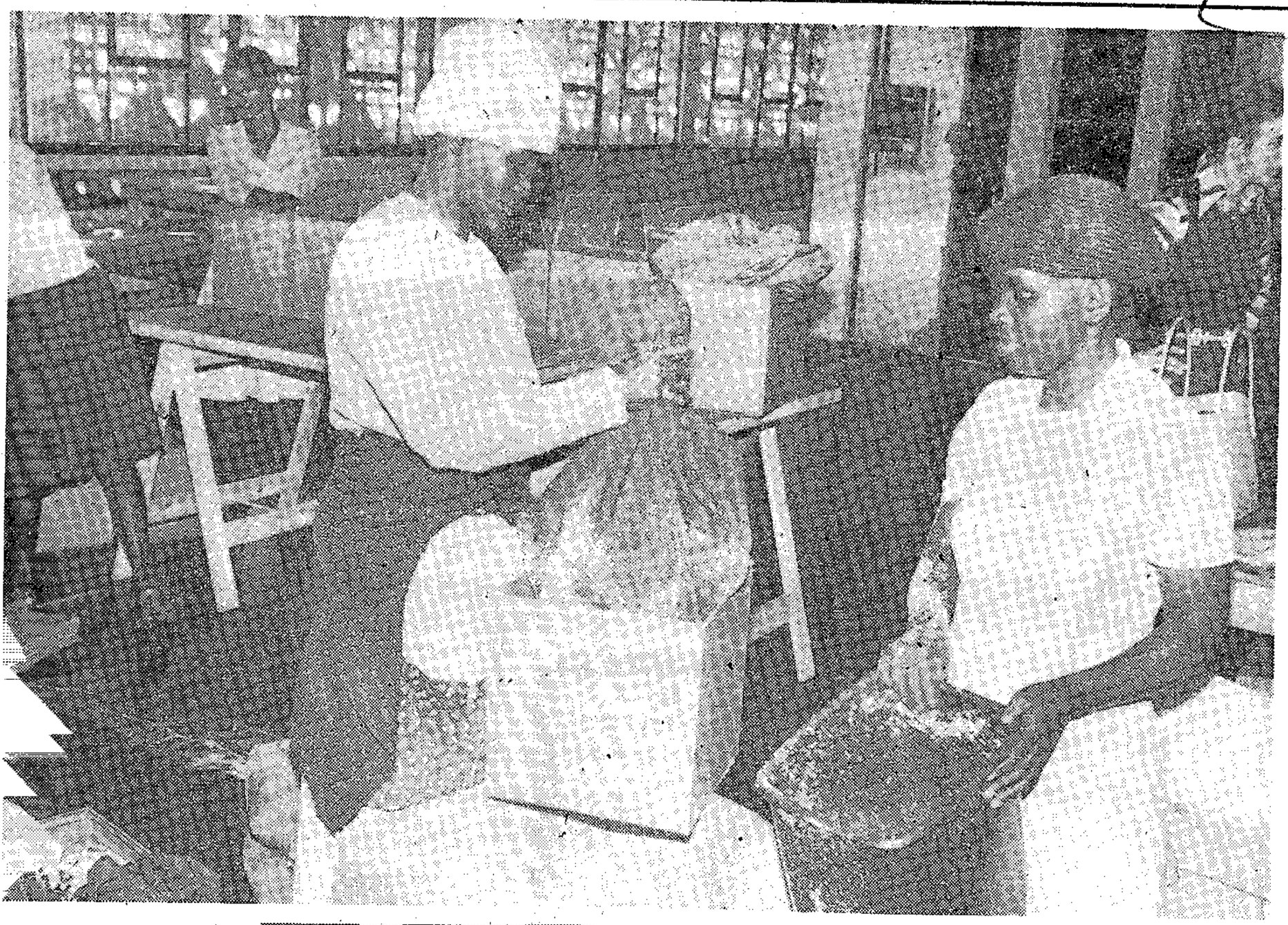
The compensation paid by the state for privately-run black mental hospitals is much lower.

At eight private mental hospitals in the Transvaal, the compensation ranges between R1,70 and R1,94 per patient. The compensation for a Coloured private hospital is R2,45 per patient, while for whites it ranges from R5,77 to R6,54.

At the Allanridge Hospital for blacks in the Orange Free State the subsidy is R2,14 per patient while at the Springfield Hospital in Durban it is R2,37.

Dr Van der Merwe said state hospitals would replace private hospitals in the Cape, Natal and Orange Free State by 1985, and in the Transvaal by 1990.

He said this in reply to a question tabled by Mr Horace van Rensburg (PFP, Bryanston). — PC.



The clinic that cares about self-help

The struggle for survival at Care Clinic continues.

The struggle involves black women and their children. They comprise widows, deserted wives and battling wives of husbands who are without employment.

For one reason or another, women are left to cope — with no means of support and no hope — until someone introduces them to Care Clinic.

The suffering is there because when a black man dies or a township father leaves his home and children, there is no protection for his wife and family.

A state pension for blacks is statutory, but it takes time and patience to organise — and often the widow has no idea how to set about it — and a maintenance grant for children is not a statutory right.

The motivating force behind the personnel of Care Clinic is their determination to break away from the traditional, benevolently patriarchal attitude of affluent whites handing out largesse to the less fortunate but never treating the root cause of the distress.

The essence of the battle for existence at Care is self-help and independence.

The aim is to guide and train each woman who comes to them to become self-supporting and to that end handicrafts play an important role in the Care training programme.

Week by week each client's particulars and progress are recorded by the voluntary counsellors

brighter more quickly, f some of them.

A wonder box is basc on the principle of the ol fashioned hay box, used keep food hot.

Two cloth cushions, fi ed with polystyrene ar packed in a box, form "stove", when a pot already boiling food placed between th cushions and left to coo slowly.

To begin with, th women were given bloc of polystyrene, to tak home, to break up int granules.

Then the women wer taught to make th cushions, by hand, and fi them, at home, for whic they are paid R2 a set c two.

Others are paid ac cording to the amount o polystyrene they 'scratch into granules.

All new cases are give food vouchers for esser tial foodstuffs fror Kupugani, but, as th woman learns to use he hands effectively, sh earns money, in lieu of food voucher — but up t a certain limit, in order t maintain the viability o Care finances, which ar limited.

These days, everythin at Care revolves aroun the wonder boxes. Hap pily, there is such a de mand for them that all the needy women are involv ed in making them.

At Care, the counselling women, who are financial ly secure and socially pampered, give hope and direction to the despairing, by their willingness to come to grips with the often un comfortable problems of

ABOVE: Filling the pillows with polystyrene granules can be ticklish work.

RIGHT: Completing two cushions in a session means a precious two rand fee. Some of the care clients stitch busily.

It's a good feeling to complete the job — the cushions are packed neatly in cardboard, to form the Wonder Box.

developed.

Knitting and crocheting are two obvious skills to encourage and train, but marketing the garments often proves less easy and not particularly remunerative.

Others are encouraged to sell vegetables and are given capital to do so. All those with homes, are given seeds to sow, in order to help feed their families.

The struggle for some of the needy women, to overcome and become self-sufficient was at times quite excruciatingly difficult and slow.

Then somebody suggested Care Clinic clients make wonder boxes for sale — and since then life has become

The women of Care are there to sort out those problems — to fight on behalf of the family until some satisfaction is achieved.

In one of the counselling rooms, Daisy, the interpreter was aiding in a conversation with Jane, who has cataracts and therefore cannot sew.

She had been given money to establish herself as a vegetable hawker, but she was explaining to Daisy that she had been forced to spend the money on school uniforms for her children, in order to have them accepted at the school.

Gloria, who has asthma and therefore cannot keep a job, reported that her vegetables were growing beautifully — and both women went off with a mound of polystyrene.

Nowest's husband was attacked by Tsotsis and blinded, which meant that the family was destitute. There is a 12-year-old girl and a baby, who, when Nowest finally arrived at the Care Clinic, one Wednesday morning, had been sucking bottles of sugarless black tea for four days.

Now both children are well-fed and Nowest is working hard at making pillows.

Nyembeji's husband is a discharged TB patient, and, with a TB stamp in his book he has found it impossible to find work.

Nyembeji's life has never been easy because she has an 18-year-old son who suffers from epilepsy, and an under-sized six-year-old.

When the voluntary helpers at Care first met Nyembeji they found her despondent, but now she is sewing well and is relieved that the clinic personnel have been able to institutionalize her son.

Nolusapho, a widow with two children, has come to life again, and developed into a confident and useful woman — thanks to Care, who met her when she was first widowed.

The two children have grown since then — the baby is just over a year old now and both are beautifully kept, bright-eyed youngsters.

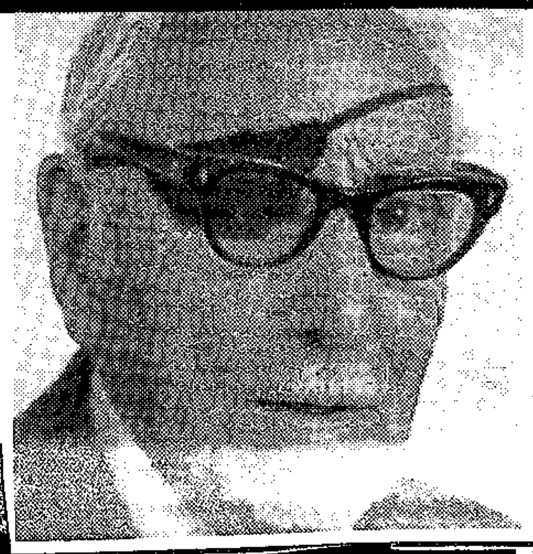
Care isn't just a place for caring — it's also a place for learning to support yourself and feel proud to do so.

— SHIRLEY SMITH

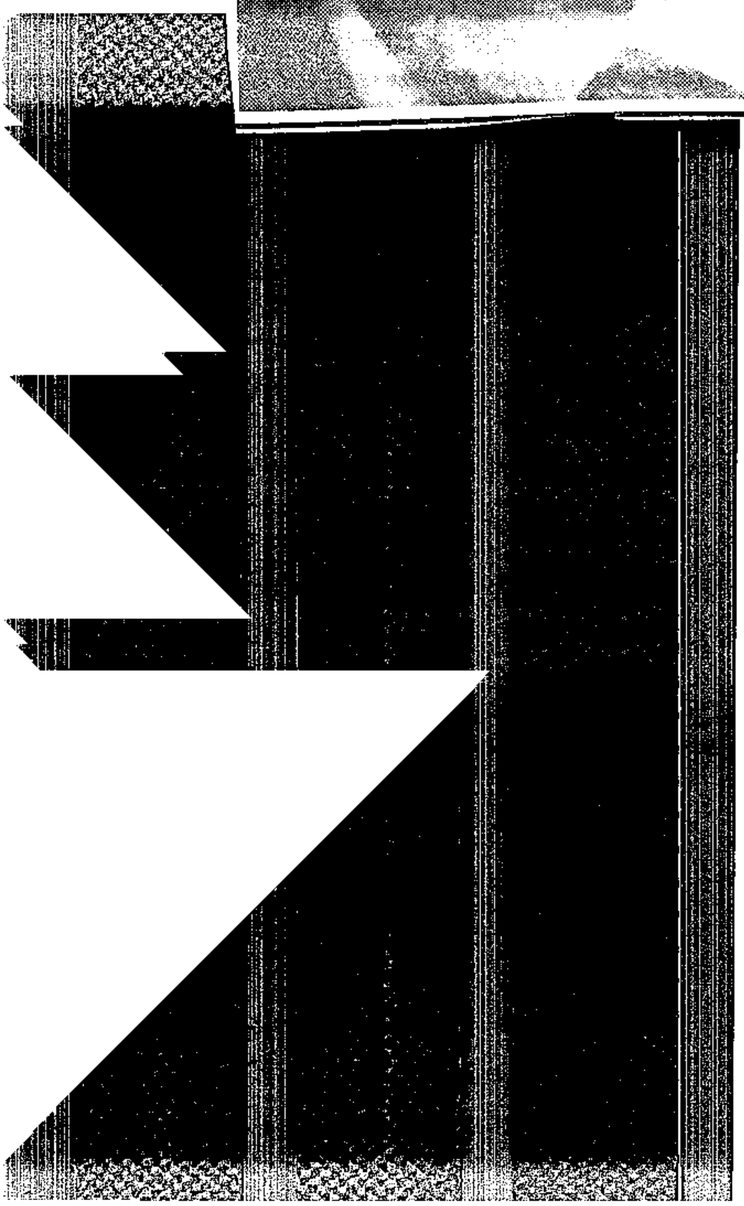
Widow Nolusapho, with her baby and young daughter, during a visit to Care Clinic, where she has been helped to rehabilitate her life.

'THEY'RE TERRIBLY SLOW — EXCEPT WHEN IT'S TIME FOR THEM TO GO HOME'

Where the old have to wait... and wait



● Mr Alf Cohen ... three-hour wait.



● Patients can make a day of it at the General, from seven in the morning until six at night ... and this can make it heavy on the old legs, especially if you've been coming every month for eight years.

OLD people say they sometimes have to wait from seven in the morning until six at night for treatment at the Johannesburg General Hospital.

The Sunday Express investigated the situation after the MPC for Hillbrow, Mr Simon Chilchick, said he had had complaints about long daily queues for elderly out-patients.

The MEC for hospital services, Mr Kallie de Haas, promised to investigate the complaints.

Mr Alfred Cohen, an 83-year-old out-patient emerged from the General with a little bottle of medicine after waiting over three hours at the dispensary. He said: "I've been coming here once a month for about eight years and often wait for up to three hours for my medicine. They must be short-staffed I suppose."

By JEREMY THOMAS

"You can make a day of it here," said one 77-year-old woman, who did not want to give her name.

"In the past I've waited from seven in the morning until six at night. The queue to get your file is even worse than the dispensary one," she added.

"The standing is terrible on the legs and I've occasionally had to stand for an hour or more. I've been here since seven this morning and at ten-o'-clock they were only on number 88.

"My number is 162."

Another man, who also did not want his name mentioned, said it didn't matter how sick you were — you just had to wait. "I've heard of sick people having to wait all day for attention," adding that he'd often seen elderly people spoken to very harshly by staff.

"Pensioners can't afford to go to private clinics which charge a fortune, so they come here instead. I think the hospital should treat us better," said one man, while others nodded.

Others spoke of the inconvenience caused by the lunch hour. "Everything stops and we just have to wait until the staff returns," one said.

"They're also terribly slow, though towards the end of the day their work rate increases drastically!"

Some patients take their complaints —to the Press

It is a curious syndrome, this maligning the hospital, writes Science Editor MARAIS MALAN. Usually there is another side to the story, and the hospital is going into the question of better communication between staff and staff as well as between staff and patients.

A nasty disease has broken out in Johannesburg. It defies accurate description, and the cause is unknown. It can be extremely virulent, and the symptoms are all mental. It can strike anyone, regardless of socio-economic status, but seems to be confined largely to whites.

For lack of a better name it is called hate-the-hospital syndrome.

The victims never tell doctors about their ailment — they tell the newspapers.

Since one of the symptoms is often mental confusion and lack of perspective, careful checking usually reveals a string of misrepresentations and gross lack of understanding.

No reason

Last week the outbreak reached a peak. The hospital was variously accused of treating patients like cattle; being totally insensitive to the pain suffered by a patient and being negligent and incompetent; of being dirty (this of a plaster room in full operation); and not wanting to admit a seriously ill baby because it did not have a "clean ward."

Take the strange case of the woman who telephoned to complain about the callous way in which her mother was treated. The mother had broken an arm, and, after it had been set and she had gone home, the hospital called her back to re-do the job. In the process, the daughter said, the staff were completely unconcerned about the patient's suffering.

Unsuspected

The matter was reported to the superintendent, and the patient was invited to come and discuss it. She was aghast when she heard about the complaint and said she was perfectly happy with her treatment.

In calling her back the hospital was actually practising good medicine. A re-examination of the X-rays by a specialist revealed an unsuspected fracture which required further treatment.

Also last week parents who took their sick baby to hospital were cross at having been told to wait, of all unlikely places, in a waiting room. Also, horror on horror, there were about 20 children in the waiting room, many "obviously ill". Fancy finding sick children in a hospital!

The "cattle" story put out by another patient? Only too true if one is confused and a nurse or doctor decides to put up the cot sides in case one falls out of bed. It may well remind one of a cattle pen.

But the man who complained did not realise that a few careless remarks harmed the reputation of one of the finest accident services in the country. He did not consider the long hours, dedication and human warmth that are being put into the service by the staff, from the head, Professor Fred Wilkinson, to the youngest nurse.

And the woman who unjustly ran down the paediatric department did not realise that she was undermining the confidence of other mothers in what is undoubtedly the best service for sick children in the country.

And so it goes on. But why so much malice towards an institution which should be the pride of every citizen of Johannesburg? For academically and therapeutically it is among the finest in the world.

No one can give a reason for this hate-the-hospital syndrome. Most complaints are directed towards the accident and casualty services. Perhaps most people believe they should receive priority in such a situation.

The hospital gives precedence only to very serious or life-threatening situations; others have to take their place in the queue. Most people accept this, but those who do not tend to turn mean and go out of their way to harm the hospital.

This is not to say that some complaints are not valid, but of all those that have come my way over the years very few are.

I have never come across any attempt at a cover-up. Each complaint reported to the superintendent has been closely investigated and the hospital has never been afraid to admit when it is wrong.

Understanding

All it asks for is understanding of its difficulties, and with constant staff shortages there have been many.

Patients who have a complaint are encouraged to discuss it with the staff first. There is always a superintendent willing to listen and usually the matter can be settled amicably.

"In fact, we welcome constructive criticism," says Dr Michael Tonkin, a deputy superintendent.

And a letter of appreciation from an ex-patient does wonders for the morale of the nurses, says Dr Ruth Drubin, another deputy superintendent.

The hospital realises it has communication problems because of its large staff, mostly working under pressure. So it has appointed a sub-committee under Dr Tonkin to promote liaison between staff members, and between staff and patients.

"We are looking into all aspects of communication," explains Dr Tonkin.

"On the one hand we try to make each staff member feel part of the team; on the other we seek to bring about a staff awareness of the patient's problems.

"My own New Year's resolution was to greet everyone I meet with a smile and spend that extra minute or two listening to the problems of both staff and patients. It is this attitude we are trying to foster among all staff members."

Teething

The Johannesburg General Hospital is in for a difficult period. It is scheduled to move to the new hospital in Parktown at the end of the year. Inevitably there will be disruption of services, teething problems and frayed tempers. But the hospital hopes the whole process will be one of controlled chaos, with the emphasis on "controlled."

And patients are asked to be patient until the new hospital has sorted itself out.

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

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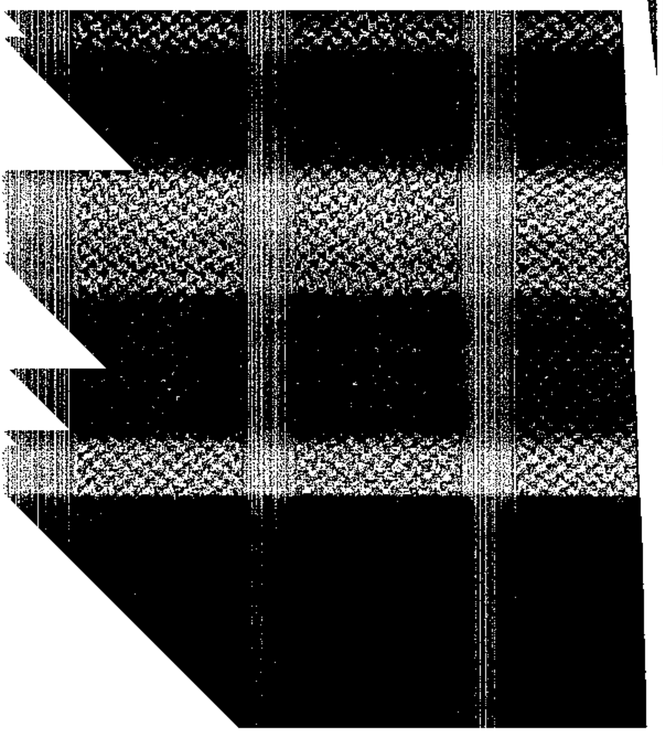
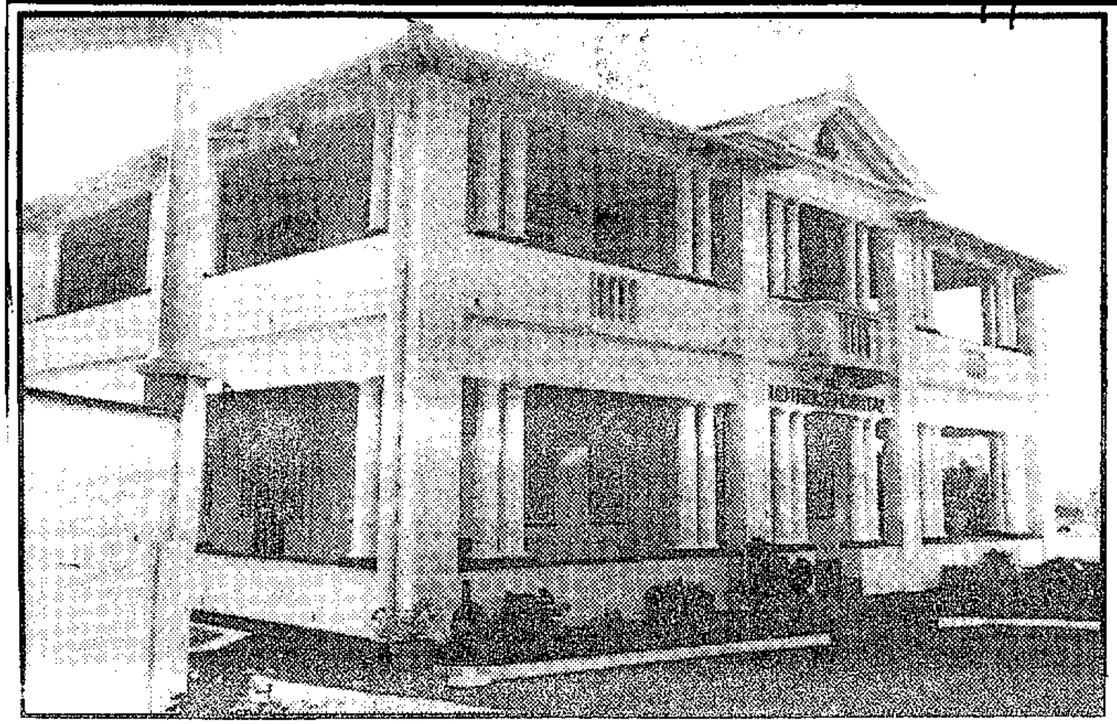




MOTHER'S HOSPITAL — 16 babies were born there in 1914.

WANTED — more babies

MORE than forty-three thousand babies have been born in the 65 years that the Mother's Hospital has been open — and unless a lot more are born there, the hospital may have to close its doors to mothers-to-be.

Over the last few years, the number of births has declined steadily — from a peak of 1 637 in 1976 to 1 287 in 1978 — and the figures for this year look like falling well below the last figure.

The Mother's Hospital — run by the Salvation Army — is affiliated to the hospital of that name in London; a hospital in which the staff is almost exclusively female and for that very reason has a special place in the British medical field.

Our Mother's Hospital was founded in 1914, largely to provide a place where destitute girls could have their babies. A rambling house — still in use as the nurses' home — was then commissioned as the entire hospital, providing lying-in facilities, labour rooms, a nursery and staff quarters.

The hospital, renamed from the original Good Hope Nursing Home to Mother's Hospital in 1923, steadily grew and in 1929 a purpose-built hospital, containing 25 beds and 2 labour wards, was opened.

By now, of course, the original purpose of providing a place for destitute girls to have their babies had been outgrown, and women from all walks of life were using the facilities.

There have been subsequent extensions to the hospital — the most recent being in 1968 when a special care nursery was built.

The original character of the hospital has, however been retained and its high-ceilinged and spacious rooms, with a maximum of four beds in one room, gives it a distinctly colonial style.

The present matron, Major Margaret Griffiths, has a staff of 18 full-time sisters, 6 part-time and 11 students. Many of the staff have been around for a goodly time; Sister Juliana Willstead has been there since 1937 and was instrumental in beginning pre-natal exercise classes to Natal in the 1950s — and Sister Ida Bowyer has been firmly installed since 1946.

"It's a special place," she says, and indeed this seems to be the case, from the chef who has ruled the kitchens with an iron hand for 25 years (flowers on everyone's tray), to the most recent mum.

The mothers, admittedly a prejudiced lot in post-parturition bliss, also declare Mothers' to be special. Delyce Titmuss, a mother of three, thinks it's the care given to the patients. Her baby was born with pneumonia and was immediately whisked away to an incubator.

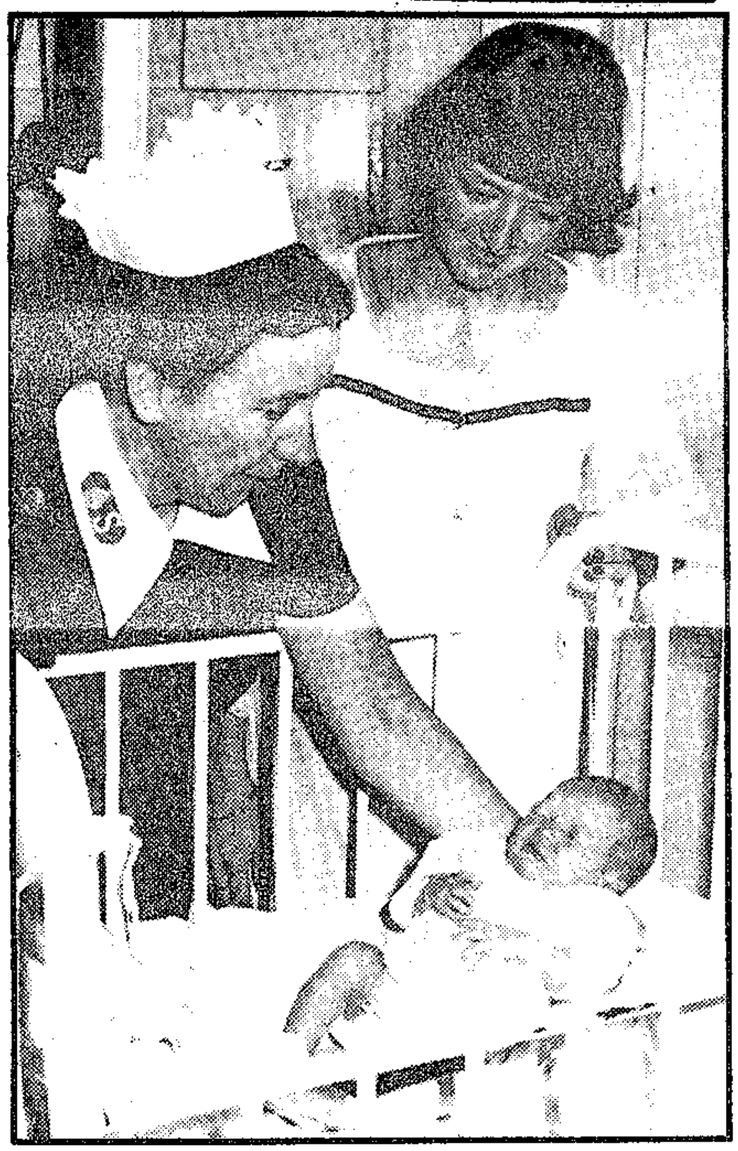
"I couldn't bear to look at him" she said. "I was so terrified that something would happen to him."

The nursing sister in charge of premature babies and those needing special nursing, marched down to Delyce, clucked her tongue, and marched her up to her son. "She explained what was happening — and I'll never forget it."

Other mothers tell similar stories. First timers can't get over the kindness; those who have had more than one baby can't get over the attention. "We're treated like mothers with babies, not patients to be fed," was one comment.

When staff are idle (this is infrequent, avers Matron) they crochet cot blankets for their small charges, give them oodles of love and have been known to cry when the babies go home with mum.

Although a Salvation Army run hospital, there is no undue religious influence. But when a mother and baby go home,



HAPPINESS is NOT being woken by anyone — even if it's Matron Major Margaret Griffiths and mum Diane Frank. Taryn's the one who's wincing.

Matron says a prayer with them. "I think it's a great privilege to be able to pray for a person and to let a baby go out into the world knowing it has been prayed for."

Mothers are then invited to fill in their comments on the hospital; sour ones are investigated. But most of them are complimentary. "Just a good home," said one mum, whilst another wrote "One of the most beautiful experiences in my life."

"That just about says it all," said Matron, closing the book. "We have a caring atmosphere and we're small enough for people to be individuals."

Like any other hospital, Mothers' derives its income solely from patients' fees and from donations. — Jennifer Cryws-Williams.

Arson bid: Cape hospital may close

98 Argus
9/7/79

THE Heideveld Day Hospital may have to close temporarily following a fire which caused R6 000 damage at the weekend – the third suspected arson attempt at the hospital in the past year.

The hospital is one of the busiest day hospitals on the Cape Flats serving about 500 patients a day.

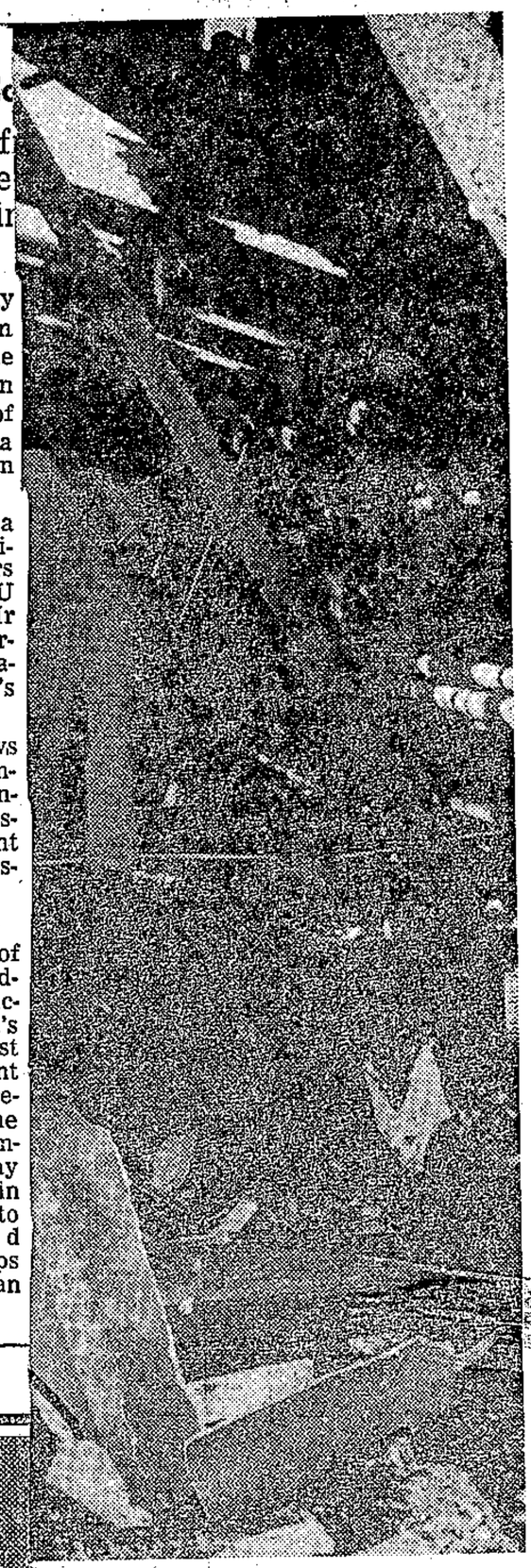
The fire, which destroyed the senior sister's office, was noticed about 4 pm yesterday by one of the hospital's nursing staff when she happened to drive past in her car. Furniture and documents were distroyed before the fire was extinguished.

Roof burnt

A section of the roof was destroyed, and rafters were still smouldering this morning as Senior Sister, Mrs R M Luden, helped to clear the blackened debris from her offire, helped by the doctor in charge of the hospital, Dr E Sacks, and a team from the Cape Provincial Administration workshops.

'It is terrible — we treat about 500 people a day and who knows where they can go now,' said Sister Luden. She said it was hoped one section of the hospital could still be used, while the damaged part was repaired.

Cause unknown



Argus Co

PARIS. — Black Af
international elite
come between warri
tinent.

The force, of possibly 2 000 men, could be drawn from 40 members of the Organisation of African Unity (OAU), each of whom would hold ready a 50-man unit to act on OAU orders.

The fact that such a force is being taken seriously by African leaders was shown by OAU Secretary-General Mr Edem Kodjo in an interview in the influential magazine Jeune Afrique's latest edition.

The Argus Africa News Service reports from Monrovia that the OAU conference of Foreign Ministers of 49 independent states held no sittings yesterday.

SANCTIONS BUSTING

Consideration of Secretary-General Mr Kodjo's crisis reports on sanctions busting, Rhodesia's hammering of terrorist bases, independent Africa's vast floods of refugees and how to get the French out of the Comores was delayed for a day while delegates sat in hotel rooms listening to broadcast services and hymn singing by groups of genteel lady American evangelists.

Arson fear

(Continued from Page 1)

Lieutenant Colonel N J J Ras, District CI Officer at Athlone, said the cause of the fire had not been determined, but as in every such fire police had opened an arson docket.

'There's forever something burning in these areas — now a school, then a shop or a hospital — so we don't regard this fire as unusual,' he said.

The police investigation was complicated by the fact that the fire brigade had poured water on to the scene and disturbed possible evidence, Colonel Ras said.

Paraffin

Sister Luden said she understood that a half-full tin of paraffin was found at the scene, and there was a strong smell of paraffin in her office immediately after the fire was extinguished.

The gutted office, with its window shattered, faces on to an enclosed courtyard. Apart from furniture and documentation, one of the severest losses was a large tray of surgical instruments and kidney basins, which Sister Luden sorted through today. All the instruments worth hundreds of rands, were coated with thick, black ash and were now useless.

Shawco

Dr Sacks said the day hospital shared the building with the Shawco clinic, and together the two institutions had been subjected to numerous burglaries, vandalism, and arson attempts.

'For three weekends in succession Shawco has been attacked. One incident was when all the taps were opened, and the building flooded. Then curtains and a dentist chair were burnt,' he said.

The Shawco clinic was not damaged in yesterday's fire, and carried on business as usual this morning, while next door patients had to be turned away from the damaged day hospital.

Stabbings

Dr Sacks said people in the area 'live in fear'. Hundreds of stabbing cases are treated at the day hospital.

He said the local police station had only one patrol van. 'We have asked them for help, but they cannot answer all calls or check the hospital regularly,' he said.

Dr Sacks said it would take at least a month to repair the damaged roof and office, and he could not say how long the hospital would have to remain closed.

Gangs

Shopkeepers to whom The Argus spoke said their businesses were adversely affected by the many unemployed youths roaming the area.

The gangs operating in the area were said to be chiefly the Pipe Killers, the Impossible Ones, and the notorious Sexy Boys — responsible for some of the most brutal gang violence recently.

About a month ago nine men — two of whom held a firearm and a knife respectively — robbed a bottle store after forcing their way past customers.

Afraid

A butcher in Heideveld proper — the area between Duinefontein Road and the railway line — said many of his customers were afraid to come to the shop, because unemployed youths were always trying to 'shark' something from them.

'We need just two or three policemen on foot patrols,' he said.

'All we have are the police vans that drive through quickly every four hours. They go so fast that people call them the 'witblits' (while flash). This helps nobody because the gangsters can see them coming. And they time them too he said.'

Other businessmen agreed that more foot patrols would solve the problem, but the Athlone District Commandant of Police, Brigadier T H I Labuschagne, said: 'The manpower is simply not available.'

(Continued on Page 3, col 2)

Mennonite Central Committee se Konferensie oor: 'Die Rol van Geskiedkundige Vrede-

Patients at Frere complain of delays

EAST LONDON — Out-patients at Frere Hospital claimed yesterday they were made to wait for hours for medicines because of a new system at the dispensary.

But the medical superintendent, Dr G. L. Bracken, said the new system was designed to protect people from the rain and wind and allow them to wait in comfort for their medicines.

In the old system patients had to wait outside the dispensary and they claimed this worked much better.

Now the dispensary has been moved and they wait in waiting rooms while nurses take their prescriptions to the dispensary.

A number of patients said at times they were forced to wait for five hours or more before they got their medicines.

Mr James Sinanda, 47, from Komga, said he brought his wife, Nowandile, by train. They were fetched at the station by the hospital vehicle at about 7 am.

He said his wife was seen by a doctor at about 9 am and her folder was taken away. They were told to sit in the corridor and wait for their medicine.

Mr Sinanda said at 2 pm they had not been given medicine and would miss their transport back home to Komga.

By 3 pm they still had not got their medicine. Mrs F. Vinjiwe, from Sada, said she was not bothered when she would get her medicine because the train she would take home left at night.

Mr Mtunji Sokoyi, from Mooiplaas, said he arrived at the hospital at about 7 am. At 10 am he was seen by a doctor. He was not given his medicine until 2.30 pm.

Mr Sokoyi said it was not the first time he had been at the hospital. It was customary for patients to wait for a long time for their medicine.

Patients were used to waiting for hours, he said.

Mr Sokoyi said it took patients between 20 and 30 minutes before they got their folders. After that they were immediately seen by a doctor, but the delay was with the medicines.

Miss Nikiwe Kweleta, of Duncan Village, said recently she had to wait until 4 pm before she got her mother's medicines.

Patients had no money for a private doctor so they had to endure the delay.

Miss Lulama Gxilishe, of Igoda, said the long wait for medicine was a normal procedure.

Dr Bracken said the patients should bring their folders when they wanted to complain so that she could have an idea of the department involved. — DDR

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

Soos voorheen gemeld, is die Sentrum vir Intergroepstudies geregistreer as 'n maatskappy. In die Memorandum en Statute van Vennootskap word voorsiening gemaak vir die benoeming van eenhonderd lede. Tans is daar 57 lede en hulle sluit die volgende in:

a) Drie stigterslede:

Mnr J.G. Benfield
Mnr H.L. Kennedy
Mnr P.G.T. Watson

b) Sewentien persone wat gedurende die afgelope 10 jaar lede van die Beheerraad was (* dui stigterslede aan):

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

What's wrong with the old Joburg Gen?

SUNDAY EXPRESS INVESTIGATION

By MARIAN SHINN

THE OLD Johannesburg General Hospital complex is bursting at the seams — and it shows. The new Johannesburg Hospital should solve the overcrowding, but poor salaries will prolong the staff shortage.

Nurses have asked the Minister of Health for increases and moves have been made to boost the rate for part-time doctors, who say they earn a nett R1 an hour.

The old hospital's newest building, the outpatient complex, is the most visible problem. Queues of people — many elderly — complain about having to wait for hours to book appointments, wait for their files and pay their fees. Then there is the long wait at the dispensary.

Those waiting for attention sit cramped in corridors or waiting rooms that look the worse for wear.

Ten years ago the hospital administrators realised the patches were wearing thin and planned the new hospital. It stands, almost empty, a kilometre away. The maternity, gynaecology and paediatric departments moved in last year, but the rest of the hospital is still in the old, red brick building in Hillbrow.

The new hospital was finished a year ahead of schedule, but the medical equipment wasn't.

Hospital superintendent Dr Neville Howes said: "We were able to move into blocks one and two because they were ready last year.

"If I could close the old hospital and move in here tomorrow I would, but it's not that easy when you are still treating patients and moving over equipment that is being used."

The move cannot happen soon enough for the hospital staff, impatient with working in confined, inadequate premises. The patients — particularly the outpatients — are tired of setting aside a whole morning to see a doctor and collect medicine.

Overcrowding increases tension between staff and outpatients and they often end up bickering at each other.

Computers have accelerated the turnover of child and pregnant outpatients. Their bookings, admissions and treatment are all much faster.

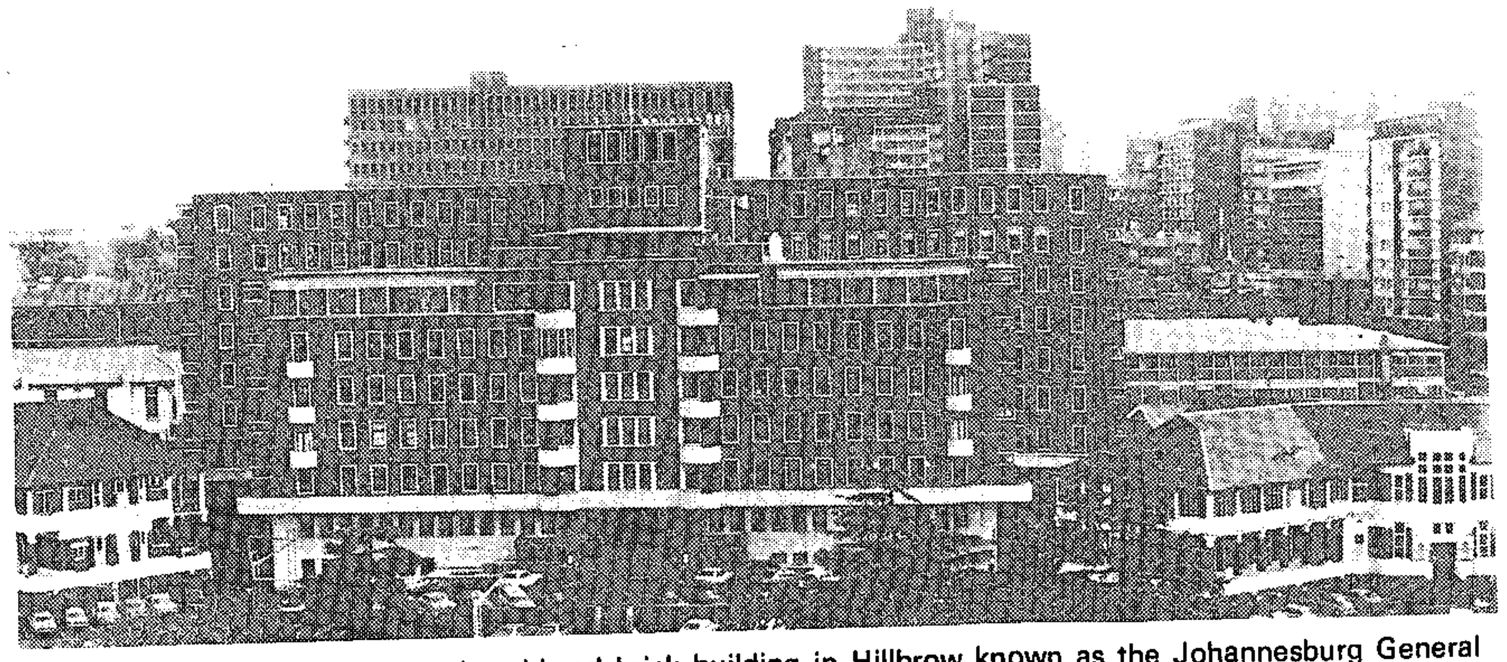
□ □ □

The new hospital's dispensary is twice the size of the old one and can accommodate more pharmacists. The old dispensary cannot accommodate more staff, although the need is desperate.

Dr Howes believes that once the move is complete the queues and inconveniences of the old hospital will disappear — but staff problems will not.

Last year the new hospital had an administrative staff turnover of about 100% in some sections — particularly computer staff. The total nursing complement is down to about half.

Dr Howes admits this is serious and stresses that a hospital is a 24-hour operation and people became fed up with shift work. Staff were also being lured by more lucrative jobs in the city.



● Outdated, overcrowded — the old red brick building in Hillbrow known as the Johannesburg General Hospital.

DELAYS, QUEUES AND IMPATIENT PATIENTS . . . WILL IT IMPROVE?

● Queues at the old Joburg General — they should become a thing of the past.

Clerks trained to use computers soon moved away to better jobs in commerce. Nurses found steady jobs at convenient hours with better pay as medical representatives or consulting room sisters.

Dr Howes said representations had been made to the Department of Hospital Services to upgrade certain clerical posts involving computers. Applicants were being given aptitude tests and many were found unsuitable for hospital jobs with computers.

Front line staff — clerks who handle admissions and inquiries — were carefully chosen for their ability to handle people in distress.

Hospital staff are civil servants and get the same pay whether they work in a platteland hospital or the big city. Their is no weighting to cover the higher cost of living in Johannesburg.

Part-timers are employed to ease the nursing staff shortages. Sisters work mornings, afternoons or evenings only. Doctors work one night a week, but the province will pay them only R4,67 an hour — irrespective of seniority or hours worked.

Representations have been made through the Medical Association of South Africa to increase this rate — a figure of 15% has been mentioned.

Doctors at the hospital doubt whether this will encourage private doctors to give up their time. "After petrol and income tax a part-time doctor actually makes about R1 an hour at this rate," said one of the department heads.

The design of the new hospital will ease the problem slightly. Doctors dealing with patients in different areas will no longer have to dash across busy streets or into other buildings.

A new, computerised information system slashes the amount of paperwork. The computer will supply, for instance, the number of free beds, a patient's medical history, or a doctor's appointment list — and from anywhere in the hospital. There is a computer terminal in every ward.

Each outpatient clinic in the new hospital has its own cashier, making the operation considerably faster.

The flow of outpatients at the General is unpredictable. There is no pattern. Dr Howes said he had tried to monitor the cases dealt with by the casualty, accident services, polyclinic and outpatients' clinic at both hospitals so he could plan resources.

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"It's totally unpredictable," he said.

People arriving at the General without appointments or without "blue cards" are a major cause of delay. No card means hours of searching through numericaly arranged records. Computers at the new hospital will find a name and number in moments.

Appointments will be made by telephone and computer advice should prevent patient bottlenecks. Sisters will be on hand to decide whether a patient needs urgent treatment or an appointment.

If a patient arrives without his card a clerk can call up all the files with similar names and select the correct one from the records department.

Dr Howes is planning a booked appointments system, already working reasonably well in the polyclinic at the old hospital. Although difficult to adhere to because of emergencies and unkept appointments, he feels it will be more convenient for patients.

Some clinics in the old hospital only open by midmorning so patients left at the hospital early in the morning have a long wait.

They believe that, as they arrived first, they are entitled to be treated first. However, people with earlier appointments get priority — except for emergencies.

The dispensary at the old hospital is seriously understaffed and nobody realises this more than chief pharmacist Sampie Rosslee.

His 10 pharmacists have to dispense drugs to more than 700 patients a day. Lack of space means only five pharmacists can deal directly with patients.

"Even if they gave me more pharmacists I have no where to put them. They would fall over each other here," he said.

Each pharmacist explains to patients exactly what drugs he is handing out, their effect, and when they must be taken. "We must make sure they understand the prescription," Mr Rosslee said.

□ □ □

The new hospital has 13 dispensing windows and the administration is working out ways to change the current system and dispense more than a month's supply of medicine to outpatients.

Mr Rosslee said dispensing activities increased by 18% in 1978 over the previous year. "Indications are that we have been handling more prescriptions this year than last."

Much of the fetching and carrying in the old hospital is done by messengers. The new hospital has a telelift which takes documents, medicines and supplies throughout the building in minutes.

More pay wanted

POST
TRANSVAAL

Telephone 27-6081

Let's have more hospitals

THE TIME has come that the authorities think seriously about building more hospitals in black urban area.

Stories of overcrowding at Baragwanath hospital and lately at Natalspruit are disquieting.

Baragwanath is regarded as one of the biggest hospitals in the southern hemisphere and this has been common purpose for a number of years.

The time will come when this hospital will literally burst at the seams as people from all over the country jam its wards. Already patients are forced to sleep on floors and in some wards even women who have just been treated are kept under the most horrifying conditions.

The community and hospital authorities, who should be well aware of the danger of overcrowding in the hospital should mount a campaign for another hospital to be put up in Soweto.

The more people crowd into the hospital the less it is possible for the medical staff to give them their best attention. This will lead to all sorts of complications, which already exist as regards the health and wellbeing of our people in the townships.

If the people are pressurised into paying increased rents then they should have facalities laid out for them. There are too many basic facilities that are unheeded for our people in the townships and hospitals constitute one of the most important.

Let's have more talk of better hospitalisation, better roads, better houses — instead of increased rents.

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).

Van sy bestaan het die
-groepstudies gereeld 'n jaarverslag oor
-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.

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Mrs Margaret Soni... dispenses medicine to some of the patients at the Witkoppen Clinic, near Sandton. Because of a lack of voluntary medical help this clinic is forced to close its doors to hundreds of patients at the end of September. Many of the patients are mothers with babies.

Red tape strangles a service

By Dee Rissik

After more than 30 years the Witkoppen Clinic, on the outskirts of Sandton, has been forced to close its doors to the hundreds of patients treated there each week.

The clinic, which was started in the early forties and has been run by Dr Louis Smuts since 1953, will close down on September 30.

Said Dr Smuts: "Over the last two years it has become increasingly difficult to find doctors who will offer their services voluntarily. We need five doctors to run the show — three on duty at a time. A paediatrician is also essential as we deal with up to 80 babies in a morning."

The clinic is open two mornings a week and handles at least 250 patients a session.

"The flow of patients has been increasing steadily over the last few years and I feel the clinic is far too big to be run as a private undertaking any longer," she said.

Dr Smuts has approached various medical organisations — Wits Medical School, the Director of Hospital Services, the State Health Department, the Provincial Health Department, Sandton municipality and even the Defence Force, but all to no avail.

"Red tape seems to be the problem," she said. "For example, we were told that because we are an out-patients clinic and have no beds we could not receive any help from the Department of Hospital Services."

Sandton municipality told Dr Smuts that as only a third of the patients treated at the clinic came from the Sandton area the municipality could not justify the expense.

In a last attempt to help the patients who come from Sandton, Randburg and the peri-urban areas beyond Sandton, Dr Smuts is investigating alternative clinics or hospitals they can make use of "but all are quite a distance from the area we serve," she said.

The deputy secretary for the State Health Department in Pretoria, Mr A D Barnard, said they would probably investigate the matter as soon as it was formally brought to their attention.

"We certainly don't want to see services that are needed and that have been in existence for so long closed down. But we will have to investigate the needs of the people in the area and make sure we are not duplicating services that are already offered by provincial or local authorities," he said.

Crowds of patients wait their turn at the Witkoppen Clinic, near Sandton. The clinic as 250 patients twice a week is forced to close its doors at the end of

'Rustic' Sandt awaits powerl

By Carolynn Dempster

The foundations have been laid, the ground cleared and during the next two weeks Escom's controversial 275 kv powerline through Sandton will become a reality when the first of the 28 m towers are erected.

The 25 km long line carrying Cabora Bassa power, will stretch from the Minerva substation near Pretoria across 127 pylons and along an 8 km section of the Braamfontein Spruit. Finally it will link up with the new Craighall substation in Sandton.

"We are committed to supply the Craighall substation by the end of this year," said Mr Bob Hardy, head of the project.

The R2,9-million line which carries enough power to "light up London" (1 500 MW) will supply Johannesburg with 2/3 and Sandton and Randburg with 1/6 each of its capacity.

Escom's original plan, announced in 1976, was to erect 35 m high pylons to carry the heavy load. This sparked off a major controversy as the route chosen for powerline servitude traversed Sandton's river park system along the Braamfontein Spruit.

Sandton was already committed to a multi-million-rand scheme to preserve its rustic atmosphere, and Escom was accused of planning without giving any thought to the effect the powerline would have on the environment.

The Sandton Civic Foundation, Town Council and ratepayers fought against the intrusion and won a compromise.

Escom's chosen route would remain the same, but the Electricity Control Board ruled that the towers be reduced in height to lessen the visual impact on the surrounding countryside.

At one stage it was

...in die Leslie Social
...huur Campus aanbied.

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...lik W. van der Merwe
Direkteur

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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 conducted 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.

"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."

13

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Morale is very low and the patients are sufferin

Underpaid nurses quit the hospitals

Start 6/9/79 - 98

Nursing staff who are dissatisfied with salaries and conditions in Johannesburg hospitals run by the province are giving up the profession and leaving the hospitals seriously understaffed.

The nurses — qualified and unqualified — are being weaned away by private enterprise — especially drug companies — which in most cases offer better salaries and conditions including car and expense allowances.

Miss Doreen Radloff, retiring executive director of the South African Nursing Association is concerned about nurses' pay.

"As the biggest group in the hospital services, nurses are absolutely essential. Yet whenever money becomes available to the medical profession it hardly ever stretches as far as the nurses.

Injustice

"This is a great injustice and one of the main reasons why we have such a shortage of nurses. They are not appreciated sufficiently and they are taken for granted because of their ethical code which states that their main object is to be of good service to the country," she said.

A Department of Health spokesman said: "We know the nurses are suffering hardships and we have endorsed further representations to the Public Service Commission."

A spokesman for the Public Service Commission said any salary adjustments would have to wait until the new financial year.

"There are no funds available for any further admendments at this stage. We are trying to do what we can with the funds available," he said.

In May, Mr Sybrand van Niekerk, then Administrator of the Transvaal, said in the Provincial Council that out of 752 paediatric and gynaecology nursing positions at the Johannesburg Hospital, 377 had not been filled.

He later denied that there was a staff shortage at the hospital saying that the commissioning of the hospital had not yet been completed.

Fear

I spoke to doctors and nurses at Johannesburg hospitals who didn't want to be named for fear of losing their jobs.

They claimed:

- The intensive care units are so full that some seriously ill patients who should be receiving intensive care (that is a ratio of one fully qualified sister per patient) were being moved into general wards.
- Areas of the intensive care unit at the new hospital have not been opened because there are not enough staff to man it properly.
- Patients were suffering from the shortage of nursing staff.
- Staff have to choose which seriously ill patients most need their help.
- Facilities provided at the hospitals are no longer limited by the size of the hospitals but by the staff shortage.
- It is not unusual at night and weekends to find two junior nurses in charge of an adult ward or ward of sick children.
- Babies do not receive the full attention they should because there is not enough staff to treat them all at the same time.
- Some medicines are not freely available and red tape is involved in acquiring them. They are frequently refused the reason given that the country is economising) so the staff have to make do with "pot luck."
- Equipment is ordered and approved — or refused — by persons not familiar with modern requirements.

The salaries of nurses in provincial hospitals went up by between four and 10 percent in June but are still not in line with those paid by private enterprise. JENNY DYER spoke to doctors and nurses who claimed poor pay had led to a serious staff shortage in Johannesburg.

The nursing staff's main complaints are that:

- Recent salary increases are totally inadequate and favour the more highly paid senior staff. The increases vary between four and ten per cent although it is believed that matrons received more.
- This means an actual increase for senior sisters is between R7 and R24.
- A senior sister with six years' experience and sometimes working a 60 hour week can hope to bring home R540 a month.
- The responsibility and pressures on sisters (especially in the intensive care units and theatre) are enormous. During an emergency they are sometimes on duty for up to 21 hours.
- The morale of staff is low.
- The overtime rates have recently been decreased.
- Weekend and public holiday duty is required with no extra pay.
- Nurses' homes—which are cheap — have too strict rules such as no alcohol and no male guests.
- Senior staff and doctors get preference for flats which are supposedly built for nursing staff.
- Sisters in some hospital departments — intensive care and theatre — have to be on call during weekends and at night. They receive no telephone allowance.
- If they are called out in an emergency, petrol can be claimed if the correct forms are filled in. This involves so much red tape that many do not bother.
- If they have to work overtime, it is inconvenient to make use of the bus service provided by the hospitals, so a car is necessary.
- Repeated meetings and representations to higher authorities have been fruitless.

"More than R100-million was spent on the new hospital and equipment and they are trying to run it on sixpence," said one source.

"Every year the province spends millions of rand training these girls and then lose them to private enterprise.

Perks

"The solution is to put salaries in line with competitive salaries in the private sector. You can't give a girl in Beaufort West the same salary as one in Johannesburg because their living expenses and work competition is different."

Points which are usually given in favour of the nursing profession are that nurses receive:

- meals at hospitals which are reasonably priced;
- cheap accommodation at nurses' homes;
- a six-monthly shoe allowance;
- free uniforms.

"All these perks don't mean anything without a decent salary," said a doctor.

HOT BUTTERSCOTCH SAUCE

Mary Snelling, Ridgeworth

1 T syrup
2 T brown sugar
squeeze lemon juice
1/2 oz butter/margarine
1/2 pt warm water
1 d custard powder mixed with
1 T water

Put butter, sugar, syru
draw aside, add water c
sauce and pour onto cust
Serve hot with ice-crear

TOMATO SAUCE

4 tomatoes
4 sliced onions
4 t sugar
8 level t maizena

1. Wash and cut tomatoes
2. Put tomatoes, onions, carrots into a saucepan wi
   seasoning; boil until soft.
3. Sieve, add maizena, blend and boil again.

---oOo---

BARBECUE SAUCE

Peggy Brown, Hal

2 onions, chopped fine
2 T vinegar
2 T Worcester sauce
1 T salt
3/4 cup water
1/4 t pepper
1 t chilli powder
3/4 cup tomato sauce

Mix all ingredients together. Simmer for 45 minutes

SHERRY SAUCE (For Steamed

Warm sherry (1/4 pt) and
a pot of nearly boiling w
once, adding sugar to tas

SAUCE WITH WHITE WINE
(For White Meats and Sea

1 cup hot cream
1/4 cup dry white wine
3 T butter
salt and pepper
1 t chopped parsley

Melt butter in saucepan. Add flour; cook till brown. Beat in cream and wine. Whip very well. Boil for 5 minutes. Add salt and pepper to taste and chopped parsley.

---oOo---

BRANDY SAUCE
(For Steamed Puddings)

K.W.V. Paarl

Make a white sauce with 1/2 oz butter, 1 oz flour, 1/2 pt milk, add 1/2 oz sugar and 2 t brandy.

EL day hospital be one of SA's biggest

EAST LONDON — The day hospital being built in Duncan Village is to be one of the biggest in the country and will cater for a community of 60 000 to 80 000 people.

Dr R. Wannenberg of the Provincial Administration's hospital services planning department said this meant the hospital could cope with 400 or 500 outpatients a day in a curative capacity.

In addition there would be facilities for the local authority to provide preventative services.

One of the vital functions of the hospital, Dr Wannenberg said, would be to educate the population of the area. Health education programmes would be carried out in most of the waiting areas throughout the day.

On the curative side she said the hospital would have physiotherapy and X-ray departments and would have an obstetrics unit for normal deliveries.

Ante-natal classes would be held where prospective mothers could be examined for any possibility of complications and if necessary arrangements would be made for them to be admitted to another hospital for sophisticated treatment.

Dr Wannenberg said day hospitals along the lines of the one being built at Duncan Village had proved the answer to health problems in such areas.

"We usually achieve a referral rate of three to four per cent as people come for treatment much earlier when there is a day hospital in their own area," she said.

The hospital should be completed by December 12, said the MPC for East London City, Mr Petro de Pontes. He said Frere Hospital had been asked to get equipment ready for the new day hospital so as to have it in operation as soon as possible after the construction work was completed.

A total of R786 000 has been set aside for the hospital, R500 000 of which is to be spent this year. — DDR.

Construction work begins on the site of the new Day Hospital in Duncan Village.

Bara's new brother: a R40-m hospital

98/343
STAR
10/9/79

By Derrick Thema

A huge new hospital — comparable to Baragwanath — will be built at a cost of R40-million near new Canada in Soweto.

A spokesman for the Department of Works in Pretoria, which is undertaking the project, says building will be started early in 1985.

The hospital will accommodate 1 000 patients, with provision being made to take on close to 2 000 patients.

The hospital will also have a nursing college to train staff.

The hospital will be between Noordgesig and New Canada station on a 66 ha plot.

"The Government has allocated an estimated R40-million, but this might be higher because of the ever escalating costs of building material," the spokesman says.

Surveyors are already busy with planning, although the date for tenders is set for early 1985.

"The hospital will cater for Soweto and will be built according to South African norms," he says.

The contract period for the building of the hospital will be four years.

Dr H A Grove, director of hospital services, told The Star his department had sent plans for accommodation to the Department of Works.

The new hospital is expected to relieve congestion at Baragwanath Hospital.

A plan to rebuild part of Baragwanath is being organised so it can cope with the congestion until the new hospital is built.

Lenasia is to get two new hospitals

Two new hospitals are to be built soon in Lenasia — and part of the old Johannesburg general hospital will accommodate Indian patients from next year, the Transvaal Director of Hospital Services, Dr Hennie Grove, has announced.

Dr Grove said that one of the hospitals would contain 200 beds and the other hospital would be a day hospital with several short-stay beds and a maternity section.

He also said that 114 beds in the old Johannesburg general hospital would be used from next year to accommodate Indian patients as an interim move until the Lenasia hospitals are built.

PRIORITY

"The new hospitals in Lenasia are our planning priority number one," he said. The day hospital will be started by the middle of next year but the other hospital was still in the planning stages.

"The 200 beds could be increased to 350 beds and the day hospital will provide short-stay facilities for out patients with 20 beds. There will also be 12 beds in the maternity section.

"From next year we will be using a 114-bed ward block at the old general hospital for Indian patients.

"We need staff and I would like to appeal to all Indian nurses, clerks and administration staff to come forwrd to help us provide a better medical service to the Indian community," he said.

Dr Grove added that he wanted to clear up the uncertainty about the building of the hospitals among the Indian community.

Although it is not yet known when the work on the new hospitals will begin, plans are believed to be in their final stages and the dates will be made known as soon as further information is available.

The estimated cost of building the day centre was R900 000 and the Transvaal Provincial Administration would call for tenders about next March, Mr P U du Plessis, the Director of Works, said today.

The second Lenasia hospital, estimated to cost more than R10-million, was still in the planning stages.

Mr du Plessis said sketch plans of the hospital still had to be approved by Hospital Services. "It is too early to speculate as to when work on the hospital will begin. but we are forging ahead as best we can," Mr du Plessis said.

JAARVERSLAG
1978
SENTRUM VIR INTERGROEPSTUDIES
(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).

Groote Schuur needs more yellow people

CAPE TOWN 20/9/79 (98)

Out & about

Fiona Chisholm

GROOTE Schuur needs more ladies in yellow — and men too for that matter. These are volunteers, who with a bit of time on their hands and the wish to do something for others, bring a bit of cheer and friendliness to patients in hospital.

The ladies in yellow, so called because they wear bright yellow tunics, were introduced at Groote Schuur in April, though their counterparts have already proved their worth in Johannesburg hospitals and at Tygerberg.

On an average of once a week, they go round the wards and various departments, helping with patients, playing with children, reading to the sick. And what sounds so simple, but is actually so important, just talking to a patient — particularly one from upcountry who might have no visitors at all.

A cheerful and friendly "Good morning. How are you? Is there anything I can do to help?" can bring such a lift to a person who may be physically and mentally low.

However, more people in yellow are needed, and if there are women and men prepared to give about three hours of their time each week, without remuneration, they should telephone Therese de Boer at 47 3311 ext 3464, between 8.30 and 2.30.

● Rewarding

However without remuneration, does not mean the work is without its rewards. What's more it is rarely possible for people to be in a hospital environment, without realizing just how lucky they are when they see the suffering of others.

I was reminded of this vividly when I took that bus ride from Rosebank by way of Groote Schuur Hospital to Cape Town, on the day the fares went down on Setpember 7.

On the seat next to me was an attractive young woman in her late 20s or possibly early 30s, who told me she was going to spend the day at her husband's bedside. He was awaiting a piggy-back heart transplant, and had already been in hospital for two months — and still no sign of a donor.

People she said, didn't seem to be conscious of the need to donate organs any more.

I asked what age her husband was — thinking he must be considerably her senior. "He's only in his mid-30s," she said, "but he's already had serious heart trouble, and he will be finished without a transplant."

Their trip to Cape Town, she chatted on, meant leaving her home in Escourt in Natal, and her two children, while she and her husband waited.

I was just beginning to think how lightly life was treating me, when she said cheerfully: "But we both realize how much better off we are than some of the people in Groote Schuur. Our experience there has taught us a tremendous lot."

A few days later there was a small item in the Cape Times that the first heart transplant in several months had been carried out on September 10. It was of the "piggy back" type, and a hospital spokesman had described the condition of the patient, "a man in his 30s" as satisfactory.

It was "my couple".

● Bowlers wanted

IN London, of course, it would be a piece of cake laying hands on half a dozen bowler hats. Just a question of hijacking a carriage of an inter-city train and swiping a few titfers off the business men in the first compartment.

But bowler hats, and top hats in Cape Town, are astonishingly difficult to obtain, so John Caviggia has found. He is designing the costumes of the Bertold Brecht play, St Joan of the Stockyards, which opens at the Baxter on October 10.

John needs at least three bowlers and two toppers for senior figures in the production who represent the wealth class. He's tried various Cape Town suppliers, and men's outfitters, without success.

So if anybody has a topper or bowler which he is prepared to lend for this Mavis Taylor production, please telephone the UCT speech and drama department at 45 1307, or the office 22 4161, and impart the good news.

QUOTE

"Ambulances come under the control of municipal fire chiefs — who are firemen first and foremost — and they tend to discard the ambulance services."

QUOTE

"Speed to the accident site is vital, but then there is poor communication with hospitals who are unprepared for accident victims."

TOMORROW'S Rand Daily Mail will carry a breakdown of the ambulance services in seven major centres — Pretoria, Johannesburg, Bloemfontein, Durban, Maritzburg, Cape Town and Port Elizabeth — and one town, Pietersburg. The on-scene evaluations were conducted by the National Institute for Transport and Road Research, CSIR. The findings, in many cases, are appalling.

QUOTE

"The cost to South Africa is R24 800 per fatality. Road accidents therefore cost the country R161-million a year."

QUOTE

Dr Du Toit says the average citizen is not aware of "the atrocious state into which the ambulance services have been allowed to deteriorate".

24/9/74

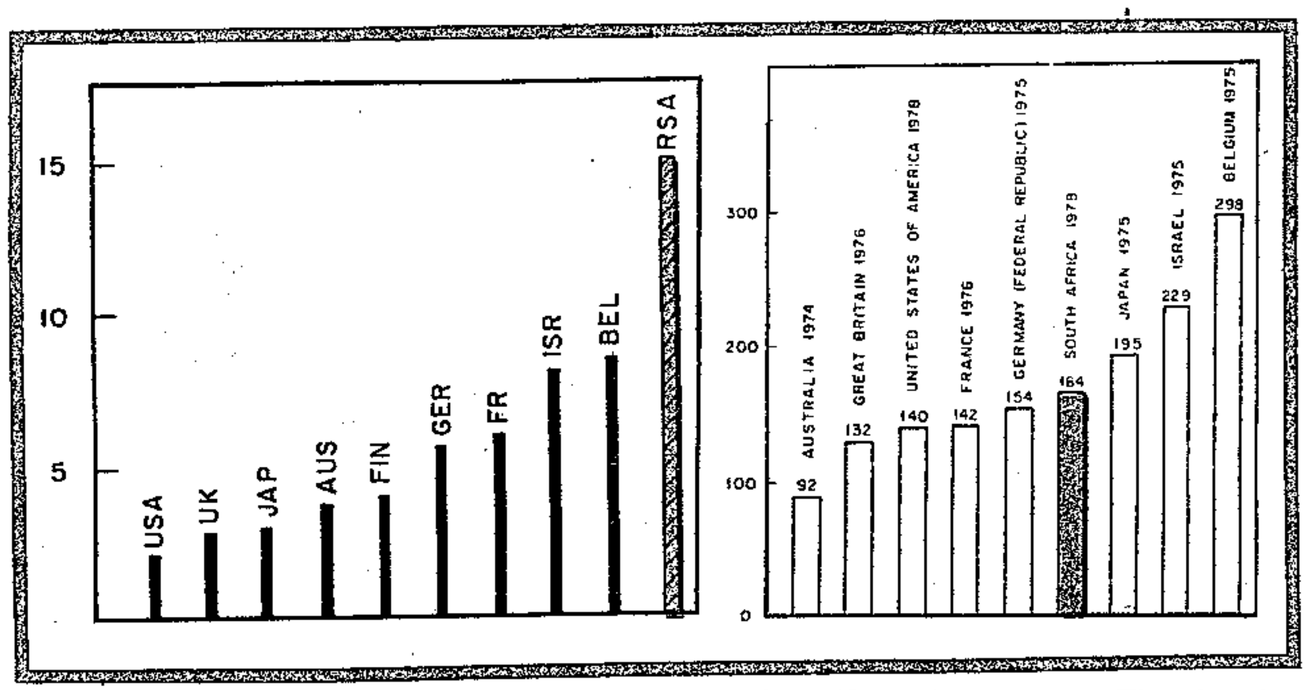
Ambulance chaos

SOUTH Africa's municipal ambulance services are in an atrocious state. Lives are being lost through inefficiency, under-trained ambulance staff and ill-equipped ambulances.

These charges are levelled by Dr J G du Toit — for 20 years head of the orthopaedic department at Pretoria's Hendrik Verwoerd Hospital, past president of the SA Orthopaedic Association and at present head of the Ga-Rankuwa Hospital's orthopaedic section — and Mr W N Van Kralingen, who has completed a three-year in-depth study for the CSIR on road accident emergency responses.

Other claims are that:

- Although South Africa does not have a particularly high incidence of road accident injuries, the fatality rate is way out of proportion — the highest in the western world at 14,5 deaths per 100-million kilometres driven. In the United States, Britain and Europe, the rate varies from 2,2 to 5.
- Poor responses to accident calls are resulting in an estimated 1 300 people losing their lives unnecessarily every year.



A CSIR graph showing South Africa's road traffic injury rates. The fatality rate bears little comparison to the relatively low traffic injury rate. Although the graph refers to 1974 figures, Mr Van Kralingen says the situation has not changed.

'MAIL' EXCLUSIVE by PETER BAYER

- Municipal services in most centres, with the exception of Cape Town, Johannesburg and a few smaller towns, are disorganised.
- Management of several municipal ambulance services is very poor.
- Matriculants and trained army paramedics are discriminated against and "driven out" of ambulance services in certain municipalities by regular personnel who feel their jobs are threatened by the more qualified men.
- Most municipal fire chiefs [illegible] interest in the ambulance divisions they control.
- Poor organisation in the casualty wards of municipal hospitals is contributing to unecessary deaths.

Mr Van Kralingen's study, which involved a study of systems in other countries, shows up most of South Africa's municipal ambulance services as disorganised, with personnel barely competent to handle anything more than minor injuries.

He has found that response times for most services are poor, general vehicle equipment is poor and in several cases, vehicles were unhygienic.

Dr Du Toit says the average citizen is not aware of "the atrocious state into which the ambulance services have been allowed to deteriorate".

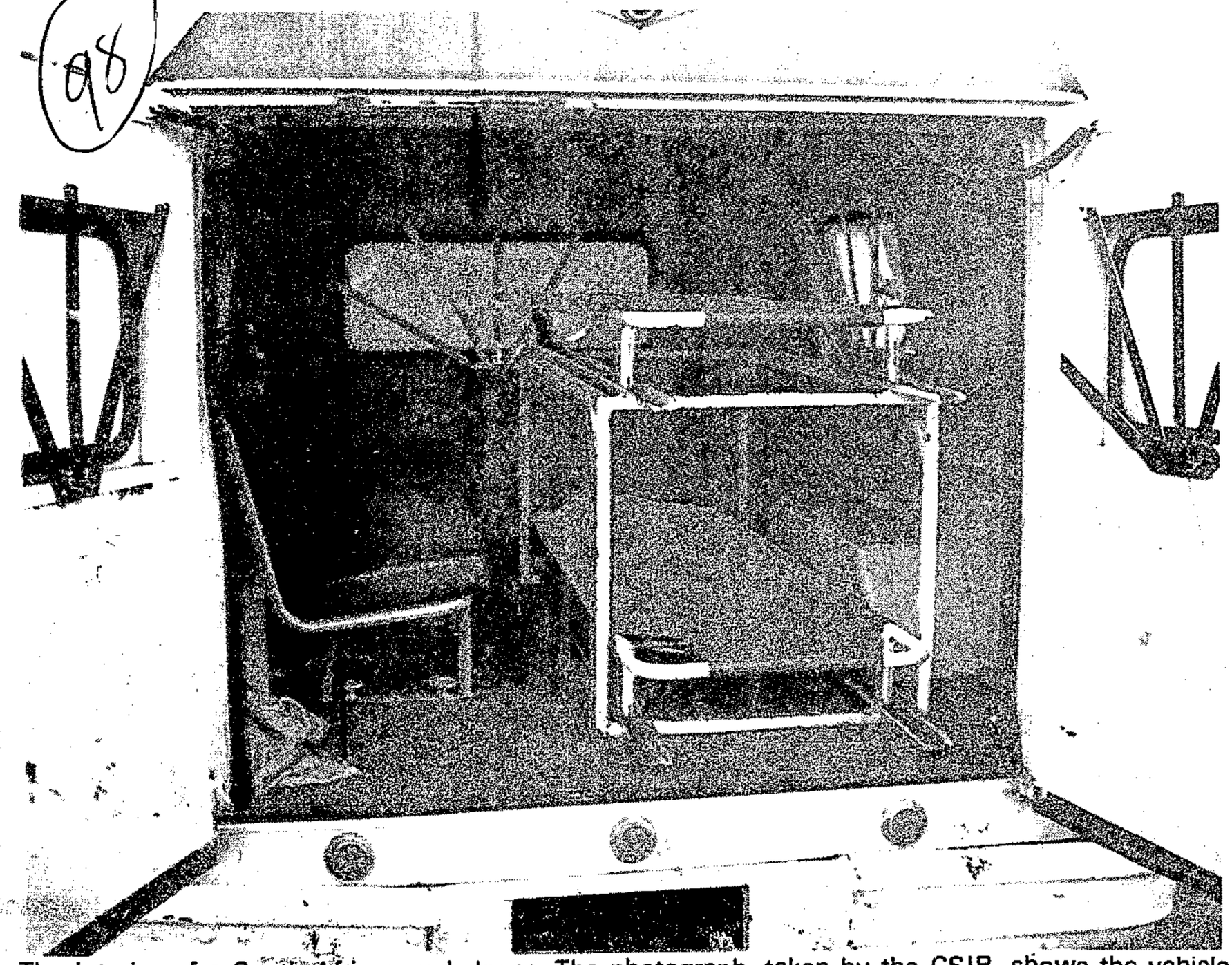
"Irrespective of the reasons why," he says, "we are faced with a serious problem through ignorance and public indifference. The public must clamour for an improved service."

He cited Mr Van Kralingen's report showing that a municipal ambulanceman's minimum educational requirement is Std 6. "He will need a diploma in basic first aid. He will earn roughly R300 a month and his status will be something between a hospital porter and a municipal bus driver.

"Potentially, the service can't be very good. In America for instance, ambulance personnel must have university degrees as minimum qualifications.

"Human lives are therefore being put in the hands of under-educated, under-trained people who are expected to perform resusci-

□ To Page 2



The interior of a South African ambulance. The photograph, taken by the CSIR, shows the vehicle has a filthy floor and doors.

Picture courtesy CSIR.

Chaos costing thousands of lives

Ailing ambulance services

By PETER BAYER

JOHANNESBURG'S Fire Chief, Mr J H De Beer, agrees that many of South Africa's ambulance services are poor.

He says the root of the problem is mismanagement.

"With a few exceptions, management in the fire departments — who control the ambulance divisions — are very bad. Notable exceptions are Boksburg and Benoni, but bad management is the cause of the trouble in other centres.

"Finance is also a problem. Johannesburg replaces about eight ambulances a year. This costs at least R17 000 per ambulance — without any equipment other than stretchers. The smaller centres cannot afford this sort of expense.

Mr De Beer says that although the Johannesburg service is not short of money — despite suffering R6 000 in bad debts each month — an ammendment to the Health Act No 63 of 1977 that will take ambulance services away from municipalities and put them under provincial control will ease the situation.

The ammendment comes into effect on April 1, 1980, although Mr De Beer is wary about a provision in the ammendment that states the provinces will assume control only if there are suffielent funds.

Mr De Beer says that in several cases "the public is wasting our time" with unecessary calls.

"We often have to fetch people who are capable of getting to hospitals by bus or in their own transport," he says.

On the subject of response to calls, Mr De Beer explained that calls regarded as "very urgent" may take no longer than 15 minutes from logging the call to arrival at the scene of the accident.

"If the ambulance takes any longer, the crew must submit a report showing why they arrived late."

Figures provided by Mr De Beer show:

- The administrative cost of running the Johannesburg fire department is R943 700.
- Ambulances, which serve the metropolitan and Soweto areas, made 98 429 calls, of which up to 5% were regarded as "very urgent".
- Ambulances travelled 1 642 396km last year.
- Johannesburg ambulances have had 91 accidents this year of varying degrees of seriousness.
- The cost of a well-equipped paralance — a mobile intensive care unit — is "at least R42 000".

tation and stabilisation tasks that would tax the average physician. The people who actually train ambulance personnel are not closely associated with current trauma problems."

Mr Van Kralingen says that the fire station-based system has been proven to be inefficient.

"Ambulances come under the control of municipal fire chiefs — who are firemen first and foremost — and they tend to discard the ambulance services. They aren't interested," he says.

Most ambulance personnel have only basic first aid training, says Dr Du Toit.

De Vries Ambulance Service, a private organisation operating in Johannesburg and Pretoria, has paramedics trained to second level, as well as trained nursing sisters.

"Speed to the accident site is vital," says Dr Du Toit. "But then there is poor communication with hospitals who are unprepared for accident victims.

"The Cape Town hospital system, tied in with their very good ambulance service — which is controlled by Dr A C McMahon, chief of the Metro Emergency Unit — benefits from separate entrances for specific cases. There is no breakdown at the hospital itself.

"Does the average casualty department physician know or care if the patient was a driver or front seat passenger . . .? These sometimes vital facts can only be obtained from the ambulanceman who brings in the passenger and who is often treated with no more interest than a messenger delivering a package."

"In Britain, the US and Australia, the new-generation ambulance services . . have proven that about 20% of present fatalities can be prevented by quick response times.

"In South Africa this would mean the saving of approximately 1 300 lives annually if all the accidents received a 10-minute or better response time with adequately-trained staff in attendance."

Dr Du Toit and Mr Van Kralingen agree that money is the cornerstone of the problem.

An amendment to the Health Act will move the control of ambulance services from municipalities to provincial authorities from April 1, 1980 — provided there are sufficient funds.

Dr Du Toit recommends, however, that the Department of Health, insurance companies and the Workmen's Compensation Commissioner contribute to ambulance services.

"The cost to South Africa is R24 800 per fatality. Road accidents therefore cost the country R161-million a year. The Workmen's Compensation Commissioner has a catastrophe fund running to several million rands.

"If this money were put into improved ambulance services and better training and salaries for personnel, fewer lives would be lost and the money would be recouped.

Men who live with danger and death

By MARILYN ELLIOTT

HE GOES on duty at 10pm, leaving a wife and kids at home. Then he's tearing down Jan Smuts Avenue at 140km/h. He finds the house after a hectic run through traffic and pacifies a 14-year-old girl who has just been raped. And he makes tea for the hysterical relatives.

This is part of the hard day's night for a Johannesburg ambulance driver. Yesterday, the "Mail" interviewed several ambulancemen at the Brixton headquarters to find out how they felt about their work and what it entails.

The interviews follow criticisms in a three-year CSIR study that describes South African municipal ambulancemen as "under-educated, undertrained people . . With a status somewhere between a hospital porter and a municipal bus driver."

A handful of men who trickled into the chief superintendent's office to be interviewed appeared hurt by the latest criticism — like bloodhounds that had lost their bones.

"We don't mind constructive criticism," says chief superintendent Chris Emerich, "but if people tell us we are bad and then tell us we are bad again, well . . . It doesn't do much for our morale.

"We've got a good bunch of chaps here. They are naughty sometimes and they make mistakes, but so do all human beings. Basically, I think our 63 white and 99 black ambulancemen are providing the public of Johannesburg with the best service we can. I would like to extend an open invitation to the public of Johannesburg to drop in anytime they like and come and see for themselves what we do."

Beyer Harmse, a pleasant-looking man with 7½ years experience as an ambulanceman, is dedicated to his job, but mentioned hesitantly that his pay packet could be better.

"Most of us earn an average of R325 a month — that's without overtime. I've got a wife and children and I guess I could earn more. My wife has got used to the shifts I work — either 7am to 3pm, 3pm to 11pm or 11pm to 7am."

Being an ambulance driver means more to Chris Harmse than hauling injured human packages to hospitals. He takes it seriously. Last year, during the floods he risked his own life to save seven people who were drowning in their submerged car in Soweto's Klipriver.

He didn't get a medal, just a hot cup of coffee back at the station before he trudged wearily home again.

Another of Johannesburg's silent heroes comes in the form of George Mkize. He's been with the service for 15 years and was one of the first blacks to get his EMA — Emergency Medical Assistant's certificate.

This is an intensive first aid course for ambulancemen which enables them to perform many of the functions normally carried out by doctors. Such procedures include setting up drips and defibrillating the heart.

George, now 52, with a Std 7 education, recalls the time when he stopped a mob of blacks attacking a group of whites who had come to assist victims of a train smash in Soweto.

"I guess it wasn't part of my job but I just had to pacify those crowds." Often his life has been in danger. "The most dangerous men in Soweto are the blanketed Sothos — or Russians, as we call them. They earmark their enemies in a faction fight with the object of killing them, not injuring them. Then, when we arrive in the ambulance, they try and kill us as well."

George supports his wife, two children and an elderly mother on a gross salary of R429 a month. "Is it enough. . .No, not really. Today, inflation and petrol eat up my salary. And my wife has no alternative but to put up with my odd hours."

For 29-year-old King Eliot Ndovele, the work of being an ambulanceman is obviously a source of great personal pride.

"I've got my medallion in first aid," he beams. "And I'm going for my matric by correspondence." After a five years at Brixton, he is taking home R290 a month to support his parents.

But he is a happy man. "This work is exciting. One day I helped to deliver a baby. This woman . . . she was having labour pains in the back of the ambulance and then suddenly, there the baby was. I had to give the baby air with my mouth and then I cleaned the mother and the child."

Not all the men are happy. Assistant chief superintendent Mr Laurence Katz says: "Let's face it, we have problems. I'd say the main one is a problem of education. Personally, I think the minimum education standard should be Std 9 or matric. Then chaps could receive comparable salaries. At the moment the average level of education at Brixton is Std 7 and the men are not getting very good money."

Mr Katz is jointly responsible for the training of Johannesburg's ambulancemen.

"I agree that in almost all ambulance centres I have visited in South Africa, the men are under-trained. Most of them only receive a 16-hour course in first aid — hardly sufficient."

At Brixton, the men have to pass a test after a 16-hour first-aid programme and then they have a month's intensive training to learn how to be an ambulanceman. They have to learn how to give oxygen, nitrous oxide (a gas that stops the patient feeling pain). They have to know how to drive quickly through traffic and find their way around the city and they must maintain vehicles and learn radio procedure.

"And the men do a bit of public relations as well. They often stop to help people stuck on roads. They stop people jumping from buildings — especially in Hillbrow where bystanding crowds usually shout 'jump, jump'."

More than 41% of Johannesburg's ambulance force has completed a rigid United States examination for providing assistance to the badly injured. Called the Paramedic exam, it is an 81-hour course that enables the men to carry out difficult life-saving procedures. Next year, a team of the men will take a 1 000-hour course in this advanced first aid.

"The public is not aware of this. I bet they don't know we have to answer an ambulance call every three minutes — most of them for cases which aren't urgent. They forget. They want an ambulance NOW. Sometimes our work is unnoticed. During the Fox Street shooting no-one knew that for 36 hours, 60 men and countless ambulances were kept on standby for that incident alone."

Opportunities for ambulancemen depend on each man's ambition. "Some of the men here regard it as a job — nothing more. They're the sort of guys who will stay in the same position for X number of years. Then, there are a few who try hard. They actually enjoy helping people — even the neurotic old granny who has to go to the hospital for her daily injection. For many, it's adventure. They like the danger and excitement attached to it; thrive on it.

"A lot remains undone. We have not yet reached the ultimate service but we will keep trying," Mr Katz said.

For Johannesburg's ambulancemen, life is a 24-hour horror movie. Mr Leon Kleyn, left, and Mr H du Plessis are seen pushing another of the city's casualties to safety yesterday.

Picture: RUI VIEIRA.

AMBULANCE SCANDAL

The good, bad and atrocious

98

KOM 25/9/19

AMBULANCE stories are legend. Some seem too outrageous to be regarded as anything more than fanciful anecdotes, lavishly embroidered to amuse, shock or astound.

Yet the people who tell these stories swear by their accuracy.

For example: an ambulance was called out to collect a man who had broken his right leg in an accident.

The ambulance arrived to find the man lying in agony, the shin bone of his right leg sticking through the skin of his leg.

Dutifully, the ambulancemen hauled out their equipment — and splinted the victim's *left* leg.

The man who told me the story is an ex-ambulance staffer.

Many of the findings in Mr W N Van Kralingen's CSIR report published in the "Mail" yesterday range from shocking to appalling.

The study, completed after three years of international travel, would indicate that even if some of those anecdotes might seem outrageous, there is sufficient lack of training and education to form some basis for believing those tales.

Mr Van Kralingen's disection of the shortcomings of most municipal ambulance services leaves little doubt that municipal ambulance services, generally, are shoddy.

He examined South Africa's seven largest cities — Johannesburg, Pretoria, Bloemfontein, Port Elizabeth, Durban, Maritzburg and Cape Town — and one town, Pietersburg.

In his notes, Mr Van Kralingen states that "overly sensitive issues such as drunkenness on duty, drug abuse, homosexuality, vicious assaults on patients . . . which were encountered will be ignored".

Mr Van Kralingen states that by ignoring these facts, he is "adhering to research protocol". But, that he says they were encountered means they were — and possibly still are — there.

General criticism of South Africa's municipal ambulance services revealed that only Cape Town and Johannesburg services are above average.

"Port Elizabeth's service," Mr Van Kralingen says, "is improving rapidly, but is not yet above average."

Worst service, by a long chalk, he says, is Durban's despite the fact that the city receives a great deal of money from a tourist influx. Mr Van Kralingen feels that with this revenue, the ambulance service should be vastly better than it actually is.

Pretoria, too, is slated. The city's imported paralance, says the report, is "completely impractical". The report indicates that the city has spent money for little more than a civic showpiece.

In the words of the report, it is "a prestige vehicle in which to transport dignitaries".

Following the "Mail" story, the reaction from fire chiefs — fire chiefs who control ambulance services — has been critical. The Benoni fire chief, whose ambulance service is regarded by Mr Van Kralingen as "very good", claims Mr Van Kralingen's report is "skimpy".

Either way, the CSIR report is explosive, though the intention is not destructive.

Mr Van Kralingen and Dr J G Du Toit, former head of the H F Verwoerd orthopaedic department and currently head of orthopaedics at Ga-Rankuwa hospital, are both committed to the idea of promoting public awareness of the problem of ambulance inefficiency.

The "Mail" yesterday published a report by an orthopaedic surgeon and a CSIR expert on the shocking state of South Africa's ambulance services. Today PETER BAYER sets out the situation in various major centres, drawn from on-scene evaluations conducted by the National Institute for Transport and Road Research, CSIR:

CAPE TOWN: Best by far

THE report is emphatic that Cape Town's fully autonomous ambulance service is "by far the largest and best run service of all".

It serves 14 local authorities, and is funded 100% by the Cape Province.

Cape Town municipality provides all administrative personnel.

A breakdown shows that the service has 180 ambulancemen, who transport 108 000 patients annually over 2,5-million kilometres. The service has 80 ambulances, built to "Cape specifications".

Other centres have ambulance bodies attached to truck chassis.

The Cape municipal ambulance service has its own highly-equipped training school.

Like De Vries Ambulance — a private ambulance enterprise — the Cape service allocates each team a vehicle which the team looks after.

New ambulancemen train for 30-40 hours before spending a week's "apprenticeship" on the road with experienced teams.

The training school also provides advanced training for rural ambulancemen, as well as a comprehensive eight-week ambulance medical assistant course.

Communications are excellent thanks to the multi-channel duplex system and the emergency services control centre, manned by senior ambulancemen.

The service is under the strict control of a qualified doctor, Dr A C McMahon, chief of the Metro Emergency Unit.

The Peninsula's ambulance service is the only one in the country controlled by a doctor.

There is minimal segregation with this service. The nearest ambulance is sent to an accident irrespective of the victim's colour.

The only measure of segregation is in the uniforms worn by coloured and white staff, and the colour of blankets used for black and white patients.

JO'BURG: Above average . . .

THE report lauds Johannesburg's ambulance service as being above average in much of the breakdown.

'However, a telephone call to the 'Mail' this morning seems to cast a different light on the subject of response to calls.

A woman, who has asked to remain anonymous, told me her daughter was picked up by an ambulance on Friday night. The girl was unconscious when she was driven away. The mother took 35 minutes to travel from her daughter's Kensington home to the General Hospital.

The ambulance arrived five minutes later — a time of approximately 40 minutes to travel, at most 8km.

The Johannesburg fire chief, Mr J H De Beer, handed me timesheets showing that urgent calls must take a maximum 15 minutes from logging in to arrival at the accident site.

That the call in the example was urgent goes without saying, and it is accepted that stabilising patients before removal is vital. However, the patient was apparently taken direct from her flat to the ambulance.

Why did the return journey take so long?

The ambulance crew refused with an unconscious patient, should take so long.

Mr Van Kralingen's report says the Johannesburg service "was one of the few that had a formal and regularly monitored response time policy when responding to emergency calls".

The report praises the ambulance staff's courtesy and efficiency, as well as the satellite system of shifts, which leads to

PRETORIA: Missing claxons

PRETORIA's Municipal ambulance service comes in for particularly harsh criticism.

Mr Van Kralingen pays a great deal of attention to the department's sophisticated Mercedes Benz paralance, which he says is "completely impractical in its present role".

He says there is no justification for its purpose other than "a prestigious vehicle in which to transport dignitaries".

"Upon arrival, it was stripped of much of its medical equipment and drugs, with the exception the respirator, suction unit, monitor/defribrillator and cardiac resuscitator.

"Even the claxon was removed, and the vehicle is restricted in use to response by a leading ambulanceman or officer, who seldom has the inclination or time, due to administrative paperwork, to respond to calls, and who only does so in disaster-type general responses or on specific request by a physician."

The report also points out that "there is a marked unequal distribution of response and travel times between the white and black services, due to the placement of of the segregated hospitals".

The report states that response times to accidents are unacceptably high, because:

- Claxons were removed from all ambulances and speeds restricted;
- After 11pm the men are normally asleep and have to be woken up to respond to calls;
- Little attention has been given to the geography and traffic patterns;
- Insufficient supply of, and control over black ambulances;
- Bad radio communications.

DURBAN: 'It's the worst'

THE CSIR report rates Durban and Maritzburg municipal ambulance services respectively as "disorganised" and "a shambles".

And Dr J G Du Toit, former head of the H F Verwoerd hospital's orthopaedic department, past president of the SA Orthopaedic Association, and current head of the Garankuwa hospital's orthopaedic section, regards Durban's ambulance service as "the worst in the country".

The CSIR report states: "To say the least, the ambulance services in the Durban metropolitan area were disorganised.

The central city had a formal response system, presented by the Durban municipality, while the adjacent 'boroughs', physically indistinguishable, had either first aid organisation services on an agency basis . . . or no formal service arrangement at all.

"As with Pretoria, the emergency ambulances are not provided with claxons and are subject to strict speed restriction enforcement".

The report shows that Durban ambulances have poor equipment, poor neatness and cleanliness, poor response times, poor staff morale and poor hospital acceptance and feedback.

". . . as Durban is the country's major holiday resort, deriving substantial sums of revenue from the periodic influx of visitors . . . these potentially disastrous mixtures of people and goods warrant a much better ambulance response and backup system . . ."

The report states that the Maritzburg service has poor equipment, average neatness and cleanliness, average to poor response times and poor feedback and acceptance from hospitals.

Breakdown city by city

JOHANNESBURG:
Type of service: semi-autonomous, linked to fire department.
Degree of autonomy: good.
Radio frequency and communications: good.
Specialised vehicles: locally converted paralance mobile intensive care units. Disaster buses.
General vehicle equipment: good.
Equipment neatness and cleanliness: above average.
Training: full-time instructor.
Response time: above average.
Racially segregated: yes.
Staff morale: good.
Hospital acceptance and feedback: average.

PRETORIA:
Service: semi-autonomous.
Degree of autonomy: poor.
Radio frequency and communications: poor.
Specialised vehicles: imported MICU.
General vehicle equipment: poor.
Neatness and cleanliness: poor.
Training: in-service first aid organisation.
Response time: poor.
Racially segregated: yes.
Staff morale: poor.
Hospital acceptance and feedback: poor.

PORT ELIZABETH:
Service: semi-autonomous.
Degree of autonomy: above average.
Radio frequency and communications: good.
General vehicle equipment: above average.
Neatness and cleanliness: good.
Training: internal training.
Response time: above average.
Racially segregated: yes.
Staff morale: good.
Hospital acceptance and feedback: above average.
- Dr Du Toit and Mr Van Kralingen say the Port Elizabeth service is "not above average yet, but is improving".

DURBAN:
Service: direct fire service.
Radio frequency and communications: average.
Specialised vehicles: disaster buses.
General vehicle equipment: poor.
Neatness and cleanliness: poor.
Training: in-service.
Response time: poor.
Racially segregated: no.
Staff morale: poor.
Hospital acceptance and feedback: poor.
- The CSIR report states: "To say the least, the ambulance services in the Durban Metropolitan area were disorganised."

MARITZBURG:
Service: direct fire service.
Radio frequency and communications: average.
Specialised units and vehicles: none.
General vehicle equipment: poor.
Neatness and cleanliness: poor.
Training: in-service.
Response time: average — poor at night.
Racially segregated: yes.
Staff morale: average.
Hospital acceptance and feedback: poor.
- Mr Van Kralingen's report states that the "shambles into which ambulance service provision can degenerate" can be seen in Maritzburg.

BLOEMFONTEIN:
Service: direct fire service.
Radio frequency and communications: good.
Specialised units: none.
General vehicle equipment: poor.
Neatness and cleanliness: average.
Training: in-service training.
Response time: average — poor at night.
Racially segregated: yes.
Morale: average.
Hospital acceptance and feedback: poor.

PIETERSBURG:
Service: direct fire service.
Radio frequency and communications: average — single channel shared with fire department.
Specialised vehicles and units: none.
General vehicle equipment: poor.
Neatness and cleanliness: average.
Training: first aid organisation.
Response time: average — poor at night.
Racially segregated: no — this means they have no black ambulance staff.
Staff morale: average.
Hospital acceptance and feedback: average.

CAPE TOWN:
Service: fully autonomous.
Radio frequency and communications: above average.
Specialised vehicles and units: multi-purpose disaster/rescue vehicle, several smaller rescue vehicles, reserve equipment vehicles, mobile medical squad.
General vehicle equipment: above average.
Neatness and cleanliness: above average.
Training: Full-time ambulance school with own instructor offering variety of courses.
Response time: better than average.
Racially segregated: yes, to a small degree.
Staff morale: above average.
Hospital acceptance and feedback: above average.

'Call-up causes ambulance chaos'

By PETER BAYER

DEFENCE manpower requirements, and transport laws, are major causes of the chaos in many muncipal ambulance services, leading to the unecessary loss of an estimated 1 300 lives a year.

This was claimed by Mr H L Schippel, correctchairman of the roads and traffic committee of the Johannesburg Civic Affairs Commitee, which is made up of Assocom and Sakekamer members.

Mr Schippel says ambulance drivers are not classified as emergency personnel by the Manpower Board.

"In terms of conditions laid down in labour laws ambulance drivers and attendants can be — and are — called on at any time for military duty. This means there is a continual manpower shortage, with ambulance staff often working 16-hour shifts, seven days a week," Mr Schippel says.

"There is a great incidence of this in major centres where paralance attendants and senior ambulancemen have been called up for military service."

He feels the laws should be amended to exclude ambulancemen.

A report submitted by Mr Schippel to the Assocom defence liaison committee for its July meeting told of discussions between Mr Schippel and the Johannesburg Fire Chief, Mr J H De Beer, in which Mr De Beer admitted that because of the shortage of ambulance drivers and assistants due to army calll-up, those who were left in the service were asked to work as much as 240 hours per month in excess of their normal shifts.

"That means that men are working consecutive 16-hour shifts seven days a week. That's Johannesburg — in smaller areas this can be chaotic. Is there any wonder ambulance services have poor response times to calls?"

Mr Schippel says labour laws preclude ambulances going from one area to another.

He says he knows of incidents where hospitals have not accepted patients because of zoning problems.

He cites the case of a member of his family, who was rushed to the General Hospital suffering from pneumonia. Mr Schippel claims it took 45 minutes before she was admitted.

Other claims made by Mr Schippel are that:

- Ambulance personnel are under-trained and their educational qualifications are far too low — he suggests Std 8 be a minimum educational qualification rather than Std 6;
- Municipal ambulances are below standard. He says they are "converted trucks without proper suspension" — dangerous for transporting patients in critical conditions; Mr Schippel refered specifically to heart attack victims, saying coronary attacks can be brought on by the rough ride.
- Ambulances are generally ill-equipped, particularly those in outlying areas;
- Ambulance personnel should be trained to administer injections and intravenous drips;
- The medical profession is at fault in that doctors travel around unprepared for emergencies; Mr Schippel cited cases of doctors arriving at accidents without any medical equipment, and being unable to render assistance.
- There is a bad breakdown in hospital casualty wards — a problem which is "the same the world over".

The red tape involved in filling in countless forms backs up suggestions by Mr W N Van Kralingen of the CSIR's National Institute for Transport and Road Research, and Dr J G Du Toit, head of the Orthopaedic Departmnet at Ga-Rankuwa hospital, who say hospitals should radically alter their casualty addmissions in order to cope with individual cases.

Mr Schippel says the failure of provincial administrations to develop the 999 emergency telephone number is another indirect cause of unecessary loss of lives.

He was one of the founders of the national 999 emergency number in 1972.

The scheme was to have extended throughout the country. Dialling 999 in any centre of South Africa would have meant ambulance assistance almost immediately — the call going via police emergency telephones to the ambulance service nearest the accident.

● See Pages 2, 15

98

Transvaal to get five new hospitals

Stars 5/10/79.

98

Own Correspondent

Multi-million rand plans for five new Transvaal hospitals are getting priority from the Provincial Administration in Pretoria.

They are Pretoria's new academic hospital, the Soweto Hospital, Laudium Hospital, Volksrust Hospital and Pholosong Hospital for blacks on the East Rand.

Mr Willem Cruywagen, Administrator of the Transvaal, who is responsible for the Finance and Works portfolios, said today these hospitals would be built over the next five years.

Ground had already been bought for the new Pretoria Hospital.

Plans for the R40-million Soweto Hospital, which would have 1 000 beds, were already on the drawingboard and the other hospitals were also being treated as top priority.

Mr Cruywagen said it was important the province catered for the progress made in health fields and kept up with the latest developments because "this service" is closely connected with the public.

"People have become accustomed to good hospital services and the province must continue to give them the best treatment available."

But Mr Cruywagen sounded a warning when he said: "Resources are not unlimited and the province has to keep a tight rein on capital expenditure."

He said one had to keep a balance between "what you know you have and what is really needed.

"It would be silly to give people everything they want with one hand and then have to grab extra taxes and other fees from them with the other hand to pay for it.

"The province will go ahead providing the essential services and making improvements wherever it can," he said.

"I do not at present think there will be any need for an increase in provincial taxes or other fees in the new financial year. The province has met Treasury officials and I am satisfied the arrangement worked out there for finance will eliminate the need for tax increases by the province for the people living here.

"You must remember that the State provides about 87 percent of our income and only 13 percent comes from our own sources.

"We depend heavily on the State, but I do feel the province will be able to cope, in spite of some extra expenses such as ambulance services, as long as we are careful in selecting our priorities," said Mr Cruywagen.

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The nurses choir entertains guests at the opening of the hospital.

'Disease knows no colour'

(98) 8/10/79 Post

THE Minister of Health, Dr L A P Munnik, at the weekend said there could be no race bars within the field of health as diseases affected everybody. "Mosquitoes do not need passports to spread malaria to other countries," he said.

Dr Munnik was officially opening the Garankuwa Hospital.

"The enjoyment of highest attainable standards of health is one of the fundamental rights of every human being without distinction of race, religion and political belief." Dr Munnik said.

The Minister added: "The Government has a responsibility for the health of its people which can be fulfilled only by the provision of adequate health and social pleasures.

"If South Africa hopes to acquire the highest standards of a healthy nation, there should be unity with neighbouring states."

The great population growth which had been taking place in the areas the hospital serves, resulting from the work opportunities offered by the Rosslyn industries, had been anticipated, with the realisation that timeous provision be made on a vast scale on adequate and acceptable health care, he said.

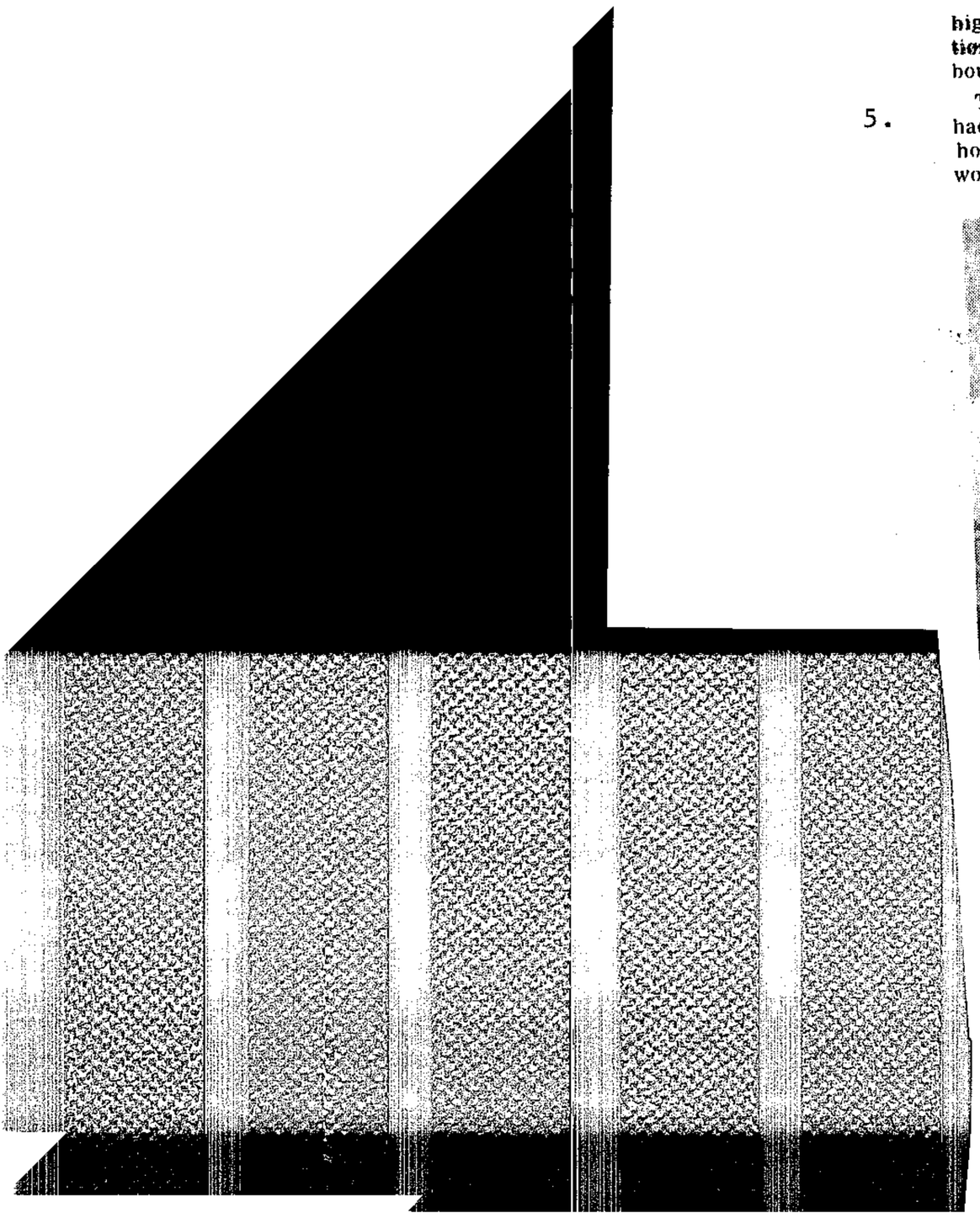
The total cost for the erection of the hospital exceeds R29-million. The administration of the hospital will require R10-million to improve the present treatment at the hospital.

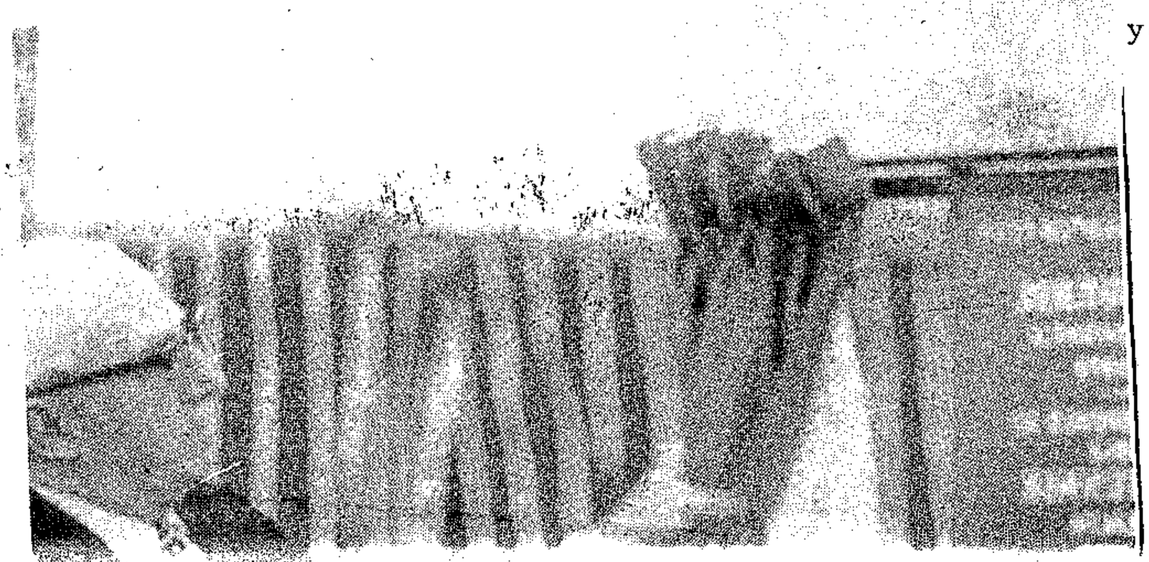
A GIANT

The hospital, during the past six months, has grown to be a giant in its own right. It was planned for 2013 beds and of these 1 500 are now in use.

It is expected that, within the next five years, the hospital will provide services for about 2 000 or 2 500 outpatients a day.

Arrangements for the planning and erection of a subsidiary fully integrated day hospital at Mabopane East (Soshanguve), where a comprehensive health service including district surgeon services on behalf of the Department of Co-operation and Development will be provided.





Dr L A P Munnik officially opening the Garankuwa Hospital.

STUFFED CABBAGE SALAD — May Bennett, Ridgeworth

1 fresh green medium size — tomat[illegible]

Facilities for chronic sick are limited

EAST LONDON — The chronically sick in Coloured areas are in a very difficult situation.

Frere Hospital will not have them unless there are beds available and the new Coloured old age home cannot accept them.

This emerged at last night's Coloured Management Committee meeting when the matter was raised by Mr J. Temmers and the Medical Officer of Health, Dr J. van Heerden, was asked to address them on the matter.

A reply was also tabled at the meeting from Frere Hospital as to whether, because of the move to Cecilia Makiwane Hospital, there was not additional space available to house the chronically ill Coloureds.

The reply said only three minor departments had been moved to the Mdantsane hospital and it was still the intention to accommodate the chronically ill but this depended on the availability of beds.

Dr Van Heerden gave the meeting the assurance that the medical superintendent at Frere, Dr G. L. Bracken, had said they would accommodate the chronically ill.

Dr Van Heerden also outlined how the Newhaven Chronic Sick Home was run by a committee with a subsidy from province. He said the committee should do a survey and then approach the director of hospitals on the matter.

The chairman, Mr Nash, agreed with the suggestion but pointed out that when they wanted to set aside some homes in Pefferville for the chronically ill, they had been told by the then superintendent at Frere, Dr F. L. Visser, it would not be necessary as they could be accommodated at Frere.

"Now when we take them up on their promises it just does not seem to be the case," he said.

A survey of the cases will be taken. — DDR

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---

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.

---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---

Urgent Govt probe into ambulances

By PETER BAYER

THE Department of Health has initiated a nation-wide inquiry into the shocking state of South Africa's municipal ambulance services.

Recommendations for change in the service are to be handled with "the utmost urgency".

Dr J P Roux, Director of Health Services, confirmed this yesterday at a meeting called by the Rand Daily Mail, following its recent disclosures that most municipal ambulance services are in a shocking state.

The meeting was also attended by Mr Horace van Rensburg, PFP spokesman on Health, and representatives of the CSIR, including Mr W N Van Kralingen, whose study of ambulance services showed ambulance personnel were undertrained, vehicles poorly equipped and response times to calls generally poor.

Dr Roux said several recommendations had been made by the Health Matters Advisory Committee (HMAC) working group regarding improvements to the service.

Among the recommendations, which have been accepted in principal are:

● Where provincial authorities agree, local authorities be allowed to continue with the provision of ambulance services until the planned Provincial Administration takeover of the services on April 1, 1980.

● An ambulance services sub-committee investigate the financial implications of the provincial takeover.

● That draft legislation be prepared by the Cape Provincial Administration for consideration by the other Provincial Administrations and the HMAC.

● That the cost of transporting patients between provinces be the responsibility of the provincial administrations.

● That the HMAC recommends to the National Health Policy Council (NHPC) that ambulance services be separated from fire services wherever desirable.

● That an HMAC working group, with Dr A C McMahon — chief of the Cape's Metro Emergency Unit — as convenor, investigates standardisation of training and equipment.

Further recommendations, all in Mr Van Kralingen's shock CSIR report, will be investigated by the sub-committee on ambulance services and put forward to the NHPC.

The blueprint for change will work through four control tiers.

The first stage is the HMAC's recommendations to the NHPC.

Their accepted principals will be regarded as recommendations by the NHPC, who will turn their recommendations, in turn, over to the Minister of Health, Dr L A P A Munnik, who will present the complete package to Parliament.

Once the NHPC makes a policy it is regarded as final, Dr Roux said.

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a) deferral method

b) liability method

(assume there are no other items causing timing differences)

3. How will the answer to 2. be affected by the existence of an extraordinary gain on disposal of a division of the company, amounting to R70 000, all of which was taxable, in the 19.7 financial year?

4. How does the answer to 3. change if the R70 000 is now a deductible loss, which can be set off against the taxable income from other sources of R50 000? Draw up the income statement assuming the deferral method is used.

5. Further to Note 4, assume now that the company has a set profit before depreciation of R60 000 in 19.8.

Draw up the income statement for the 19.8 financial year under a) liability method

b) deferral method

Assume the tax rate remains 42%

STUFFED CABBAGE SALAD

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carrots

Cut the centre from the
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GERMAN POTATO SALAD

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mayonnaise

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salt and pepper. Use

EGG SALAD

hard boiled eggs
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Cut eggs in half and la
down. Pour over salane

Boss warning to Bara doc

98 18/10/79 Post

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.

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---

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---

R16m-plus to improve Wentworth Hospital.

Mercury Bureau

PIETERMARITZBURG — A massive R16,6 million for improvements to Wentworth Hospital in Durban was approved by the Natal Provincial Administration's Executive Committee here yesterday.

The MEC in charge of hospitals, Mr. Frank Martin, said the money would be used for extensive improvements and renovations to facilities at the hospital, including the out-patients' department and the wards.

More specialist services would also be provided.

Mr. Martin said work would start in the next financial year, which begins on April 1.

"Wentworth is a multi-specialist and multi-racial hospital. The facilities there can now be improved and the special services strengthened. The existing specialist services will continue in much more modern surroundings," he said.

"For a long time now the staff have been doing a tremendous job under very difficult circumstances."

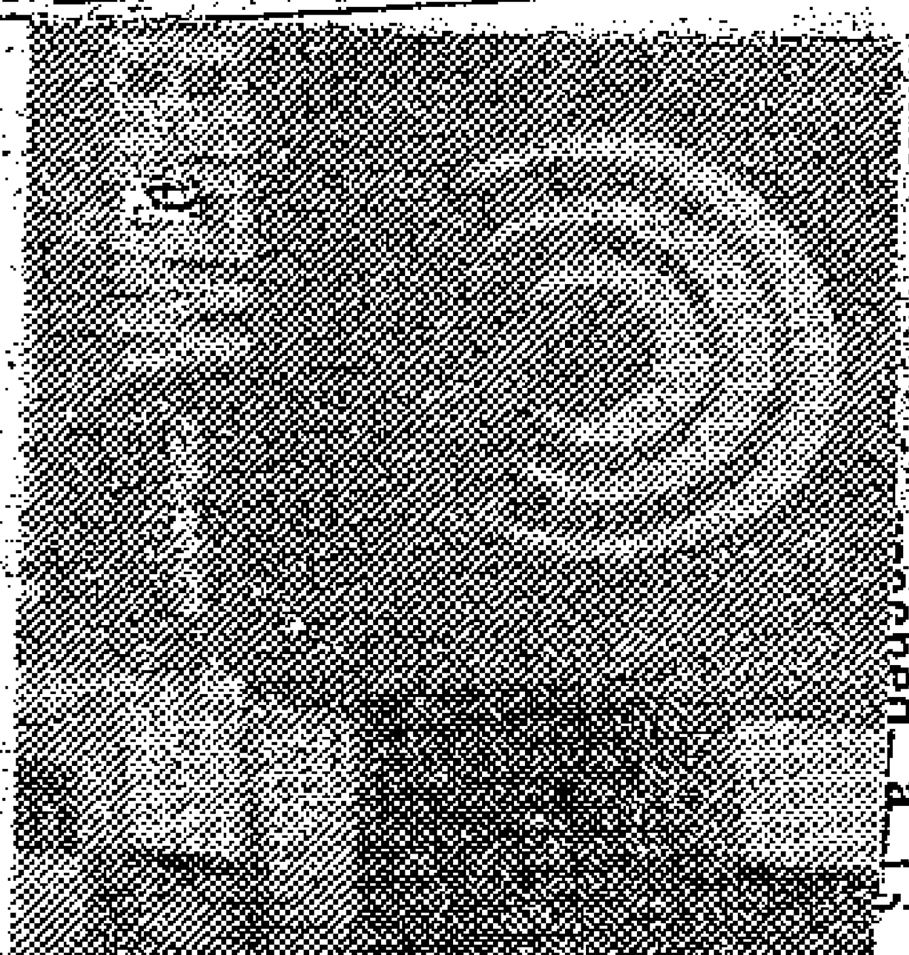
Mr. Martin said plans and drawings for the work had been completed, and were passed by Exco yesterday.

Dr. N. Dawber, medical superintendent of the hospital, said last night the grant would be used for the building of new central facilities, including operating theatres, cardiac - catheterisation laboratories, brain-scan and diagnostic facilities, a new X-ray centre and out-patients' facilities.

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



suring 84-59-84. It's going
nber boards during the fig
ring too, also displayin

... inconsistencies. It was noted that a logical axiom, ... 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 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.

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Star 20/10/79

Doctors back protest over Baragwanath

(98)

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 ... reached a

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."

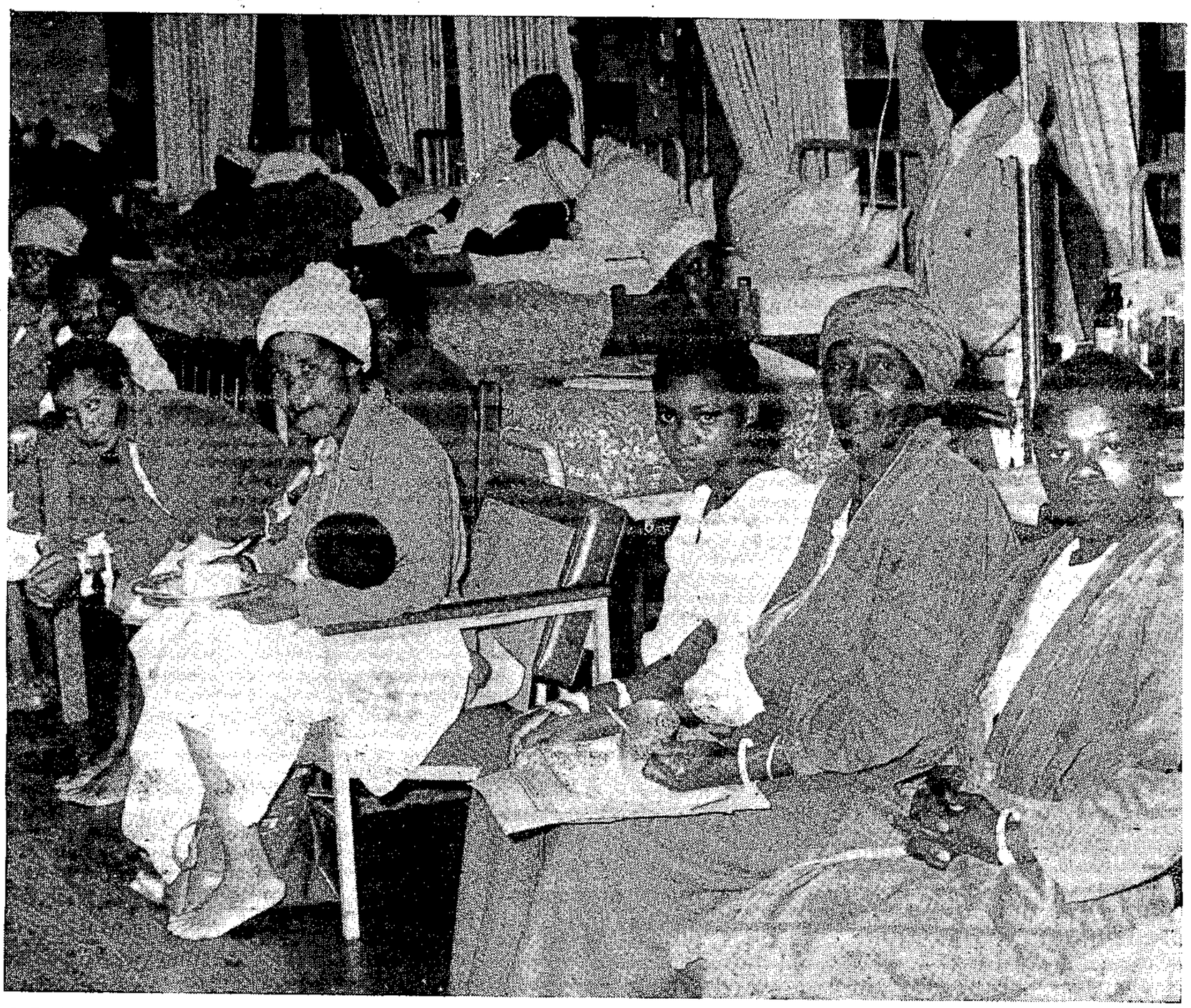
"But," he added, "because blacks don't have the vote it is no emergency for anybody — except for blacks."

Diagram 1...

Problem					Total
Large & poo... spaced fam...					96
Inadequate ...natal & obs... care					48
Malnutritio...					36
Need for me... care					12
Specific ...					
V.D.		.	++	++	16
Dental probl...	.	+	++	++	16
TB	+++	+++	+++	++	54
Common cold*	++++	+	+	-	0
Yaws*	-	++	+++	++++	0

* Added to test scoring method

It's not too few beds —



● Patients sitting in chairs in the wards show the scarcity of beds at Baragwanath Hospital. The trouble is not just the shortage of accommodation, but the number of "outsiders".

DR ROGER Blackwood, the cardiologist who said this week that patients were dying at Baragwanath Hospital because doctors were too busy, has sent files on two deaths to chief superintendent Dr P J Beukes to back up the claims.

And while the great Baragwanath row continued, the Sunday Express made its own investigation.

Reporter Marian Shinn went on an official tour of the hospital. She was told not to speak to staff, and when she put questions to Dr Beukes he quoted Regulation 5 of the Hospital Service Regulations and said he could not answer them.

He later relented and phoned on Friday evening and answered some of the questions.

Reporter Barney Mthombothi went to the hospital unofficially. He spoke to patients and staff about the problems.

Together, they put together a bleak picture of a vastly overcrowded hospital where patients, as they start getting better, graduate to sleeping on the ground, under the beds of those who are more ill.

The row, which flared after SABC-TV man Kevin Harris was fired by Auckland Park because of a dispute over his documentary on the hospital and representations on it by Dr Beukes, continued when Dr Blackwood made his allegations.

Dr Beukes then interviewed Dr Blackwood and asked him to substantiate his claims. He also warned him not to speak to the Press or he would get into "deeper water".

But the Sunday Express found that the hospital's doctors are firmly behind Dr Blackwood.

This week they plan to inform Dr Beukes by letter of their support for Dr Blackwood's allegations.

"Dr Blackwood was telling the truth and we've decided to back him. The work load on all medical staff is extremely high. I'm sure the superintendents are equally overworked," one of them said.

"Doctors on every level look upon this as an opportunity to rectify what has been going on for a long time.

"The superintendent has long received

We do a good job — hospital chief

By MARIAN SHINN

THE main cause of overcrowding at Baragwanath Hospital is that people from other areas use the facilities at the Soweto hospital, Dr P J Beukes, chief superintendent, claims.

If they used hospitals in other parts of the Vaal Triangle, such as at Tembisa or Vereeneging, it would ease the load on his hospital.

"I can't say there is a shortage of beds. I can say we have too many patients," he said.

"You have to plan according to the number of people who live in your area," he said.

The official population figures for Soweto were 800 000 and the usual general hospital allocation was four to five beds per thousand. This meant that there should be at least 3 200 general hospital beds available in Soweto now.

Soweto's general hospital, Baragwanath, has 1 850 beds. The other two hospitals in the complex, St John's Eye Hospital and the maternity hospital, take the total number of beds to 2 400.

When the extensions to Baragwanth are complete, the general bed count will be 2 000.

The new hospital planned for New Canada will give Soweto's residents another 1 000 beds, taking the total general bed population in Soweto to 3 000 by the late 1980s.

This would still be far below the necessary bed count for today's conservative official population and totally inadequate for the future expanded population.

Why are bigger hospitals not being built for Soweto?

Dr Beukes replied that the new medical trend throughout the world was expand preventive medicine and treat illnesses at their source.

"I am in favour of this trend and am developing it at the hospital.

"We don't want to build disease palaces. We want to relieve the illness at its source. This will relieve Baragwanath."

Dr Beukes would not comment on whether it had been a political decision not to develop Baragwanath as the problems it has today were there 20 years ago.

He said the number of doctors in each department was investigated by the Deaprtment of Hospital Services whenever a head requested it.

"The department of internal medicine was looked at a year ago and they got eight new doctors. Now Dr Blackwood says they are too overworked to do their jobs.

"Two or three months ago the professor of the department asked for more staff and we will be looking at the department again."

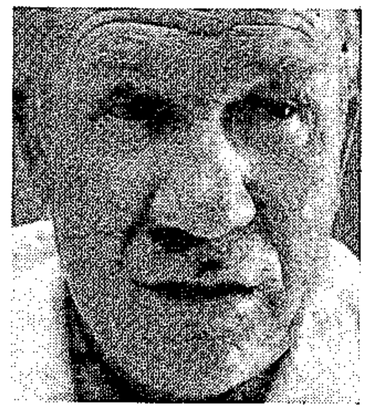
Dr Beukes explained that the Department of Hospital Services did a time-and-motion study in each department before deciding whether more staff should be allocated. It was not calculated on the number of beds.

"Every hospital has its aches and pains, but I believe this hospital does a tremendous task. We have too many patients and there aren't enough beds, but we take them in and try to do something for them.

"I believe this hospital operates efficiently. I have not had a complaint from the nursing staff that they are overworked or short staffed.

"I don't believe we are desperately short of doctors. Some who left in recent months are returning."

Dr Beukes added that he would be open to any approach on the hospital's problems that the staff took to him.



● Dr P J Beukes
. . . a tremendous task

it's just too many people

PATIENTS DIE AS DOCTORS SCURRY TO AND FRO

A SUNDAY EXPRESS INVESTIGATION

BY MARIAN SHINN and BARNEY MTHOMBOTHI

letters from doctors about the problems. He's well aware of them. But now it has gone public and something must be done."

This week Dr Beukes allowed the Sunday Express to tour the hospital to see whether Dr Blackwood's allegations could be substantiated.

The tour on Friday was made in the company of the deputy superintendent Dr Chris van der Heever and Dr S Cronje.

We were not allowed to talk to the staff.

Barney Mthombothi toured the hospital privately — as a visitor.

The most obvious problem at the hospital is the shortage of bed accomodation. In some wards patients sleeping on stretchers and on the floor outnumber those in beds.

From what we saw, and what we were told by those members of the staff to whom we were able to talk, it would appear that about one-third of the hospital's patients have not got proper beds.

During the day these "stretcher cases" laze on the lawn in the sun or, when it is raining, as on Friday, they sit on chairs in the wards, cluttering up the aisles.

A shortage of blankets adds to patients' discomfort in winter. Patients sleeping on the concrete floors of enclosed verandahs have only one blanket.

Propped up against the outside wall of one of the men's wards on Friday were the six stretchers allocated to it. It was pouring with rain.

"They'll be dried off before tonight" said one of my guides in reply to a question as to why they were not brought inside.

After the tour my first question to Dr Beukes was about the bed shortage.

I asked him how many patients slept on the floor each night and, as this problem went back many years, what he had done to allieviate the problem.

He replied by asking whether I knew the Hospital Service Regulations, which say hospital officials may not talk to the Press about their duties without the permission of the Director of Hospital Services.

He then refused to answer any questions as he had been unable to contact the Director.

On Friday evening he telephoned the Sunday Express to answer some of the allegations. He would not discuss Dr Blackwood or any of the allegations he made, saying these were being looked into.

But Dr Blackwood was not the first person to talk about patients dying because doctors were too busy.

Newspaper files show similar allegations were made by unnamed doctors in a report in the Rand Daily Mail in March 1965.

They read very much like Dr Blackwood's allegations — doctors overworked and working long hours, gross overcrowding, particularly in the casualty section.

Nothing was done and the problem got worse.

Nobody seems able to say why, but the guess is that Baragwanath, like Soweto, was never meant to be a permanent fixture. Any black hospital development was expected to take place in the homelands.

A new Bara was requested in 1968. After a search for a suitable site in Soweto, which came to nothing, it was decided to rebuild the existing hospital.

So demolition and building work going on at Baragwanath now is aggravating the situation there.

Rebuilding will be complete in 1994. But even then the hospital will cater for only 150 more general hospital beds than at present. But it is hoped that a hospital to be built at New Canada, starting in 1981, will help ease the load.

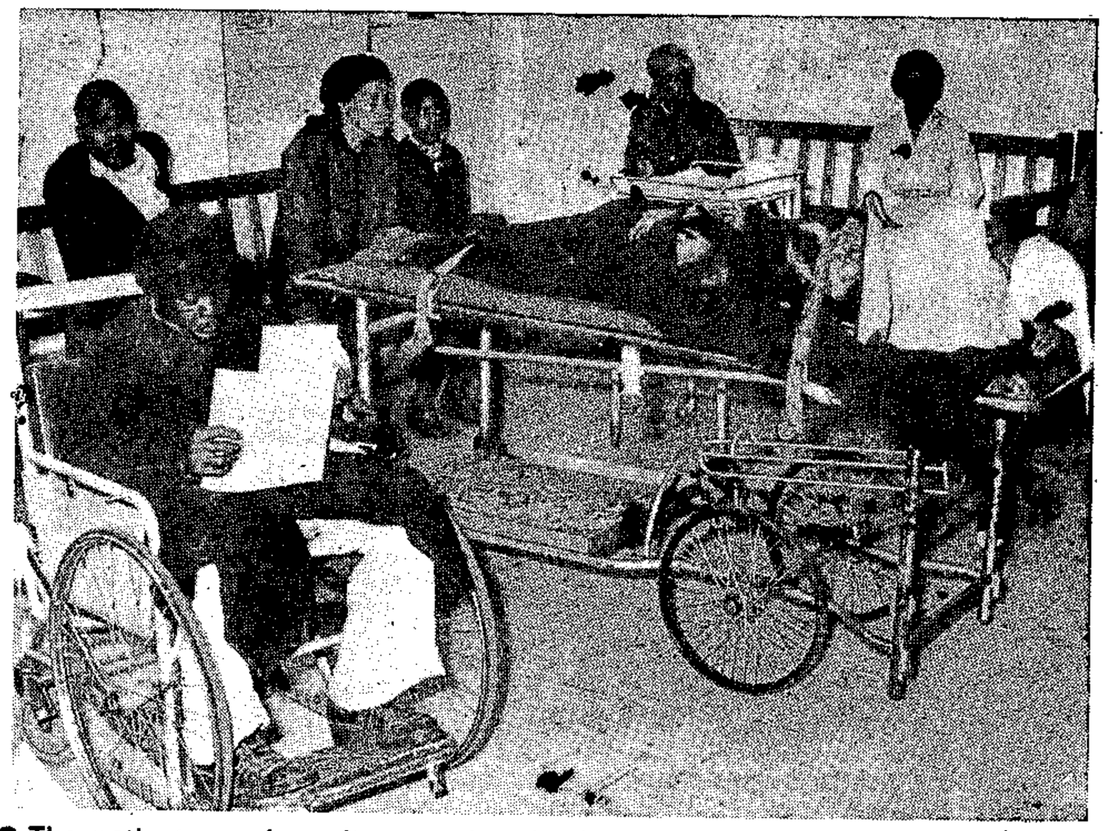
The Leratong Hospital is apparently easing the load on Bara by taking patients from Dobsonville.

This easing of the load is not apparent.

When we visited Ward 21 there were 77 patients. Thirty-one sleep on blankets on the floor and six sleep on canvas stretchers.

But this was apparently a light load for this ward. Those who have worked there said that there were sometimes more than 100 patients in the ward.

In Ward 20, a men's medical ward, there were 81 patients. Forty had beds, eight had stretchers and the rest sleep in blankets on the floor.



● The patient people wait, some in wheelchairs, some on stretchers, some on seats as the staff work at full stretch to treat them.

ONION RINGS — May Bennett, Ridgeworth

Peel and slice large onions, and separate the rings. Heat a pan; add oil. Dip the rings in milk and then coat with flour, and fry till brown in the hot oil. Drain the oil off on a paper towel, and season with salt and pepper.

---oOo---

OLD FAMILY [illegible] BOOK

Bake and Eat Th[illegible]

FRENCH PANCAKES - 1903

2 eggs	2 ozs
1 dsp butter	1/2 pt
2 ozs sifted flour	

Beat eggs thoroughly, add butter and f[illegible] sugar and flour, and when well mixed a couple of minutes. Pour on to butt[illegible] quick oven for 20 minutes. Serve wit[illegible] sugar, or pile on a hot plate, with a[illegible] ade between them. Time, 25 minutes, at any time.

---oOo---

SPATCHCOCK - 1908

1 young fowl	parsl[illegible]
brown bread crumbs	onio[illegible]
herbs	

Cut the fowl through the back bone, [illegible] melted butter. Sprinkle with salt a[illegible] chopped parsley on both sides. Scor[illegible] till 1/2 done, then cover with bread[illegible] till well done. Serve with a sharp [illegible]

---oOo---

PLUM PUDDING

2 cups flour	1 sm[illegible]
1 t baking powder	1/2 [illegible]
1 large cup brown sugar	1/2 [illegible]
1 cup currants	1/2 [illegible]
3 beaten eggs	a little mixed peel finely cut
1/4 t ground spice	

Mix all ingredients together well. Tie in a pudding cloth, and boil for three hours. Serve with hot nutmeg sauce. This recipe was used for Christmas dinner in 1916 by my mother and gran, she says "We used 1 cup of flour and 1 cup of stale breadcrumbs instead of 2 cups of flour. Very successful".

---oOo---

MUTTON, ROAST SHOULDER OF [illegible]

shoulder of mutton	salt
dripping	flour

Put the joint to a bright clear fire, floured well. Baste contin-

Registrars of Bara[illegible] to meet Dr Beukes

Baragwanath Hospital registrars plan to meet the Hospital Superintendent and possibly the Director of Hospital Services about the facilities at the hospital.

This follows allegations of overcrowding and a shortage of medical personnel at the hospital made last week by a senior physician at the hospital, Dr Roger Blackwood.

The registrars are understood to be awaiting the outcome of a meeting held yesterday between the hospital superintendent, Dr P J Beukes, and department heads.

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[illegible]nd
[illegible]ill
[illegible]g

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 Beard, 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.

... and peas with French dressing. ... 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---

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, 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 ...

---oOo---

POST, Thursday, October 25, 1979 (98) Page 21

Heads to meet on Bara facilities

BARAGWANATH Hospital registrars plan to meet the hospital superintendent and possibly the Director of Hospital Services on facilities at the hospital.

Allegations of over crowding and a shortage of medical personnel at the hospital were made last week by a senior physician at the hospital, Dr Roger Blackwood.

The registrars are understood to be awaiting the outcome of a meeting between the hospital superintendent Dr P J Beukes and department heads.

A spokesman for the registrars said: "We are not willing to release details to the Press at this stage. We are following a different tack from Dr Blackwood and are going through all the channels available — the superintendent, the Director of Hospital Services and possibly the Medical and Dental Council. But we are not there yet."

He said conditions at the hospital had been "amply described" by Dr Blackwood. The issue had also been raised by the hospitals' registrars in August this year.

"We are now carrying on with moves initiated at that time," he said.

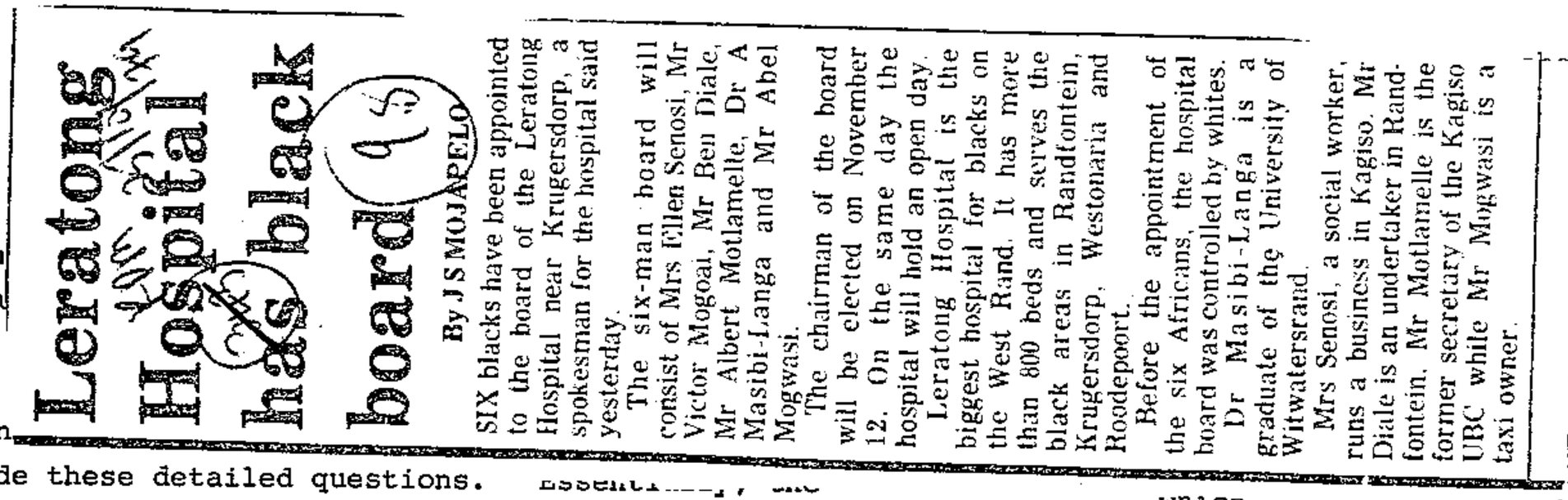
the cost of raising the necessary funds has to be taken into account. The funds themselves are already justified by comparison with the alternative methods of provision, but there are additional costs involved in raising them: interest on loans, or administrative and incentive costs of raising taxation. These are normally insignificant for any given project, but may affect the overall amounts available for the health budget.

Where the methods of providing a given service use the same kinds of resources in different proportions, the decision-making can be simplified by means of Linear Programming, though health service choices cannot usually be presented in the simplified way required by this method.

2. CHOICE OF PROGR

So far, we have discu
objective. But what
ives themselves? Ca
to be given to partic
more to child welfare

Overall criteria are n
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.



Lerato
Hospital
has
board

By J S MOJAPELO

SIX blacks have been appointed to the board of the Leratong Hospital near Krugersdorp, a spokesman for the hospital said yesterday.

The six-man board will consist of Mrs Ellen Senosi, Mr Victor Mogoai, Mr Ben Diale, Mr Albert Motlamelle, Dr A Masibi-Langa and Mr Abel Mogwasi.

The chairman of the board will be elected on November 12. On the same day the hospital will hold an open day.

Leratong Hospital is the biggest hospital for blacks on the West Rand. It has more than 800 beds and serves the black areas in Randfontein, Krugersdorp, Westonaria and Roodepoort.

Before the appointment of the six Africans, the hospital board was controlled by whites.

Dr Masibi-Langa is a graduate of the University of Witwatersrand.

Mrs Senosi, a social worker, runs a business in Kagiso. Mr Diale is an undertaker in Randfontein. Mr Motlamelle is the former secretary of the Kagiso UBC while Mr Mogwasi is a taxi owner.

(c) to know the effectiveness of a given amount of money when spent on different objectives, so that choices can be formulated in terms of the alternatives we might afford - so many geriatric day care centres, so many child welfare clinics, etc.

Financial statistics are not traditionally arranged on this basis but in categories such as 'salaries', 'transport', 'medicines', etc. A separation, e.g. between expenditure on different disease groups or age groups cannot be made.

The grouping of expenditure into programmes is an art. Pole, an economist in the U.K. Department of Health, writes:

> ...uld, in my view, be mainly determined
> ...taking of which one wishes it to con-
> ...ggest that where decisions are primarily
> ... moral judgement - of determining basic
> ...ant the activities to be compared to
> ...rammes - the mentally handicapped against
> ...re it is a more technical question of
> ...s can best be achieved - drug therapy
> ...apy - one would want the activities to
> ... a particular programme. This distinc-
> ...nomic jargon of slightly older vintage -
> ... cost-effectiveness; and through that
> ...eoclassical welfare economics, which attempts
> ...etween the choice of the composition of the
> ...he choice of the set of resources from
> ...which each ... be produced. The former is, in a broad sense, a question of tastes, values, or utilities; the latter is a question of techniques".

He adds:

> "In practice, it is not an easy matter to make a hard and fast distinction between technical matters and matters of values or utilities in the health services. From one point of view, the question whether to treat schizophrenics in hospital or in the community is a technical one. Which is the cheaper way to fulfil whatever are the society's requirements for the treatment of this group? But 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

ONION RINGS

May Bennett, Ridgeworth

Peel and slice large onions, and separate the rings. Heat a pan; add oil. Dip the rings in milk and then coat with flour, and fry till brown in the hot oil. Drain the oil off on a paper towel, and season with salt and pepper.

---oOo---

OLD FAMILY

FRENCH PANCAKES - 1902

2 eggs
2 ozs butter
2 ozs sifted flour

Beat eggs thoroughly, sugar and flour, and a couple of minutes. quick oven for 20 min sugar, or oils on a ade between them. T at any time.

SPATCHCOCK - 1900

1 young fowl
brown bread crumbs
herbs

Cut the fowl throug melted butter. Spr chopped parsley on till 1/2 done, the till well done. S

SLUM PUDDING

2 cups flour
1 t baking powde
1 large cup brow
1 cup currants
3 beaten eggs
1/4 t ground spice

Mix all ingredients together well. Tie in a pudding cloth, and boil for three hours. Serve with hot nutmeg sauce. This recipe was used for Christmas dinner in 1916 by my mother and gran, who says "we used 1 cup of flour and 1 cup of stale breadcrumbs instead of 2 cups of flour. Very economical".

---oOo---

MUTTON, ROAST SHOULDER OF 1900

shoulder of mutton
dripping
salt
flour

Put the joint to a bright clear fire, floured well. Baste contin-

Hospital plan 'is admission'

Star 22/10/74 p8

The authorities have acknowledged that Baragwanath Hospital is overcrowded by planning a new 2 000-bed hospital to serve Soweto, the superintendent, Dr P J Beukes, has said in an interview.

Dr Beukes said he had known of the overcrowding at Baragwanath for a long time.

"I could have done much in my personal capacity as superintendent. I tried a lot, but had no success," he said.

He wanted patients to be transferred to other hospitals and had instituted 80 beds at Leratong Hospital for them.

But the Department of Medicine at Baragwanath "did not come back to me on this issue," Dr Beukes said.

"I had a definite arrangement with them and had organised transport for patients. They got the message clearly—I don't know why they didn't come back to me on this.

"They were to give me names and I was to take further action but I did not receive the names of any patients for transfer," he said.

"The whole uproar is over the medicine department.

"We've had several meetings and are trying to solve the problems."

Mr Horace van Rensburg, chief Opposition spokesman on health, has called for a new hospital in Soweto.

The need for such a hospital was raised in Parliament in April, he said.

Mr van Rensburg said he was pleased that the shortage of hospital accommodation and medical staff had been exposed by the "courageous action" of a number of doctors.

ONION RINGS

May Bennett, Ridgeworth

Peel and slice large onions, and separate the rings. Heat a pan; add oil. Dip the rings in milk and then coat with flour, and fry till brown in the hot oil. Drain the oil off on a paper towel, and season with salt and pepper.

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O L D F A

Staff shortage at Bara being probed

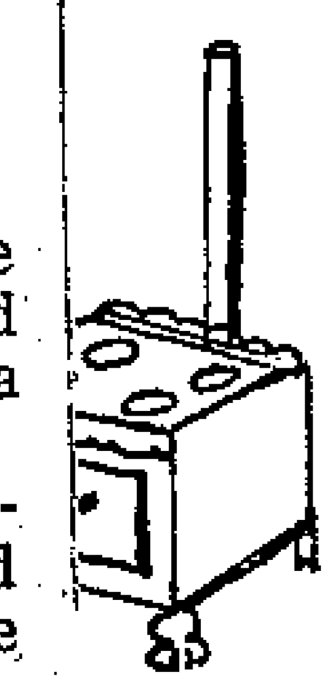
Officials from the Department of Hospital Services in Pretoria are believed to be investigating allegations of a serious staff shortage and overcrowding at Baragwanath Hospital.

Doctors at the hospital have said they would take the matter "to the highest level, and to the SA Medical and Dental Council" if necessary.

"The council should be concerned with ethics and practices in medicine," a doctor said.

Doctors said unless tangible changes to staff and patient conditions were made after a meeting today they would take the matter to the council.

Doctors are reported to be "very distressed" about conditions at the hospital.



FRENCH PANCAKE

2 eggs
2 ozs butter
2 ozs sifted f [illegible]

Beat eggs thor [illegible] sugar and flou[illegible] a couple of mi[illegible] quick oven for [illegible] sugar, or pile [illegible] of preserve or marmalade between them. [illegible] minutes, average cost, 6 d, seasonable at any time.

---oOo---

SPATCHCOCK - 1900

1 young fowl	parsley
brown bread crumbs	onion
herbs	

Cut the fowl through the back bone, and open out flat. Brush with melted butter. Sprinkle with salt and pepper, chopped onion and chopped parsley on both sides. Sprinkle with mixed herbs. Grill till 1/2 done, then cover with breadcrumbs and continue cooking till well done. Serve with a sharp sauce.

---oOo---

PLUM PUDDING

May Bennett, Ridgeworth

2 cups flour	1 small cup chopped raisins
1 t baking powder	1/2 grated beef suet
1 large cup brown sugar	1/2 pt milk
1 cup currants	1/2 t salt
3 beaten eggs	a little mixed peel finely cut
1/4 t ground spice	

Mix all ingredients together well. Tie in a pudding cloth, and boil for three hours. Serve with hot nutmeg sauce. This recipe was used for Christmas dinner in 1916 by my mother and gran, who says "we used 1 cup of flour and 1 cup of stale breadcrumbs instead of 2 cups of flour. Very successful".

---oOo---

MUTTON, ROAST SHOULDER OF 1900

shoulder of mutton	salt
dripping	flour

Put the joint to a bright clear fire, floured well. Baste contin-

ONION RINGS — May Bennett, Ridge

Peel and slice large onions, and separate the rings. add oil. Dip the rings in milk and then coat with flo till brown in the hot oil. Drain the oil off on a pap and season with salt and pepper.

---oOo---

The Star 30.10.79.

Bara staff situation is being investigated

Officials from the Department of Hospital Services are believed to have held a meeting at Baragwanath yesterday to investigate the number of doctors and the staff situation.

Dr P J Beukes, the superintendent, said the meeting was at the request of Professor Leo Schamroth of the hospital's Department of Medicine.

"Professor Schamroth requested this meeting as far back as August or September this year, long before the Press began looking at the position," he said.

On Friday, Dr Beukes told The Star he had offered to transport patients to other hospitals. He had received no response from the Department of Medicine.

BEDS FULL

"My offer to transport patients to other hospitals still stands, as long as people inform me of the names of the patients and whether they want the service," he added.

Dr Beukes admitted every bed in the hospital was full at present. Last week, The Star published photographs of patients sleeping on floors due to alleged overcrowding.

Dr Beukes said there was one doctor to five or six patients at Baragwanath. This meant that 500 doctors treated about 3 000 patients.

This estimate took in the general, maternity and St Johns sections of the hospital.

NO COMMENT

Professor Schamroth declined to comment on yesterday's meeting, but the director of Hospital Services of the Transvaal, Dr Hennie Grove, claimed no knowledge of the meeting.

At first he insisted that The Star submit all questions in writing, but later promised to provide details of what action had been taken since 1974 to alleviate overcrowding.

Public attention was drawn to conditions at the hospital as far back as 1974 when newspapers reported on alleged overcrowding and inadequate facilities.

And since The Star published its first reports about alleged conditions at Baragwanath, there have been claims of poor conditions at other hospitals for blacks.

The Star is investigating alleged overcrowding at Coronation Hospital. Dr Grove said he was "unaware" of this, adding that many hospitals have building programmes, and Coronation is one of them.

1 cup [illegible]
3 beaten eggs
1/4 t ground spice

Mix all ingredients together well. Tie in a pudding cloth, and boil for three hours. Serve with hot nutmeg sauce. This recipe was used for Christmas dinner in 1916 by my mother and gran, who says "we used 1 cup of flour and 1 cup of stale breadcrumbs instead of 2 cups of flour. Very successful".

---oOo---

MUTTON, ROAST SHOULDER OF 1900

shoulder of mutton — salt
dripping — flour

Put the joint to a bright clear fire, floured well. Baste contin-

12/11/79 Post

(98)

Black board for hospital

By ALINAH DUBE

THE DIRECTOR of Hospital Services in the Transvaal, Dr A H Grove, introduced an all-black hospital board for the Natalspruit hospital, near Germiston at the weekend.

Dr Grove said the board would act as the observers for the superintendent.

"The board must always investigate the complaints of the community," he added. "They must be our guide and advisers so that we build the image of the hospital".

The newly-elected chairman of the board is Dr J A M L Moshesh.

Dr Grove said the hospital was officially opened in 1965 to serve people in the East Rand. At the moment there were 1 538 people working in the hospital of which only 158 were whites.

With only 10 percent of the staff white, it was advisable that the hospital have an all-black hospital board.

Some members of the board, he said, were chosen by the provincial administration board according to their former achievements.

According to the superintendent of the hospital, Dr A F Chemaly, 103 meetings had been held since 1962.

The Director of Hospital Services in the Transvaal, Dr A H Grove, meets with members of the Katlehong Hospital Board. From left is Rev S Nkosi, Mr M B Maja, Dr J M Moshesh, Mr Motloung, Mrs T G Phaleng, Dr Grove and Mr Mpiyakhe Kumalo.

The new Natalspruit Hospital Board sits with Dr Grove in the chair to inaugurate the new regime.

98

EXPRESSCOPE

SPENDS A 12-HOUR S

My cut-figh

I HAVE never felt so useless. With my white coat and stethoscope I looked like a doctor but there was nothing I could do to help.

Yet all around me were woman, some younger then myself, fighting expertly for someone's life.

They do that quite often in the course of their work. Sometimes they win, sometimes they lose. Each battle takes it out of them — and each time they fail, they feel a personal sense of loss, though the victim was a total stranger until he or she was admitted to a ward of the Johannesburg Hospital.

These young, dedicated nurses with whom I did the rounds through the night shift on Wednesday work 12 hours a day, sometimes nine days in a row.

At the end of the month, for their dedication and their expertise, they often take home less than R200 to live on.

I went to see the night through with them because of the current pressure for an increase in nurses' salaries. I emerged from the hospital the next morning, weary and strained, and convinced of one thing.

If anyone needs an increase in salary, it's these young people.

When they fought death in the ward shortly before midnight, I could only watch helplessly and move apologetically out of the way every time they hurried by me.

They lost the uneven struggle, and it ended tragically for the patient's family. But the nurses, and the doctors they had summoned, knew they had done all they could.

Yet for the nurses it nevertheless was a blow to have failed — a blow they are doomed to experience time and again throughout their working life.

However many times it happens it hurts them.

Except for emergencies nurses can't handle, doctors and specialist sleep at night — and depend on the alertness and skills of these nurses who must keep a constant vigil on the well-being of sometimes 20 patients each.

They will be the first on the scene when a patient's life is in the balance and have the responsibility of keeping that person alive until doctors arrive.

On Wednesday night I went on night shift with the eight nurses and one ward sister responsible for four medical wards in the old General Hospital.

I left with them at 7am the next morning, my eyes red from sleeplessness — and a massive dose of depression.

Work began that night with the usual duties. The ward sisters met to collect their records of that night's patients. Then followed the routine blood pressure, pulse and temperature taking, bedwashes, and linen changes.

All carried out with a smile, a bit of backchat, a reassuring word.

Before lights out, oxygen apparatus and drips are checked, medicines painstakingly handed out according to the charts.

Some wards, the males usually, were easier than others. The women patients are far more demanding and the nurses return endlessly to the bedside to pick up a pillow or a book.

At 8pm it was tea time for the patients. Soon afterwards the lights went out.

The nurses settled down with their books under light, their chairs ma comfortable with their favourite m ing softly.

It looked as t long night was goi slowly by with hourly checks, hourly tempera the 6-hourly inj worry about until

But like most routine was to b shattered by an e

At 10.45pm I witness to the life struggle in Ward

A phonecall se and the sister downstairs.

A patient who e evening had jokii

By PADDI CLAY

Pictures: DOUG LEE

● A patient is in danger of dying — and it is the lot of one nurse to contact relatives and tell them.

● One battle the young nurses helped to f most of them feel i

M
SA

"I am in no position to judge the level of Black anger."
Mr David Thebehali, chairman of the Soweto Community Council:

"I do not think I am qualified to say whether people are angry or frustrated. And if I said people were angry, it would just incite others to anger. I don't want to comment or get into any controversy."

HIFT WITH THE NURSES — AND SALUTES...

night with the price angels who t for each life

de more cushions, usic play-

ough the ng to drag only the he four- ures and ctions to 4am.

nights the suddenly. nergency. became a and death .5.

it myself scurrying

arlier that gly called

herself a "pillbox" as she took her medication, had started displaying the signs of ventricular failure.

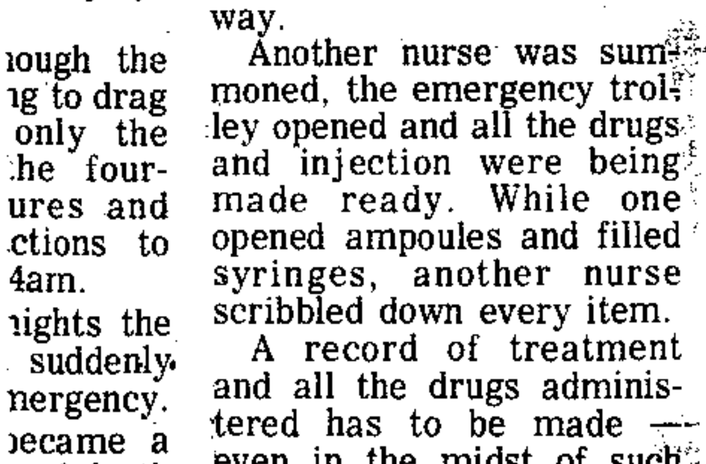
Within seconds the houseman on duty was in the ward with us. In time to see the woman go into cardiac arrest.

Things started happening at an incredible rate. The sister was on the bed thumping the patients chest with all her strength, the nurse had produced a tube and handed it to the doctor; resuscitation was underway.

Another nurse was summoned, the emergency trolley opened and all the drugs and injection were being made ready. While one opened ampoules and filled syringes, another nurse scribbled down every item.

A record of treatment and all the drugs administered has to be made — even in the midst of such desperate activity.

The doctors who had been dozing downstairs were now at the bedside. Six of them and four nurses struggled in the confined space, trying everything to get the woman's heart beating again. Orders were issued and carried out despite the confusion.



ght during the night is lost — and personally.

● Reporter Paddi Clay helps out with some small tasks around the hospital wards. "I felt so useless," she said afterwards.

Another nurse appeared with the cardiac monitor, a drip was set up, the main lights in the ward switched on.

In the rush, contradictory instructions came from all round. The nurses obeyed them all.

Then, in the midst of the struggle, a confused patient wandered from her bed in the by-now awake and murmuring ward and started towards the trolley and instrument crowded section.

One of the nurses broke away from the knot round the bed and gently but firmly ushered the disturbed woman back to bed. Then went to comfort the dying woman's neighbour who stared at the curtain cutting her off from her friend's bed and wept silently.

□ □ □

Somehow during all this, a nurse had managed to phone the next-of-kin.

The struggle went on for three-quarters of an hour as the doctors attempted to change the straight line on the cardiac machine. Finally they admitted defeat. Their patient was dead. One by one they left the bedside and walked out.

The nurses were miserable. Slowly they started to put the ward back in order, tidying the woman, collecting her belongings and packing away the intruments strewn all around.

The sister appealed to the houseman for help in facing the relatives. The two of them delayed the moment as long as possible then when all seemed ready they went through to face the dead woman's distressed family.

The nurses in the ward tried to cheer one another up — they had to get back to their routines and their other patients.

But they could not lift their depression.

They were all asking themselves: "Did we do enough, did we do it right?"

SUDDENLY DEATH CAME TO THE WARD AS I WATCHED

The sister with five years experience (and a salary that probably leaves her with R260 a month) has never learnt to harden herself against a death, each little old man, each moaning and demanding woman patient, is precious to her.

Each ward that Wednesday night experienced some drama.

No sooner had–I settled back in Ward 17 when a patient in the opposite female ward had a relapse. The woman, a diabetic whose change of insulin regime was affecting her badly, needed attention. The sister was called again, she decided to wake the houseman who was trying to snatch some sleep.

"Lunch" was served in two shifts but for those who had to attend to an emergency there was nothing but the tea and toast — and sweets presented by happy patients — to dampen the hunger pangs.

At 2.30am in Ward 14 the specialist arrived to do the job only he could do. He had been called to help unblock a shunt which had been causing pain and he endeared himself to those nurses for forever. He never complained when he was phoned at his home and he took the trouble to teach them about the technique he was applying.

With the first light of dawn came another crisis. A patient in Ward 17 started vomiting blood. The doctor was consulted on the telephone again — but mainly the patient needed someone to listen to his fears — he was scared of dying.

The sister and the nurse sat and listened, reassured him where they could, and persuaded him to rest.

Just after 4 am downstairs in the Matron's office next to casualty, the sisters met together to give the acting-matron, Sister Slabbert, an official account of the night's activities.

The medical wards, under Sister Beddy had had their share of drama. But the sister from the psychiatric ward also had a busy night to report. She and her staff had spent the night trying to restrain a schizophrenic woman who had upset the sleep of all patients and even managed to terrify a male nurse.

□ □ □

Then it was back upstairs to start the early morning rounds, the "beds and backs routine", the emptying of bedpans and bottles, the ferrying of patients to the toilet, the dispensing of six-hourly medication.

The nurses seemed to have a new lease on life with the sunrise — home and sleep were only three hours away and only one ward would have a death to fill in on the many forms that are part of nursing.

As the patients woke, their pillows were plumped, the beds straightened, their conditions checked. The nurses, after hours of duty, even found time to brush a patient's hair and tell her how to go about arranging for a hairdo in the hospital.

They tidied up the corner where they had waited the night through and put back caps that had gone astray, examined stockings that had laddered during the emergency. At 7am, 12 hours after first walking into the hopital, they were on their way to bed.

I think I understand now what nursing is all about. It is fascinating, it is challenging — but I can echo the words of one "regular" patient, Mr Morris Tamari.

"There are no other people like nurses in the world, they are unbelievable — but stone mad to do it for no thanks — and as far as I am concerned no wage."

Debate rages on plan for sperm bank

RDM 20/11/79 (132) (98)

Staff Reporter

THE Department of Health's proposal to set up a State-controlled sperm bank has sparked sharp debate on whether artificial insemination (AI) is a matter of individual or State concern.

And some religious leaders have condemned AI as contrary to Christian ethics.

The Progressive Federal Party spokesman on health, Mr Horace van Rensburg, welcomed the plan, saying it would prevent "commercialisation" of artificial insemination.

But the New Republic Party health spokesman, Mr Nigel Wood, was totally opposed to it.

They were reacting to an amendment to the Anatomical Donations and Post-Mortem Examinations Act of 1970, published in the Government Gazette.

In terms of the draft amendment, no person who is not medically licensed and who does not have official approval may handle donations of semen. The sale of semen would also be prohibited.

Mr Van Rensburg said: "I was very concerned for the public after the report that private individuals were intending to sell sperm on a commercial basis, as this would involve serious medical, moral and ethical considerations.

"I intended making representations to the Ministers of Health and Police in this connection.

"I will now take an interest in the development of this service to ensure that it is in the interests of the public."

Mr Wood came out strongly against the prospect of State control, insisting it should be a personal decision by the families concerned and their doctors.

But he conceded "not just any member of the public should be allowed to do it".

Spokesmen for the Hervormde Kerk and the Afrikaanse Calvinistiese Beweging described the plan as "against Christian ethics", but the Rev Peter Storey of the Central Methodist Church welcomed it cautiously, saying "it does need to be well-controlled".

The scribe of the Hervormde Kerk, Ds P M Smit, said: "I am totally against it. If it is between married couples it is all right, but as long as it is not it must be opposed."

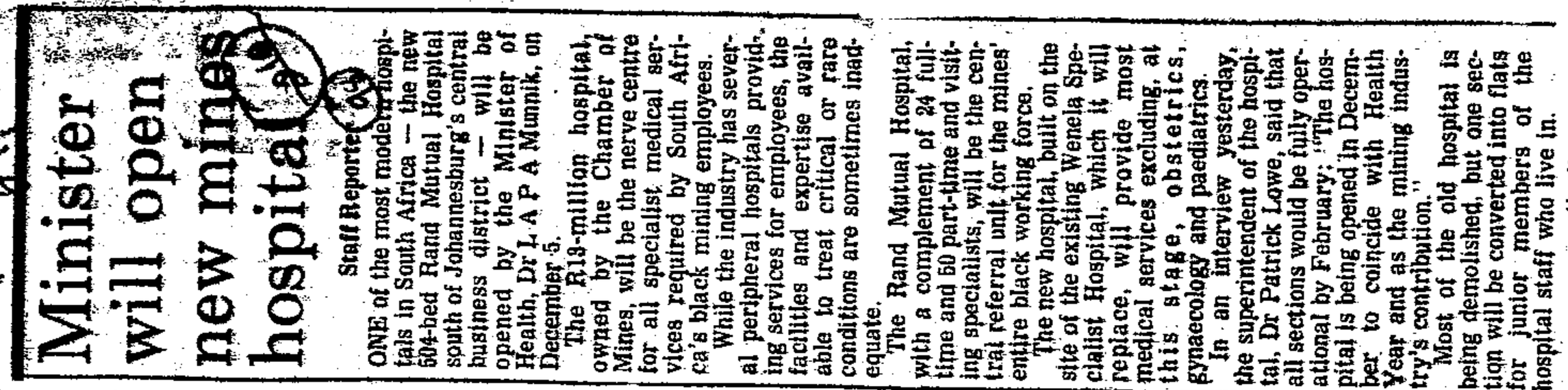
The director of the Afrikaanse Calvinistiese Beweging, Professor A J Heyns, likened the scheme to "adultery".

"I cannot imagine how the Government can even consider such a concept," he said.

Mr Storey said the view that such a setup would amount to adultery was "ridiculous".

However, he felt "competent counselling by clinically trained people" on AI was necessary.

The secretary of the Nederduitse Gereformeerde Kerk could not be reached for comment.



Minister will open new mines hospital

Staff Reporter

ONE of the most modern hospitals in South Africa — the new 604-bed Rand Mutual Hospital south of Johannesburg's central business district — will be opened by the Minister of Health, Dr L A P A Munnik, on December 5.

The R18-million hospital, owned by the Chamber of Mines, will be the nerve centre for all specialist medical services required by South Africa's black mining employees.

While the industry has several peripheral hospitals providing services for employees, the facilities and expertise available to treat critical or rare conditions are sometimes inadequate.

The Rand Mutual Hospital, with a complement of 24 full-time and 60 part-time and visiting specialists, will be the central referral unit for the mines' entire black working force.

The new hospital, built on the site of the existing Wenela Specialist Hospital, which it will replace, will provide most medical services excluding, at this stage, obstetrics, gynaecology and paediatrics.

In an interview yesterday, the superintendent of the hospital, Dr Patrick Lowe, said that all sections would be fully operational by February; "The hospital is being opened in December to coincide with Health Year and as the mining industry's contribution."

Most of the old hospital is being demolished, but one section will be converted into flats for junior members of the hospital staff who live in.

type lists, and far more rigorous attention to provenience (Cooke 1961). Furthermore, the concepts of culture, industry, variant, stage, period, and phase were in free and variable circulation in the literature. The framework appeared to be near collapse once again.

The Burg-Wartenstein Symposium in 1965 recommended that the Three Age system be scrapped and replaced by Industries which would eliminate several of the less well-defined slots (Kleindienst 1967; Clark et al 1966). Although local sequences of Industries were proposed for Rhodesia (Cooke, Summers, and Robinson 1966) and for South Africa (Sampson 1972), these recommendations have been otherwise ignored. Instead, several active researchers have opted for the escape-clause in the Burg-Wartenstein recommendations which stated that the three Ages could continue in use as "informal" terms until such time as they could be discarded. Thus it has come about that two systems of classification are now in use to describe available fragments of the prehistoric continuum.

Another major upset has been caused by the discovery that levels previously labelled Second Intermediate repeatedly yield radiocarbon dates near the upper limits of the dating methodology. If, as Beaumont et al (1978) suggest, the real age of this "stage" is greater than 70,000 B.P. then a gap must exist on the time-axis between Middle and Later Stone Ages which is longer than the entire LSA itself. Preliminary attempts to push back the accepted date for the beginning of the LSA do not look promising because assemblages from the earlier part of the gap do not fit the original LSA definitions. Parts of the gap are now documented by excavations at Nelson's Bay Cave (Deacon 1978), Klasies River Mouth (Singer and Wymer in press), Boomplaas (Deacon 1977), Heungingneskraal and Border Cave (Beaumont 1978), Ha Soloja (Carter 1976), and Makwe (Phillipson 1976). Other fragments of the record — previously forced into available slots — now appear to fall within this large and disorderly period. These include parts of

several other miscellaneous assemblages coarse Stillbay" reported from between the in the pioneer excavations at Fear's Cave categories have been tentatively isolated, (Deacon 1977), an increasing number of belled (eg. "Early LSA") and floating uncertainl of the Middle and Later Stone Ages. ies inherent in even these large categories, an increasing number of authors have recently turned to terms such as Holocene and Upper Pleistocene to define broad units. Thus a third sytem is being introduced into the literature. The time-axis of the framework is clearly in the throes of its fourth major crisis.

Development of the space-axis

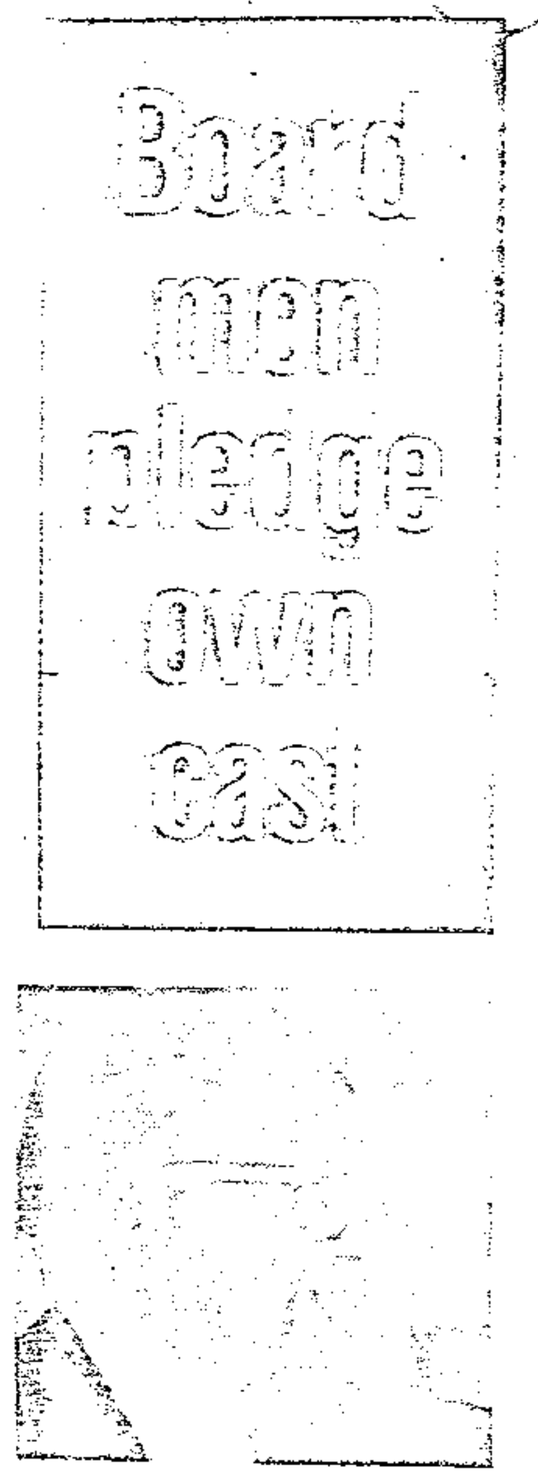
It is hardly surprising that the space-axis of the framework has undergone similar episodes of strain during the course of its development, but the causes were not always the same as those outlined above. W.D. Gooch (1881) was the first to recognize the need for subdivisions in South Africa, although the classifiers of his times in Europe appear to have avoided this approach. By subdividing his field observations into five geographical regions, Gooch anticipated that we should not expect the Stone Age continuum to advance in an orderly progression of contemporary phases throughout the subcontinent. However, the later accumulation of field results showed that his regional/landscape slots did not covary with "culture-areas" represented by mapped distributions of similar-looking stone artifacts. Although Goodwin (1946b) was attracted to regional subdivision, he seems to have realized this and the units known as Cultures and/or Industries became the common approach to both spatial and chronological subdivision of the three Stone Age blocks.

Inevitably, new Cultures tended to spring up wherever a pioneer archaeologist happened to be located — either because of his place of employment or because of his personal field interests. The first ones to appear in the literature tended to cluster around Cape Town, Grahamstown, the Kalkfontein dam on the Riet River, the diamond-diggings on the Vaal, and so on. By the time of the 1929 meetings of the British Association, vast uncharted regions still existed between these oases of research.

Bara board

THE director of hospital services in the Transvaal, Dr N Grove, congratulates Dr W M Matole after he had been chosen chairman of the Baragwanath Hospital Board at a ceremony last night. Between them is the new secretary of the first all-black board for the hospital, Mr N Mokoena. The nine-man board is to advise the superintendent and the director of hospital services on things like planning. Dr Matole is employed by the Johannesburg City Council.

Board men pledge own cash



Mr S A Modise.

By ALNAM DUBE

THE members of the newly-instated Tembisa Hospital Board this week pledged to donate their allowances in aid of the hospital.

The new chairman, Mr S A Modise, said the hospital would not progress if there was [illegible] from the community.

"This is our hospi-

1-4	0,05	0,04	0,05	0,05	0,05	0,62	0,05	0,04	0,05
0-1	1,57	0,76	0,60	1,03	1,24	0,79	0,89	0,74	
	M	F	M	F	M	F	M	F	
	W		A		C		B		

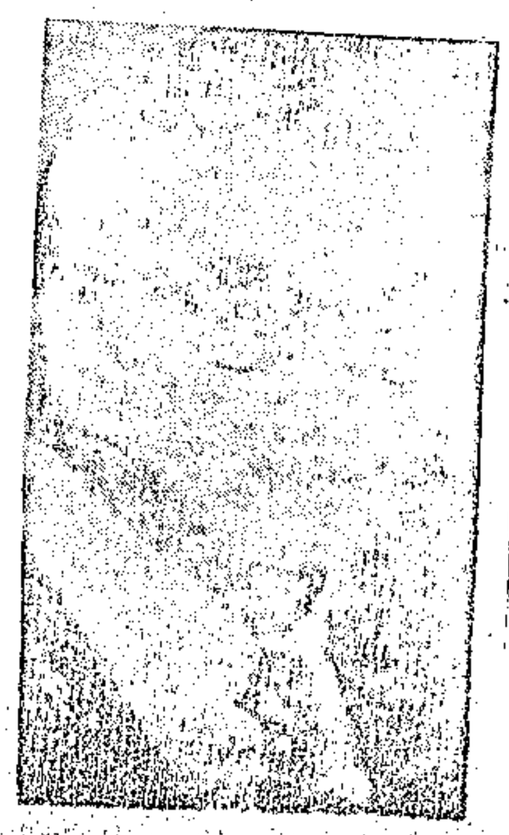
1-4	0,01	0,01	0,00	0,00					
0-1	0,17	0,08	0,10	0,21					
	M	F	M	F					
	W		A						

tal and we should be good examples towards improving the black nation," he said.

The Director of Hospital Services in the Transvaal, Dr H A Grove, said it was time blacks showed their true colours so that they could serve their own people.

"Time will come when blacks will play the major role in the administration of this hospital. To achieve that, we need competent people," Dr Grove said.

Referring to board members, Dr Grove added: "The board will maintain active participation between the community, staff and the superintendent to assess the mistakes."



Dr H A Grove, Director of Hospital Services in the Transvaal.

Bara has a black board now

Report and pictures: PETER SETUKE

BARAGWANATH HOSPITAL had a party in the doctors' quarters diningroom to mark the inauguration of the first all-black board since the inception of the Baragwanath Hospital Board in 1948.

The public relations' officer for the hospital, Mr L Faul, said the board would act in an advisory capacity to the superintendent and the Director of Hospital Services in the Transvaal.

Their terms of office will vary. Three members will hold office for one year, the second three for two years while the last three will act for three years so they can alternate all the time. They must meet once every two months.

Dr W M Matsie, chairman of the Baragwanath Hospital Board, said in his inaugural address: "As the first chairman of the first-ever black hospital board, it will be my duty to solve the problems of the entire hospital, the personnel and the community that patronises it.

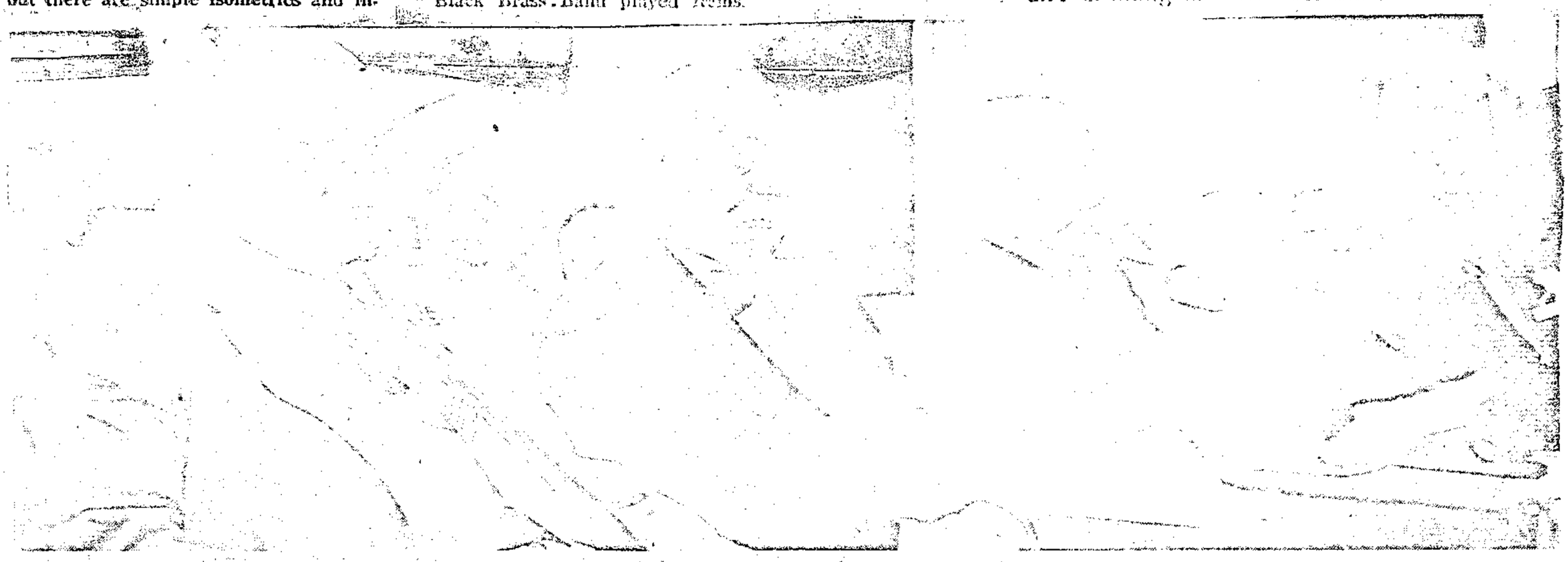
"I pledge myself to influence the public to stop smoking and drinking and to exercise. This does necessarily imply that they must be athletes or gymnasts, but there are simple isometrics and indoor exercises as well as just a little jogging".

The elected members are: Dr Matsie, Mr Nelson T Botile, chairman of the Orlando YMCA (DOCC), Mr M A Dlamini, lecturer in African languages at Rand Afrikaans University Mr Maphike, lecturer in African languages at the University of South Africa (Unisa), Rev N Khumalo, Rev E M Mathebogo, Mr Stephen Kgame, owner of the Dobsonville Cinema; Mr J C Mahubushe, chairman of the Diep-Meadow Council, and Mr Ngwako D Thebehali, chairman of the Soweto council.

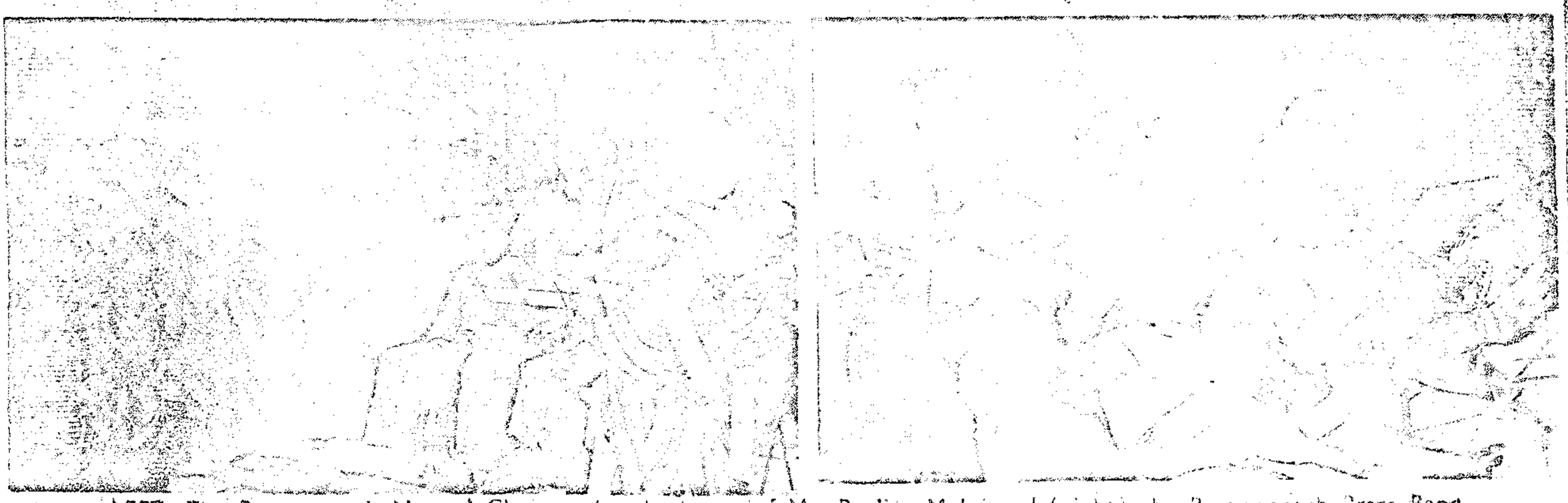
Also present were the Mayor of Johannesburg Major D Opperman and Mrs Opperman, the Director of Hospital services in the Transvaal, Dr H A Grove; the superintendent of Baragwanath Hospital, Dr P J Boukes, and the chairman of the Dobsonville Council, Mr Donald B D Mmesi.

The Baragwanath Hospital Choir sang under the baton of Mrs Pauline Moloi and the Baragwanath Hospital Black Brass Band played items.

Dr W M Matsie, chairman of the first ever black Baragwanath Hospital Board: "I will influence the public to stop smoking and drinking and to exercise".



Mr Nelson T Botile (left), Orlando YMCA (DOCC) chairman, one of the first chosen blacks Baragwanath Hospital Board, with some of the guests.



LEFT: The Baragwanath Nurses' Choir under the baton of Mrs Pauline Moloi and (right) the Baragwanath Brass Band.

Transkei hospitals short of medicine supplies

DD 17/12/79

QUEENSTOWN — Transkei is running low on medical supplies.

Residents at Ilinge near here say it is common for patients to be turned away from the clinic because a medicine or injection is out of stock.

Most common among the shortages was cough mixture.

During September an elderly man paid 20c for treatment at the clinc. He had a kidney complaint and was told to come back the following Wednesday when the doctor would see him.

On the Wednesday the old man was turned away because he did not have another 20c. He protested he had paid the money on the previous visit and had not been treated. He produced a receipt but this was ignored and he was obliged to go home without seeing the doctor.

Prior to Transkei's independence in 1976, Glen Grey was a mission hospital run by the Catholic Church and subsidised by the South African Government.

"It is highly regrettable we have to admit the present situation did not exist then," the Transkeian secretary for Health, Mr N. Mbabama said. "As far as the alleged Transkeinisation of the hospital's administrative staff is concerned there had been no change. There were Indian, Coloured and white doctors," he said.

In the past mission hospitals, one of which was Glen Grey ordered their own medicine but towards the end of last year the department decided to centralise medical supplies, he said.

There had been some delay in processing tenders for medical supplies to the central medical stores but since about June this year tenders for the supply of medicines were approved and orders placed.

He said it took about six weeks from ordering to delivery of supplies to the central stores and this had caused some shortages in the past.

Mr Mbabama said, however, the position was improving as reserves of stocks were being built up. As regards the complaints of a patient being charged twice, he said: "I am unable to comment without having full particulars of his name and date of treatment." — DDC.

R10m addition to hospital

R1m 20/12/79 (98)

Pretoria Bureau

NEARLY R10 000 000 will be spent extending and modernising services at the H F Verwoerd Hospital in Pretoria over the next five years.

One of the most expensive projects is the R3 000 000 nine-storey special services block.

This block will be erected between the existing out-patients section and the nurses' home, and will accommodate a new specialist out-patients department, where 1 000 people a day can be treated.

A spokesman of the Transvaal Works Department said advances in medical techniques had demanded changes in accommodation.

He said the nine-storey building had been designed to make such changes possible with minimum inconvenience to the working of the clinics.

It would be a concrete framed structure with flexible developments inside. The building will face north and south.

Air-conditioning had not been provided for in the design of the building, because adequate precautions had been taken to protect it from sun.

But where medical requirements demanded air-conditioning, it would be supplied.

Tenders would be called for during June and July next year, and the contract period will be about three years.

Other projects included in the R10 000 000 hospital development are: an extension by 300 beds to the nurses' home, extensions to the PABX telephone exchange system, modernising of the casualty department, alterations to three vacated black wards to house a new orthopaedic workshop and artificial limb factory, a new department to house sonar and body scanner X-ray equipment, and a new emergency electricity plant.

An emergency water supply and water reticulation system was recently completed at a cost of R170 000.

Ward 18, for sick nurses, will be changed into a medical intensive care ward, and a R40 000 air-conditioned storeroom for X-ray film, is also being built. They should be completed by March.

H F Verwoerd will have its own heliport — construction begins next month on top of the hill behind the hospital.

New-hospital boss denies race bar to facilities

(98)

Star 21/12/79

The superintendent of the Johannesburg Hospital has given the assurance that facilities not available elsewhere would be offered by the hospital to patients regardless of race.

Dr Neville Howes was replying to an allegation that certain facilities — such as a xeroradiogram — previously offered to black patients at the Johannesburg General Hospital were no longer offered to blacks at the new hospital.

The allegations were contained in a letter to The Star. It was claimed that when a doctor tried to make an appointment for a black patient for a xeroradiogram the application was turned down by a booking officer at the new hospital. The applicant was told it was "because of a new ruling" from the superintendent.

The letter also claimed that the facility was not available at Baragwanath and the patient had therefore to "make do with an inferior and potentially more dangerous form of investigation — namely a mammogram."

Dr Howes said he had issued no directive barring blacks from the facility.

But, he said, a mistake could have occurred at a junior level. He would look into the matter.

He said the hospital policy was that where any patient needed any facility not available elsewhere he would apply for the necessary authority to provide this. He would look into the matter of xeroradiogram bookings.

'4 DIED IN BARA QUEUE'

By LEN KALANE

FOUR people died while waiting for treatment in the casualty section of Baragwanath hospital, relatives have claimed during an investigation by POST.

The four died over last weekend (December 14-17). This means that at least one person died while waiting for treatment every day of the long weekend.

They are Mr Gilbert Thloloe (33), of 216 Zone 1, Diepkloof; Mr Victor Radise, of 301 B, Zone 1, Meadowlands; Mr Eric Ngubeni (21), 380 Zondi; and Mr Vell Chauke (19), of 1851 Chiawelo.

Relatives and friends claim that the victims died before doctors could attend to them while waiting at casualty.

The hospital has refuted the claims.

The Deputy-Superintendent of Baragwanath, Dr Chris van der Meever, confirmed that Mr Thloloe died in the casualty section. He said he died while doctors were examining him.

Dr van der Meever said that according to his records Mr Radise and Mr Ngubeni were already dead when they arrived at the hospital. Mr Chauke's records cannot be traced therefore the hospital cannot comment on his death.

According to Mrs Annah Chauke, her son was rushed by friends to the hospital after he was stabbed on Sunday night.

To Page 3

POST 24/12/79 98

Private medical costs up

(98) 28/12/78 Star

Own Correspondent

Private hospital tariffs have been raised by an average 12,5 percent from January 1.

This new health shock for the public follows an agreement in Pretoria between representatives of medical aid schemes and private hospitals.

"The tariffs are up by an average of 12,5 percent," Mr J P H Steyn, the Registrar of Medical Schemes, said today.

He said some tariffs had been left as they were but others had risen as much as 15 percent.

The new tariffs are published in today's Government Gazette.

The general ward fee for people who have surgery is R22 a day and if a doctor prescribes a private ward the fee is a maximum of R35 a day with a 10 percent discount if the patient's medical scheme undertakes to pay for it.

Theatre fees are R15 for the first 15 minutes and R7,50 for every 15 minutes thereafter.

Patients treated in an intensive care unit will have to pay R51,50 in basic fees and more for various extras.

WOMAN'S ARGUS 28/12/79 (98)

HOSPITAL HYGIENE

The recent closure of units both at Groote Schuur Hospital and New Somerset Hospital due to outbreaks of bacterial and viral infections respectively — the former adding to the suffering of some patients and the latter leading to the deaths of two infants — prompts the question: How safe are patients in hospital?

Hospital acquired infection could be costing South Africa a staggering R29-m a year, this amount being based upon a recognised figure of about 3 percent of all hospital infections being of this type.

However, it must be borne in mind that where hundreds and in the case of Groote Schuur Hospital, thousands of people — sick and well — are of necessity thrown together in close proximity, cross infection remains a hazard. It must also be appreciated that the modern hospital now accommodates a large number of highly 'compromised' patients, that is patients whose primary underlying disease process (for example leukaemia, cancer, and so on) makes them much more vulnerable to infection — often due to bacteria carried on their own bodies. A relatively small percentage of infection is acquired from 'outside' of the patient. However it is this latter group of infections that are amenable to even infection preventative measures.

Of all categories of staff, the majority live out, some under unhygienic home conditions, and some of whom may carry potential pathogens, that is bacteria capable of causing infection in sick patients. It must also be remembered that both patients and visitors bring germs with them into the hospital

Hospital staff blamed

Hospitals therefore of necessity, carry a formidable responsibility in ensuring that suitable preventative measures are carried out to minimise hospital acquired infection. Despite modern technology, despite the fruits of many years of research, the standard of hygiene in a hospital is determined finally by people.

THIS is understood by hospital authorities. It was also emphasised by the more than 300 delegates to the Sterilisation and Disinfection Society's symposium on 'Nosocomial Infection And The Infection Control Sister' held at the medical school, UCT in September. Speakers, all professional people and from all parts of the globe, agreed that hospital infection was increasing. And they placed the blame squarely on all categories of hospital staff.

Having said this, in what areas are hospitals failing to prevent cross-infection? Are the steps taken adequate? Are we staring ourselves blind at the glittering array of modern techniques and antibiotics and ignoring (or forgetting) the basic, simple truths of Pasteur, Lister, Jenner, Theiler and Nightingale? Have these pioneers laboured in vain to prove the virtues of plain cleanliness?

A mother in the maternity ward of a modern hospital told me this week that she had seen the same woman wiping the sinks

My own experience as a patient in a private (R30 a day) hospital provided small comfort. When I reported to the chief housekeeper on one of her daily rounds that my room had not been cleaned for two days she replied that she was aware of this, but hesitated to take action as, when she had reprimanded the cleaner responsible on a previous occasion, he had struck her.

Some male cleaners are members of gangs, who may then threaten supervising staff. Her report to the hospital management had resulted in a shrugging of shoulders. We may well ask hospital hierarchies: What is the calibre of your domestic staff?

The same hospital had edge-to-edge fitted carpeting in the patients' lavatories on which the sick, unsteady on their feet, had left evidence of their frequent mishaps. Does fitted carpeting in hospital toilets spell hygiene?

Should the lowest tender of any cleaning material necessarily be accepted without regard to its efficacy?

In one hospital it was decided to switch from one brand of cleanser to a cheaper one. Sisters in charge of wards who are responsible for the cleanliness of lavatories, baths and basins, say that the new cleanser is half as effective. They have not been listened to. Who, on the hospital staff, decides what to buy? Is it the Medical Superintendent, who has a knowledge of microbiology and who is advised by the matron, or is buying the prerogative of clerks, such as the hospital secretary?

Economy at what cost

In some provincial hospitals it was decided — for reasons of economy and not by the professional staff — that the purchase of bottled pasteurised milk would cease and milk powder be used instead. But the resultant mixing of powder and water is done by unskilled labour without adequate supervision under conditions which are, to say the least, not sufficiently hygienic. How much money is actually saved, and at what cost to the health of patients and staff

One may enquire from hospital authorities whether their staff are all free from overt disease. Consider: The kitchen worker with a skin ailment is found handling food in the hospital kitchen. That domestic working in the sluice room as well as with the baby's bottles.

Who decides on the removal (or transfer) of such workers? the chef? in the case of the kitchen? (Remember this is the chef's domain). The matron? Or does the decision rest with hospital management? And who is hospital management? Crisp question: Who is the boss? This very point was raised at the symposium.

One delegate made the point that most, if not all, hospitals did not keep to the basic health principles simply by not enforcing them. A shortage of money should not be used as an excuse for infection in a hospital. Economy is all very well, but should this lead to a shortage of soap, towels and good disinfectant?

Florence Nightingale's policy

Isobel Maurer, world-famous authority on hospital hygiene who also attended the symposium, states in one of her books: 'It is impossible to be too fussy about the details of a disinfectant policy. Its success will depend on the attention given to the tiresome, often dull, but always vitally important, details.'

In other words, we need to return to the 'think clean' policy of Florence Nightingale. Her teachings are as valid today as when she expounded them in the quaint language of many decades ago: '. . . would it not be better if you remove the dunghill before the door, put in a window which opens, and drain, cleanse and limewash your cottages?'

BERYL CONLAN

	750 38.0%	287 42.4%	122 36.6%	28 26.9%	572 26.3%	161 24.7%	282 15.1%	59 18.2%
	485 24.6%	104 15.4%	42 12.6%	13 12.5%	84 3.9%	18 2.8%	76 4.1%	11 3.4%
	59 3.0%	41 6.1%	41 12.3%	2 1.9%	680 31.3%	167 25.6%	806 43.1%	89 27.5%
	1973 100%	677 100%	333 100%	104 100%	2175 100%	652 100%	1868 100%	324 100%

poisoning by motor vehicle exhaust gas" is a code used in South
.C.D. (8th revision). See Ref. 13.

	W		A		C		B	
	M	F	M	F	M	F	M	F
0-1	21,76	16,18	40,44	27,11	133,70	119,02	91,30	88,18
1-4	1,17	0,94	2,42	2,39	17,22	16,21	10,23	9,93
5-24	1,05	0,46	1,31	0,74	2,26	1,25	1.64	1,12
25-44	3,02	1,47	4,33	2,48	8,80	4,96	4,78	3,70
45-64	17,46	9,49	26,27	18,72	24,27	17,87	18,06	15,57
65+	73,62	54,55	92,20	82,93	96,90	71,79	53,38	45,89
ALL	9,44	7,40	8,03	5,51	14,62	11,00	8,77	8,13
NO.	19600	15374	2828	1967	16632	12847	18348	13062

ALL CAUSES

	W		A	
	M	F	M	F
0-1	0,51			
1-4	0,04			
5-24	0,01			
25-44	0,05			
45-64	0,44			
65+	1,84			
ALL	0,22			
NO.	463			

	M
0-1	0,85
1-4	0,49
5-24	0,71
25-44	1,18
45-64	1,25
65+	1,26
ALL	0,95
NO.	1973

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A mother in the maternity ward of a modern hospital told me this week that she had seen the same worker cleaning the sluice-room and, minutes later, washing babies' feeding bottles in the ward kitchen without even a change of apron. A patient in another hospital complained that the patients' lavatories were cleaned irregularly and her sickroom swept carelessly. In response to her complaint the sister-in-charge had stated that there was a shortage of good domestic staff.

Patients notice — and

Private patients to pay more

98
299
RDM
29/12/79

By ARNOLD GEYER

PRIVATE hospital patients face an average fee increase of 12,5% from January 1, 1980.

This considerable hike in hospital tariffs follows an agreement in Pretoria between representatives of medical aid schemes and private hospitals.

The new tariffs were published in yesterday's Government Gazette.

Mr J P H Steyn, registrar of medical services, said yesterday some tariffs had risen as much as 15%. Others had been left as they were.

The new fees for white private hospitals with fewer than 70 registered beds will be:

- R22 a day for surgical cases in a general ward;
- A maximum of R35 a day if a doctor prescribes a private ward — with a 10% discount if the patient's medical scheme undertakes to pay for it;
- R15 for the first 15 minutes and R7,50 for every 15 minutes thereafter in theatre, and
- R51,50 a day in basic fees for treatment in an intensive care unit.

The tariffs for private hospitals with more than 70 registered beds will be:

- R25 a day for surgical cases in a general ward;
- A maximum of R38 a day for private ward treatment — less a discount of 10 percent if the relevant medical scheme guarantees payment;
- R57,50 a day in basic fees for intensive care treatment.

Province hospital fees shock

31/12/79 (98)

Mercury Reporter

CHARGES at Provincial hospitals in Natal will be increased in 1980.

This shock disclosure comes hard on the heels of a 12,5 percent increase in fees at private hospitals and the huge 52 percent increase in doctors' and dentists' fees.

Mr. Frank Martin, MEC in charge of hospital services in Natal, said yesterday that increases at all hospital institutions had become inevitable because of rising costs.

"We will have to consider seriously the price structure at Provincial hospitals in the new year."

director of Parklands and St. Augustine's Hospitals, said yesterday the new general ward fee would be R25 a day as from tomorrow, compared with R21,50.

The fee for a private ward would be R38 instead of R36. For intensive care the tariff would be R57,50 instead of R45.

The theatre tariff for out-patients would rise from R14,50 for the first 15 minutes to R16,50. Thereafter it would be R8,20 instead of R7,20 for

◆ TURN TO PAGE 2

Not as high

Mr. Martin said that, if there were an increase, it would not be as high as the one negotiated between the Association of Medical Aid Schemes and the Association and Federation of Private Hospitals.

Mr. M. W. Friedman, a

Hospital fee shock in 1980

NM

31/12/79 (98)

◆ FROM PAGE 1

every 15 minutes.

The fee for the main theatre (general anaesthetic and major surgery) would be R64 for the first hour instead of R56, and R16 instead of R14 for every 15 minutes thereafter.

Commenting on the increases, Mr. Ray Swart, national vice-chairman of the Progressive Federal Party, said they would be an additional burden on the public, many of whom were already finding the fees at private nursing institutions beyond their reach.

Profit

"Clearly private hospitals operate on the basis of a profit motive in the same way as other businesses. However, it will not be in the interests of those who administer them if they price these institutions out of the market," he said.

St Augustine's and Parklands nurses will receive a 10 percent increase in salary from tomorrow.

Mr. Friedman said wages comprised the major expense in running the hospitals. The necessity for an increase in nurses' wages was one of the reasons for the 12,5 percent "hike" in private hospital tariffs.

There was no other way of meeting increases in fuel, foodstuffs, laundry and wages, he said.

Salaries

Mr. Nigel Wood, New Republic Party spokesman on health, said yesterday that if the increases were translated directly into higher salaries for nurses, the public did not have much ground for complaint. It was widely agreed that nurses would have to get a better deal.

only has to look at

nursing services to realise that there is widespread dissatisfaction in the profession about their pay," he said.

"Something like a 25 percent increase in salary for the next three years is needed to get the nursing profession on a par with other professions."