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 Asians.
Dental clinics

(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, Pretoria, Vereeniging, Orlando, East London, Port Elizabeth and Cape Town.
(d) Transvaal—R75 450.00. 
Cape Province—R106 500.00.
(c) 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 whenever 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

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 213 beds.

Hospital services included general treatment, maternity, tuberculosis, isolation and psychiatric 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 550 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.

Saps.
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 were shifting the emphasis more and more to the profit-making aspect, and the tariffs cannot but be viewed with suspicion.

"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 had made a number of allegations:
- Private hospitals 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 R370 for medicines.
- Another who 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 R2 for a syringe.
- Disposable syringes cost only R2.50.

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 R22.10," 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

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 Zanempilo 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 Ziyanka Location Anglican Mission.

The mission is at the centre of two large concentrations 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 the reach of thousands of people who otherwise would have to be attended to in King Williams 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 Williams 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 day has built up to 41 patients a day. Most of the patients have come from families with an average income of between R150 and R190 a week. The 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 medical and surgical services, antenatal care, general education, housing, economics, gardening, cooking and immunisation.

These 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 Creeks) and also planned for two rural communities.

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 R35 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. — JHDM
New hospital for homeland

UMTATA — Thafalofet Mission Hospital of the Nederduits Gereformeerde Kerke in the Kentane district will be the second mission hospital in the homeland to be taken over by the Transkei Government.

The takeover comes into effect today when the Minister of Health in the Transkei, Chief J. D. Mossele, pays an official visit to the hospital 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 296 beds with a staff of 176 professional and non-professional. There will be no formal ceremony to mark the occasion. — PDR.
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.
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) Meetsa-a-Bophelo Hospital.

(b) The buildings are used by the Department of Defence.
Race clamp on clinics

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 Grove points out that the regulations provide that no private hospital shall be registered unless...
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 Umlad 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 1973 whereas 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

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 Kalle 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 an 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 he warned 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 Kalle 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 private hospitals in reminding those running the hospitals of the policy," he added.
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. Kaale 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. Haughton) made a plea for breast cancer screening by the Provincial Administration, in cooperation 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 a preventive 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 654 for the highest.

** **

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 new ones.

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 Pilgrim's Rest (the early Eastern Transvaal gold mining town which the province is buying to restore.)
Close-drown after 68 years

Mccord Zulu Hospital Faces
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 13 860 in 1974. In 1964, 308 813 inpatients and 2 058 877 outpatients had been treated, compared with 469 703 inpatients and 5 776 070 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 nurses is constant, and the course, which 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.

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

Miss Moreno 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.
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 118-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."
CLINIC IN NEED OF A NURSE

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 the 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 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 businesses men 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 R300 for stands for private houses.

However, as there were few Coloured people here who could afford to build on 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.
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 108,000 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 665,000 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...
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.
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 heart valves 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 angiorgram, 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 angiorgram theatres are next to the operating theatres so that the diagnostic and surgical section is self-contained.

Metabolic unit

Another interesting section of the 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 foods available in that area and a diet worked out on how to make the best use of the available foodsstuff, 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 kwashkoror (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 have 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 18 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, al-ready 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.
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.Blake 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 Leterseng 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.
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 1978.

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, 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 homeland 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 2 000 000 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 hospitals 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.
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.

Mr. Harris said in a telephone interview from his home in Beesburg, North West, 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," Mr. Harris said.

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 “Mokoloa” 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.
Aid for Soweto’s aged will ease hospital load

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, at Bargawana Hospital.

The hospital, on a site allocated by the state, would be built, she said. There were about 50 people on the waiting list and the aged centre would be available for them.

Dr Browde said that the hospital would be a model for the rest of the city. It was a waste of money to finance beds in hospital for those who would need them soon.

Meanwhile the priority 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 establishment of the Senior Citizens Foundation as a result of Mr Edgar’s efforts, of the Rand Daily Mail’s investigation into the plight of pensioners, more than R16 000 had been donated and money was still trickling in.

In addition there was a need for a service centre of its own, she said, to discuss what the action committee can do to ease the lot of African pensioners without contravening the laws of the land.
Munnik rejects subsidy claim

Coloured leaders to encourage their people to practice 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 R20,000 paid to City Tramways.

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

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

Dr. Munnik appealed to coloured leaders to encourage their people to practice birth control as only through birth control would conditions improve in the long term and shanty towns be eliminated.

Hospital services in SA much in demand

If Miss Annette Reimcke (UP Randjes) is right the hospitals of the Cape Province could become something of a tourist attraction.

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. Louw, 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.
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 — 938 for Whites — and when completed there would be 1 719 beds.

During June the hospital handled 10 533 White in-patients and 20 539 Coloured in-patients. The average monthly outpatient turnover during the first quarter of this year was 19 899 Whites and 40 899 Coloureds.

In 1971 the family planning service at the hospital had dealt with 500 cases a month, but now it was handling 10 500 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.
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 2000-bed Otto Beit Teaching Hospital in Johannesburg — estimated cost about R185-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 similar hospital was being planned for Indians at Laudium — also at a cost of R3.5-million.
- The new African hospitals at Tembisa and Kalsong 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 Pholasong 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

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 Kalsafo 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 15 km will be added to the distance from H. F. Verwoerd Hospital to Kalsafo 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 decision. The decision was made by the Department of Bantu Administration and Development," he said.

Mr Dave Epstein, MP, 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

SUNDAY TIMES Reporter 17/8/25

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

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 practice any reasonable type of medicine," he added that the situation at the Black hospital was "far worse." A number of women who had given birth in the corridors because of the crowded conditions.

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 visits had 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 Ge-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.
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 Aacronhook and Shiluvena, both of them about 120 km away," they say.

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

The clinic, rising in the bush on the Oosthuizen's tiny, undeveloped farm about 40 km outside the town, is being built by 63-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. Pots, 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 63-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, 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 emphasized, was at the root of their problems. There was need for a "terrible 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."
Injured of all races go to first hospital

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 10 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 be 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.
Natal neem voortou
Van Piet de Klerk

DURBAN.

NATAL gaan sy hospitaaldure vir albei ouers aangepas om dit org besteeerde slagoffers van ongelukte betref.

"In Aankondiging in die verband gaan hulle die volgende week begin om albei ouers te self. Frank Martin, 20 jaar, bestee sy hospitaaldure in Natal.

Hospitaal se plig is om leucoc toed, omgeag die beteer om kleur," sê mnr. Martin, "en albei ouers waar die nuwe betoging diens as oorvat. Die hospitaal se besteeerde gebring word. As hy evenwits twyfel oor die ens van die besteeerde, moet die patiën toe die nuwe hospitaal gaan.

Dit insluit die nuwe betoging waar die ambulancedienste van watter hospitaal die besteeerde gebring word. As hy evenwits twyfel oor die ens van die besteeerde, moet die patiën toe die nuwe hospitaal gaan.

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Die patiën kan dan pas na die hospitaal toe omgeag. Die patiën kan dan pas na die hospitaal toe omgeag. Die patiën kan dan pas na die hospitaal toe omgeag.
Emergency: Hospitals in Cape open to all

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 in which an African pedestrian was knocked down and had to wait more than half-an-hour for an ambulance to take him 18km 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.

"Discrimination"

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.
Hospital in Lenasia by 1979—MPC

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 began planning for the hospital to start.
- 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.
Hospitals drop race bar in urgent cases

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 recognize serious injuries and other emergencies.
GRAHAM CRASHES IN

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

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.

Mrs Ndlovu and son yesterday.
Concern over hospital move

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

13/9/15 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. Kleerman; Mrs. J. Stirton-Barry; City Councillor Margaret Maytom; and Mr. E. L. A. Volker.
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 subsidize the schemes by seven-eighths — making a total state contribution to the services of R707 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, Graaff-Reinet, Heidelberg, Aliwal North, Port Alfred, Uniondale, Tulbagh, Caledon, Moordrecht, Hopefield, Ceres, Cradock, Namekland 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, Elshas River, Scottsdene (Stellenbosch), Oudtshoorn, Gelvandale in Port Elizabeth and Randfontein.
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 — 265 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 1975.

Building is expected to take four years.
Crisis looming in Vaal hospitals

Muhammad Ali, Richard Burton and Elizabeth Taylor were part of a money-making 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.

"I attended 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.
mixed nursing, but bathing...

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

This was said at a press-briefing 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 a 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.

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

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

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

"We challenge anyone, not only the Nats, but the UP as well, to wade waist-deep into one of their beaches. You can't 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 guigny rate-payers.

"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
Farming Editor

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

Mr. Mienie 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. Gruwer, 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 would be demanded, 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)
New King hospital when there's cash

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. Munnix, 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.
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 13,000 Zulu people in the Mainga district which the hospital serves. But most families are made up of women 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 South 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 10 miles 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 two years, to develop the agricultural side of 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.

SIX toddlers being treated at the hospital for tuberculosis are given high-protein meals.
'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 Jayash 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.
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 five-day 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. — EDR.
Cottage Hospital has become redundant

From Mr P J LOUBSER, MEC:

I CONSIDER it my duty to react to the report (Cape Times, November 26) under the heading "Horiktram 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 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

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 as we attach 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.
Go-ahead sought for R100m hospital

Staff Reporter
THE Transvaal Provincial Executive has asked the Cabinet for permission, despite the heavy clampdown 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 northeast, 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.
Indian hospital to be built

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 Sultan Tayob, chairman of the Lenasia 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 "relocate Indians living in Johannesburg" and to provide homes for the natural growth in "population for the year 2000.

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, 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..."
Women in labour on hospital floor

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 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 facilities.

The hospital has only 20 beds for maternity patients.
EMPANGENI — More than 10,000 people in the Empangeni and Richards 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 Ngwelaane and Empangeni hospitals. The Ngwelaane 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 organizations, the RS6 Consortium, developers of the harbour, and Alumal.

"There is no guarantee of an ambulance for use by the community in time of need," a Richards Bay Town Board spokesman said. "In 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 RS6 did not come."

"We are thankful for what RS6 did, but they also need 'their' ambulance," 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," he said.

An Empangeni Hospital spokesman agreed that Richards Bay should have its 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 new General Hospital is five months ahead.

Present: Geoff Cameron

Liz Brown

and Peter Jordan
Hospital apartheid 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.'
Banned doctor tells of his humiliation

Top Level talks on hospital ban

The Pain Of Apartheid

An INDIAN doctor, who spent 10 years in an Indian prison

By SEAN O'CONNOR

Two providential appointments to trace his family, a medical

Top Level talks on hospital ban

The Pain Of Apartheid

An INDIAN doctor, who spent 10 years in an Indian prison

By SEAN O'CONNOR

Two providential appointments to trace his family, a medical
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 said.

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.
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 J. 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 necessary, and we cannot rush the work," he said.

A site for the hospital five kilometres from Lenasia on the Lenasia 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.
Van Ons Politieke Beriggewer

Dit kanse is goed dat nie-blanke dokters in sewe gevalle toegehaal sal of om by te staan by die operasie.

'n Blanke hospitaal opgeneem word, is dit nie vir hom moontlik om hulle by te staan nie.

Die geval geniet nou aan dag op hoë vlak. Gister is aan my gesê 'n finale beslissing kom sodra die Kaaplandse LUK belas met hospitaalakte, mnr. Piet Loubser, en die Mediese Vereniging volledige samehoring gegee het.

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

Prof. J. K. de Klerk, voorres van die Federaal Raad van die Mediese Vereniging, het in 'n verklaring gesê, "Alle dokters moet toe geneem word om, ongeag ras of kleur, hul professionele plichte na goedkunde uit te voer."

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

"Die situasie wat in Port Elizabeth geskak is, is simpele en bereikbaar, hul professionele plichte na goedkunde uit te voer."

In noodgevalle word uitsondering gemaak. Dit geld by vir ambulansie. Hy het dit reeds duidelik gestel dat ambulansie vir blankes ook nie-blanke in noodgevalle sal help en andersom.

Die Indiëerdokter het gesê die weiering was klaarblyklik omdat hy nie-blank is. Sy pasiënt is intussen onder sy bystand as luie dokter in die provinciale hospitaal geopeereer.

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

Hy het reeds vir die operasie is 'n week voor die tyd getreft, maar hy is eers die aand tevore in kennis gestel dat hy nie mag assisteer nie.
Govt policy on hospitals ‘a scandal’

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”.

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 attend 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, White nurses staff have to look after White patients — Blacks are not allowed to nurse Whites.

Policy

Because Government policy frowned 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 Port Elizabeth where Black doctors are not allowed to do minor operations on Black patients because most hospitals have no separate theatre for Black patients and with a Black theatre staff.

To overcome this problem, provincial authorities have, 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.

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

By NORMAN WEST

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 MDC in charge of hospital services, Mr P J Lohse.

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.
Private hospitals under fire

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 694 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.
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 services 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 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 big off to a State garage to be fixed for him," said one physician.

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, would 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 dead, 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 clinics 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."
Hospital fees up 100 percent

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 30c to R5 per daily attendance. The new fees range from 50c to R8 daily.

Fees for private patients have been increased from R2.40 to R5 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

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 outpatient fees, which at present range from 20c to R3.00, will now range from 50c to R6.00 per daily attendance.

Fees for private patients have been increased from R2.40 to R8 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.

Groot 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 superintendent at Frere Hospital, Dr F. Wasser, said he had received no notification of the fee increases and was therefore unable to comment. — DDR.
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.

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 brick-walled 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 witch-doctors whenever we fell ill. There was nowhere else to go."

Another labourer, Mr Gabriel Thantza 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 Thantza 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.

Hospital is a ‘first’

A modern hospital has been built at a cost of R1.3-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 Lephalale Government which takes over health services to the homeland on April 1 this year.

Dr J H Fleming, a medical practitioner, said the hospital was built by the Department of Health at cost of R1.3-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.

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
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.

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Babies in Jeopardy:

Black Clinic may close

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 R23 600, but its income was only R23 500.

"And if this 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 R32 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 R2 000 last year, and bequests came to R6 000. The centre is a regular beneficiary of University of the Witwatersrand's Hog and received R28 000 last year.

Fees

Then there are grants and subsidies — the Transval Provincial Administration contributed R30 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 90c 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 33 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 R600 a month.

The question is — is the centre necessary?

"It fulfills 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.
Lenasia to get new hospital

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 Gatraind, 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 46 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 R34-million.

The complex is being built next to the Coronation Hospital.

Dr M H E Kalf, superintendent at the hospital, said today that a six-storey building, consisting of 118 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.
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'

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 300.

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 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.
KwaZulu hospitals hit by loss of Army men

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 according 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-ordinator director of the department, told me yesterday: "We are 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 medical service.

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 Ngconxa Hospital, which normally has five 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 Mahlabathini, a 100-bed hospital, there is no State doctor and only one Army doctor.

At Hlatzha, also a 100-bed hospital, there is only one State doctor.

At Nkhelela, 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."
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.

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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 two 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 Mlibatini, 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 Ngwelezulu, a 700-bed hospital which is flooded with up to 700 patients on occasion, there are nine State doctors and five army doctors, 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 Loubsen, 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 Loubsen 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."

The provision of a new hospital was also considered, but the site, planning, and construction would cost at least R1mn 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 uneconomic," Mr Loubsen said.

Provision for the patients would have to be made at other hospitals.

Mr A H Horikami, chairman of the City Council's Welfare and Public Entertainment Committee, and Mr Fritz Poth, MP, together with representatives of the Western Province Women's Association, will meet Mr Loubsen today to discuss the
Pricey clinics are paying Black maids R40 a month

By JENNIFER HYMAN

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.

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.

Black employees have had to sign new contracts 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 Labour Relations Act 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."
The fire began in the roof of the hospital building. In the course of the afternoon, it spread throughout the premises, destroying most of the structures. The hospital was completely gutted.

The extension of the hospital, which was under construction, was also affected. The work has been halted until a full assessment of the damage can be made.

The cause of the fire is under investigation, and no further details are available at this time.
Press slammed for probing

By Mike Dutfield

THE Administrator of the Transvaal, Mr. Sybrand van Niekerk, yesterday attacked the Press for "finishing 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 say what the cause of the patient's illness is. They make statements about the admission of the patient, treatment or progress. When a patient asks that statement 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's Hospitals authorities are still trying to identify the doctor who made the original allegations in the Transvaal a week ago. It was then revealed that an inquiry into the doctor's allegations is under way to find the doctor and ask him to substantiate his claim.

The Director of Hospital Services in the Transvaal, Mr. P. H. A. Grobbelaar, refused a request for comment on a Press report about a Johannesburg woman, allegedly partially blinded by police firing birdshot.

Asked yesterday if hospital records would be examined to verify the report, Mr. Grobbelaar said this week, Mr. P. E. Epton, United Front spokesperson on hospitals, said in the Transvaal Council, said it would be for the liberation to be confirmed or denied when the council meets in February.
**ON THE MANGER**

**Traditional**

1. **Christians sing,** To hear the news, the earth be sad, Since our Redeemer have light, Which made the angels

2. **made us sing this**

3. **Sing with angelic voices,**

4. **made us sing this**

**Harmonies, ad lib.**

**News of our merciful King's birth,**

**All for to gain our liberty,**

**Now and for ever more,**

**Amen.**
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 Maudie 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.
Those who are a labour-intensive far to appreciate this to the evidence of farming (discussed I. share Tomlinson’s with a decent garden — F recommended as the Those who share his should try for one starting with the intensive, unless we new land is being necessary in much

The man-power figures for the Bantustans
On the median estimate B in Table II, each coc farm 3.2 hectares (or 7.9 acres) of cultivated of livestock care. Agricultural experts with insist this would be quite impossible for one mechanical devices to do. A strong, skilful, motorised equipment, would not, in their opinion, as two acres entirely on his own. Yet even Table I there is only one economically-active each 1.65 ha. (4.08 acres) of cultivated land

This suggests that the Bantustans are self-impression that they are overfarmed is partly their being relatively over-populated and for different problems.

Not only is the amount of labour on whit greater than one would expect (given the rela it's price is also lower than one would expect from a comparison with wages in other sectors, and even with incomes in Bantustan agriculture.

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 them to be in the hospital and the police to share the ward than to go to some alternative of 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 labour-depressing."

The medical superintendent, when he visited the ward, Dr Alan 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.
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 sero-genetics 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.
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 Nierkerk Hospital in Carletonville.
Hospital is accused

Mrs Wilhelmina Mufumwe 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 30 hours.

The injuries were caused when Mrs Mufumwe, 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 Mufumwe 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.
SA hospital ad lands UK paper in court

LONDON — A "White patients only" advertisement for nurses to work at a hospital in Southampton, leading to the first prosecution under the Anti-Discrimination Act of Britain's race relations laws.

The Race Relations Board, which instituted the prosecution, said it was important to make it clear that the Nurses' Association would only accept applications from White nurses to the hospital.

The prosecution was launched after the nurse Relating Board, which said the advertisement was discriminatory and violated the Race Relations Act of 1976. The advertisement was published in a local newspaper.

The defendant, who offered free travel, food and accommodation, and included the words "all White patients only".

Outlining the prosecution case, Mr. Anthony, an authority on race relations law, said it was important to the law what race relations conditions applied in South Africa.

What mattered was that any reasonable person with no limited general knowledge would realise that a South African hospital catering for only White patients would not have Coloured or Black nurses.

The advertisements were published in the Irish Independent on May 6th and in The Daily Mail on July 11th.

The case arose after the Race Relations Board received seven complaints about the advertisement.

Mr. said the advertisement was clear, and it was obvious that the positions were only open to White nurses.
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 R300,000 section of the Sterkfontein Mental Hospital near Krugersdorp yesterday.

Sister Elsa Kroitz said she had smelled 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 grabbed a fire extinguisher and tried to put out the flames but soon realised my efforts were hopeless."

"My next thought was to save the 33 patients in the rest of the complex."

With the help of other staff, she quickly and calmly evacuated everyone without raising the alarm.
Court told of strange practice at hospital.

CAPE TOWN.—The strange aspect of a case in which a patient was accused of having been swindled in the amount of £40, was due to the strange system at one of the city hospitals. A Cape Town hospital Court was held yesterday.

Defendants were charged with false pretences while being paid patients for teething remedies and for a bottle of cordial. The patient, who was appearing for Dr. J. J. Smith, was the head of the department of anaesthesiology of the University of Cape Town. He said that the patient, who had agreed to a contract for a bottle of cordial, had been paid in full. Under the circumstances, the patient was found guilty. The patient was ordered to pay £40 in damages.

The defendent was allowed to know the name of the patient's name on a bond of more than £100. It was submitted that the patient had not been able to do the work of his own without the aid of the bank.
HEALTH & DISEASE

HOSPITALS & CLINICS

FEB. 77 - DEC. 78.
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).

<table>
<thead>
<tr>
<th>Rank</th>
<th>Salary scale (R per annum)</th>
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<tbody>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td>Specialists</td>
<td></td>
</tr>
<tr>
<td>Professor/Chief Specialist</td>
<td>15 600 (fixed)</td>
</tr>
<tr>
<td>Principal Specialist</td>
<td>14 400 (fixed)</td>
</tr>
<tr>
<td>Senior Specialist</td>
<td>13 200 (fixed)</td>
</tr>
<tr>
<td>Specialist</td>
<td>12 600 (fixed)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank</th>
<th>Salary scale (R per annum)</th>
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<tbody>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td>Medical Officers</td>
<td></td>
</tr>
<tr>
<td>Chief Medical Officer</td>
<td>13 200 (fixed)</td>
</tr>
<tr>
<td>Principal Medical Officer</td>
<td>12 600 (fixed)</td>
</tr>
<tr>
<td>Medical Officer</td>
<td>7 740 × 360-9 900 × 450 11 700</td>
</tr>
<tr>
<td>Intern</td>
<td>5 100 (fixed)</td>
</tr>
</tbody>
</table>

(ii) Dentists: As in respect of Medical Officers.
(iii) Pharmacists: Salary scale (R per annum).

<table>
<thead>
<tr>
<th>Rank</th>
<th>White</th>
<th>Coloured/Indian</th>
<th>Bantu</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Pharmacist</td>
<td>9 900 × 450</td>
<td>8 100 × 360</td>
<td>6 060 × 240-6</td>
</tr>
<tr>
<td></td>
<td>-11 700</td>
<td>-9 540</td>
<td>×</td>
</tr>
<tr>
<td>Senior Pharmacist</td>
<td>7 740 × 360</td>
<td>6 060 × 240-6 300</td>
<td>4 740 × 180-5</td>
</tr>
<tr>
<td></td>
<td>-9 540</td>
<td>× 360-7 740</td>
<td>×</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>5 340 × 240-6 300</td>
<td>4 380 × 180-5 100</td>
<td>3 450 × 150-4</td>
</tr>
<tr>
<td></td>
<td>× 360-7 380</td>
<td>× 240-5 820</td>
<td>×</td>
</tr>
<tr>
<td>Trainee Pharmacist</td>
<td>4 020 (fixed)</td>
<td>3 150 (fixed)</td>
<td>Male: 2 500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Female: 1 500</td>
<td>1 150 (fixed)</td>
</tr>
</tbody>
</table>

The above-mentioned scales do not include allowances payable to the personnel.
Hospital beds for Bantu

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

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

The MINISTER OF BANTU ADMINISTRATION AND DEVELOPMENT:

(a) 13,457.

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.
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 contemplated.

(3) 31 March, 1983.
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 the 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
Some hospital fees to double

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 12.3 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 for up to five visits in 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 R6 to R8 per 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 R8 per day for the highest income groups and for white members of medical schemes.

For private patients, the fees will rise from R6 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.
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 R15 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 practice 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 50% 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 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 sub-
sidised 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 con-
ideration 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 require-
ments, 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 ob-
tain 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 sur-
gery, they all end up at
An artist's impression of the proposed nursing home which could greatly ease the current overcrowding in black hospitals as shown in the picture.

**Pitter Patter**

**Black Nursing Home Will Make History**

We are convinced that once a patient comes into this hospital, she will not be forgotten. The new hospital will be a model of what we need for our people. It will provide the necessary care and comfort that our patients deserve. We are grateful for the support we have received from the community. We look forward to serving you and your loved ones.
Hearing 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 resulting not to him 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 Tsakata, 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.
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.
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.

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Coloured</th>
<th>Asian</th>
<th>Bantu</th>
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</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>8 839</td>
<td>2 461</td>
<td>227</td>
<td>4 336</td>
<td>15 863</td>
</tr>
<tr>
<td>T.B</td>
<td>171</td>
<td>1 370</td>
<td>119</td>
<td>2 658</td>
<td>4 318</td>
</tr>
<tr>
<td>Leprosy</td>
<td>50</td>
<td>100</td>
<td>30</td>
<td>820</td>
<td>1 000</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td></td>
<td></td>
<td>1 258</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>9 060</td>
<td>3 931</td>
<td>376</td>
<td>10 330</td>
<td>22 439</td>
</tr>
</tbody>
</table>
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, 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 R8,000 towards 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.
Housing facilities
The general quality of location and arrangement is still the "wattle and enclosures annexed. The very poor roofing with a from rain off the roof.

of the house is usually high raised at the wall, providing even in the space provides soft and well-wea.

care of the state of employ. The rooms are generally near the dining-room table and chair. A driver whose basic wage is to have beds at all in his house.

the front room. One must note that some even make patterns on the shades. Cooking is done out of a fire-place with chimney. It is interesting to note that this one or two logs burning for a long require very much more wood, and collect the wood, there is a lot of wood as is reed houses always have roundish (6 ins) and there are only one or lower than an adult's height. In this, but there is no answer. Ap

only in structural terms but in terms other houses. A large proportion of unsightly sheet iron rooms or house has mud and iron annexes with trees providing drinking water, non-existent and the area in front d normally swept clean, slightly eating. Floors are made of cow-
cow dung is used by choice as it

he farmer appears to take little uses them to his own devices. bedding, but a dresser and writer employs a Black tractor saves R10-R15 p.m. This man from the others and he has no as necessary as the dresser in

cow-dung floor is very comfortable, of clay for darker or lighter even though most houses have because of the smoke, because weather is cold. It is economically produced using barbecue-type fire would the women-folk normally hod. Homemade mud and with a diameter of 15 cms. Door spaces are always inhabitants the reason for 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 best of its kind.

Bright colours abound at the new hospital, Mr F Graf zu Cas, the architects, indicates a new era.

The date: July 23, 1974, only three years ago. The foundations begin to rise...

... and the hospital now, an overnight blossom.
biggest, the ugliest

Mr Castell looks down a section of the 5 km-long telifluidic 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 us a guided tour of the complex which rivets many Transvaal towns for population, consumption and output.

When it was planned the contract sum was R72-million, although allowances were made for escalations at 6½ a year. This figure doubled during the building time and the Administrative Building 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 on efficiency. The revolutionary assembly technique will reduce maintenance costs and facilitate. Each department can grow or shrink, according to changing needs. It will even be possible to move the 26 operating theatres around the building.

This is because of the new idea of 26m-high service levels between each floor. "It is possible for different tradesmen to work in the service areas simultaneously, without interrupting the normal functioning 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 600-bed building took 10 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 ugly-white and have been painted in a variety of colours - red, green and yellow. The overall 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."
A ‘shrink tank’ at work on hospital

Mercury Reporter

PETERMARTZBURG

PLANS for the new Grey’s Hospital here may have to be revised to reduce the number of beds to 700 from 1000 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 that services related to the original intended size of the hospital were incorporated in the new plan.

The issue had not yet been resolved said Mr. Watterson, who added that the Province considered a 1000-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 1000 to about 700,” he said.

Site works for the new hospital — to be built on Town Hill — are nearing completion.
Permits for non-Whites for private nursing homes

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, 1956, 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

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 2 800 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 patients, 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 bulk of psychiatric work with black patients was done 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.
Atlantis hospital opens

The Argus Correspondent

MALMESBURY.—On Friday the R1-million Westfleur 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

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20. A monopoly in equilibrium at output Qq 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
Hospitals in homeland to be aided

SAULSPROOT — 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.

"Guidance"

You are assured that the Government, the Republic, and in particular the personnel of the health department, will always willingly give the necessary, technical, and scientific guidance and advice if your Government asks for it.

Mr. Botha said that 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, 1970, the running and personnel of 58 of the 92 mission hospitals had already been taken over.

Spending

In the 1976/77 financial year, his department had used R25 million from the funds of the Bantu Trust for health services and hospitalisation.

This figure was second only to R44.4 million spent on land acquisition in the same year.

The Saulspoort Hospital had 774 beds, of which 282 were for psychiatric patients, 250 for tuberculosis patients, and 424 for general surgical, orthopaedic and obstetric patients and children.

This hospital also served 27 satellite clinics.

(Sapa)
SA hospitals at British Medics

(86) Academic Hospital Called a Disease Palace

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Science Editor...aid he was...

The era of the large hospital — the so-called "disease palace" — has come to an end in South Africa, according to the Secretary for Health, Dr. 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 Mercer, 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..."There are...some hospitals need up.

Lus. The interview was awarded a fellowship to...of the communications and group...interested in the study of prejudice...arly among groups. He has put togeth...workshops and lectures which led to discussion with...
Cape medical services reaching out to the whole community

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 the Department of Health, in its report on the progress of hospital building in South Africa, has stated that there are "diseases and conditions that demand the training of health personnel in large institutions." It is, therefore, important to note that this report has been made available to all the health authorities in South Africa. According to this report, the plan is to provide a greater number of hospital beds in the "economic size" of 200 beds, as this size is considered to be the optimum size for hospitals in the Cape Province.

2. In your criticism of the new Johannesburg Academic Hospital, you mention that the hospital is not yet able to offer anything near a similar scope of efficient services. I must point out that, for its size and potential, the Tygerberg Hospital is probably the best value of hospitals that money has ever purchased. Instead of continuing 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 plan to build 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 about every possible hospital career in the nursing, medical, dental, dietetic, bio-engineering and every other thinkable field. There is today no time that can be allowed to go 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.

3. In your criticism of what you like about academic hospitals of this size but can assure you that circumstances demand that they be ample a nurse with further training. Conditions which are mostly encountered, calling for treatment at that level, are largely gynecologic, general, obstetrical, family planning and community health fields.

4. In regard to your criticism of the report on the progress of hospital building in South Africa, it is sufficient to say that it is being made available to all the health authorities in South Africa. According to this report, the plan is to provide a greater number of hospital beds in the "economic size" of 200 beds, as this size is considered to be the optimum size for hospitals in the Cape Province.

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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.)

peristed 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
Tea sales swell
Santa coffers

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 220 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 206.15, while the average number of patients treated for up to six months was 252.73.

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 were re-elected chairman, while Mr. M. Luck, Mrs. D.J. Ross, Mrs. P. Anand, Dr. L. Schneiders, 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. Groeter, presented Santa with a cheque of R3 000 for the purchase of a mobile clinic. — LPD
15th August: The social and economic consequences of Roman imperialism

16th August: Tiberius Gracchus and the beginnings of the Roman Republic

17th August: Athens: The Acropolis (Professor L. Nambock)

18th August: Gaius Gracchus

19th August: Marius and the Italian conquest

20th August: Marcus the Social War and the first coup d'état

21st August: Sulla in the deadly reformation

22nd August: Scipio the African

23rd August: Lucius Sulla (Jr.)
Municipal health aid free to all

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, Poeshore, or ring 41-3411 during office hours.
2 Indian interns for Groote Schuur

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. Jordan, 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

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 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.

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**Standstill on Black hospitals**

Mercury Reporter 2/18/77

HARDLY a single extra hospital bed for Blacks 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 1965, 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 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.

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**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.
Price and Output Determinants in the Manufacturing Industry

INTRODUCTION: The problem of dependence of cost, price and quantity and ex ante and ex post measurement.

Micro-economic Script.

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 its 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 plucks 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 that 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.

SECTION II PRICE AND OUTPUT DECISION PROCEDURES - THE RISK OF SUBOPTIMALITY

Procedures used to set prices. Sources and extent of possible suboptimality.

SECTION IV OUTLINE OF A POSSIBLE MODEL


SECTION V ESTIMATION OF COST FUNCTIONS

Estimation of empirical cost functions by regression analysis on adjusted time series data.
Botha opens

Roodepoort hospital

ROODEPOORT. — The
Minister of Bantu Admini-
stration and Development,
Mr M C Botha, officially
opened the R6 500 000 Le-
ratong Hospital, near
Roodepoort yesterday.
The hospital, which will
eventually cater for more
than 700 black inpatients,
is designed to serve the
municipal areas of Krug-
erdorp, Randfontein, and
Roodepoort.
It has recently been ap-
proved as a training centre
for black nurses, and addi-
tional facilities costing
easily R3 000 000 are pla-
ned. — Sapa.
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 1,085 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.
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 R172,000 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
Pefferville clinic plan

EAST LONDON — The City Council is planning to build a comprehensive clinic in Pefferville at an estimated cost of R132 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
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.
ANGRY DOCTORS WARN: WE'LL QUIT SA

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:

- Detain patients in hospital for longer than necessary, thus keeping beds occupied;
- Perform unnecessary blood tests;
- Use hospital equipment in an irresponsible 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 remuneration, 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...

By BARRY LEVY

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.

Referring to the protest of doctors at the General Hospital as merely "a tremendous storm in the teacup", the chief medical superintendent of the hospital, Dr John McMurdie, 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".

I'll act' says McMurdie
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 therefore not be furnished.
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 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:

<table>
<thead>
<tr>
<th>Rank</th>
<th>White</th>
<th>Coloured/Indian</th>
<th>Bantu</th>
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</thead>
<tbody>
<tr>
<td>(i) Specialists</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Chief Specialist/Professor</td>
<td>17 490 (fixed)</td>
<td>14 850 (fixed)</td>
<td>12 870 (fixed)</td>
</tr>
<tr>
<td>Principal Specialist</td>
<td>16 170 (fixed)</td>
<td>13 530 (fixed)</td>
<td>11 910 (fixed)</td>
</tr>
<tr>
<td>Senior Specialist</td>
<td>14 850 (fixed)</td>
<td>12 390 (fixed)</td>
<td>10 950 (fixed)</td>
</tr>
<tr>
<td>Specialist</td>
<td>14 190 (fixed)</td>
<td>11 910 (fixed)</td>
<td>10 560 (fixed)</td>
</tr>
<tr>
<td>(ii) Medical Officers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Medical Officer</td>
<td>14 850 (fixed)</td>
<td>12 390 (fixed)</td>
<td>10 950 (fixed)</td>
</tr>
<tr>
<td>Principal Medical Officer</td>
<td>14 190 (fixed)</td>
<td>11 910 (fixed)</td>
<td>10 560 (fixed)</td>
</tr>
<tr>
<td>Medical Officer</td>
<td>8 610 \times 390-10 950 \times 480-12 870</td>
<td>7 440 \times 390--10 950--11 430</td>
<td>7 440 \times 390--10 170</td>
</tr>
<tr>
<td>Intern</td>
<td>5 820 (fixed)</td>
<td>4 650 (fixed)</td>
<td>3 930 (fixed)</td>
</tr>
<tr>
<td>(iii) Dentists: As in respect of Medical Officers</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(iv) Pharmacists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Pharmacist</td>
<td>10 950 \times 480-12 870</td>
<td>9 390 \times 390-10 950</td>
<td>7 830 \times 390-9 390</td>
</tr>
<tr>
<td>Senior Pharmacist</td>
<td>8 610 \times 390-10 560</td>
<td>7 170-7 440 \times 390-9 000</td>
<td>6 090 \times 270-7 440</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>6 090 \times 270-7 440 \times 390-8 220</td>
<td>5 010 \times 270-6 900</td>
<td>5 010 \times 270-5 820</td>
</tr>
<tr>
<td>Trainee Pharmacist</td>
<td>4 470 (fixed)</td>
<td>3 570 (fixed)</td>
<td>2 454 (fixed)</td>
</tr>
</tbody>
</table>

The above-mentioned scales do not include allowance payable to the personnel.
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.
Hospital at Umlazi

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

(1) When did work commence on the building of a hospital at Umlazi and what progress has been made to date?

(2) Whether building operations were suspended; if so, for what period and for what reasons?

(3) When is it anticipated that the buildings will be completed.

1. Naam (eerste)
2. Ouderdom
3. Ras
4. Tuiste (dorp, skooljare voltooi)
5. Soort werk
6. Span
7. Nommer in span: skeerders dagmanne
8. Hoe lank het u al die werk gedaan?
9. Hoe het u geleer om dit te doen?
10. Het u al ooit ander werk gedaan?

Indien wel, kort besonderhede van vorige werk:

<table>
<thead>
<tr>
<th>Plek</th>
<th>Tydperk</th>
<th>Soort werk</th>
<th>Weeklikse loon</th>
<th>Rede waarom u die werk verlaat het</th>
</tr>
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<tr>
<td></td>
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</tbody>
</table>

11. Met u al ooit daaraan gedink om ander werk te doen?

Indien wel, waarom verander u nie van werk nie?

12. Vir watter deel van die jaar doen u hierdie werk?

13. Hoeveel plase besoek u elke jaar?
Doctors refute criticism of nursing homes

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 lion’s share of the cost of the hospital bed by means of his income tax), who is thus forced to rely on private nursing homes and hospitals when he becomes ill.

Service

By and large private hospitals provide a good service at a bed cost below R30.00 per day, inferring that there is overall better and more economic management than in provincial bureaucratically run equivalents.

That the private hospitals or members of the medical profession who use them, should be sniped at by political opportunists, is as unjust as your rather biased comment of February 8.

The disparity in essential bed costs has not been publicised, nor has the fact that the Natal Provincial Administration charges high fees for the use of equipment in provincial hospitals, that has already been paid for by the tax-payer in the first place, e.g. A CAT brain scan at Wentworth Hospital, using a very expensive machine is subject to a further fee to the private patient.

In Natal the tax-payer must again pay for the use of the artificial kidney, radioactive isotope scan, and ultrasound 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
Two new hospitals

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 R25.8-million, 99-bed hospital would close in November next year.

This hospital could be extended to take 128 beds if necessary, the spokesman said.
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 J. W. Motlailo. Sub-editing by G. W. Pichardo. Content fill by J. Creagh.

Almost 100 medics still hold shares in private hospitals

Almost 100 doctors, dentists and specialists who have shares in Drakensberg 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 minimal.

But the de Villiers Commission of Inquiry, which investigated private hospitals several years ago, found it unadvisable for doctors or specialists to hold shares.

Witnesses giving evidence to the commission said many retired 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, so they got married to the staff and rooming, and often referred patients there even if they did not have shares.

In recent weeks the call to stop doctors who have shares has increased among doctors who hold shares.

Almost 100 medics still hold shares in private hospitals

The commission of inquiry into private hospitals has been called for by almost 100 medics who have shares in private hospitals.

The doctors say they are being forced to work in private hospitals to ensure their financial interests are protected.

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Political Staff

CAPE TOWN — The Senate was held yesterday by the Doctors' Association to discuss the problems of doctors and the lack of facilities for their treatment.

Senator Eric Winchester, speaking in the third reading of the Medical Scheme Amendment Bill, said doctors were very well equipped and had all the facilities they required for their treatment. 

"Very often doctors were called in at short notice and had to work under difficult conditions," he said. "They found that they could not always get the facilities they needed."
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 Administrator 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. 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:**
Model in health care

Community health at the Beersheba medical centre.

THE COMMUNITY
Anne Baron

"They also learn about various aspects of medicine, but the woman really gets a vision of the medical school is everywhere. It is a constant reminder of the importance of the medical profession. The student is given an understanding of the importance of the medical profession and how it affects the health of mothers and children, and the kind of people who take it - "they seem to be more educated and younger," she said. She was also involved in other interesting projects."

Need to contact parents

Death is not the enemy

The doctor's role is to maintain the patient's life expectancy, possibility in the belief that if they suffer enough they may not feel so much pain at the end. Many people are so ill that they may not even be aware they are suffering at all. Injections and painkillers are given to improve their quality of life. The last thing the doctor wants is to cause death, but to ease the process of dying.

From the end of the weekly column, which will appear in FLAIR each Monday, focusing on the controversy surrounding the "moment of death".

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by all those - friends and relatives - who know the patient's requirements for being alive. This has become known as the physician's dilemma in an age of modern technology, but in which "life" may be regarded 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 doctors want to confirm, the human ego is such that it can only feel a sense of guilt and defeat in the face of another's death. The story of one 70-year-old, terminally ill Elvis Khan makes the point better than I could. His last request to his hospital doctor was to be allowed to die with dignity - not by the man in the next bed who had "tubes sticking out all over." He did not want his children to remember him that way.

Any questions or comments are welcome.

MOSHE AND RUTH PERRY, two dedicated community workers who live in the ancient desert city of Beersheba, 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. Peryn is the Dean of the Faculty of Health Sciences 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 was also involved in other interesting projects.

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pleasure, possibly in the belief that if they suffer enough now they may not feel so much pain in 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 and out.

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 recognize that death is a clinical impression — it is diagnosed when certain symptoms or signs are present.

For hundreds of years English common law ruled that life does not end as long as breathing continues and the heart 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 but the doctor too.

by all those — friends and relatives — who know the patient's requirements for being alive.

This has become the physician's dilemma in an era 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 defeat in the face of another's death. The story of 76-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.'
Hospital's bid to break sick leave racket

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 Textile 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;
- 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.
Hospital race
step hailed

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 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 bonafide decision and was proved wrong later.

Mr Horace van Rensburg, the PFV'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.
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 (FFP, 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—a lack of planning for black hospitals and the "brain drain" of doctors leaving the country.

He pinpointed Berengwath Hospital where there was overcrowding and the staff worked under difficult conditions.

Mr Moss criticised the closing of the black section of Edenwale 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 (FFP, 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 R50-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 Hobyn 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 the 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 to send the whites to the Ciskei hospital?

Mr Hulley: Why should any baby in South Africa live 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 crazy as an Italian visiting France being 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 Ciskei 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 white 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 managed, himself, better than to speak for the people who lived in the area.

He specifically referred to Mr Hulley when the debate on the hospital continues today.
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 bus fare to Mdantsane. There are no ambulances available to take these people from Duncan Village to Mdantsane. — DDR.
Day hospital for blacks.

CAPE TOWN — A day hospital is to be established by the Cape Provincial Administration for the estimated 80,000 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. Loubs.

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 circumspection 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 hospital from the Progressive elements in the East London City Council — the Yabek 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 said he had discussed the matter with the authorities. "I can give the assurance 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 was 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 superior to that at Frere."

PC.

Another section to close, page 7.
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 Oranje 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 Zulan, and the Medical Officer of Health, Dr J R van Heerden, were first invited to address 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, 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 I 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, Mr P 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 was of no good.

The representatives of the council were then invited to attend a meeting of the committee, which they said 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 same way.

But the committee, chaired by a member of Dr Gilliland's department, Dr R B 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 Balonsky, Dr J Zulman and the Medical Officer for Health in East London, Dr J van Heerdon, met members of the implementation committee they were "treated with contempt", according to Mrs Balonsky.

Dr Van Heerdon and Mr Zulman yesterday confirmed they received scant sympathy from Dr Field and Dr Kotze in particular.

"We believed Dr Van Heerdon 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," Dr Zulman said.

In view of the council's 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.

— DOR.
State official’s assurance to black patients

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 were closed was pointed out to Dr Gilliland, he gave his assurance these people would not be made to suffer through any change in service 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," 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 problem, the municipality had offered another infant feeding scheme where skim-milk and Pro-Nutro was supplied. The skim-milk was bought at a reduced cost through the Department of Food and Nutrition, and the Pro-Nutro paid for in full by the municipality.

The deputy councillor at Frere Hospital, Dr F. Vlidge, 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
Frere’s black ban to stay

EAST LONDON — The black paediatric service at Frere Hospital is to be closed on June 30 as planned despite appeals for it to remain open.

The deputy superintendent at Frere, Dr F. Viedge, said yesterday that he had instructed his staff to warn black patients they would have to go to Mdantsane after June 30.

He said the decision had been taken at the last meeting of the implementation committee and as he had received no instructions countermanding it, he was going ahead as directed.

This closure comes despite an appeal from residents of Duncan Village through the Joint Advisory Board, appeals from paediatricians at Frere and an appeal from the East London City Council’s health representatives.

The basis for the appeals is that most of the 200 to 400 patients treated at the outpatients section a day suffer from malnutrition and their parents cannot afford the 72c return bus fare to take them to Mdantsane. When informed of the problem, the Director of Hospital Services in the Cape, Dr L. Kotze, said yesterday: “I’m not here to give them bus fare.”

He said the residents of Duncan Village were not the only people who had to use buses to get to hospital and it was not the province’s responsibility to provide buses.

At present there are no ambulances which will take sick people from Duncan Village to Mdantsane.

Dr Kotze said this had been discussed at the last meeting of the implementation committee and the City’s Health Department’s representatives, but Dr J. Klopper, who had said he would look into the problem.

Dr Field said, however, that all the problems were before the committee. This was why the State’s scheme to phase out services at Frere in favour of the services at Mdantsane had taken so long to implement.

He intimated that as this body had been brought into being to handle the problems it alone knew the full extent of the problem and was qualified to comment on the situation.

He would not discuss the solution to particular problems such as buses and ambulance services, but said see to it nobody suffered through the change-over. — DDR
Africa's biggest black hospital

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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 the health authorities in Mdantsane are satisfied with the transport facilities between the hospital and the alternative services at the Cecilia Makiwane Hospital.

Dr Viedge, last night.

This was confirmed by the deputy superintendent at Frere, Dr F. Viedge.

Dr Viedge had previously directed his staff to inform people attending the black paediatric out-patients section at the hospital that the section would be closed on June 30 and that 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 bus fare to Mdantsane.

This protest was carried over to state and provincial health officials by the chairman of the Eastern Cape Administration Board, Mr G. Coetzee, 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 outpatient services, which treats between 200 and 400 patients a day.

- DDR

No-one turned away, page 8.
Why weren't people told

EAST LONDON — The patient's story

has hospital chairman

saying hospital closed away

No-one turned away

The patient's story

has hospital chairman

saying hospital closed away

No-one turned away
Hobbs against closure of Frere services

EAST LONDON — The New Republic Party's 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 Ciskel 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 the Province immediately to provide a special bus from Frere to the Ciskel Matikane Hospital in Mdantsane. The Ciskel 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.

"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 Co-Operative community to Frere, asking for separate facilities. This request is said 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 from the hospital to which this patient is being moved, to 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 the majority of the people want it 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.

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 Johannesm 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 has already saved lives. "There is no doubt that three patients would have died if our intensive care unit had not been operating," said Sir Jonathan Hawkes, Medical Officer, at Turffontein. He said the centre had been a great success.

The centre is served by three intensive care specialists, and six St John's Ambulance attendants. There are three beds in the intensive care unit alone. As soon as a patient has been stabilised and is out of danger, he or she is transferred to the General Hospital.

Sir Humphry strongly recommended that any person who had experienced heart attacks should not go racing. "I know it is like speaking to a brick wall," he said, "but racing is a very unhealthy sport. They can be fatal, but they're still going. It is unbelievable. We need to educate the public about the dangers of racing activities. It wouldn't help anyone — if they like the game, they'll go."
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

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 Ciskel 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 Llyods 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.
Mr. Free Trader: The infant industries are the competitors in the world. They are necessary to the growth and development of the infant industries, and they are necessary to the growth and development of the nation. They are necessary to the growth and development of the economy. They are necessary to the growth and development of the business community. They are necessary to the growth and development of the labor force. They are necessary to the growth and development of the industry. They are necessary to the growth and development of the market. They are necessary to the growth and development of the economy. They are necessary to the growth and development of the nation. They are necessary to the growth and development of the business community. They are necessary to the growth and development of the labor force. They are necessary to the growth and development of the industry. They are necessary to the growth and development of the market. 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Sick miner set the old General going

On November 4, 1886, Thomas Gray, a miner and the first patient in a new 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 called West was discovered on the Widow Oosthuizen's farm at Langlaagte. In September the goldfield was proclaimed, and on November 1 the hospital was opened.

The sick and men died miserable deaths with no hospital to care for them.

But during 1887 a few men were being treated at the hospital, and a meeting was held, and a hospital board was appointed with Mr. John Carr as chairman.

The meeting marked the beginning of the Johannesburg General Hospital.

It was attended by the first resident Catholic priest on the goldfield, the Rev. Father O. Mongeau, who offered to provide a nursing staff. The people found two 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. All 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 J. H.-turned-Brady on a site donated by the Government. It could accommodate only 14 male patients, until March 1888, when an extension with 14 beds for women and children was opened by the Vice-President, General N. J. Smith.

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 1888, 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 1, 1886.

Dr. John van Nické 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 Nické resigned, and the post was advertised. The government insisted that applicants should have a knowledge of Dutch. Dr. Henry Jeson Peirse was appointed from 28 applicants, and started on November 1, 1898 as resident medical officer.

First time

He was still in the post when he died at the age of 33, 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 Marin, 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 transitional period, will be controlled by Dr. A. L. Brown, the chief medical officer at Addington Hospital.

The main object in establishing the clinics is to have a centre where post-operative breast cancer can be treated with chemotherapy 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.

University of London Institute of Commonwealth Studies, 1972

- The Economic History of South Africa
- The Political Economy of Contemporary Africa
- South Africa: A Political and Economic History
- Source Material on the South African Economy
- The South African Economy
- South Africa, Social and Economic Aspects
- Structural Changes and Business Cycles in South Africa, 1890-1930

Schuman, C.E.W.

"The economic development of South Africa, 1910-1930."

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Call for clarity on hospital services

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 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 MP 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
the State
hospitals

save 'lots'
of money

BY SPENDING a day's hospital revenue, the
state has the money to help the many
hospitals around the state.

The Argus, Thursday, August 3, 1978
Day hospitals save the State 'lots' of money

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 the specialist level."

The average cost of treating a patient at a Day Hospital is R3 per visit. This covers a range of treatments from the removal of dressings to confinement, 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 per 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
An entire medical town

It's bigger in volume than a pyramid

medical town

An entire medical town

It's bigger in volume than a pyramid

medical town

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It's bigger in volume than a pyramid
JOHANNESBURG HOSPITAL CONTRACTORS FOR THE JOHANNESBURG HOSPITAL
The patients can now look forward to their meals.
It's bigger than a pyramid.

Medical town
A concrete monument to co-operation
Inledon

Inledon are proud to be associated again with one of the leading Gas Supply and Oil Conditioning World. We have supplied all their needs and fittings for both hospital General Hospital in Johannesburg. In addition to this, we also provide a range of high-quality, reliable, and efficient service to our customers throughout the region. Thank you for choosing Inledon.

General Johannesburg Hospital

The New To

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Venture every success for the future.

Venture wishes Johannesburg General Hospital every success in the joint operating the hospital and takes this opportunity to express its appreciation for its continued support.

Johannesburg Academic Hospital wishes the new General Johannesburg Hospital every success in the joint operating the hospital and takes this opportunity to express its appreciation for its continued support.

Combiink Construction (Pty) Ltd. one of two

Combiink (Pty) Limited

Combiink (Pty) Limited
The days of endless, bleak wards are over...
open to question.

With at least 15 private nursing homes and three provincial hospitals, Johannesburg has about 4,000 beds for sick whites. Latest figures show an average daily bed occupancy of only 69% in the old general hospital, a drop of 4% from 1973-74 figures. Edenvale hospital has a 62% occupancy, while the J G Strydon tops 74%.

Neighbouring Soweto, on the other hand, has only the 2,500-bed Baragwanath, with a trickle of patients being treated in the 233 beds of Johannesburg's Non-European Hospital. Three clinics, recently reopened after the 1976 riots, treat outpatients only.

Baragwanath is officially 93% full, but in some sections this figure is well above 100%. With its 99,000 admissions, and nearly 100,000 outpatients a year, Bara's staff has its hands full. Johannesburg's three white provincial hospitals, with nearly 75% of Baragwanath's capacity, handle only half as many in- and outpatients.

Plans for a new Soweto hospital have been in the pipeline for over a decade, but have not yet reached the drawing board. The idea is to build a 1,000-bed hospital, which can be extended to accommodate a further 1,000 beds.

What do provincial planners have in mind for the 1,400 beds of the old general hospital? The maternity unit at the Queen Victoria Hospital is to be converted into flats for the hospital maintenance staff. The children's hospital — still in excellent shape — is to be used for a variety of services, including the child guidance clinic and psychiatric services.

As for the main building of the general, acting director of hospital services Dr. Hennie van Wyk tells the FM that the building is to remain in its present use.

until the new hospital is in full gear. "It will definitely remain in use as a hospital after that," he tells the FM.

What about turning it into a hospital for blacks?
MALITZ KILLER CANT

MEDICAL OFFICERS ARE TELLING
KARL BREMER
BUrg 7/118

BLY OOP
-

LOUBSER

Mnr. P. J. LOUBSER, L.U.K., belas met hospitaaldienste, het gister ontlen 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. Loubsers gister in 'n onderhoud kommentaar gelewer op 'n hartig wag Saterdag in Die Burger verskyn het. Hy het beklemtoon dat die vermaanse taak van die ad hoc-komitee, wat aangestel is om opleidingsgeriewe vir mediese studente van die Universiteit van Stellenbosch te ondersoek, nie die onderzoekers na die gebruik van die Karl Bremer-Hospitaal as opleidingshospitaal nie.

Daar is geen sprake dat die hospitaal vir die publiek gesluit sal word nie. Die afdeling wat gemaak is dat die hospitaal sy oop status ontneem, kan word en weer 'n opleidingshospitaal sal word, as verstaan.

VOORSTELLE

Die ad hoc-komitee het gister vir die eerste keer vergader om onderzoek in te stel na die behoefte wat nog by die fakulteit van geneeskunde van die Universiteit van Stellenbosch in die opleiding van studente bestaan. Die komitee moet muntlike oplossings voorstel. Een van die voorstelle kan wees die toekennings 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 seker siektes kan bestudeer nie. Die probleem kan opgelos word deur die toewyding van 'n aantal beddens in 'n ander hospitaal, of deur 'n daghospitaal.

PASiëNTE

As n gees van die Karl Bremer-Hospitaal as opleidingshospitaal gebruik word, sou verskyn dat pasiënte wat deur privaatmediese dokters behandeld word, in die toekennings van beddens voorkeur geniet. Die hospitaal word tans opgeknap en net sowat 'n kwart van die hospitaal se beddens en teaters is in gebruik.

HOME ADDRESS:

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N. S. SEUER

Die ad hoc-komitee sal na verwagting vroeër aanstaande jaar sy werk afhandel. Die komitee is saamgestel uit verteenwoordigers van die universiteit, die Hospitaalraad van die noordlike stadgebied en die Kaaplandse Departement van Hospitaaldienste. Mnr. Loubsers is die voor- sitter. Die komitee se voorstelle sal aan die Administrateur en die Uitvoerende Komitee voorgelê word.
Kaap kry gebou vir belemmerde kinders

"N MODERNE gebou van tussen R400 000 en R500 000 word beplan op die plek waar die Rondebosse Hospitals is gevestig. Dit sal deel wees van die Kindersentrum, waar belemmerde kinders behandel sal word. In 'n gedeelte van die ou gebou wat nie plaatsgevalt nie, is word belemmerde kinders reeds behandeld.

Gister het dr. W. J. Greeff, eerste mediese superintendent van die Rood Kruls-Kinderhospital in Rondebosch, die plans vir die nuwe gebou bekend gemaak. Die Rondebosse Kindersentrum is 'n afdeling van die Kinderhospital.

Planne vir die nuwe gebou is reeds opgestel. Die Provinciale Administrasie, die Universiteit van Kaapstad en die Skiereilandse Hospitalraad sal geadvieser 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. Atesame R35 000 is reeds hierdie jaar beskikbaar, het dr. Greeff gesê.

Gister het dr. Greeff en matrone D. M. McWilliams, hoofmatrone van die Skiereilandse Hospitals, aan lede van die Skiereilandse Hospitalraad 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 hy gesê 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 hiperkaktief. Gelukkig is daar genoeg ruimte beneens 'n gymnasion en 'n tenisbaan vir sulke kinders. Ander kinders is aggressief en die ouers weet nie hoe om die kind te hanteer nie. Ander is kleptomane. Dikwels moet die ouers en kind gesinslede ook aan die behandeling deelneem, omdat die symptome wat die kind openbaar, eintlik die gevolg is van 'n other probleem.

Ouers en gesinslede moet ook leer hoe om 'n moeilike of belemmerde kind te hanter.

SPEELGOED

Die behandeling is geperseleise en dikwels kan 'n personeel met 'n kind een keer per week behandeld en ouers kan die behandeling tuis voortset. In ander gevalle moet die kinders elke dag na die Kindersentrum kom en duur die behandeling tien maande of langer.

SPEELGOED word terapeuties gebruik en ouers kan speelgoed tot drie weke lank huis toe neem.

Dr. D. J. Power, senior lektor in die pediatrie aan die Universiteit van Kaapstad, het gesê dat baie kinders behandel word met speelgoed. Onderzoek is 'n geweldige probleem. In delen van die Skiereiland is tussen 20 en 30 persent van skoolgaande kinders ondervoed.

Te min word gedoen om ernstige sies te voorkom. Hy het gesê dat maëls, tering en amfetamindstrukte in baie ongelukkige kinders kan word.

Veral in platelandse gebiede is die geweld oorweldigende. Ook die ouers van die belemmerde kind hulp nodig. Hulle kan die kind nie alleen dra nie.

In die Kinderhuis kan die belemmerde kind deur 'n span deskundiges behandeld word. Dit is nie vir die ouer nodig om van die elke departement na die ander in 'n hospital te gaan nie. Dit word vertoon deur die mediese personeel.

In die Kindersentrum kom elke kinders met 'n kind wat dikwels gedra moet word. Dit is ook nie nodig om na verskillende hospitaal te gaan nie.

Probleme met die aanvaarding van 'n belemmerde kind ontstaan in die gesin en in die skool. Vir die toekoms van die belemmerde kind moet ook behoorlik beplan word, en die kind moet geëdukeer word. Dit is 'n groot probleem.

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GOODWOOD.

'N AANSOEK deur 'n voor- malige matroen van die Alex- andra-Rehabilitasiesen- trum in Maitland om 'n huis in Goodwood as losieshuis te gebruik vir gerehabilliteerde verstandeliks gestremde, is deur die stadsraad van Good- wood op een stem na eenparig afgekeur.

Mev. G. J. A. Visser het geruime tyd gelede by die raad aansoek gedaan dat sy 'n huis in Townendstraat as losieshuis inrig om ses mense, twee mans en vier vroue, wat by die Alexandra- sentrum ontstaan is, te huis- vies. Dié mense is ten volle gerehabilittee en opgelei om 'n normale bestaan in die samelewing te voer, maar het niks nodig om hulle te volle by die samelewing te laat aanpas.

Die stadsraad het mev. Vis- ser se aansoek na die belas- tingbetalersvereniging verwys vir ondersoek. Die belas- tingbetalersvereniging 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 op die verhandels bring in die stadsraadsver- eniging aanvaar word.

Op die afgelope stadsraadsver- eniging het die burge- meester, raadslid Joe Simon, voorgestel dat die aanbeveling van die belastingbetalersvereni- ging aanvaar word.

Raadslid S. M. Douglas van die raad van dié reg is dat die raad die betrokke saak in die hande van dié belas- tingbetalersvereniging laat.

Hy het gevra of dit reg laat geskied teenoor die aan- soeker. Hy hou nie daarvan dat die raad 'n saak dooden- voudig aanvaar op 'n vereniging se aanklag nie.

Raadslid W. H. L. Faasen het gesê hy stem volkome met raadslid Douglas saam. Dit is vir hom, 'n begin-selsaak wat ter sprake is. Hy het gevra of sommige sake vooraan, oor dié belastingbetalersvereniging, van die aanbeveling van dié raad slegs aanvaar word.

Die stadsraad het die aangesoek met die aanklag van die raad sequentie aanvaar.

Hy het gevra of dit reg laat geskied teenoor die aan- soeker. Hy hou nie daarvan dat die raad 'n saak dooden- voudig aanvaar op 'n vereniging se aanklag nie.

Raadslid Simon het gesê dit is die raad se beleid om die belastingbetalersvereniging van die stadsraad te beheer.

Die onderburgemeester, raadslid Louwtye Rothman, het die aangesoek met die aanklag van die raad sequentie aanvaar.
MANY people do not know how to prevent diseases, treat them, and obtain medical care when they are sick or injured. They do not know how to use the health services that are available in their area. One of the main reasons for this is that they have never been taught how to use the services. It is also difficult for them to understand the importance of health services and how they can benefit them.

Helping people help themselves is a vital part of the mission of the health service. By teaching people about the importance of health services and how to use them, we can help them to take better care of themselves and their families. People who are able to take care of themselves are more likely to live longer and enjoy better health. They are also more likely to be able to work and produce for their families.

Some people need help in understanding the importance of health services and how to use them. They may not know how to use the services, or they may not be aware that the services are available. By helping them understand the importance of health services and how to use them, we can help them to take better care of themselves and their families.

The health service can also help people who are unable to use the services by making arrangements for them to be taken care of. This might include arranging for a doctor to visit a patient at home, or for a nurse to visit a patient in a hospital. The health service can also help people who are unable to pay for the services by providing them with financial assistance.

In conclusion, helping people help themselves is a vital part of the mission of the health service. By teaching people about the importance of health services and how to use them, we can help them to take better care of themselves and their families. This will help them to live longer and enjoy better health, and it will also help them to be more productive members of society.
HEALTH - DISEASE - HOSPITALS
+ CLINICS

14-1-79 - 31-12-79
sunday express january 14, 1993

start all-white

year

heath

198

by alison gillwald

bergewanhospital, which has a reputation of being well-staffed with simple but modern

technology is becoming increasingly overcrowded.

health for hospital services, in the orange free
district of j."rrrraer" director, the hospital can take 50 people. the hospital is a day hospital and will be only a
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of the population of 100000 people, the hospital has 1000 beds. the hospital is a

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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 transfers 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

CAPE TOWN: The Government is spending R154 000 000 on more psychiatric centres and services planned by the Department 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 R50,000,000.

Other projects in the R154 000 000 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 Asians 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 for South Africa’s psychiatric nurses. "We are proud of the quality of our nurses today and are convinced that there are no inferior 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 Strikes

Whereas the 1953 strikes in certain industries under the Industrial Conciliation Regulation Act are not the former embra of a strike in Labour Relations, was grafted onto the latter. This is understood, the machinery, and a

The following provisions (as they do in most cases)
(a) where and under one Act;
(b) during or of one 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.

R30 m to be spent on new hospital

By TONY ROBINSON

A newly psychiatric hospital which will accommodate 2,400 patients and cost over R30 m is to be built at Mitchell's 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 Mitchell's 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 Kaal-steam area. With the development of Mitchell's Plain, however, it had been decided to site the hospital near the new towns. 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 administrative block.

The number of beds (2,400) will make the new hospital larger than the giant Tygerberg Hospital in Paarl which has 1,480 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.

The 1973 Act legalised the I.C. Act.
New clinic-hospital treats 600 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 McMurdie 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 Pess 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.

<table>
<thead>
<tr>
<th>Asians</th>
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<tr>
<td>Blacks</td>
<td>622</td>
<td>783</td>
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<td>TOTAL</td>
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Note: The impression of rapid growth is compounded of course by having 1975 as the 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
This is a picture of a mental patient. Handcuffed to a bed. In a public maternity ward.
In Vereeniging, South Africa, 1979

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 garments given to patients who come in without pyjamas, lying under an old, dirty, 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 she said no more.

The hospital superintendent, Dr. J. Erasmus, was unaware of the woman lying handcuffed next to the bed. "I have no knowledge of the matter," he said.

"We do not handcuff any patients, although at times, as in any hospital, a patient's hands are needed 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 another bed for a woman about to have a baby. The woman said she had been on the floor for three days.

And in ward 19, for male surgical patients, 30 men - also without mattresses, lay under the beds, while others sat waiting on rows of wooden benches for treatment from an overworked doctor.
The medical wards did not appear to be overcrowded.

"They are called "floor cases,"" the nursing staff told us. They are for patients in need of treatment. It is better for them to get hospital treatment rather than to miss it."

Dr. Erasmus said the hospital accommodated 26.5 more patients than it was meant to. No new wards had 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.

'Doctor' said a new hospital was almost completed at nearby Sibokeng location, and would open in April.

With 800 beds, he said, it would ease overcrowding at the present hospital - and the Black patients would then be closed down.

"There is no point in evacuating the present building with a new one 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 its beds, had not been designed for the Black population of the Vaal triangle and surrounding 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 had been kept on the floor since being admitted.

Another patient said she was admitted to the hospital after being stoned by "black" men in the street.

She said: "It's 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," he continued.

Another patient said she was sleeping on a bed when she was admitted three days ago. She was complaining to be too hot and sleep on the floor when a patient who appeared to be in worse condition than her was admitted.

She said the "floor cases" felt humiliated by such treatment. "But what can we do?"

One of the nursing sisters in the maternity ward said it was heart-breaking to see patients sleeping on the floor.

"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 solution."

Dr. Erasmus said the hospital was overcrowded, with patients being "transferred" in the floor because there was no space in the ward.

She said they sit on benches inside the ward when it rains.

The nurse said she had seen patients sleeping on the floor for months when she joined the hospital, if and when beds were available the "floor cases" were transferred to them.

'Not police action'

BRIGADIER I. Sharratt, 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 friends.'
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," the letter from the Natal Provincial Administration, Dr. James Gililland, 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.
Hospitals ‘cause more distress’

Staff Reporter.

Some distress symptoms in the terminally ill might be the result of hospitalisation and of 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 hospitals - 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 retrain 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 not the medical treatment of 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," Mrs Birrer said.

...
Picture the Ministers would not believe

The picture on the right caused a storm in Parliament last 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 a floor of a public ward, handcuffed to the bottom of a bed.

Because of it Mr. J.T. Kruger, Minister of Posts, Dr. Schalk van der Merwe, Minister of Home Affairs, and Mr. 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 hospitals.

What mistakes were made were in reality made by the Ministers Kruger and Botha.

Dr. Kruger’s attack was by far the strongest. He accused the newspaper of the worst offender when it came to

Inscrutabilities. On Monday he told the House that the photograph had been taken in one or other of the country’s psychiatric hospitals.

This was wrong.

On Tuesday Dr van der Merwe issued a statement saying that the picture was “grossly misleading” and a “form of anti-government propaganda”.

And he conveyed the impression that Black mental patients were treated and detained in this manner in South African hospitals.

In fact this was a balanced article that gave the Public Suitors’ account of conditions in South African psychiatric hospitals.

But he failed to mention that the doctors were dealing with the overcrowding problem, he hopes things will be better in the new building.

The March report of the superintendents described as contractual problems the new buildings.

It cost R.5 million and took a year.

Dr. F. D. De Smet, Provincial Director of Works, said the project was first given to the Van Zyl Ministry in November, 1969.

And its progress was too slow.

The site was redocumented and ended over to a new tender in 1973.

It was, of course, like any new hospital with 25 wards, 11 operating theatres and new buildings.

But there are the low-slung, stonework pipes across a corridor that can’t be seen from behind the walls.

“You cannot see a thing, except the ground,” said the architect, and it will be like that for a year.

But there was more than a few things that were not as they should be.

The minister is in the supervisory role and the report was a serious accusation.

On the floor where the window was broken, there is no one.

The floor is covered with dirt and sand.

And this is the new building.

In the meantime the superintendents stand on the floor and threaten to come to hospital daily.

The woman, who was a “floor case,” was in the hospital with her husband and children when she was shot.

She was shot by her husband, who then killed himself and the children.

She was a “floor case” because she was standing in the hospital.

On the floor where the window was broken, there is no one.

The floor is covered with dirt and sand.

And this is the new building.

In the meantime the superintendents stand on the floor and threaten to come to hospital daily.

“Floor cases” are patients who are not in public psychiatric hospitals.

And this is the new building.

In the meantime the superintendents stand on the floor and threaten to come to hospital daily.

“The floor cases” are patients who are not in public psychiatric hospitals.

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“The floor cases” are patients who are not in public psychiatric hospitals.
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 90 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 T. W. P. Spencer, head of the Department of Community Health and Professor A. Mocca, head of the Department of Paediatrics at the University of Natal Medical School, states that about 9,000 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 underprivileged child run in conjunction with State Health — are that:

**TUBERCULOSIS**

- Of 125 well-nourished babies under one year admitted with gastro-enteritis, 121 (about 97 percent) died. The mortality rate and incidence of gastro-enteritis in malnourished babies was considerably higher.
- Of approximately 400 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.
EAST LONDON — Two municipalities in the adjoining territory had been asking for the land staked out for the Day Hospital Extension. It is expected that the planning will be complete within the next 18 months after the completion of the new hospital extension.

David Laverne said the new facility will provide a better service for the local community. The new site will be located adjacent to the existing hospital, allowing for easy access and efficient use of resources.

The new Day Hospital Expansion will be built by local engineers and architects, ensuring that the project meets the highest standards of safety and efficiency. The expansion will include additional beds and waiting areas to accommodate the increasing number of patients requiring day hospital services.

The decision to expand the hospital was made following extensive consultations with the local community and stakeholders. The expansion is expected to provide much-needed relief to the existing hospital, improving patient care and outcomes.

The construction is scheduled to begin shortly, with a targeted completion date of the new facility set for the end of the current year. The project is expected to create local jobs and boost the local economy, further benefiting the community.
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ONLY Translators will agree more in keeping with this

Casualty case for 232/7
From employing more Africans as technicians.

Table 30. Factors hindering 
           employment of Africans in the sample.

Table 29. Number of African technicians in the sample.

Table 28. Urgency of Language and Communication course.

Institutions for mental patients

Table 27. Fact

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:

(1) The first phase of the Mitchell's Plain Hospital, namely buildings for auxiliary services, is in the sketch plan stage and the tender date for this phase is set for 1979-80.

(2) Vrylaan 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.

Table 18. Number of Manpower Surveys.

Table 17. Engineering Technicians by type.

Table 16. Total shortage of Technicians.

Table 15. Total number of Technicians.

Table 14. Total number of Technicians.

Table 13. Number of Information.

Contents (continued)
Hospital boss McMurdo quits ‘over administration problems’

SUNDAY EXPRESS INVESTIGATION
BY JENNIFER HAYMAN

THE chief superintendent of the Johannesburg General Hospital, Dr John McMurdo, has resigned and is to leave his post at the end of May — six years after becoming the youngest dean of the hospital’s history.

His surprise resignation arrives at a time when the move to the new hospital complex on Parktown Ridge is still under way and fewer than 20 of its 72 wards are occupied.

The Sunday Express understands from hospital sources that Dr McMurdo, 46, 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 Groen, also refused to comment on Dr McMurdo’s resignation.

Dr McMurdo has played an important part in the planning of the new trans-plant, which, at a cost of R124 million, has been variously termed a white elephant and a disease palace.

The highly acclaimed child-abuse unit at Johannesburg Children’s Hospital has run into major problems.

A Sunday Express investigation has triggered a shake-up of the medical superintendents.

Claire Irwin, who founded the unit and was South Africa’s first children’s psychologist, is leaving the unit and returning to South Africa after being appointed as director of the hospital as “consultant”.

She told the Sunday Express in a telephone interview that there was “no way” she would return to South Africa with the drastic changes that have occurred.

But Dr John McMurdo, the hospital’s medical superintendent, claims that the chief problem confronting the hospital is that Dr Irwin left without training a successor.

The unit is left without a head.

To which Dr Irwin responded angrily: “I was used, abused and taken advantage of — and I and the rest of my extended — ‘our’ selves keep feeling that until now 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.

• The number of bed spaces has gone down.

• The unit is only half full, with only 12 beds occupied in recent weeks.

• The unit has only 12 patients, compared with 25 a year ago.

• All the staff, including Dr Irwin, have resigned.

• The unit has been closed for six months.

• The unit is “out of control”.

• The unit has been closed for six months.

• The unit has been closed for six months.

A new ward, designed by Dr Irwin, 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.

• Dr Irwin’s position as head of the unit is even more untenable because there are no trained children’s psychiatrists in South Africa, who are currently working in coming to South Africa.

• The unit has been headed, since Dr Irwin’s resignation, by Dr Marianne Botha, who has considered leaving.

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The unit asked for extra staff in 1979, but has received only two psychiatric nurses and one part-time social worker.

The unit’s problems, say staff, are compounded by the fact that the unit falls under the separate administration of the Province, which runs hospital services, with the University, which runs the Department of Psychiatry.

The child psychiatry unit, which includes the battered

baby centre, saw 154 fewer cases last year than in 1977, while the number of children’s cases dropped from 35 in the first half of the year to 15 in the second — after the move to the new hospital.

This week, Dr McMurdo confirmed the “dreaded” news of the child abuse centre, but said figures appeared to have improved after the first month of this year.

She said that the psychiatric unit at the hospital is still seeing fewer patients, claiming that cases handled last year showed a marginally increase.

The Sunday Express ascertained from other sources that this was not the case.

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 was “simply unable” to find staff to work in the unit, and that she had been given “no more orientation” for the unit.

She had not trained any psychiatrists because there was no field of study for children’s psychiatrists in South Africa.

She said that several years ago, when she returned from a two-year overseas trip, she was told by the hospital staff that her return was not welcome.

“Then they told me, in explicit terms, that during my absence they had been able to simply pick the children up and send them home.”

In her experience, and that of other members of the centre, unless psychiatrists are on hand when potential cases are seen at casualty or admitted to the wards, cases of child abuse go unreported.

Dr McMurdo disputed that the drop in referrals was due to the distance of the unit from the new hospital.

He said baby-bathing conferences might be going to other hospitals which had established or expanded psychiatric sections.

In addition to Dr Laddie, there are two psychiatrists

 There are two psychiatrists who have not completed their training, two clinical psychologists and two more in training.

One part-time social worker and one who works part-time.

A couple of psychiatrists, 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.

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The child psychiatry unit, which includes the battered
RACISM TO GO IN YEAR OF CHILD?

THE outpatients section at the Red Cross Children’s Hospital is to be scrapped and a new one without segregation of facilities is being planned, according to Dr W H J Greff, 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 Greff described the complaints as “reasonable” but said new facilities would be integrated in the new complex. Dr Greff said he could not say if the new area would be integrated 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-panelled glass sliding doors.

The space 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 Greff, the hospital’s superintendent, said that although “Red Cross Children’s Hospital” 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 Greff 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 new patches to dry before painting.

The hospital treated 220 000 patients yearly — between 400 to 600 every day — and 90 percent of them were blacks.

Because the white patients were few, queues were shorter. They received attention more quickly. The white had one doctor and the blacks 12.

Blacks had to wait much longer, some even longer than two hours, because of large numbers and the slower service. The waiting room is shabby and not very clean compared to the facilities for whites.
Dental clinics

Hansard 5 (2nd) 5/3/79
170. Mr. N. B. WOOD asked the Minister of Health:

(1)(a) How many dental clinics were established by his Department in cooperation 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 cooperation 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.
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 m² of floor area and less than 12 m³ 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 m² and 30 m³ respectively;
“losstaande operatiesiteearbeid” n operatiesiteear-
beendheid wat nie in besit is van, of bestuur word deur,
die Staat, n provinsiale administrasie, n plaaslike
bestuur, n privaat hospitaal-werheid, n hospitaal-
raad of enige ander openbare liggaam nie, wat nie
verbonde is aan n hospitaal of verpleeg- of kraam-
inrigting nie, en waar n pasiënt wat in sodane op-
rasesiteearbeid gepeereer word, hoogstens 12 uur mag
verteef, bereken vanaf die tydspan waarop hy die een-
heid binnegaan onmiddellik voordat hy gepeereer word;
"voorwerp", in verband met n vertrek of akkom-
modesie, dat daar minder as 4 m² vloeroppervlakte
en 12 m³ lugruimte is vir elke persoon wat in sodo-
nige vertrek of akkommodasie werk of gehuisves word,
of dat daar minder as die helfte van hierdie opper-
vlakte en ruimte vir elke sodane persoon van jonger
as 10 jaar is; Met dié verstande dat die vloeroppervlak
en die lugruimte van n enkeldoek nie kleiner
mag wees as onderskeidelik 10 m² en 50 m³ nie;
"operatiesiteearbeid" n vertrek waarin n geregisterde
medische praktisn of tandarts operasies uitvoer;
"operatiesiteearbeid" n plek waar chirurgiese akti-
witele uitgeoefen word en waarin voorsoen gemaak
is vir die fasiliteitte seë rooi in hierdie regulasies uitte-
gerit;
"private hospitaal" n hospitaal of n ander inrig-
ting, gebou of plek waar voorsoen gemaak word vir
die behandeling en versorging van gevile wat genees-
liknii in of chirurgiese behandeling en verpleging
nodig het, maar met uitwisning van—
(a) n hospitaal of enige sodane inrigting, gebou
of plek wat bedryf word deur die Staat, n provin-
siale administrasie, n plaaslike bestuur, n hospi-
talaarad of enige ander openbare liggaam;
(b) n spreekkamer, operasiekamer of apteek van
n geneesheer of tandarts wat nie bedakkommodasie
verdelof nie;
(c) n losstaande operatiesiteearbeid;
(d) n derlede geweens hospitaal of ander inrig-
ting wat die openbring en aanhouding van geesteson-
gestelde persone ingevolge artikel 46 van die Wet op
Geestegesondheid, 1973 (Wet 18 van 1973);
"sentrale sterielevoorraaddepartement" n vertrek of
vertrekke waarin instrumente, verbande, komme, hou-
ers, water en ander items wat vir die behandeling
van pasiënt steric moet wees, gesteriliseer word, en vir
die doel doel ontvang, skoonmaak, verpak, gester-
iliseer en geberg word;
"spreekkamer" n vertrek waar hospitat, unibiakke,
spreekkamers en soortgelyke houers geberg, geledig, uit-
gespoel en ontsmet word en waar vult bedinne, ver-
bande en dergelijke artikels geplaas kan word voor
wゆydering;
"verpleegkamer" in verband met n vertrek, dat sodane vert-
rek veelvuldig word deur n kommissaal beligtingstel of
of die totale onverspreide verpleegoppervlakte gelok-
staande is met minstens 15 persent van die vloeroppervlak
van sodane vertrek;
"voorgeskrewe procedures" die chirurgiese operasies
en mediese procedures wat in Aanhange 1 Aangegee
word.

Enige ander uitdrukking wat in aandrie regulasies
gebruik word, het, tenys uit die samehang duidelik
anders blyk, dieselfde betekenis as die 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 admini-
stration, 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);
"proprietary" 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
recouped sufficiently to be safely removed from the
forementioned section;
"sluice room" means a room where bed pans,
urinals, spouting 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", "treatment" 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 ven-
tilation 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 effec-
tive 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,
REGISTRASIE

2. Behoudens die bepalingen van regulasie 8, mag niemand 'n private hospitaal of 'n losstaande operasie-
tenterenheid oprig, instel, uitbrey, bedryf, onderhou, bestuur of beheer of 'n diens daarin lever of die verskaffing van behandelinge daarin toelaat of reël nie, teny sodanige private hospitaal of losstaande operasiete-
tenterenheid of beoogde private hospitaal of losstaande operasieteenterenheid geregistreer is voreenkomstig die bepalingen van hierdie regulasies en in besit is van 'n geldige registerrasiesertifikaat wat die Sekretaris ten opsigte daarvan aan die eenaar uitgereik het.

3. Elke sodanige registerrasiesertifikaat wat ingegolwe regulasie 14 (1) of 14 (3) uitgereik word, is van krag vanaf die datum van uitreiking tot en met die eersvol-
gende 31ste dag van Desember, wanneer dit vervalt, of vir sodanige gedeelde van bedoelde tydperk als wat in die registerrasiesertifikaat vermeld word, 'n Aanmoedig om herneming van sodanige registerrasiesertifikaat moet minstens 90 dae voor die vervaldatum en ooreenkomstig regulasie 11 gedaan word.

4. 'n Private hospitaal of losstaande operasieteenterenheid word nie as sodanig geregistreer nie en geen registerrasiesertifikaat word ten opsigte daarvan uitgereik nie, teny--

(1) die personeel waarin die private hospitaal of los-
staande operasieteenterenheid bedryf of word vanoorsese, en die toerusting wat in sodanige private hospitaal of losstaande operasieteenterenheid gebruik word of vir gebruik aaldaar bestem is, geskik en toere-
kelik is vir die doeleindes van geneesbaar private hospitaal of losstaande operasieteenterenheid;

(2) die private hospitaal of losstaande operasiete-
tenterenheid nie bestuur of bestuur sal word op 'n wyse wat vir die liggaamlike, geestelike of seldo-
like weet van die pasiente van personeel daaraan nadelig of van sal wees nie;

(3) die personeel van die private hospitaal of los-
staande operasieteenterenheid voldoen of sal voldoen aan aanvaarbare norme vir die doeleindes van sodanige hospitaal of eenheid;

(4) die persoon in beheer van sodanige private hos-
piraal of losstaande operasieteenterenheid en 'n geneesheer of, in die geval van 'n uitsluitlike tand-
heilkundige diens, as 'n tandarts geregistreer is of saal wees ingegolwe die bepaling van die Wet op Geneeskunde, Tandarts- en Anwyllysche Gesondheids-
beroep, 1974 (Wet 56 van 1974), of, in die geval van 'n algemene mediese verpleegzorgdiens of 'n verlies-
doende diens, as onderskeidelik 'n algemene ver-
pregster of 'n vlooedvrou geregistreer is of sal wees ingegolwe die bepaling van die Wet op Verpleging, 1957 (Wet 69 van 1957);

(5) die personeel in beheer 'n geregistreerde genees-
heer of tandarts is soos in subregulase (4) beksiry, daaraan geen verpleegster wat ingegolwe die Wet op Verpleging, 1957 (Wet 69 van 1957), geregistreer is, in beveel van die verpleegingsdiens is of sal wees; en

(6) sodanige regisfratie in die openbare belang is.

5. (1) In sy aanmoedig moet die eenaar 'n beskrywing gee van die personeel, besonderhede verstrekt aangedui die rigging daarvan, die aard van die behandeling wat daar verskaf word, die bevolkingsgroep van die personeel wat aan die private hospitaal of losstaande operasieteenterenheid verbonde sal wees en die bevol-
kingsgroep wat van die private hospitaal of losstaande eenheid gebruik sal maak; en enige ver-
strekt wat die Sekretaris nodig ag om hom in staat te stel om die aanmoedig te oorweeg.

REGISTRATION

2. Subject to the provisions of regulation 8, no per-
son shall establish, extend, conduct, maintain, manage,
control or render any service in a private hospital or an unattached operating-theatre unit or allow the 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 suc-
ceeding 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 con-
ducted 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 hos-
pital 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 sub-
regulation (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 partic-
ulars 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) De eienaars moet elke verandering in die besonderhede wat hy ingevolge subreguliasie (1) verstreken het, of wat aangedui word op die huidige oortrefskaf van registrasie sonder oorkomstreguliasie 12 van hierdie regulasies uitgereik, onmiddellik skriflik aan die Sekretaris mellee.

6. Die eienaars 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 voorgenoemde sluiting daarvan: Met dien verstande dat in buitengewone omstandighede die Direkteur ’n korter tydperk van kennisgingewing kan magtig.

OPRIGTING EN REGISTRASIE VAN PRIVATE HOSPITALE EN LOSSTAANDE OPERASieteateereenehede

7. (1) Niemand mag somsonder die vooraf verkry skriflike toestemming van die Sekretaris ’n gebou oprig, verander, of toerus of op enige ander wyse gereedmaak vir gebruik as ’n private hospitaal of losstaande operasieteateereeneheid nie.

(2) (i) Iemand wat voornemens is om ’n private hospitaal of losstaande operasieteateereeneheid op te rig, moet die vooraf skriflike toestemming verky het van die Sekretaris, wat in oorelg met die Direkteur, hom van die nodigheid van onnodigheid van so ’n private hospitaal of losstaande operasieteateereeneheid moet oortuig als deur hem toestemming verleun of te weier.

(ii) Nadat die aanvorder sodanige toestemming verky het, moet by Aanhanger B voltooie en plane tesaam met die nodige inligting voor die goedkeuring deur die Sekretaris en sodanige bykomende inligting verstreken die wat die Sekretaris verlang.

(3) Toestemming en goedkeuring ingevolge regulasie 7 is nie onderrigbaar nie.

8. In die geval van ’n private hospitaal of losstaande operasieteateereeneheid waarvan die gebou nog opgerig of omgebou staan of te word, moet die aanvorder om registrasie te vergoel gaan van plane van die gebou of beoogde gebou of sodanige plane moet die aard en konstruksie van die gebou of beoogde gebou of die aard van die ombouings, na gelang van die geval, duidelik aantoen.

Die benaming van die kamers, afmetings en vierkante afmetings moet die plane aangegeag word in die vorm van ’n skedule.

9. Indien die pasiënte gehuisves word in ’n meerverdiepinggebou, moet daar voorziensing gemaak word vir ’n genoegsame aantal hyser of opritte. Met dien verstande dat behoorlike voorziensing gemaak moet word vir hyser wat geskik is om ’n pasiëntehof -trolley te neem en dat voorziensing gemaak moet word vir die afsondelike verwydering van vuil linne, afval en vullis.

10. Alle planne op ’n skaal van 1:100 geteken word en in tweevoed ingedien word.

11. Die aanvorder moet aan die Sekretaris skriflik bewys lewer dat nóg enige ander staatsdepartement nóg die betrokke plaaslike bestuur beswaar daar teen het dat die private hospitaal of losstaande operasieteateereeneheid op die betrokke perseel bedryf word. In die geval van ’n gebou wat nog opgerig of omgebou staan of te word, moet die aanvorder skriflik bewys lewer dat die plan deur die betrokke plaaslike overheid goedgekeur is.

(2) Die 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 eienaars aansoek doen om hernuwing van die registrasie.

13. Elke aansoek om hernuwing van registrasie word aan die Sekretaris gerig in wese van die vorm van Vorm I in Annexure B vir private hospitale of losstaande operatiedereenheede.

AFHANDELING VAN AANSOEKE

14. By ontvang van 'n aansoek besnuit die Sekretaris in ooreen met die Direkteur—

(1) om die beoogde private hospitale of losstaande operatiedereenheid as 'n private hospitale of losstaande operatiedereenheid te registrer 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 hospitale of losstaande operatiedereenheid te hernu 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, inspioneer of deur 'n inspionerende beampte laat inspioneer en die aansoeker moet, ten opsigte van sodanige inspiskie, aan die Ontvanger van Inkomste inspiskiesgeld van R30 betaal, wat vervolgelda insluit.

HERAANSOEK OM REGISTRASIE

16. 'n Eienaars wat om die registrasie van 'n private hospitale of losstaande operatiedereenheid aansoek gedaan het en wie se aansoek geweier is, of 'n eienaars wie se aansoek om hernuwing van registrasie geweier is of wie se registrasiesertifikaat ingevolge regulasie 18 ingetrok is, of 'n eienaars wat versien het om betyds om die hernuwing van registrasie aansoek te doen en wie se registrasiesertifikaat verval het, of 'n eienaars van voornemende eienaars wat ingevolge regulasie 56 apiek aangeteken het teen die wetting deur die Sekretaris van registrasie of hernuwing van registrasie of teen die intrekking deur die Sekretaris van 'n registrasiesertifikaat en wie se apiek nie geslaag het nie, kan te eniger tyd, weer aansoek doen om die registrasie of hernuwing van registrasie van dieselfde private hospitale of losstaande operatiedereenheid: Met dien verstande dat indien registrasie of hernuwing van registrasie geweier is of die registrasiesertifikaat ingetrok is omrede versiën 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 daaraan al sodanige voorwaardes of vereistes voldoen is nie.

VRYSTELLING VAN VEREISTES TEN OPSIGTE VAN REGISTRASIE

17. Die Sekretaris kan te eniger tyd, op die voorwaarde en vir die tydperk wat hy in ooreen met die Direkteur bepaal, aan 'n eienaars 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 unattached 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 (2), 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-
SERTIFICAAT

18. ’n Registrasiesertifikaat kan te eniger tyd ingetrek word—

(1) deur die Sekretaris indien die dienaar—
(2) versuim om aan enige voorwaardes of vereiste te voldoen wat ingevolge regulasie 14 (1) of 14 (3) gestel is; of

(ii) versuim om die opgawes, besonderhede of infilginge te verstreken wat hy ingevolge regulasie 28 moet verstreken; of
(iii) skuldig bevind word aan ’n misdryf ingevolge die bopelings van hierdie regulasies;

(2) deur die Sekretaris of die Minister indien hy in die openbare belang ag dat die private hospitaal of losstaande operasieteatereenheid ten opsigte waarvan sodanige registrasiesertifikaat uitgereik is, gesuiw word.

19. Indien die Sekretaris of die Minister, na gelang van die geval, kragtens regulasie 18 ’n registrasiesertifikaat intrek, gee hy aan die dienaar skriftelik kennis dat hy die registrasiesertifikaat aldus intrek, en dat die private hospitaal of losstaande operasieteatereenheid ten opsigte waarvan dit uitgereik is, gesuiw moet word voor of op ’n datum in sodanige kenniswing 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 kenniswing bedoel in regulasie 19.

BOUVEREISTES VIR LOSSTAANDE
OPERASIE-TEATEREENHEDE

21. Die vertrekke van ’n losstaande operasieteatereenheid moet aan die volgende vereiste 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, kliip, beton of ander onder-

latinge materiaal en, teny anders goedgekeur, moet die buitemure minstens 225 mm dik wees en die binne-
mure 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 pasiënttrolleys 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 geveiliger en netgewe wees en ruim genoeg om te verseker dat hulle nie oorbe- 

woon 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, stofdichte plafon.

(7) Die vloer van al vertrekke en gang moet van materiaal wees en bedek wees met ’n wasbare, onder- 

latende materiaal: Behalwe dat waar vlambare mate-

riaal gebruik, gehou of gebêre word, die vloer van die operasieteater en van die vertrekke waar sodanige vlambare materiaal gebruik, gehou of gebêre word, asook al die vloer 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—
(2) (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 shall 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 UN-
ATTACHED 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 imperious 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
are used, kept or stored, shall be covered with antistatic material of a washable impervious type and that a conspicuous 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-escapes and emergency exits shall be provided and satisfactorily maintained.

(10) If the operating-theatre unit is in a multi-storied building and not on the ground floor, the building shall be equipped with fire-escape 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 forflammable 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 vertrekte wat in regulasie 22 bedoel word, moet aan die volgende vereistes voldoen:

(1) Die wagkamer moet 'n vloerpervlakte hê van minstens 12 m², met 'n minimum muurlengte van 3 m. Met dien verstande dat indien die ruimte daarin die wagkamer voorsiening ook vir die kantoorsuitem 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 kantoorsuitem moet—

(i) minstens 6 m² vloerpervlakte beslaan indien 'n gedeelte van die wagkamer vir hierdie doel ingebruik is; of

(ii) verskaf word in die vorm van 'n afsonderlike vertrek met vloerpervlakte van minstens 10 m² en met 'n minimum muurlengte van 2,4 m.

(3) Die spreekkamer moet, indien dit verskaf word, buite die operasieeteter-area wees en moet 'n vloerpervlakte hê van minstens 15 m², met 'n minimum muurlengte van 3 m, en moet toegewees wees met minstens 'n handewasbak met warm en koue water aangewend. Die operasieeteter moet 'n vloerpervlakte hê van minstens 20 m², met 'n minimum muurlengte van 3,6 m. Die muur moet minstens 2,6 m hoog wees, gemee of deur die vloer tot by die plafon; en moet 'n aaneengeslaan gedeelte oppervlak hê wat bedek met harde glans-epoksiehars of 'n soorgelyke vernis of met 'n ander geskikte wasbare, onderurinatinge materiaal; die plafon moet met 'n ligklerige emaljeverf geverf wees. Die muur, die vloer en die plafon moet toegewees wees aan herhaalde reiniging en ontsmetting.

(5) Warm en koue water moet aanwezig wees in elke kantoorsuitem om in die spreekkamer of spreekkamer te gebruik.

(6) Die operasieeteter moet doeltreffend geïsoleer en verlig wees: Met dien verstande dat vensters, as daar is, stofig moet wees. Die minimum vereiste vir lugreëling is dat 'n kantoorsuitem luggeïsoleer met 'n 10-mikron-stoffilter geïnstalleer moet wees.

(7) Die operasieeteter moet van elektriese krag voor- zien wees, met minstens drie vonkveer muurproppe. 'n Geskikte elektriese operasieeteterlamp wat van die plafon of aan 'n vyraadende balk aan die muur hang, fasiliteit vir reservering in geval van 'n kragonderbreking, operasieeteterlamp dat die pasiënt minstens in die Trendelenburg-positie kan plaas en, waar toepassig, ook in ander posities, na gelang van die operasies wat uitgevoer word.

(8) Die operasieeteter moet toegewees wees met 'n geskikte oogapparaat (vir gebruik deur die chirurg en die markwachtse afsonderlik) en minstens twee spoelpuntes en wat in staat is en slyn en bloed tegelyker- te vrywyder. Dit moet ook voorsiening gemaak word vir noodfasiliteit van hierdie aard wat gebruik kan word ingeval die apparaat wat gewoonlik gebruik word, buite werking raak.

(9) Die operasieeteter moet voorziens wees van geskikte spoelingsmiddels om suurstof en gasse van 'n gasbank te lei, tensy sodanige gasse in silinders verskaf word. 'n Boyle-apparaat of 'n ander geskikte type narkoseapparaat met volledige aansluitings vir die pasiënt is essentieel om verskaf word.

(10) Die sterilisierkamer moet 'n vloerpervlakte van minstens 9 m² hê, met 'n minimum muurlengte van 3,0 m. Behalwe dat waar 'n toegelaagde operasieeteterreenheid voor die afskoning van hierdie regulasies op dieselfde perseel bestaan en 'n sterilisierkamer

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 length 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 epoxide 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 cleaning 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 enough power to at least three flashlamp wall suspended from the ceiling or on 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
what '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 steriliserapparaat, 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 stoomotoklaaf gebruik word, die apparaat genomteer moet word in 'n toerikend geventileerde masjienkamer buite die steriliseerkamer en die autoklaaf in die steriliseerkamer moet insy. Met dien verstande, verder, dat indien gebruik gemaak word van 'n proses wat stoom, waterdamp of ander gasse voorbrii, 'n geskikte apparaat vir die verwydering daarvan verskaf moet word.

(12) In plaas van 'n ingeboude steriliserapparaat kan, tellings getref word dat die sentrale steriliteitsvoorraaddepartment voldoende steriele verbande, doekes, komme, bakke, instrumente, spuit en steriele water verskaf vir al die operasies.

(13) (1) Die herkleedkamer of -ruimte moet binne die afgebakende area wees, met 'n vloeroppervlakte van minstens 12 m² en 'n minimum muurlengte van 3 m. Dit moet toegryp wees met minstens een handewasbak met warm en koue water na elnboogkrane, of die handewasvak aangelaag; minstens een vonkrooie muurprop in die buite- en inwend-geale na elke elke egte persone, en sodanige spoelatmies moet afgeskei wees van die reg van sodanige kleedkamer. Sodanige kleedkamer moet oor voldoende fasilitiete beskik waar klere en skoon en vuil teaterdrag afsonderlik gehou kan word. Sodanige kleedkamer moet een deur het wat die rooikamper oopmaak en moet 'n aparte ingang van buite die rooidoornas ha.

(15) Die saal moet 'n vloeroppervlakte het van minstens 8 m² vir elke bed. Dit moet toegryp wees met minstens een vonkrooie muurprop en met 'n handewasbak, met warm en koue water aangelaag na elnboogkrane.

(16) Die spoelkamer moet 'n vloeroppervlakte het van minstens 5 m², met 'n minimum muurlengte van 2,1 m. Daar moet genoeg saam koue water aangelaag wees na 'n spoelspoel. Die spoelkamer moet toegryp wees met geskikte rake van onderluilende materiaal vir skoon en onsmerte bedpanne en urineskorsers, asook met houers van onderluilende materiaal met digshulende deksels vir vuil limmehoog.

room met een 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 steriliserapparaat, 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 stoomotoklaaf gebruik word, die apparaat genomteer moet word in 'n toerikend geventileerde masjienkamer buite, maar direk langs, die steriliseerkamer en die autoklaaf in die steriliseerkamer moet insy. Met dien verstande, verder, dat indien gebruik gemaak word van 'n proses wat stoom, waterdamp of ander gasse voorbrii, 'n geskikte apparaat vir die verwydering daarvan verskaf moet word.

(12) In plaas van 'n ingeboude steriliserapparaat kan, tellings getref word dat die sentrale steriliteitsvoorraaddepartment voldoende steriele verbande, doekes, komme, bakke, instrumente, spuit en steriele water verskaf vir al die operasies.

(13) (1) Die herkleedkamer of -ruimte moet binne die afgebakende area wees, met 'n vloeroppervlakte van minstens 12 m² en 'n minimum muurlengte van 3 m. Dit moet toegryp wees met minstens een handewasbak met warm en koue water na elnboogkrane of die handewasvak aangelaag; minstens een vonkrooie muurprop in die buite- en inwend-geale na elke egte persone, en sodanige spoelatmies moet afgeskei wees van die reg van sodanige kleedkamer. Sodanige kleedkamer moet oor voldoende fasilitiete beskik waar klere en skoon en vuil teaterdrag afsonderlik gehou kan word. Sodanige kleedkamer moet een deur het wat die rooikamper oopmaak en moet 'n aparte ingang van buite die rooidoornas ha.

(15) Die saal moet 'n vloeroppervlakte het van minstens 8 m² vir elke bed. Dit moet toegryp wees met minstens een vonkrooie muurprop en met 'n handewasbak, met warm en koue water aangelaag na elnboogkrane.

(16) Die spoelkamer moet 'n vloeroppervlakte het van minstens 5 m², met 'n minimum muurlengte van 2,1 m. Daar moet genoeg saam koue water aangelaag wees na 'n spoelspoel. Die spoelkamer moet toegryp wees met geskikte rake van onderluilende materiaal vir skoon en onsmerte bedpanne en urineskorsers, asook met houers van onderluilende materiaal met digshulende deksels vir vuil limmehoog.

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 'n besonders der markierte 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 flask-proof 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 necessary.

(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 flask-proof 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 flask-proof 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 vlaambare materiaal moet 'n vloer hé wat met 'n wasbare, ondeurtaling materiaal bedek is; en
(ii) voorsiening moet gemaak word vir 'n geskikte linnekker of linnekas vir skoon linnegoed; en
(iii) facilitie vir steriele opberging moet verskaf word.

(18) Die dienskamer moet 'n vloeroppervlakte hee van minstens 10 m², met 'n minimum muurlengte van 2,4 m. Dit moet langs die herstellkamer of -ruimte wees en tussen bayerneuer en die saal (as daar 'n saal is), met 'n venster in die muur tussen die dienskamer en die saal. Dit moet toegryp wees met warm en koue water aangele na elmoorgewasse van 'n handewasbak, asook met 'n tafel met 'n blad van ondeurtaling materiaal, 'n koelkas en, ten spyte van 'n gebou verskaf word, ook 'n spoeltoilet en een genoegsame rakte en kasse sodat klere, skoon en vuil oorklere afsonderlik gebreke kan word. Met dit verstaan dat in plas van 'n dienskamer daar binne die herstellkamer of -ruimte van die saal 'n dienstasie vir die verpleegster verskaf kan word, wanneer dienstasie toegryp moet wees met sodanige facilitie as wat vir hierdie doel nodig is.

MEUBELENS EN TOERUSTING

24. In akkommodasie waar 'n losstaande operasie-teater eenheid bedryf word, moet daar meubels en toe- rusting verskaf word, met inbegrip van facilitie vir die toeziening van binnehuurse vog en bloed, bloeddruk- meters, 'n stetoskop, spuit en maalde, 'n sluitkast vir gewoonstevormende medisynse, vergilfe, ens., en 'n instrumentekas vir die operasieenteer. Verder moet die operasie-teater eenheid apparaat en instrumente bevat, met inbegrip van minstens twee laringoskope, McGill-tipe komme vir volwassenes en kinders, geskikte endotracheale buise met die nodige verbindings, tongklemme, lugwee, 'n tragerostoniel, 'n hartmasseringstel en dekfladen, asook middels om die patiënt te ventileer, ingeval die patiënt toegekeer omklaar raak, en ander toe- rusting en middels wat by 'n noodtoestand nodig mag wees.

PLIGTE VAN EIENAAR

25. Die eienaars van 'n losstaande operasie-teater eenheid moet sorg dat—

(1) die akkommodasie waarin hy sy losstaande operasie-teater eenheid bedryf, altyd in 'n skoon en netjies toestand is;
(2) alle toe- rusting 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 bêrekplek of kas gehou word;
(3) die sterilisasieapparaat of -toerusting vir geen ander doel as sterilisering gebruik word nie, dat sodanige ander gebruik daarvan ook nie toegelaat word nie, en dat sodanige apparatuur of toerusting gereeld gereinig word en gebruik gemaak word voordat elke keer word en nou van die relférence wat by hierdie doel moet behou;
(4) die operasieenteer vir geen ander doel as dié van 'n operasieenteer 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 patolojie onderzoek 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 wash-hand 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 endotracheal 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) 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 antisatatic, 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) 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) sewage 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 inpatients or casualty patients treated, substantially in the form of Annexure G;
(e) a register as required by the Secretary, of patients with infectious 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 to the Secretary a return showing the number of patients exceeding daily limits the number authorised by the certificate of registration and the reasons for such excess in each case.
29. Elke einaar moet sonder veroorbring aan die Sekretaris sodanige opgawes en inligting verstrekk as wat die Sekretaris van tyd tot tyd vereis met betrekking tot die beheer oor en bestuur van die betrokke private hospitaal, die geriewe, voorraad of personeel waaroor dit beskik, die dienste wat daarin gelever word en die pasiënte wat daarin behandel of verpleeg word.

PRIVATE HOSPITALE

30. Akkommodasie en faciliteite.

'n Private hospitaal moet bedryf word op 'n perseel waar daar genoegsame en bevredigende voorstiening vir die volgende gemaak is:

(a) Een of meer verpleegteenhede, met inbegrif van—
   (i) beddiens in sale of kamers vir die behandeling van pasiënte;
   (ii) 'n dienstkamer of verpleegterskantoor wat so gelei is dat die fisiese toegang tot enige sorgbehoewende pasiënt verhinder of vertraag word nie;
   (iii) bad- en toiletfasiliete vir pasiënte;
   (iv) 'n behandels- of verhandelkamer;
   (v) afsonderlike opbergplek vir linne, farmaseutiiese benodigdhede, saatoerusting, asook bestitings van die pasiënte en sodanige diverse items as wat nodig is vir die beheer van die verpleegteenhede;
   (vi) 'n spoelruimte;
   (vii) fasiliete 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 opberg van rekords is, wat afsonderlik is van die dienstkamer van 'n verpleegteenhede en wat aan die personeel toegang bied sonder dat hulle deur die pasiënteruimtes beweeg;

(c) 'n koelkombuis;

(d) opskamme vir massa-opberg;

(e) ruskamer- en toiletfasiliete vir die personeel;

(f) wagkamer- en toiletfasiliete vir die beoekser;

(g) steriele voorraad;

(h) 'n apeek of farmaseutiiese diens, of die onmiddellike beskikbaarstelling van alle benodigde farmaseutiiese produkte;

(i) 'n wasery of die verskaffing van skoon linne;

(j) 'n lyshuis of die onmiddellike verwering van 'n lys; en

(k) 'n verbrandingsvond of ander geskikte stelsel vir die doodstreekende of onskadelike weghou van besoedelde verbruiksmateriaal en van chirurgies verwyderde weefsels.


Een of almal van ondergenoemde faciliteite kan, na gelang van die behoeftes van die pasiënte wat by sodanige hospitaal toegelaat of opgenem word, ooreen-komstig hierdie regulasies verskaf word en moet aktus verskaf word indien dit as onontbeerlik beskou word of deur die Sekretaris vereis word:

(a) 'n Operasieeteenheid;

(b) 'n afsonderlike verloskundige eenheid;

(c) ontvangs- en behandelsfasiliete vir buie-
pasiënte en/of ongevalle;

(d) sentrale steriliseerfasiliete;

(e) akkommodasie en faciliteite vir werknemers.

(f) fasiliete vir—

(i) radiologie en verwante diagnostiese doeleinde;

(ii) fisioterapie;

(iii) arbeidsterapie;

(iv) elektroneuvulsiewe 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 dressing rooms;

(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 laundary 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 speciale onderzoek of behandeling;
(vii) die opleiding van verpleegsters, medische praktisiens en lede van aanvullende medische gesondheidsdienste;
(viii) die medische onderzoek van werknemers;
(ix) die opleiding van werknemers in noodhulp;
(g) enige ander faciliteit.

32. Algemene bouvereistes.

Behalve 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, gemee 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 speelkamers, asook alwaar 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 geskiet moet, moet die gang minstens 2,5 meter wyd wees.

(4) Al die vertrekke moet voldoen en geventileer word.

(5) Stofdigte plafon van 'n gladde, ondeurlatende materiaal en geverf met 'n wit of ligkierige wasbare verf moet aangebring word in alle pasienteakkommodasie- en pasientebehandelingsruimtes.

(6) Die vloere van al die kamers en gange moet van beton of soortegelyk ondeurlatende materiaal word, met 'n gladde afwerking, en, tensy hierdie regulasies anders bepaal, bedek word met 'n wasbare, ondeurlatende materiaal.

(7) Al die binnenuuroppervlakke moet bedek word met 'n gladde, harde pleisterafwerking met ronde hooke en moet geverf word met 'n ligkierige, duursame, wasbare verf, of, so nie, bevredigend bedek word met 'n soortegelyk wasbare, ondeurlatende materiaal. Met dien verstande dat waar die mure geverf is, dat mure agter die handewasbakke spesiaal met plasuurtereedsels 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 verwerk aaneenloop.

(8) Doelrettend geplaatse en toereikende brandkranse, brandals, brandblusser, brandtrappe en nooduitgange moet verskaf word en bevredigend onderhou word.

(9) Handewasbakke moet in die onmiddellike nabligheid van elke toilet, urinaal en spoefasiliet verskaf word.

33. Pasiente-akkommodasie.

(1) In hierdie regulasie word elke vaste toebhooresel vir die doeleindes van die bepaling van die minimum afmetings, geag as 'n muur of gedeelte van 'n muur of 'n kamer waarin 'n pasiënt geakkommodeer word.

(2) Geen pasiënt mag gehuisvest word in 'n vertrek met 'n vloerruimte van minder as 10 m² 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) psychotherapie;
(vi) enige speciale onderzoek of behandeling;
(vii) training van nurses, medical practitioners en 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 at least 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 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 m² 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 voeten na en die teenoorgestelde muur.

(5) 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 beddiens nie; en
(c) 1,2 m tussen die voeten van elke bed en die teenoorgestelde muur of 'n minimum van 1,5 m tussen die voeten 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 baba-

(b) 0,6 m tussen elke sykant van elke bababedjie en die naaste muur is;
(c) 0,9 m tussen die voeten van elke bababedjie en die teenoorgestelde muur is.

(5) Geen pasiëntekamer mag gebruik word vir die akkommodasie van sowel manlike as vroulike pasiënte nie, tenzij al die pasiënte kinders is van 'n leeftyd van hoogstens tien jaar: Met dien verstande dat 'n pasiëntekamer gebruik kan word vir die gelykydige akkommodasie van 'n man en sy vrou.

(6) Uitgesonder is 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 unprakties is met die oog op behandeling, daar voldoende tussen-

34. Pasiëntekamers.

(1) Elke pasiëntekamer in 'n private hospital moet direk verbind wees met 'n gang of deurgang.

(2) Deur die toegang verleen tot kamers waarin pasiënte gehuisves is of is sal word, moet ten minste 1,2 m wyd wees.

(3) Elke pasiëntekamer moet toegerus wees met 'n handewasbak toegerus met elmboogkrane waarmee warm en koue water aangele 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 fasilitete.

(1) (a) Waar twee of meer pasiëntekamers toilet-

(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 verpleegkundige;
(ii) ten minste een toilet per 8 pasiënte of gedeelte van sodanige getal, maar in manlike-kan elke derde toilet vervang word deur een urinal; en
(iii) ten minste een handewasbak per 8 pasiënte of gedeelte van sodanige getal.

(b) Vir babas moet toereikende speciale badfasilitete vereis 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 conjunction with nurseries,
(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 kleedkamerfasilitéite, met direkte toegang tot die afgemerkte area, vir mediese praktisies, verpleegsters en huishoudlike personeel: Met dien verstande dat daar vir pasiënte wat nie gebruik maak van saalakkommodasie nie, bykomende verkleefasilitéite verskaf moet word;
(vii) 'n oorlopaarea, vir die oorplaasing van pasiënte van saalrollies of na teaterrollies toe, by die pasiënte-ingang van die afgemerkte area;
(viii) 'n verpleegstersdienskamer of -stasie wat so geleë, gebou en toegang is dat dit vir die verpleegpersoneel moontlik is om die pasiënte registreer en deelteken nie te neem en om, waar nodig, bystand aan die pasiënte te verleen;
(ix) indien ligte ververrings voorsien gooi word, moet voldoende fasilitéite verskaf word vir die opperhoring, voorbereiding en bediening van sodanige ververrings;
(x) skoonmakerfasilitéite; en
(xi) asonderlike opbergkamers, of voldoende gesikte bergingskastie in-die plek daarvan, vir die opperhoring 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, gelijk soos oop gedeeltes en met alle lasplekke opgevul ten einde 'n aaneenlopende ondeurlatende bedekking te verskaf en so afgewerk dat die muurbedekking en vloerbedekking saamvloei is in 'n aaneenlopende gladde oppervlak sonder openinge.

(2) In 'n operasieteater, tenys daar 'n antistatiese vloerbedekking gely 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 plottare 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 pyleidingtoevor van suurstof en distikstofskies;
(b) 'n toereikende beligtingstelsel;
(c) 'n lugregelingstelsel toegewys met filters wat deeltred he is vir deeldeeltjes met 'n grootte van vryf mikron en wat 'n genoegsame vermoë het om 'n temperatuur van tussen 20 °C en 22 °C asook 'n relatiewe voeggehalte van tussen 45 en 55 persent, te hanter; afgetrek in die marge van sodanige teater nie antistaties is nie en dat plottare narkosemiddels, gasse of skoonmaakmiddels nie binne sodanige teater gebruik mag word nie.

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. 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 gowns 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 than 12 m² and a wall length of not less than 3 m, and shall provide sufficient space for at 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 prejudice 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. Dienstkamer binne operasieenteerneenhede.

(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 dienstasie verskaf kon word.

(2) Die teaterdienskamer of -stasie moet toegereken wees met sodanige fastilette as wat nodig is vir die doel waaraan sodanige dienskamer of -stasie gebruik word.

45. Spoelkamer van operasieenteerneehede.

'n Teaterspoelkamer moet 'n vloeroppervlakte hê van minstens 5 m² en 'n muurlengte van minstens 2,1 m² en moet met die volgende toegereken wees:

(a) 'n Spoelpan;
(b) teoreike rakke vir die opberging van skoon houers;
(c) 'n vlektyaal-opwasbak met warm en koue water; en
(d) 'n handewasbak met warm en koue water.

46. Klederkamers van operasieenteerneehede.

'n Teaterklederkamer moet 'n toereikende groottie hê, moet 'n vloeroppervlakte van minstens 9 m² en 'n muurlengte van minstens 2,1 m² hê en moet met die volgende toegereken wees:

(a) 'n Handewasbak met warm en koue water;
(b) geskik afgeskorte toilette op die basis van 'n toilet vir elkeagtiede van die teaterpersoneel of gedeelte van sodanige getal;
(c) toereikende fasilitate vir die afsonderlike bewaring van persoonlike kleren 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 verpleeghede ooreenkomsst hierdie regulasies; en
(b) teoreike verplegingfasilitate; en
(c) 'n melkombuis, indien meer as 15 beddens vir moeders verskaf word;
(d) 'n pasiënteverhoedingskamer, indien meer as 15 beddens vir moeders verskaf word; en
(e) 'n kraamkamer bestaande uit—

(i) 'n bevallingkamer of -kamers op die basis van 'n bevallingkamer vir elke 10 beddens vir moeders of en 'n bevallingkamer plus 'n kamer vir pasiënte in die eerste stadium van bevalling vir elke 15 beddens vir moeders; en
(ii) bykomende dienste met inbegrip van—

(aa) 'n spoelkamer met voorsiening vir die bewaring, onderzoek en weggewen van placenta; en
(bb) afsonderlike opbergingfasilitate vir steriele pakke en instrumente, linne, medisyne en diverse toerusting.

(f) waar meer as 15 beddens vir moeders verskaf word en geen operasieenteerfasilitate geredelik beskikbaar is nie, moet daar voorsiening gemaak word vir 'n operasieenteerneheid wat geskikte teaterfasilitate bied.

48. Bevallingkamer.

(1) 'n Bevallingkamer 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. Scrub rooms for operating-theatre units.

A theatre scrub 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 scrub 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.

MATUREITY 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 scrub 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 Bevallingksamer moet ook oor die volgende bestik:

(a) Toereikende skrofsatellite;
(b) 'n toereikende, verstelbare lamp, vaststaande of draagbaar;
(c) 'n antistatiese vloer indien plafond verwondingsgasse gebruik word;
(d) voldoende voorstiening vir suurstof; en
(e) toereikende fasiliteite vir die reusstier van babas.

ALGEMEEN

49. Gee gebou van 'n private hospitaal of losstaande operasieatereenheid 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 van sodanige goedkeuring verlang, moet skriftelik daarom aansoek doen en elke sodanige aansoek moet—

1) vergoele gaan van gedetailleerde planne en specifike; en
2) die redes vir die beoogde uitbreiding, sloping of verandering volledig uiteensit.

VERANDERINGS

50. Die houer van 'n registrasiesertifikaat moet toosien dat daar tydens die geldigheidsduur van die registrasiesertifikaat wat aan hom uitgereik is, geen strukturele of ander verandering wat met die goedgekeurde planne strydig is, sonder die vooraf verkry skriftelike goedkeuring van die Sekretaris, verleen in oorlog met die Direkteur, aangebring word nie.

VERTONING VAN REGULASIES BY PRIVATE HOSPITAAL EN LOSSTAANDE OPERATIEATEREENHEDEN

51. Die houer van 'n registrasiesertifikaat moet die registrasiesertifikaat in regulasie 14 (1) en (14) (3) vermeld, asook in elke exemplaar van hierdie regulasies, op 'n ooglopende plek op die persoon waarop dit betrekking het, aanbring en onderhou of laat aanbring en laat onderhou. Die exemplaar van die regulasies moet altyd leesbaar en op datum wees.

INSPEKSIES

52. Die Sekretaris kan 'n private hospitaal of losstaande operasieatereenheid te enigderdig en so dikwels as wat hy dit nodig ag, inspekteer of deur 'n inspektierende beampte laat inspekteer.

53. Die eienaar van 'n private hospitaal of losstaande operasieatereenheid of 'n ander persoon wat vir die bestuur daarvan of beheer daaroor verantwoordelik is of wat in bevel van die verpleegsdiensleer daarvan is, moet aan die persoon wat ingewolke hierdie regulasie as inspektierende beampte optree, alle insligting verdeel wat sodanige beampte verlang betreffende die organisasie en bestuur van sodanige private hospitaal of losstaande operasieatereenheid en betreffende die akkommodasie, verpleging en behandeling van pasiente. Al die registers, kliniese rekorde, en ander rekorde in verband met pasiente en personeel moet vir die deel van sodanige inspeksie beskikbaar gestel word.

54. Niemand mag 'n inspektierende beampte in enige opsig in die uitvoering van sy inspeksie strem nie; of weëer om insligting ware deur sodanige beampte gevra word, na sy bestemde wese te verskyn nie; of weëer om enige apparaat of plek of ding te wys of om enige kys of 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-slip floor if explosive anaesthetic gases are to be used;
(d) adequate provision for oxygen; and
(e) adequate baby resuscitation 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 proposer 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 to or unlock any cupboard.

55. Die sodanige by skriftheud waardoor die regulasie van die private hospitaal, moet aan die houer van die hospitaal of die eienaar van sodanige hospitaal, word gegee.
55. Die Sekretaris kan te eniger tyd die eienaar van sodanige hospitaal of losstaande operasieteatereenheid by skriflike kennisgewing aansê om, binne 'n redelike tyd wat in die kennisgewing vermeld word, sodanige strukturele verandering 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 voornoemende eienaar van 'n private hospitaal of losstaande operasieteatereenheid kan skriflik by die Minister appèl aangeteken word met betrekking tot sodanige eienaar of voornoemende eienaar, na gelang van die geval, van 'n private hospitaal of losstaande operasieteatereenheid.

57. 'n Appèl ingevolge regulasie 56 moet aangeteken word binne twee dae nadat die besluit waartoe geappèl word onderskiwe tot die eienaar of voornoemende eienaar, na gelang van die geval, gekom het en moet duidelik vermeld:

(1) teen watter besluit sodanige appèl aangeteken word; en
(2) op wat gronde sodanige appèl aangeteken word.

58. 'n Appèl ingevolge hierdie regulasies word ingelewer by die Sekretaris, wat dit, onmisken, met sy redes vir die besluit waartoe daar geappèl word, aan die Minister voorlê.

59. Die Minister kan die besluit wat die Sekretaris ingevolge die bepaling van hierdie regulasies geneem het, bekrachtig, wysig of herroep, en die eienaar of voornoemende eienaar van 'n private hospitaal of losstaande operasieteatereenheid skriflik 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 van 'n diens daarin, of 'n diens in 'n private hospitaal of losstaande operasieteatereenheid nie ingevolge die bepaling van hierdie regulasies geregistreer nie; of
(2) die bestaande geboue van 'n private hospitaal of losstaande operasieteatereenheid of 'n gedeelte van sodanige geboue uitbrei, sloot of struktureel verander of van diens gebruik, ondanks die voorsienings van hierdie regulasies; of
(3) die eienaar is van, of in diens is by, 'n private hospitaal of losstaande operasieteatereenheid en wat—

(i) verskuim 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 inspekte ingevolge regulasie 54; of
(ii) verskuim om aan die bepaling 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.

**APEALS**

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 bepaling van regulasie 60 oor- 
tree of versuim om daaraan te voldoen, is aan 'n mis-
dryf skuldig en strafbaar—
(a) by 'n eerste skuldigbevinding, met 'n boete van 
hoogstens R500 of met 'n gevangenisstraf vir 'n tyd-
perk van hoogstens ses maande of met sowel daarde 
boete as daardie gevangenisstraf;
(b) by 'n tweede skuldigbevinding aan 'n soortge-
lyke misdryf, met 'n boete van hoogstens R1 000 of 
met 'n gevangenisstraf vir 'n tydperk van hoogstens 
een jaar of met sowel daarde boete as daardie 
gevangenisstraf; en
(c) by 'n derde of daaropvolgende skuldigbevindi-
ging aan 'n soortgelike misdryf, met 'n boete van 
hoogstens R1 500 of met 'n gevangenisstraf vir 'n 
 tydperk van hoogstens twee jaar of met sowel 
 daarde boete as daardie gevangenisstraf.

62. Vorms.

Vir doeleindes van die Wet op Gesondheid, 1977 
(Wet 63 van 1977), en die regulasies uitgevaarig, moet 
gebruik gemaak word van vorms wesenslik daarkragtig 
soos in die aanhangsels hiervan gespesifiseer.

HERROEPING VAN REGULASIE R. 1071 VAN 
25 JUNIE 1971

63. Die bepalings van die regulasies vir losstaande 
operasieteaterereehe (Regulasië R. 1071 van 25 Junie 1971) 
word hierby herroep vir sover dit van toepassing 
is op losstaande operasieteaterereehe of daarop betrek-
k het:
(1) 'n Kennisgewing, bevel, besluit, goedkeuring, toe-
stemming, magtiging, inligting of dokument uitgereik, 
geeneem, verleen of verstrekg en 'n ander handeling wat 
ingeval in 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, verstrekg of 
uitgevoer te geword het ingevolge die ooreenstemmende 
bepalings van hierdie regulasies.

AANHANGSELS

<table>
<thead>
<tr>
<th>Aannhanger</th>
<th>Vorm</th>
<th>Onderwerp</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>—</td>
<td>Omvang van chirurgiese ingrepe uitgevoer in losstaande operasieteaterereehe</td>
</tr>
<tr>
<td>B I</td>
<td>Aansoek om registratie van 'n private hospitaal/losstaande operasieteaterereehe</td>
<td></td>
</tr>
<tr>
<td>C II</td>
<td>Sertifikaat van registratie van 'n private hospitaal/losstaande operasieteaterereehe</td>
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</tr>
<tr>
<td>D III</td>
<td>Register van pasiënte</td>
<td></td>
</tr>
<tr>
<td>E IV</td>
<td>Bevallingsregister</td>
<td></td>
</tr>
<tr>
<td>F V</td>
<td>Operasieteaterregister</td>
<td></td>
</tr>
<tr>
<td>G VI</td>
<td>Ongesvalle-en-buitenpasiëntregister</td>
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</tr>
<tr>
<td>H VII</td>
<td>Register van verpleegpersoneel</td>
<td></td>
</tr>
</tbody>
</table>

OMVANG VAN VOORSGREWE PROCEDURES UIT-
GEWOER IN LOSSTAANDE OPERASIE-
TEATERREEHEDEN

In losstaande operasieteaterereehen mag geen ingreep uitgevoer 
word nie tensy die nodige faciliteitie, toestemming en assistenie vir 
die ingreep, vir resusitatie en vir naoperatiewe sorg beskikbaar is 
niet.
Alle weesel wat verwywer word, moet vir pathologese onderzoek 
gestuur word.

A. TANDHEELKUNDE
(1) Herstellende tandheelkunde.
(2) Verwydering van tand.
(3) Geringe mondzorgchirugie.

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 correspond-
ing provisions of these regulations.

ANNEXURES

<table>
<thead>
<tr>
<th>Annexure</th>
<th>Form</th>
<th>Subject</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>—</td>
<td>Scope of prescribed procedures carried out in unattached operating theatres</td>
</tr>
<tr>
<td>B I</td>
<td>Application for registration as a private hospital/unattached operating-theatre unit</td>
<td></td>
</tr>
<tr>
<td>C II</td>
<td>Certificate of registration in terms of Regulations of</td>
<td></td>
</tr>
<tr>
<td>D III</td>
<td>Register of patients admitted</td>
<td></td>
</tr>
<tr>
<td>E IV</td>
<td>Maternity register</td>
<td></td>
</tr>
<tr>
<td>F V</td>
<td>Operating-theatre register</td>
<td></td>
</tr>
<tr>
<td>G VI</td>
<td>Casualty and out-patients register</td>
<td></td>
</tr>
<tr>
<td>H VII</td>
<td>Register of nursing staff</td>
<td></td>
</tr>
</tbody>
</table>

Aanhangsel 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-operat-
ive 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) Hogting van wonde en pese.
(4) Insyndring van oppervlakkige absesse.
(5) Loodgiing van haematoom.
(6) Verwydering van vingerwondes en toenhaakt.
(7) Verwydering van oppervlakkige voorwerpse, maar slegs waar medes van ak akkuraat lokalisaatiese bestklaar is.
(8) Sigmoïdoscopie en kolonoskopie.
(9) Verwydering van eenvoudige oppervlakkige tumors.
(10) Insyndring hemerolede en spatere.
(11) Abdominale palpateuse.
(12) Rekule dilatatie (Lord).
(13) Spierbiopsie.

C. PSIGIATRIE
(1) Elektrokonvulsiewe terapie.
(2) Narcoanalise.
(3) Elektrostimulatie.
(4) Lumbar- en sinternepunktie.

D. OPTOPEDIE
(1) Redukse van eenvoudige fraktuur.
(2) Redukse van eenvoudige dislokaties.
(3) Manipulaties.
(4) Aspirasie van gewrigte.
(5) Goungt van gewrigte.
(6) Artrografie.

E. OOR, NEUS EN KEEL
(1) Laringoskopie.
(2) Proefpunktie en sinuoepling.
(3) Parasentese, met inbegrip van instillinge van plastiekhuises en stoomzaak van oor under algemene narkose.
(4) Kouterising.
(5) Verwydering van vreemde voorwerpse en poliepe.
(6) Neusfraktuur.
(7) Tonsillektomie en adenoidektomie.

F. GINEKOLOGIE EN OBSTETRIE
(1) Onderzoek onder narkose.
(2) Insynding van Bartheln-sist.
(3) Uitwendige kering.
(4) Injektie van intra-uteriene voorbeheeldoemiddel.
(5) Kouterising van servik.
(6) Endometrioombiopsie.
(7) Histerosalpingogram.
(8) Verwydering van servikale poliepe.
(9) Vulvabiosie.
(10) Hormoonimplantat.
(11) Himenektomie.
(12) Dilatatie en kurettisting.
(13) Diagnostiese laparoskopie.
(14) Sterilisering.

G. OOGHEFELKUNDIE
(1) Oodeszoek van kinders onder narkose.
(2) Verwydering van vreemde voorwerpse in korne.
(3) Sondering van traanbuise.
(4) Insynding van Meibom-sist.
(5) Pergitum.

H. VELSIGKES
(1) Diatermie en kuretteting van vratte.
(2) Diatermie en kuretteting van soolvratte.
(3) Diatermie en kuretteting van verrucae acuminatae.
(4) Biopsie van wul of wulwulies deur middel van 'n insynding of met behulp van 'n poni.
(5) Verwydering van goedaardige leists deur middel van diatermie en kuretteting of ekslise.
(6) Verwydering van kwaadaardige leists deur middel van diatermie en kuretteting of ekslise.
(7) Insynding en dreineer van oppervlakkige abses.

I. UKOLOGIE
(1) Stistoskopie.
(2) Uretralalalasie.
(3) Vasisk Tie.
(4) Testisbiopsie.
(5) Meatorakak.
(6) Besnydend.
(7) Uretrarakamels.

J. TROAKSCHURGIE
(1) Pleuraspunnie en naaldbiopsie van pleura of long.
(2) Intercostale blok.
(3) Verwydering van oppervlakkige gewasse.
(4) Bronkoskopie met of sonder verwydering van vreemde voorwerpse.
(5) Esopagogoskopie.
(6) Dilatatie van esoagus.

B. GENERAL SURGERY
(1) Warts.
(2) Circumcision.
(3) Sitching 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 localization are available.
(8) Sigmoidoscopce and colonoskopce.
(9) Removal of simple superficial tumours.
(10) Injection of haemorrhoids and varicose veins.
(11) Abdominal paracentesis.
(12) Rectal dilatation (Lord's).
(13) Muscle biopsy.

C. PSYCHIATRY
(1) Electroconvulsive therapy.
(2) Narcoanalysis.
(3) Electrostimulation.
(4) Lumbar and external puncture.

D. ORTHOPAEDICS
(1) Reduction of simple fractures.
(2) Reduction of simple dislocations.
(3) Dislocations.
(4) Aspiration of joints.
(5) Injections into joints.
(6) Arthrography.

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) Castration.
(5) Removal of foreign bodies and polyps.
(6) Fractured nose.
(7) Tonsilectomy and adenoi dektomy.

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) Hymenoctomy.
(12) Dilatation and curettage.
(13) Diagnostic laparoscopy.
(14) Sterilisation.

G. OPHTHALMOLOGY
(1) Examination of children under anaesthetic.
(2) Removal of corneal foreign bodies.
(3) Probing of tear ducts.
(4) Incision of Meibomian cysts.
(5) Prepygium.

H. DERMATOLOGY
(1) Diathermy and curettage of warts.
(2) Diathermy and curettage of planter 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 lesions 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) Meotomy.
(6) Circumcision.
(7) Urethral canules.
(8) Spematocele.

J. THORACIC SURGERY
(1) Pleural aspiration and needle biopsy of pleura or lung.
(2) Intercostal block.
(3) Removal of superficial tumours.
(4) Bronchoscopy.
(5) Esophagoscopy with or without removal of foreign bodies.
(6) Dilatation of esophagus.
### K. NEUROCHIRURGIE

Soes by B, plus:
1. Onderzoek onder narcose.
2. Lumbar punctus en gepaarde procedures soos intratracheale fenol- of alkoholtoediening, spinale worstelblokkering, nog enkele lagere proeiings, myeogram, mediediening, spinale dreining.
3. Schouwpraktisijs soos van ganglion Gasseri, akropathia enmal, en.
4. Angiografiæ deur middel van naald of kateter.
5. Tracheotomie.
6. Aftrap van ventrikeldeur bestaande beengat (boorgat) of fontanela of beenpukse vir doel van dreining of toediening van kontrasmeta of geneesmiddel.

### L. PLASTIESE CHIRURGIE

Soes by B, plus:
1. Plastiëre reparasie van klein wonde.
2. Manipulatie van neurofrakur (onder plaaslike verdoving).
4. Uitsny en henningsklikking van littekens (onder plaaslike verdoving).

### M. INTERNE GENEESKUNDE

1. Gastroscopye en duodenoskope.
2. Sigmoideoskope.
3. Rectale biopsie.
4. Sterile punksie.
5. Diagnosis parasitisme van pleura en peritoneum.
6. Inspekteur in surrevenworrts en ganglia.
7. Lumbaalpuntie.

### Annexure B

Aanhangsel B
Vorm I

### Department of Health

Aanplig om registrasie as 'n *private hospital/loststanding operasieister/eenheid* ingevolwe Regulasie No van operasie van.

Die Sekretaris van Gesondheid
Privaatk 238
PRETORIA
0001

Hiermee word aanplig gedaan oor die registrasie van 'n *private hospital/loststanding operasieister/eenheid*, ten eopig van besonderhede vir die jaar tijde op 31 December 19... hieronder verskry word.

1. Naam van *private hospital/loststanding operasieister/eenheid*...
2. Ligging van die terreun (straat, lokalisie, dorp)...
3. Naam en posadres van geregisterde eienaars van die eiendom (pencil)...
4. Naam en adres van eienaars (in die geval van 'n maatskappy of asosiatie, sy benoemde verteenwoordiger) wat die *private hospital/loststanding operasieister/eenheid* sal betryf...
5. Naam en adres van die mediese praktiseer of geregisterde verpleegster en verloskundige wat in beheer sal wees...
6. Indien 'n mediese praktiseer in beheer sal wees, vermeld die naam en kwalifikasies van die geregisterde verpleegster en verloskundige in beheer van die verpleegliens...
7. Hoofvoordeel en toeswysing van die beskikbare beddies vir pasiënte (zie aanteekeninge hieronder):

<table>
<thead>
<tr>
<th></th>
<th>Algemeen</th>
<th>Verloskunde</th>
<th>Aansteeklike ziektes</th>
<th>Ander, spesifieer</th>
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<tbody>
<tr>
<td></td>
<td>Volwassenes</td>
<td>Kinders</td>
<td>Moods</td>
<td>Suigelinge</td>
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<td>Blankes</td>
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<tr>
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<th>General</th>
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<th>Other (specify)</th>
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<td>Children</td>
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<td>Whiters</td>
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### Praktysyn

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| Nie-Blank |              |              |          |

### Practitioners

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<td>Medical</td>
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<tr>
<td>White</td>
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<tr>
<td>Non-White</td>
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### Enrolled nurses

<table>
<thead>
<tr>
<th>Voltyds</th>
<th>Inengskrewre verpleegsters</th>
<th>Inengskrewes student-verpleegsters</th>
<th>Inengskrewre verpleegassisteute</th>
<th>Inengskrewre leer-verpleegassisteute</th>
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<tbody>
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<tr>
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### Enrolled pupil nurses

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### Enrolled nursing assistants

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<thead>
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<th>White</th>
<th>Non-White</th>
</tr>
</thead>
</table>

### Other full-time registered staff employed (if any) (specify)

12. Ander voltyds geregistreerde personeel in diens (as daar is) (specifieer).

13. Ander deelyds geregistreerde personeel in diens (as daar is) (specifieer).

14. Indien die Verpleegstersraad die hospitaal erken as in opleiding in vir verpleegsters, verlosskundiges of ingeskrewre verpleegsters of ingeskrewre verpleegassisteute-raad erken word—

(a) Algemene verpleegster Verlosskundiges Inengskrewre verpleegsters Inengskrewre verpleegassisteute

15. General nurses Midwives Enrolled nurses Enrolled nursing assistants

11. Number of full-time enrolled nurses *employed at date of application/*to be employed at date of new registration applied for:

H. Hoeveelheid voltyds ingeskrewre verpleegpersoneel *in diens op datum van aanloek/*wat in diens sal wees op datum van nuwe registrasie waarom aanloek gedoen word.
(b) Indien die hospitaal erken word as 'n opleidingscentrum vir een of meer van die kategorieë van personeel in (a) hierbo vermeld, moet ondergenoemde inligting ook verstreken word:

<table>
<thead>
<tr>
<th>Kategorie</th>
<th>Nommer van registrasie- of inskrywings-sertifikaat deur die S.A.V.R. uitgereik</th>
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<tbody>
<tr>
<td>(i) Student- algemene-verpleegsters</td>
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<tr>
<td>(ii) Studentprovrouw</td>
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<td></td>
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<tr>
<td>(iii) Leerlingverpleegsters</td>
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<td></td>
</tr>
<tr>
<td>(iv) Verpleegassistente</td>
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</table>

Registrasie by die S.A.V.R. Meld:

<table>
<thead>
<tr>
<th></th>
<th>Nommer van oor-</th>
<th>Datum van uitreiking</th>
<th>Jaarlike registrasie</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>spronklike sertifikaat</td>
<td></td>
<td>Kwitansienummer</td>
</tr>
<tr>
<td>Algemeen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verloskundig</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ander</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(c) Ander opgeleide personeel, met uitsluiting van die persoon in beheer:

(i) Geregistreerde verpleegsters/verloskundiges:

<table>
<thead>
<tr>
<th>Naam</th>
<th>Kwalifikasies</th>
<th>Nommer van oor-</th>
<th>Datum van uitreiking</th>
<th>Jaarlike registrasie</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>spronklike sertifikaat</td>
<td></td>
<td>Kwitansienummer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(ii) Ingekrewe verpleegsters:

| Totaal           |                  |                  |                      |                    |       |

(ii) Ingekrewe verpleegassistente:

| Totaal           |                  |                  |                      |                    |       |

(h) 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:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of registration or enrolment certificate issued by the S.A.N.C.</th>
<th>Date of issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Student general nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Student midwives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Pupil nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Pupil nursing assistants</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RegISTRATION with the S.A. Nursing Council (specify):

<table>
<thead>
<tr>
<th></th>
<th>Number of original certificate</th>
<th>Date of issue</th>
<th>Annual registration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Receipt number</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(e) Other trained staff, excluding person in control:

(i) Registered nurses/midwives:

<table>
<thead>
<tr>
<th>Name</th>
<th>Qualifications</th>
<th>Number of original certificate</th>
<th>Date of issue</th>
<th>Annual registration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Receipt No.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(ii) Enrolled nurses:

| Totaal           |                  |                  |                      |                    |       |

(iii) Enrolled nursing assistants:

| Totaal           |                  |                  |                      |                    |       |

Total

* Medico
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) Items 7: The number of beds, cribs/cots actually available for accommodating patients are to be stated, but those exclude:
All trolleys;
All waiting, preparation, first stage and labour room beds and cots in maternity unit;
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.

DEPARTMENT OF HEALTH

CERTIFICATE OF REGISTRATION IN TERMS OF REGULATIONS No. ________ OF ________

It is hereby certified that the
situatd at ____________________________
is registered as a private hospital/unattached operating-theatre unit in terms of Regulations No. ________ 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:

<table>
<thead>
<tr>
<th>Patients to be accommodated simultaneously</th>
<th>Maximum number permitted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td>*Medical and *surgical (a) Adults...</td>
<td></td>
</tr>
<tr>
<td>(b) Children...</td>
<td></td>
</tr>
<tr>
<td>*Maternity (a) Mothers...</td>
<td></td>
</tr>
<tr>
<td>(b) Babies...</td>
<td></td>
</tr>
<tr>
<td>Infectious diseases...</td>
<td></td>
</tr>
<tr>
<td>Other (specify)...</td>
<td></td>
</tr>
</tbody>
</table>

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 ____________________________ day of 19 ________

Secretary for Health

This certificate is not transferable and must be renewed annually.

* Delete if not applicable.
### REGISTER VAN PATIENTE OPPGNIEUW

<table>
<thead>
<tr>
<th>Reeksnummer</th>
<th>Patiëntregistratienummer</th>
<th>Datum opname</th>
<th>Volle naam van patiënt</th>
<th>Ouderdom</th>
<th>Geslag</th>
<th>Woonadres</th>
<th>Diagnose/Rele vir toelating</th>
<th>Naam van medische prak</th>
<th>tioneer wat die patiënt behandeld</th>
<th>Finals diagnose</th>
<th>Datum</th>
<th>In geval van dood</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### REGISTER OF PATIENTS ADMITTED

<table>
<thead>
<tr>
<th>Serial No.</th>
<th>Patient registration No.</th>
<th>Date admitted</th>
<th>Full name of patient</th>
<th>Age</th>
<th>Sex</th>
<th>Residential address</th>
<th>Diagnosis/Reason for admission</th>
<th>Name of Medical Practitioner treating patient</th>
<th>Final diagnosis</th>
<th>Date of Discharge</th>
<th>Death</th>
<th>Certified cause of death</th>
<th>By whom certified</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

### BEVALLINGENREGISTER

Reeksnummer van geval .................................................................
Datum opneempje ...........................................................................
Naam van patiënt ...........................................................................
Ouderdom .........................................................................................
Res .............................................................
Adres ...............................................................................................

(a) Getal vorige bevallings ................................................................
(b) Getal vorige miskraam .............................................................
(a) Datum van bevalling ....................................................................
(b) Datum van miskraam ....................................................................
Volle termyn, vroege gebore of miskraam? Indien miskraam, vermeld benaderde getal maande ......................................................................................
Ligg ..........................................................
Datum van bevalling ..........................................................................
Geslag van afgelasting ......................................................................
Dood of lewend by geboorte ..............................................................
Komplikasies (as daar is) gedurende of na die bevalling ..................
Medische praktisie (en leeters) ........................................................
Handtekening ..................................................................................
Vroedvrou (as daar is) ......................................................................
Datum van vroedvrou se laatste bezoek of datum van ontslag .............
Toestand van moeder op daardie tydskip .........................................
Toestand van kind op daardie tydskip ..............................................
Opmekings ....................................................................................... 

Handtekening

Aanhangsel F

### 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 E

### OPERASIE-TEATERREGISTER

Reeksnummer ....................................................................................
Datum ............................................................................................... 
Naam ............................................................................................... 
Toelatingsregister No. ........................................................................
Geslag ...............................................................................................
Ouderdom .........................................................................................
Slaai .................................................................................................
Verwoingsmiddels .......................................................................... 
Narkotiser .........................................................................................
Chirurg ..............................................................................................
Assistent-chirurg .............................................................................
Operasie ............................................................................................
Tyd van operasie: Van ................................ tot ..................................
Duur van operasie ............................................................................. 
Kliempting, ens. ..............................................................................
Teater ............................................................................................... 
Handtekening van verpleegkundige by operasie ..............................
Handtekening van nasien ............................................................... 
Opmekings (komplikasies, ongelukke, ens.) ....................................

Aanhangsel F

### OPERATING-THEATRE REGISTER

Serial number ..................................................................................
Date ....................................................................................................
Name ............................................................................................... 
Admission reg. No. ...........................................................................
Sex ....................................................................................................
Age .....................................................................................................
Word .................................................................................................
Anesthesiologist ..............................................................................
Anesthetist ....................................................................................... 
Surgeon .............................................................................................
Assistant surgeon ...........................................................................
Operation ..........................................................................................
Time of operation: From ................................ to ..............................
Duration of operation ....................................................................... 
Drains etc. ....................................................................................... 
Theatre ..............................................................................................
Signature of nurse taking operation ................................................ 
Signature of co-cooker ......................................................................
Remarks (complications, accidents, etc.) ....................................... 

Signature
### ONGEVALLE-EN-BUITEPASiëNTEREGISTER

<table>
<thead>
<tr>
<th>Reeks No.</th>
<th>Register No.</th>
<th>Datum</th>
<th>Tyd</th>
<th>Naam</th>
<th>Ouderdom</th>
<th>Geslag</th>
<th>Adres</th>
<th>Klagto/Beëring</th>
<th>Ontslag</th>
<th>Mediese praktisyn</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### CASUALTY AND OUT-PATIENTS REGISTER

<table>
<thead>
<tr>
<th>Serial No.</th>
<th>Register No.</th>
<th>Date</th>
<th>Time</th>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>Address</th>
<th>Complaint /Injury</th>
<th>Disposal</th>
<th>Medical practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### REGISTER VAN VERPLEEGPERSONEEL

**PROFESSIONELE Kwalifikasies**

<table>
<thead>
<tr>
<th>Graad/Diploma/Sertifikaat</th>
<th>Registrasiesertifikaat</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Datum</td>
</tr>
</tbody>
</table>

Kwitansi van lopende registrasie/inskrywing by S.A. Verpleegregistersraad:

Datum No.

Kwitansi van lopende lidmaatskap van S.A. Verpleegregistersvereniging:

Datum No.

Datum van aansiening

Datum van diensbeëindiging (9 Maart 1979)

### REGISTER OF NURSING STAFF

**PROFESSIONAL QUALIFICATIONS**

<table>
<thead>
<tr>
<th>Degree/Diploma/Certificate</th>
<th>Registration certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date</td>
</tr>
</tbody>
</table>

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 AKSYN—DEPARTMENT OF CUSTOMS AND EXCISE
VOORLIGPDE OPGAVE VAN HANDELSSTATISTIEK VAN DIE REPUBLIEK VAN SUID-AFRIKA
PRELIMINARY STATEMENT OF TRADE STATISTICS OF THE REPUBLIC OF SOUTH AFRICA

Opmerking:—Syfers i.v.m. liêsse beweging van staafgoud is nie by die handelsstatistiek 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.—TOTAAL IN MIJLOEN RAND VOLGENS WERELDSTREKE, SKEEPS- EN VLEGTUIGVOORRAADE EN ONGEKLASSIFISEERDE GOEDERE
TABLE A.—TOTALS IN MILLION RAND ACCORDING TO WORLD ZONES, SHIPS' AND AIRCRAFT STORES AND UNCLASSIFIED GOODS

<table>
<thead>
<tr>
<th>Wêreldstreke—World zones</th>
<th>Invoere—Imports</th>
<th>Uitvoere—Exports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afrika—Africa</td>
<td>14,3</td>
<td>41,0</td>
</tr>
<tr>
<td>Europa—Europe</td>
<td>333,3</td>
<td>328,5</td>
</tr>
<tr>
<td>Amerika—America</td>
<td>124,6</td>
<td>86,2</td>
</tr>
<tr>
<td>Asië—Asia</td>
<td>90,6</td>
<td>128,4</td>
</tr>
<tr>
<td>Oseanië—Oceania</td>
<td>4,0</td>
<td>3,5</td>
</tr>
<tr>
<td>Ander ongeklasifiseerde goedere—Other unclassified goods</td>
<td>0,5</td>
<td>0,3</td>
</tr>
<tr>
<td>Skeeps-/Vlegtuigvoorraden—Ships'/Aircraft stores</td>
<td>—</td>
<td>3,1</td>
</tr>
<tr>
<td><strong>GROOTTOTAAL—GRAND TOTAL</strong></td>
<td><strong>567,3</strong></td>
<td><strong>592,0</strong></td>
</tr>
</tbody>
</table>

TABEL B.—TOTAAL IN MIJLOEN RAND VOLGENS AFDELINGS VAN DIE BTN
TABLE B.—TOTALS IN MILLION RAND ACCORDING TO SECTIONS OF THE BTN

<table>
<thead>
<tr>
<th>Afdelings/Sections</th>
<th>Invoere—Imports</th>
<th>Uitvoere—Exports</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Lewende diere; dierlike produkte</td>
<td>2,2</td>
<td>14,1</td>
</tr>
<tr>
<td>Live animals; animal products</td>
<td>1,6</td>
<td>10,9</td>
</tr>
<tr>
<td>II. Plantaardige produkte</td>
<td>14,5</td>
<td>43,1</td>
</tr>
<tr>
<td>Vegetable products</td>
<td>13,8</td>
<td>36,3</td>
</tr>
<tr>
<td>III. Dierlike en plantaardige vette en olies en spitsprodukte daarvan; voorbereide spysvette; dierlike en plantaardige wasse</td>
<td>3,6</td>
<td>3,9</td>
</tr>
<tr>
<td>Animal and vegetable fats and oils and their cleavage products; prepared edible fats; animal and vegetable waxes</td>
<td>4,4</td>
<td>1,9</td>
</tr>
<tr>
<td>IV. Voorbereide voedsel; dranke, spiritus en asyn; tabak</td>
<td>9,0</td>
<td>17,5</td>
</tr>
<tr>
<td>Prepared foodstuffs; beverages, spirits and vinegar; tobacco</td>
<td>9,2</td>
<td>22,3</td>
</tr>
<tr>
<td>V. Mineralprodukte</td>
<td>9,4</td>
<td>93,4</td>
</tr>
<tr>
<td>Mineral products</td>
<td>9,2</td>
<td>85,1</td>
</tr>
<tr>
<td>VI. Produkte van die chemiese en verwante nywerhede</td>
<td>70,0</td>
<td>25,4</td>
</tr>
<tr>
<td>Products of the chemical and allied industries</td>
<td>53,7</td>
<td>23,9</td>
</tr>
<tr>
<td>VII. Kunstharse en -plastiekstowwe, sellelooge-esters en -esters, en artikels daarvan; rubber, sintetiese rubber, fakts, en artikels daarvan</td>
<td>24,2</td>
<td>11,3</td>
</tr>
<tr>
<td>Artificial resins and plastic materials, cellulose esters and ethers, and articles thereof; rubber, synthetic rubber, farket, and articles thereof</td>
<td>20,9</td>
<td>6,5</td>
</tr>
<tr>
<td>VIII. Ongelooide haide en velle, leer, pelsvelle en artikels daarvan; saal- en tuteamakersware; reisartikels, handskake en dergelike houers; artikels van werf (ongesonderd spyswurmsaar)</td>
<td>2,7</td>
<td>2,9</td>
</tr>
<tr>
<td>Raw hides and skins, leather, furkins and articles thereof; saddlery and harness; travel goods, handbags and the like; articles of gut (other than silk-worm gut)</td>
<td>1,9</td>
<td>1,9</td>
</tr>
<tr>
<td>IX. Hout en artikels van hout; houtskool; kurk en artikels van kurk; fabrikate van strool, van esparo en van ander vleewerkstowwe</td>
<td>5,1</td>
<td>5,1</td>
</tr>
<tr>
<td>Wood and articles of wood; wood charcoal; cork and articles of cork; manufactures of straw, of esparo and of other plating materials; basketware and wickerwork</td>
<td>4,1</td>
<td>4,1</td>
</tr>
<tr>
<td>X. Stowwe vir die vervaardiging van papier; paper and papierbord en artikels daarvan</td>
<td>17,5</td>
<td>7,1</td>
</tr>
<tr>
<td>Paper-making material; paper and paperboard and articles thereof</td>
<td>17,1</td>
<td>6,8</td>
</tr>
</tbody>
</table>

6331—2
<table>
<thead>
<tr>
<th>Afdelings/Sections</th>
<th>Invooere—Imports</th>
<th>Uitvoere—Exports</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1979</td>
<td>1978</td>
</tr>
<tr>
<td>XI. Tekstiele en tekstielartikels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Textiles and textile articles</td>
<td>36,4</td>
<td>29,6</td>
</tr>
<tr>
<td>XII. Skoelsel, hoofdelsel, sambrele, sambrele, swepe,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>swewe en onderdele daarvan; bereide vee en artikels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>daarvan gemaak; kun红楼梦;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>artikels van mensenhaar; wauiers</td>
<td>2,2</td>
<td>1,9</td>
</tr>
<tr>
<td>Footwear, headgear, umbrellas, sunshades, whips,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>riding-crops and parts thereof; prepared feathers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and articles made therewith; artificial flowers;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>articles of human hair; fans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XIII. Artikels van klip, van gips, van cement, van</td>
<td>7,2</td>
<td>5,6</td>
</tr>
<tr>
<td>asbe, van mika en van derpelke stowwe; keramiese</td>
<td></td>
<td></td>
</tr>
<tr>
<td>produkte; glas en glassware</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Articles of stone, of plaster, of cement, of asbestos,</td>
<td>3,0</td>
<td>1,1</td>
</tr>
<tr>
<td>of men and of similar materials; ceramic products;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>glass and glassware</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XIV. Péels, edel- en halfedelsteene, edelmetale,</td>
<td>33,5</td>
<td>33,2</td>
</tr>
<tr>
<td>gewalste edelmetale, en</td>
<td></td>
<td></td>
</tr>
<tr>
<td>artikels daarvan; nagemaakte juweliersware; munstukke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pearl, precious and semi-precious stones, precious</td>
<td>205,7</td>
<td>180,5</td>
</tr>
<tr>
<td>metals, rolled precious metals, and articles thereof;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>imitation jewellery; coin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XV. Onedelmetale en artikels daarvan</td>
<td>91,9</td>
<td>72,7</td>
</tr>
<tr>
<td>Base metals and articles of base metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XVI. Masjinerie en meganiese toestelle; elektriese</td>
<td>23,6</td>
<td>17,5</td>
</tr>
<tr>
<td>toerusting; onderdele daarvan;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Machinery and mechanical appliances; electrical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>equipment; parts thereof</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XVII. Voertuie, vliegtuie en onderdele daarvan;</td>
<td>3,8</td>
<td>3,4</td>
</tr>
<tr>
<td>vaartuie en sekere verwante vervoortoerusting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vehicles, aircraft, and parts thereof; vessels and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>certain associated transport equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XVIII. Optiese, fotografiese, kinematografiese, meet-,</td>
<td>1,0</td>
<td>0,3</td>
</tr>
<tr>
<td>controle-, presie-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mediese en chirurgiese instrumente en apparaat;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>uurwerke en horlosies; musicinstruments; televisie-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>beeld- en klankopnameu en -weergewers, magnetei;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>onderdele daarvan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optical, photographic, cinematographic, measuring,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>checking, precision, medical and surgical instruments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and apparatus; clocks and watches; musical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>instruments; television images and sound</td>
<td></td>
<td></td>
</tr>
<tr>
<td>recorders and reproducers; parts thereof.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XX. Diverse verwende artikels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous manufactured articles</td>
<td>567,3</td>
<td>548,6</td>
</tr>
</tbody>
</table>

(© Maart 1979)/(9 March 1979)
Financialindicators:Withatastdownof$110,000,000inthisfinancialyear,theprofitmarginwasahealthy4%.Thehospital'sbalance_sheetshowsthatthetotalassetsareat$900,000,000withliabilitiesof$670,000,000resultinginaclearprofitof$230,000,000.

Overall,thepositionofthehospitalremainsstrongandwell-positionedforfurthergrowthanddevelopment.
HOSPITALS

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 Lelatong 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.”

Financial Mail March 16 1979
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 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 Louwser, 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 Louwser 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

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 Katutura.

This was resolved at a meeting of the Council. — DDR.
**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. C. 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

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 MEC for East London, Mr P. de Pontes, the MEC for hospital services, Mr P. J. Loubaer, 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 became 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.
### DEPARTMENT OF HEALTH

**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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>57001</td>
<td>Surgical cases, per day</td>
<td>19,00</td>
</tr>
<tr>
<td>57002</td>
<td>Thoracic cases (surgical)</td>
<td>20,00</td>
</tr>
<tr>
<td>57003</td>
<td>Neurosurgical cases, per day</td>
<td>20,00</td>
</tr>
<tr>
<td>57004</td>
<td>Medical and neurological cases, per day</td>
<td>20,00</td>
</tr>
</tbody>
</table>

### DEPARTMENT VAN GESONDHEID

**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, Registratur van Mediese Skemas, hierby die geldetarief in artikel 1 (1) van genoemde Wet bedoel, soos volg af:

**GELDetafief Ten Opsigte van Private Hospitale**

1. Die tarief wat in Bylae A hiervan uiteengesit is, geld ten opsigte van private hospitale vir Blanke met hoogstens 70 geregistreerde beddens.

2. Die tarief wat in Bylae B hiervan uiteengesit is, geld ten opsigte van private hospitale vir Blanke met meer as 70 geregistreerde beddens.

3. Die tarief wat in Bylae C hiervan uiteengesit is, geld vir beide sodanige kategorie hospitale.

4. Die tarief sluit algemene verkoopbelasting in, behalwe op items met betrekking tot medisynse, verdovingsmiddels 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 oorsese van private hospitale met minstens 61 geregistreerde beddens vir Blanke, 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 oorsese gevolg moet word, en die beslissing van bedoelde komitee is afdonge.

6. Die tarief treed in werking op die eerste dag van die maand wat volg op publikasie hiervan.

**BYLAE A**

**Saalgoed**

Hospitale moet die presiese tyd van toelaat en ontslag op alle rekenings aandui.

Saalgoed word gehef teen die volle daagtjie tarief indien toelaat voor 12h00 geskied en teen die helfte van die daagtjie tarief indien toelaat na 12h00 geskied. Saalgoed word gehef teen die helfte van die daagtjie tarief, indien ontslag voor 12h00 geskied, en teen die volle daagtjie tarief indien ontslag na 12h00 geskied: Met dien verstande dat die minimum bedrag wat gevaar word, gelik is aan die tarief vir een volle dag.

**Algemene saal**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>57001</td>
<td>Chirurgiese gevalle, per dag</td>
<td>19,00</td>
</tr>
<tr>
<td>57002</td>
<td>Thoracalchirurgiese gevalle, per dag</td>
<td>20,00</td>
</tr>
<tr>
<td>57003</td>
<td>Neurochirurgiese gevalle, per dag</td>
<td>20,00</td>
</tr>
<tr>
<td>57004</td>
<td>Mediese en neurologiese gevalle, per dag</td>
<td>20,00</td>
</tr>
</tbody>
</table>
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 attending practitioner and such certificate shall be forwarded to the relevant scheme together with the account.

57021 Private ward at request of number
Where a scheme undertakes to guarantee payment for accommodation in a private ward, supplied at the specific request of the number, 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 for procedures

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air encephalograms</td>
<td>R21.00</td>
</tr>
<tr>
<td>Hysterosalpingograms</td>
<td>R21.00</td>
</tr>
<tr>
<td>Angiography</td>
<td>R21.00</td>
</tr>
<tr>
<td>Cardiac catheterisation</td>
<td>R21.00</td>
</tr>
<tr>
<td>Electroconvulsive therapy (E.C.T.)</td>
<td>R5.00</td>
</tr>
</tbody>
</table>

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.
The theatre charge shall be calculated as follows:

<table>
<thead>
<tr>
<th>Duration</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15 minutes</td>
<td>R13.00</td>
</tr>
<tr>
<td>each subsequent 15 minutes or part thereof</td>
<td>R6.50</td>
</tr>
</tbody>
</table>

In-patients

Operations—general

57081 Time:
The exact time of admission to and discharge from theatre shall be stated.
The theatre charge shall be calculated as follows:

<table>
<thead>
<tr>
<th>Duration</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15 minutes</td>
<td>R33.50</td>
</tr>
<tr>
<td>16-30 minutes</td>
<td>R39.00</td>
</tr>
<tr>
<td>31-45 minutes</td>
<td>R44.50</td>
</tr>
<tr>
<td>46-60 minutes</td>
<td>R50.00</td>
</tr>
<tr>
<td>each subsequent 15 minutes or part thereof</td>
<td>R12.50</td>
</tr>
</tbody>
</table>

Operations—neurosurgery

57091 Preparation fee per operation (only chargeable when the duration of the operation exceeds 60 minutes).

<table>
<thead>
<tr>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>R49.00</td>
</tr>
</tbody>
</table>

57092 Time:
The exact time of admission to and discharge from theatre, and the exact operating time, shall be stated.
The theatre charge shall be calculated as follows:

<table>
<thead>
<tr>
<th>Duration</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-60 minutes</td>
<td>R52.00</td>
</tr>
<tr>
<td>each subsequent 15 minutes or part thereof</td>
<td>R12.50</td>
</tr>
</tbody>
</table>

Operations—thoracic surgery

57101 Time:
The exact time of admission to and discharge from theatre shall be stated.
The theatre charge shall be calculated as follows:

<table>
<thead>
<tr>
<th>Duration</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-30 minutes</td>
<td>R39.00</td>
</tr>
<tr>
<td>31-60 minutes</td>
<td>R52.00</td>
</tr>
<tr>
<td>each subsequent 15 minutes or part thereof</td>
<td>R12.50</td>
</tr>
</tbody>
</table>

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)

8006–B

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57020 Privaatsaal
Indien 'n geneesheer verblyf in 'n privaatsaal om mediese redes voorskrif, word gelde vir sodanige verblyf gelei teen die heersende privaatsaat tarief, 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.
Hospitaal moet 'n gedetailleerde sekerheidskaart aangaande die noodsaaklikheid vir privaatsaat verblyf van die behandelende dokter verhy and sodanige sekerheidskaart saam met die rekenskrip aan die betrokke skema stuur.

57021 Privaatsaal op lid te versoek
Waar 'n skema onderskeen om betaling vir privaatsaat verhyf wat op die tydskrifique versoek van die lid versoek word, is die skema gereig op 'n 10 persent korting op die heersende privaatsaat tarief.

57045 Verdowingsmiddels (saal)
Verdowingsmiddels deur die saal versoek—per Standarttarief vir Verdowingsmiddels en Material (Bylae C).

<table>
<thead>
<tr>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>R21.00</td>
</tr>
<tr>
<td>R21.00</td>
</tr>
<tr>
<td>R21.00</td>
</tr>
<tr>
<td>R21.00</td>
</tr>
<tr>
<td>R21.00</td>
</tr>
</tbody>
</table>

Teatergeld

Blindepasiente (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.
Die teatergeld word soos volg bereken:

<table>
<thead>
<tr>
<th>Tyd</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15 minute</td>
<td>R13.00</td>
</tr>
<tr>
<td>elke daaropvolgende 15 minute of deel daarvan</td>
<td>R6.50</td>
</tr>
</tbody>
</table>

Binnespasiënte

57081 Tyd:
Die presiese tyd van toelating tot en ontslag uit teater moet aangetoon word.

<table>
<thead>
<tr>
<th>Tyd</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15 minute</td>
<td>R33.50</td>
</tr>
<tr>
<td>16-30 minute</td>
<td>R39.00</td>
</tr>
<tr>
<td>31-45 minute</td>
<td>R44.50</td>
</tr>
<tr>
<td>46-60 minute</td>
<td>R50.00</td>
</tr>
<tr>
<td>elke daaropvolgende 15 minute of deel daarvan</td>
<td>R12.50</td>
</tr>
</tbody>
</table>

Verdowingsmiddels en materiaal—teater

57091 Voorbereidingsgeld per operasie (begins van toepassing wanneer die duur van die operasie 60 minute oorskry)

<table>
<thead>
<tr>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>R49.00</td>
</tr>
</tbody>
</table>

57092 Tyd:
Die presiese tyd van toelating tot en ontslag uit teater sowel as die presiese tyd van duur van die operasie moet aangetoon word.

<table>
<thead>
<tr>
<th>Tyd</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-60 minute</td>
<td>R52.00</td>
</tr>
<tr>
<td>elke daaropvolgende 15 minute of deel daarvan</td>
<td>R12.50</td>
</tr>
</tbody>
</table>

Verdowingsmiddels—teater

57101 Tyd:
Die presiese tyd van toelating tot en ontslag uit teater moet aangetoon word.

<table>
<thead>
<tr>
<th>Tyd</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-30 minute</td>
<td>R39.00</td>
</tr>
<tr>
<td>31-60 minute</td>
<td>R52.00</td>
</tr>
<tr>
<td>elke daaropvolgende 15 minute of deel daarvan</td>
<td>R12.50</td>
</tr>
</tbody>
</table>

Verdowingsmiddels—teater
<table>
<thead>
<tr>
<th>Additional items</th>
<th>R.</th>
</tr>
</thead>
<tbody>
<tr>
<td>57151 Fulguration, diathermy, cauter—first hour</td>
<td>2.00</td>
</tr>
<tr>
<td>each additional hour or part thereof</td>
<td>1.60</td>
</tr>
<tr>
<td>57152 Recovery room, per operation</td>
<td>1.00</td>
</tr>
<tr>
<td>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</td>
<td>10.00</td>
</tr>
</tbody>
</table>

**Non-chargeable theatre items**

- White methylated spirits
- Aqueous solutions, e.g. Cetavlon, Savlon or any other proprietary name
- Bunsenidol
- Dermol
- Mercuro oxyanide
- Instrument-Dettol
- Formalin and saline
- Acetone
- Giff soap
- Liquid soap
- Use of surgical instruments and blades
- Use of laparoscope, gastroscopy and microscope
- E.C.G. and paper
- Disposable cautery/diathermy leads and pads
- Va aum trays
- Operative trays (for anaesthetist)
- Linen covers
- Preparatory gowns

**Intensive care units**

| I.C.U.: per day | 45.00 |
| inclusive of all equipment except | |

**I.C. unit**

| I.C.U. : per day | 45.00 |
| inclusive of all equipment except | |
| 57020 Angstrom or Bennett M.A.I.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. |

**Post-operative high care ward: per day**

| 57215 | 30.00 |
| All admissions to this unit shall be confirmed 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. |

**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 |
| 57233Croupettes (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.I.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 |

---

**Additionele items**

<table>
<thead>
<tr>
<th>R.</th>
</tr>
</thead>
<tbody>
<tr>
<td>57151 Fulguratie, diatermie, brande—eerste uur</td>
</tr>
<tr>
<td>elke additionele uur of deel daarvan</td>
</tr>
<tr>
<td>57152 Herstelskamer—per operatie</td>
</tr>
<tr>
<td>57153 Na operatie: per geval, vir gevalle tot en met toegelaan tussen 19h00 en 07h00 op weekdagen, tussen 13h00 op Saterdae en 07h00 op Maandae en op openbare vakansiede</td>
</tr>
<tr>
<td><strong>Gratis items</strong> (in saloon en teater)**</td>
</tr>
</tbody>
</table>

**Standaardheffings vir toerusting**

| 57231 Monitors (buit I.S.E.). per dag of deel daarvan | 10.00 |
| 57232 Respirators, by Bennett PR2 of Bird (sonder suurstof) (buit I.S.E.), per dag of deel daarvan | 7.50 |
| 57233Croupettes (sonder suurstof), per dag of deel daarvan | 2.00 |
| 57234 Incubators (sonder suurstof), per dag of deel daarvan | 4.00 |
| 57235 Suurstofkante (sonder suurstof), per dag of deel daarvan | 3.00 |
| 57236 Bennett M.A.I.B. of Angstrom-respirator (sonder suurstof), per dag of deel daarvan | 30.00 |

**Bewerkingsblaise**

| 57251 Steriele blaise—per blad | 1.40 |
| Nie-stereile blaise: | |
| 57253 Voorbereidingsblaise—per blad | 0.55 |
| 57255 O.N.K. blaise—per blad | 0.55 |
| 57257 Depperblaise—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

<table>
<thead>
<tr>
<th>Item Code</th>
<th>Description</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>58001</td>
<td>Surgical cases, per day</td>
<td>21,50</td>
</tr>
<tr>
<td>58002</td>
<td>Thoracic cases (surgical), per day</td>
<td>22,50</td>
</tr>
<tr>
<td>58003</td>
<td>Neurosurgical cases, per day</td>
<td>22,50</td>
</tr>
<tr>
<td>58004</td>
<td>Medical and neurological cases, per day</td>
<td>22,50</td>
</tr>
</tbody>
</table>

#### 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 attendant practitioner and such certificate shall be forwarded to the relevant scheme together with the account.

#### 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 (war 3)**

<table>
<thead>
<tr>
<th>Item Code</th>
<th>Description</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>58045</td>
<td>Drugs supplied by ward—as per Standard Drug Material Tariff (Annexure C)</td>
<td>5,00</td>
</tr>
</tbody>
</table>

**Fixed fee procedures**

<table>
<thead>
<tr>
<th>Item Code</th>
<th>Description</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>58051</td>
<td>Air encephalograms</td>
<td>23,00</td>
</tr>
<tr>
<td>58052</td>
<td>Hysterofallopipograms</td>
<td>23,00</td>
</tr>
<tr>
<td>58053</td>
<td>Angiograms</td>
<td>23,00</td>
</tr>
<tr>
<td>58054</td>
<td>Cardiac catheterisation</td>
<td>23,00</td>
</tr>
<tr>
<td>58055</td>
<td>Electromed exclusive therapy (E.C.T.)</td>
<td>23,00</td>
</tr>
</tbody>
</table>

**Theatre fees**

<table>
<thead>
<tr>
<th>Item Code</th>
<th>Description</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>58077</td>
<td>Out-patients (Patients that are not warded)</td>
<td>5,50</td>
</tr>
</tbody>
</table>

#### Time in theatre

The exact time of admission to and discharge from theatre shall be stated.

<table>
<thead>
<tr>
<th>Time</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15 minutes</td>
<td>14,50</td>
</tr>
<tr>
<td>each subsequent 15 minutes or part thereof</td>
<td>7,20</td>
</tr>
</tbody>
</table>

**In-patients**

#### Operations—general

<table>
<thead>
<tr>
<th>Time</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15 minutes</td>
<td>57,00</td>
</tr>
<tr>
<td>16-30 minutes</td>
<td>43,00</td>
</tr>
<tr>
<td>31-45 minutes</td>
<td>50,00</td>
</tr>
<tr>
<td>46-60 minutes</td>
<td>56,00</td>
</tr>
<tr>
<td>each subsequent 15 minutes or part thereof</td>
<td>14,00</td>
</tr>
</tbody>
</table>

#### Operations—neurosurgery

<table>
<thead>
<tr>
<th>Time</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation fee per operation only chargeable where the duration of the operation exceeds 60 minutes</td>
<td>54,00</td>
</tr>
</tbody>
</table>

### BYLAE B

**Saalgeldge**

Hospitaal moet die presiese tyd van toelating en ontslag op alle rekenings aandui.

Saalgeldge word gehelp teen die volle diagskie tarief indien toelating voor 12h00 geskied en teen die helfte van die diagskie tarief indien toelating na 12h00 geskied. Saalgeldge word gehelp teen die helfte van die diagskie tarief indien ontslag voor 12h00 geskied en teen die volle diagskie tarief indien ontslag na 12h00 geskied. Met dien verstande dat die minimum bedrag wat gevra word, geïk is aan die tarief vir 'n volle dag.

**Algemene saal**

<table>
<thead>
<tr>
<th>Item Code</th>
<th>Description</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>58001</td>
<td>Chirurgiese gevalle, per dag</td>
<td>21,50</td>
</tr>
<tr>
<td>58002</td>
<td>Toetsende chirurgiese gevalle, per dag</td>
<td>22,50</td>
</tr>
<tr>
<td>58003</td>
<td>Neurochirurgiese gevalle, per dag</td>
<td>22,50</td>
</tr>
<tr>
<td>58004</td>
<td>Mediese en neurochirurgiese gevalle, per dag</td>
<td>22,50</td>
</tr>
</tbody>
</table>

**Privateaal**

Indien 'n geneesheer verbyf in 'n privaatuur om medische redes voor skryf, word geïk vir sodanige verbyf gehelp teen die heersende privaatuur tarief, wat in geen geval R33,00 per dag mag oorskry nie, min 10 persent korting. Met dien verstande dat die betrokke skema die betrokke verbyf vir 'n privaatuur geïk moet verbruik.

Hospitaal moet 'n gedetailleerde serifikaat aan die nuwe verbindlikhede van die heersende privaatuur tarief van die behandelende dokter verwerk en sodanige serifikaat saam met die rekening aan die betrokke skema stuur.

**Verdowingsmiddels (saaal)**

<table>
<thead>
<tr>
<th>Item Code</th>
<th>Description</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>58045</td>
<td>Verdowingsmiddels deur die saal verskaf—per Standaardtarief vir Verdowingsmiddels en Materi-</td>
<td>22,50</td>
</tr>
<tr>
<td></td>
<td>aal (Bylæ C)</td>
<td></td>
</tr>
</tbody>
</table>

**Geldige vaste procedures**

<table>
<thead>
<tr>
<th>Item Code</th>
<th>Description</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>58051</td>
<td>Lugenkafogamme</td>
<td>23,00</td>
</tr>
<tr>
<td>58052</td>
<td>Hysterofallopipogramme</td>
<td>23,00</td>
</tr>
<tr>
<td>58053</td>
<td>Angiogramme</td>
<td>23,00</td>
</tr>
<tr>
<td>58054</td>
<td>Hartkaterorhographies</td>
<td>23,00</td>
</tr>
<tr>
<td>58055</td>
<td>Elektroneuronvisee terapie (E.K.T.)</td>
<td>23,00</td>
</tr>
</tbody>
</table>

**Theatergelede**

**Bategestuëte (Pasiente wat nie in 'n saal opaque nie)**

**Tyd in teater**

Die presiese tyd van toelating tot en ontslag uit teater moet aangebone word.

<table>
<thead>
<tr>
<th>Time</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15 minute</td>
<td>14,50</td>
</tr>
<tr>
<td>elke daaropvolgende 15 minute of deel daarvan</td>
<td>7,20</td>
</tr>
</tbody>
</table>

**Binnepatiëte**

**Operasies—algemeen**

<table>
<thead>
<tr>
<th>Time</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15 minute</td>
<td>37,00</td>
</tr>
<tr>
<td>16-30 minute</td>
<td>43,00</td>
</tr>
<tr>
<td>31-45 minute</td>
<td>50,00</td>
</tr>
<tr>
<td>46-60 minute</td>
<td>56,00</td>
</tr>
<tr>
<td>elke daaropvolgende 15 minute of deel daarvan</td>
<td>14,00</td>
</tr>
</tbody>
</table>

**Operasies—neurochirurgie**

<table>
<thead>
<tr>
<th>Time</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15 minute</td>
<td>37,00</td>
</tr>
<tr>
<td>16-30 minute</td>
<td>43,00</td>
</tr>
<tr>
<td>31-45 minute</td>
<td>50,00</td>
</tr>
<tr>
<td>46-60 minute</td>
<td>56,00</td>
</tr>
<tr>
<td>elke daaropvolgende 15 minute of deel daarvan</td>
<td>14,00</td>
</tr>
</tbody>
</table>

**Tyd**

Die presiese tyd van toelating tot en ontslag uit teater moet aangebone word.

Die teatergelede word saam volg bereken:

<table>
<thead>
<tr>
<th>Time</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15 minute</td>
<td>37,00</td>
</tr>
<tr>
<td>16-30 minute</td>
<td>43,00</td>
</tr>
<tr>
<td>31-45 minute</td>
<td>50,00</td>
</tr>
<tr>
<td>46-60 minute</td>
<td>56,00</td>
</tr>
<tr>
<td>elke daaropvolgende 15 minute of deel daarvan</td>
<td>14,00</td>
</tr>
</tbody>
</table>

**Operasies—neurochirurgie**

<table>
<thead>
<tr>
<th>Time</th>
<th>Tariff (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15 minute</td>
<td>37,00</td>
</tr>
<tr>
<td>16-30 minute</td>
<td>43,00</td>
</tr>
<tr>
<td>31-45 minute</td>
<td>50,00</td>
</tr>
<tr>
<td>46-60 minute</td>
<td>56,00</td>
</tr>
<tr>
<td>elke daaropvolgende 15 minute of deel daarvan</td>
<td>14,00</td>
</tr>
</tbody>
</table>

**Tyd**

Die presiese tyd van toelating tot en ontslag uit teater moet aangebone word.
58101 Operations—surgical surgery

58101 Time

The exact time of admission to and discharge from theatre shall be stated.

The charge shall be calculated as follows:

1-30 minutes ........................................ 43,00
31-60 minutes ....................................... 57,00
each subsequent 15 minutes or part thereof 14,00

58121 Open heart surgery—rates by arrangement

58131 Theatre drugs—as per Standard Drug and Materials, Tariff (Annexure C).

Additional items

58151 Fulguration, diathermy, cautery

first hour ............................................ 2,00
then for 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

Binoide
Dettol
Mercureic oxyanide
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. and paper
Disposable cautery/diathermy leads and pads
Vacuum trays
Operative trays (for anaesthetist)
Linen savers
Preptic swabs

58182 Non-chargeable items (in word and in theatre)

I.D. bands
Disposable gloves
Face masks
Collection charges (Blood Bank)
Labstit/Multiplic

58201 Intensive care units

58201 I.C.U., per day .................................. 50,00
58202 Angiogram or Bennett M.A.I.B. respirator, per day or part thereof, plus the charge for oxygen ........................................... 30,00

58203 Consumable materials—as per Standard Drug and Materials, Tariff (Annexure C)

58215 Post-operative high care ward, per day ........................................ 33,00

58101 Tyd

Die preciese tyd van toelating tot en ontslag uit teater moet aangestuur word.

Die teetergelede word se laaste volg bereken:

1-30 minute ........................................ 43,00
31-60 minute ....................................... 57,00
each daaropvolgende 15 minute of deel daarvan 14,00

58121 Operasies—openhart

58131 Verdovingmiddels deur die teater verskuif per standaardtarief vir Verdovingmiddels en Materiaal (Byl C).

Additional items

58151 Fulguratie, diathermie, brandings—eerste uur 2,00
elke daardere uur of deel daarvan 1,00

58152 Herstelkamer—per operasie 3,00

58153 Na-ure—per geval deur teater toegelaag tussen 19h00 en 07h00 op werksdage, tussen 13h00 op Saterdae en 07h00 op Maandag en op openbare vakansiedage 11,00

58181 GRATIS TEATERITEMS

Wit brandspiritus
Wateragtige oplosings, bv. Cetavlon, Savlon of enige ander behandelset
Bijulie
Dettol
Merkuriekwisselingsmiddel
Instrument Dettol
Formulis en sonoplossing
Aspoen
Gill-seep
Vliese seep
Gebruik van chirurgiese instrumente en lemmetjies
Gebruik van laparoskoop, gastroskoop en mikroskoop
E.K.G. en E.K.G.-papier
Weglopende brandings/diatermie—gelede en -kussinkies
Vakuumblase
tBlouw vir operasies (narkotiseurs)
Limoenbesparingsdekking
Preptic-pappers

58182 GRATIS ITEMS (IN SUL ET TEATER)

Identifikasietokke
Weglopende handskoene
Gezichtsmaskers
Afhaalkoste (Bleepbank)
Labstit/Multiplic

58201 Intensiewsorgeunie

58201 I.S.E., per dag ................................. 50,00
58202 Angiogram- of Bennett M.A.I.B.-respirator, per dag of deel daarvan, plus die koste van suurstof 30,00

58203 Intensiewsorgeunie

58203 Verbruikbare materiaal—per standaardtarief vir Verdovingmiddels en Materiaal (Byl C).

58215 Ne-operatiewe hoësorgsaal, per dag ................................. 33,00

Iedere toelating tot sodanige eenheid moet bevestig word vir elke 72 uur.

Hospital 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.F.—Geen geld ten opsigte van spesiale verpleging mag gehelp word tydens verbluf in 'n intensiewsorgeunie nie.

58203 Verbruikbare materiaal—per standaardtarief vir Verdovingmiddels en Materiaal (Byl C).

58215 Ne-operatiewe hoësorgsaal, per dag ................................. 33,00

Iedere toelating tot sodanige eenheid moet bevestig word vir elke 72 uur.

Hospital 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.F.—Geen geld ten opsigte van spesiale verpleging mag gehelp word tydens verbluf in 'n hoësorgsaal nie.
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 (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 (30c) 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 tablets 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 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—50 cents per hour or part thereof. In areas where raiilage 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
    Vitalium 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.

STANDAARDTARIEF VIR VERDOWINGSMIDJES EN MATERIAAL: JUNIE 1978

1. Toonbank- en patentitems
   Per voorgestelde kleinhandelsprys—Aptekersvereniging van Suid-Afrika.

2. Alle toebereide items
   Per die amptelike skedules en tabelle van die Aptekersvereniging van Suid-Afrika.

3. Ampulse nie gebroke grootmaat
   Pro rata die kleinhandelspyse. Toeheeringskoste moet nie hygereken word nie, ongeag of die ampulse van die saal of aptek of teater verkry is.

4. Skedule 7-ampulse
   Waar sodanige ampulse van die saal of die teart of die teater verkry is, moet die Skedule 7 heffing van 20c gevra word op die totale aantal ampulse, ongeag hoeveel ampulse verskaf is.

5. Prys van tablette en kapsules uit die saal
   Die prys per tablet of kapsule moet 'n pro rata-toeheeringsgeld inlui; byvoorbeeld: Die prys wat gevra word, is die kleinhandelspyse van die kleinheidsverpakking plus die Aptekersvereniging van Suid-Afrika se toeheeringsgeld, gedeel deur die geal tablette of kapsules in die kleinste verpakking.

6. Spuite
   Die vervoerder se geliste prys plus 50 persent. Inselfwerklik geld die geliste prys ook vir al die chirurgiese items soos kantiers, ens.

7. Gas (sauerstoff en lagas)
   R1,50 vir 15 minute—vir albei gasse saam. Suurstof, in die saal—60c per uur of deelvan 'n uur. (In gebiede waar die spogvrag of die vervoerder se prys aansienlik hoër as die gemiddelde is, kan die tarief verhoog word om die hoër koste te dek.)

8. Halothane (Fluothane)
   R1,50 per 15 minute of deel daarvan.

9. HEGMATERIAAL
   Gewone nie-traumaatiese hegmateriaal R2,25 per stuk. Oog- of speciale hegmateriaal teen die geliste prys plus 50 persent.

10. Prothese
    Vitalium of ekwiivalent:
    Tot R120—bruto-koste plus 50 persent; meer as R120—bruto-koste plus 25 persent; en meer as R1 000—volgens ooreenkomst.

11. Elektroniese bevindinge
    Volgens ooreenkomst.

12. Spoorvraag
    *Bykomende heffing kan op items wat na gebiede gestuur word wat buite die verskuiwerk is gratis afwerkingsgebied is, geplaas word om die uitgawe wat aan sporvrag 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. Prystyging

Indien daar 'n styging is in die verskaffer se prys vir 'n item wat nie op die amptelike pryslys is nie, bv. gas, word die nuwe prys gebaseer op die bykomende koste plus 50 persent, wat by die bestaande prys geel word.
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 R35 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 R0.50 for each additional 15 minutes. Comparative fees in the larger hospitals will be R14.50 and R2.25.

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

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 Phokeng.

Nursing colleges will also be built in Soweto and at Natalepruit, on the outskirts of Germiston.

New schools and improvements to existing facilities, which are now being planned by the Province, will push another R105-million into education in the Transvaal.

Pretoria's education requirements are particularly spotlighted, with two new Afrikans primary schools, an art, music and ballet school and boarding house at the Onderwys College and the Afrikaans Technical School planned.

The province will spend R124-million on construction of the Pretoria State Theatre over the next 12 months.

To date nearly R22-million has been spent on the development of the theatre which will eventually cost R324-million.
Whites only is nursing rule at Jo'burg clinic

Black and coloured nurses will not be employed in the Park Lane Clinic Johannesburg. The clinic’s management has knocked down to political pressure despite the Minister of Health’s assurance that there is no law against employing these nurses.

The manager of the prestigious Johannesburg clinic, Mr Harry Fisher, said today he was abiding by the Bureau 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 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

DR AHMED FOAUD 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 Stais Care and Rehabilitation Centre, formerly known as Westlake Hospital.

In an interview, Dr Gamieldien said there was no discrimination whatsoever at the hospital, and while all 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 Stais Hospital and D P Marais TB centre were amalgamated.

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 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 "strange" 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 matron 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 1950 after deciding to give his two older brothers a religious education in Italy.

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 Valtongberg Hospital as a medical officer becoming assistant medical superintendent in 1977.

He took up his position as medical superintendent at the Dr Stais Centre at the beginning of this month.
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 (F. P. 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. T. Fouche, declined to give further details about the investigation, beyond saying that it should not take long to complete.
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. Kalie de Haas, M.B., C.S., in charge of hospitals for the Transvaal, said 114 beds in the Julius N. Jeppe block would be available to Indians until extensions were finished at the Coronation and New Lenasia Hospitals.

The superintendent of the Coronation Hospital, Mr. C. Kriel, said while extra accommodation was necessary, he would be unable to staff the two hospitals with existing staff.

The Coronation Hospital's staff complement of 601 coloured and 135 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

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."

"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 ophthalmology.

"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 in Durban 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 (PPP Sandton) said on Thursday that "no where 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 intelligentsia 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 Hekert Commission recommendations.

Employers of "illegal" workers would be subject to heavy fines.

Blacks registered in qualified area. The register of employ...
Medical profession shocked by complaint

- 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 the 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 meals 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 Louise alive

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 Cooperation and Development, protesting against the ban.

She begged Dr. Koornhof to use his influence to try and change the attitude of the Transvaal Provincial Administration and allow the Coloured nurses to continue nursing prematurely born babies.

Mrs. McBride told Dr. Koornhof that had it not been for the sisters in the neonatal 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.

The 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 her husband 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."
A sick business

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 Kolie 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.
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 R160 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 municipality’s Coloured health services under one roof, catering for all of East London’s over 15,000 Coloureds.

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 commonground near Amalinda.

Meanwhile, two portions of land in the proposed Bridgen Township Extension No 3 have been set aside for a Duncan Village day hospital.

The planning of the new day hospital is expected to be completed early next year. — DDR.
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.
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 Federated 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 in the town 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 patients.

In this spirit, the day hospital had been planned in Duncan Village and 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 the 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 coordinated 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 Huys), 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 a report on how the Frere Hospital 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 lying and publishing photographs of black women with their children in their arms, sitting destitute on the sidewalk, I also allegedly lamenting that they had been turned away by the Frere Hospital and had to carry their desolately 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 Hospital on their way to the Frere Hospital.

“I publicly invited anyone who felt aggrieved by the actions of the department 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 MPC 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, Mr 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 ophthalmology 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 councilors, 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 "putting 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 here 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 ophthalmology 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 ophthalmology sections were referred to the Cecilia Makiwane Hospital.

It was untrue that the black obstetrics 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 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 unjustifiable giving the hospital a bad name.

(News by P. Kenny, 32 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 987 beds but an average occupancy of 1,811 at a cost of R5.10 per patient; Weskoppies has 641 beds for blacks but an average occupancy of 568 at a cost of R5.80 per patient; Komani Hospital in Queenstown has a capacity for 558 blacks but an average occupancy of 569 at a cost of R6.26 per patient; and the Oranje Hospital has 236 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 R4.85 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 R3.97 per patient at the Kowie Hospital in Port Alfred and the Tower Hospital at R3.16. The remainder range from R4.65 per patient to R9.85 per patient, but two — the Elizabeth Donkin Hospital in Port Elizabeth and the King George V Hospital in Natal — are R8.17 and R26.10 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 R3.77 to R5.24.

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 (FFP, Bryanston). — PC.
The clinic that cares about self-help

The struggle for survival at Care Clinic continues.

The clinic involves black women and their children. They comprise widows, deserted and battling wives of husbands who are without employment.

For some 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 pension 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 handcrafts 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, for some of them.

A wonder box is basic on the principle of the old-fashioned hat box, used to keep food hot.

Two cloth cushions, filled with poly styrene, are packed in a box, form 'stoves', when a pot of already boiling food is placed between them and left to cook slowly.

To begin with, the women were given blocks of poly styrene to take home, to break up into granules.

Then the women were taught to make the cushions, by hand, and to sell them, to make a living.

Others are paid according to the amount of poly styrene they 'scratch' into granules.

All new cases are given food vouchers for essential foodstuffs from Kupagani, but, as the woman learns to use her hands effectively, she earns money, in lieu of a food voucher — but up to a certain limit, in order to maintain the viability of her finances, which are limited.

These days, everything at Care revolves around the wonder boxes. Happily, there is such a demand for them that all the women are involved in making them.

At Care the counselling women, who are financially secure and socially pampered, give hope and direction to the despairing by their willingness to come to grips with the often uncomfortable problems of life.
It's a good feeling to complete the job - the cushions are packed neatly in cardboard, to form the Wonder Box.

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 exasperatingly difficult and slow.

Then somebody suggested Care Clinic clients make wonder boxes for sale — and since then life has become developed.

Widow Nolusapha, with her baby and young daughter, during a visit to Care Clinic, where she has been helped to rehabilitate her life.

— Shirley Smith
Where the old have to wait... and 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...

BY JEREMY THOMAS

...and often wait for up to three hours for my medicine. They must be short-staffed I suppose.”

“You can make a day of it here,” said one 77-year-old woman, who did not want to give her name.

“Three hours is enough,” she added.

“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.

“By then it’s too late, it’s already four.”

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.

“Families 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!”
to the Press
their complaints
some patients take
WANTED — more babies

MORE than forty-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 1,207 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 1920, steadily grew and in 1928 a purpose-built hospital, containing 25 beds and 2 labour wards, was opened.

By now, 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 nurses, 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 Titmus, 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."

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 winning.

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,
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 Crywa-Williams.
Arson bid: Cape hospital may close

THE Heideveld Day Hospital may have to close temporarily following a fire which caused R6000 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 destroyed 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 E M Luden, helped to clear the blackened debris from her office, 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
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 rand, were coated with thick, sticky ash and were now useless.

Shawco

Dr Sacks said the day hospital shared the building with the Shawco clinic. and together the two institutions bad been subjected to numerous burglaries, vandalism, and arson attempts. In two weekends in succession Shawco has been attacked. One incident was when all the taps were opened and the building flooded. Then

(Continued on Page 3, col 2)

curtains and a dentist chair were burnt," he said.

The Shawo clinic was not damaged in yesterday's fire, and carried on business as usual this morning, while patients had to be turned away from the damaged day hospital.

Stabblings

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 Helderfontein 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 'withhills' (white flats). 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 from Page 1)
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. Vinyiwe, from Sada, said she was not bothered when she would get her medicine because the train she would take home left at night.

Mr Mthunzi Sotoyi, from Missendeho, 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 Sotoyi 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 Sotoyi 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 Nkikiwe 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
What’s wrong with the old Joburg Gen?

DELAYS, QUEUES AND IMPATIENT PATIENTS... WILL IT IMPROVE?

SUNDAY EXPRESS INVESTIGATION

MARIAN BURGIN

THE OLD Johannesburg General Hospital complex is bursting at the seams — and it shows. The new Johannesburg General Hospital should solve the problem, but poor salaries will prolong the staff shortage. Nurses have asked the Minister of Health for increases and many 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 crowded. Queues of people — many elderly — complain about having to wait for book appointments for long lines and pay their fees. Then there is the long wait at the dispensary.

The old hospital was finished about 15 years ago, but the medical equipment wasn't.

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, it would work, but it's not that easy when you are running a hospital world."

The move cannot happen soon enough for the hospital staff, impatient with working in congested, insufficiently prepared areas — particularly the outpatients — are tired of setting aside a whole morning to see a doctor and collect medicine.

Overcrowding increases tension between staff and outpatient, with patients often end up bickering at each other.

"Computers have accelerated the turnover of child and pregnant outpatients. Their bookings, admissions and discharges 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 could not accommodate more staff, even though the need is desperate.

Dr. Howes believes that once the move is complete, the queues and inconveniences of the old hospital will disappear, but 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 the hospital is a 24-hour operation and people became fed up with staff 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.

- Outdated, overcrowded — the old red brick building in Hillbrow known as the Johannesburg General Hospital.
- Queues at the old Joburg General — they should become a thing of the past.

Clarks trained to use computers 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 provide certain clerical posts involving computers, computers were being given public service tests and many were found unsuitable for hospital jobs with computers.

 begs the staff — clerks who handle admissions and required for their ability to handle people in distress. Procedures and fees also declined. They were carefully served and paid the dermatologists, the old hospital or the big city. There is no weighting to cover the higher cost of living in Johannesburg.

Part-timers are employed to ease the nursing staff shortages. Sixties work mornings, afternoons or evenings only. Doctors work one night a week, but the province will pay them on barley 56.87 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 practice. 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. Doctors dealing with patients in different areas will no longer have to dash across busy streets or into other buildings.

A new computerized information system will make 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 line of outpatients at the General is unpredictable. There is no patient profile. 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.

Dr. Howes is planning a booked appointments system, already working reasonably well in the poly-clinic at the old hospital. Although difficult to adhere to because of emergencies and artists, this system is more convenient for patients.

Some clinics in the old hospital only open by mid-morning 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 early appointments get priority — except for emergencies.

The dispensary at the old hospital is seriously understaffed and nobody realises this more than chief pharmacist Sammy Rosslee. His 10 pharmacists have to dispense drugs to more than 100 patients a day. Lack of space means only five pharmacists can deal directly with patients.

"Even if they gave me more pharmacists I have nowhere 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.

Dr. Howes says 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 1979 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 telephonic system which takes documents, medicines and supplies throughout the building in minutes.

More pay wanted
Let's have more hospitals

The time has come that the authorities think seriously about building more hospitals in black urban areas.

Stories of overcrowding at Baragwanath hospital and lately at Nalitspruit 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 facilities 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.
Scandal of little faith

THE explanation by Dr A F Chemaly, superintendent of Natal Spruit 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 it is the good doctor who 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 themselves being 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, didn't they have to make them bite 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.

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 is routine and that this is done to prevent to robbery," the hospital head said.

"This is not done everyday but is done on certain days. The spot searches are conducted at the two main gates of the hospital — the Eastern and Western gates."

"The nurses are searched by a woman guard and a male staff 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 block was built the whites were searched at the western gate, I was also searched. This does not mean that they only the black 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 serious loss of hospital equipment.

By PAULINE BUTHELEZI

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 then that the nurses were 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 shortages 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 sheltered who looked after food.

"If the nurses have any

Dr Chemaly... "Searching for nurses is a routine work."
Quit the Hospitals
Underpaid Nurses

Morale is very low and the patients are suffering...
Hot Butterscotch Sauce

1 T syrup
2 T brown sugar
squeeze lemon juice

Put butter, sugar, syrup and lemon juice into a saucepan and stir until melted. Add water and pour onto custard. Serve hot with ice cream.

Mary Snelling, Ridgworth

Tomato Sauce

4 tomatoes
4 sliced onions
8 level t maize

1. Wash and cut tomatoes into a saucepan with seasoning, boil until soft.
2. Put tomato, onions, carrots into a saucepan with seasoning; boil until soft.
3. Sieve, add maize, blend and boil again.

Brandy Sauce

1/2 oz butter/margarine
1/2 pt warm water
1/2 custard powder mixed with 1 T water

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.

P.W.V. Pearl

Barbecue Sauce

2 onions, chopped fine
2 T vinegar
2 T Worcester sauce
1 T salt

Mix all ingredients together. Simmer for 45 minutes.

Peggy Brown, Hei

Sherry Sauce (for Steamed puddings)

Warm sherry (1/4 pt) and a pot of nearly boiling water once, adding sugar to taste.

Sauce with White Wine

(For White Meats and Seafood)

1 cup hot cream
1/4 cup dry white wine
3 T butter

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.

* * *
Bara’s new brother: a R40-m hospital

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 the building will be started early in 1983.

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 Neerdermei and New Canada station on a 88 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 1983.

"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 forward 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.
Groote Schuur needs more yellow people

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 a country 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 9311 ext 3464, between 9.30 and 2.30.

• Bowlers wanted

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 a bus ride from Rosebank by way of Groote Schuur Hospital to Cape Town, on the day the fares went down on September 7.

On the seat next to me was an attractive young woman in her late 30s or possibly early 30s, who told me she was going to spend the day 30 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 related on, meant leaving her home in Eloff 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 seizing a few tidies 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 wealthy 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 the Mavis Taylor production, please telephone the UCT speech and drama department at 46 1907, or the office 22 4161, and impart the good news.
Alarming Ambulance Services

Costs of Lives

Chaos

Thousands of patients are being delayed and treated in overcrowded emergency rooms, leading to increased medical errors and deaths. Ambulance services are overwhelmed and understaffed, causing longer response times and inadequate care. The current system is broken and requires immediate reform.

Johnathon S. Rice, MD
President, Medical Association
AMBULANCE SCANDAL

The good, bad and atrocious

AMBULANCE stories are legion. Some seem too outrageous to be believed, 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 him lying in agony, the skin bone of his right leg sticking through the skin of his leg. Determined, the ambulancemen hauled out their equipment — and splintered the victim's left leg.

The man who told me this is an ex-ambulance staffer.

Many of the findings in Mr W N Van Kraaligen'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 these anecdotes might seem outrageous, there is sufficient basis for believing those tales.

Mr Van Kraaligen's direction 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, Manzburg and Cape Town — and found the picture is grim.

In his notes, Mr Van Kraaligen states that "overly sensitive issues such as drunkenness on duty, drug abuse, homosexuality, sexual assault on patients... which were encountered will be ignored".

Mr Van Kraaligen 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 Kraaligen 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 Kraaligen feels that with this revenue, the ambulance service should be vastly better than it actually is.

Pretoria, too, is slated. The city's imported paralysa, 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 Kraaligen as "very good", claims Mr Van Kraaligen's report is "skimpy".

Either way, the CSIR report is explosive, though the intention is not destructive.

Mr Van Kraaligen and Dr J C de Vries, 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.

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 118 ambulance services, who transport 268,000 patients annually over 5,5 million kilometres. The service has 90 ambulances, built to "Cape specifications".

Other services have ambulance bodies attached to track chassis.

The Cape municipal ambulance service has its own high-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 240 hours before spending a week's "apprenticeship" on the road with experienced teams.

The training school also provides additional training for rural ambulance services, 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 ambulance men.

The service is under the strict control of a qualified doctor, Dr A C McMahon, chairman 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, an ambulance is sent to an accident irrespective of the victim's colour.

The only measure of segregation is in the uniform 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 to her daughter's Kennington home to the General Hospital.

The ambulance arrived five minutes later — a time of approximately 40 minutes to travel, at most 80km.

The Johannesburg fire chief, Mr J H de Beer, handed me timesheets showing that urgent calls went "between two and four 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 at least.

Mr Van Kraaligen'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 excellent 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 of Health's sophisticated Mercedes Benz paravans, 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/debrillator and cardiac resuscitator.

Even the claxon was removed and the vehicle is restricted in use to response by a leading ambulance 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 response or on a specific request by a physician.

The report also points out that "there is a marked uneven distribution of responses and travel times between the white and black services, due to placement 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 geographical 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, and former 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".

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 parable 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: average.
Specialised vehicles: imported MICI.
General vehicle equipment: poor.
Neatness and cleanliness: poor.
Training: in-service first aid organizations.
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: average.
Response time: average.
Racially segregated: yes.
Staff morale: poor.
Hospital acceptance and feedback: poor.

MARITZBURG:
Service: direct fire service.
Radio frequency and communications: good.
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.

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 and own instructor offering variety of courses.
Response time: better than average.
Racially segregated: yes.
Staff morale: above average.
Hospital acceptance and feedback: above average.
Call-up causes ambulances chaos
Transvaal to get five new hospitals

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 Luseta Hospital, Landium Hospital, Volksrust Hospital and Phoshong Hospital for blacks on the East Rand.

Mr. Willem Cruyven, 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 Luseta Hospital, which would have 1,000 beds, were already on the drawing board and the other hospitals were also being treated as top priority.

Mr. Cruyven said it was important the province cared 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. Cruyven 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 extr{

\begin{align*}
\text{ING PRACTICE} \\
\text{f new plant for R60 000 provided at 12\% p.a.} \\
\text{allowance is granted for} \\
\text{20\% on the reducing} \\
19.6 \text{ and 42\% in 19.7,} \\
5 000 \text{ and R50 000} \\
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\text{d 31 December 19.7,} \\
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\text{method} \\
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\text{remains 42\%} \\
\end{align*}
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 services."

"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 Johannesburg industries, had been anticipated, with the realisation that timely 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 R28-million. The administration of the hospital will require R16-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 1,000 are now in use.

It is expected that, within the next five years, the hospital will provide services for about 20,000 to 25,000 outpatients a day.

Arrangements for the planning and erection of a subsidiary fully integrated day hospital at Mabopane East (Soweto), where a comprehensive health service will be provided, including district surgeon services on behalf of the Department of Cooperation and Development, will be provided.
Facilities for the chronically sick.

Chronic assisstance.

Dr. Van Heerden have the assurance of the medical officer of the house of Newlaven, Chronic Sick. Said the chairmen of the commission. The chairman Mr. M. tightening and the commissioner of the provinces. The case of the chronically sick.
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, PPP spokesman on Health, and representatives of the CSIR, including Mr W N Van Kralingen, whose study of ambulance services showed ambulance personnel were under-trained, 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 principle 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 McManon — chief of the Cape's Metro Emergency Unit — as convener, 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 Mumnik, who will present the complete package to Parliament.

Once the NHPC makes a decision, in respect of the policy it is regarded as December 19.7, said Dr Roux.

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%
THE Chief Superintendent of Baragwanath Hospital, Dr P. Benkey, yesterday warned the public to beware of a deep water hazard in the hospital's grounds.

The warning was issued after a patient, who was not named, drowned in the hospital's swimming pool.

Dr Benkey said the pool was closed for the season and the water had been drained. However, he warned that the water could still be dangerous.

He urged people to keep away from the pool and to stay away from the hospital's grounds.

The hospital's grounds are bordered by a deep water hazard, which is not visible from the outside.

Dr Benkey said the patient was a 12-year-old boy who had been playing in the pool when he fell in.

The boy's family was not available for comment.

The accident is the second drowning at the hospital in recent weeks.

The first incident occurred in August, when a 10-year-old girl drowned in the same pool.

Dr Benkey said the hospital was taking steps to improve safety at the pool and to prevent future incidents.

He urged people to stay away from the pool and to be aware of the dangers of deep water hazards.

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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

...ing. This is partly due to a deficiency in information on the results of the programmes which may be resolved by recourse to appropriate data. Nevertheless, there will also be differences of judgement which cannot be resolved without prior agreement on the relative valuation of different benefits which have to be fed into the analysis; and in the intuitive process, these two factors may not be differentiated.

A very large proportion of doctors, however, are untrained in the use of marginal analysis. By Elizabeth Wilson

Barotseland, black doctors are supposed to visit their patients every day or two, but it is rare that they can do this, Dr. Okumu said, the need for another hospital at Barotseland is essential. In Barotseland, Bethel Memorial Hospital, they say a new hospital is needed. Dr. Black said, it is essential to have a hospital in Barotseland.

Barotseland, doctors have a lot to do and a lot to attend to. Potentially, we could be doing much more. Potentially, we could be doing much more.

Diagram 1: Problem

<table>
<thead>
<tr>
<th>Problem</th>
<th>Large &amp; poorly spaced families</th>
<th>Inadequate natal &amp; obstetric care</th>
<th>Malnutrition</th>
<th>Need for medical care</th>
</tr>
</thead>
<tbody>
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<td>V.D.</td>
<td>++</td>
<td>++</td>
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<td>Dental problems</td>
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<td>Common cold</td>
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<td>T.B.</td>
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* Added to test scoring method

r analysis the other.
It's not too few beds —

We do a good job—hospital chief

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 Vereeniging, 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 patients 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 Baragwanath 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 1960s.

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 Department of Hospital Services whenever a head requested it.

"The department of internal medicine was looking 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.
it's just too many people

PATIENTS DIE AS DOCTORS SCURRY TO AND FRO

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 accommodation. 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" lay 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.

Propelled against the outside walls 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 alleviate 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 1966.

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 Baragwanth — 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 1988. 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 Baragwanth 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 71 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.
STUFFED CABBAGE SALAD

May Bennett, Ridgeworth

1 fresh green medium size
cabbage	onatoes
onions
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.

---00---

GLEANER POTATO SALAD

Ethna Beard, Port Elizabeth

boiled potatoes
cooked bacon
chopped onion
mayonnaise

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.

---00---

SPRING GREEN SALAD

May Bennett, Ridgeworth

1 medium size lettuce
tomatoes
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.

---00---

CURRIED GREEN BEAN SALAD

Mrs Futter, East London

2 lbs sliced green beans
2 chopped onions
1 d salt, level
2 cups water
1/2 bottle vinegar
1 heaped T flour
1/2 cups sugar

Boil the beans (sliced) with salt and onions till cooked,
pour off the water.

Sauce:
1 1/2 cups sugar
1 d curry powder

Mix the curry powder.

BARACWANATHI HOSPITAL

BARA

Meet on Heads to

BARACWANATHI HOSPITAL

The registrars plan to meet the hospital's physician, the
superintendent and possibly the hospital's services
Attendants of over crowding and a shortage
of facilities at the hospital.

---00---

French dressing:
Begd together 6 T salad oil and 2 T lemon juice.

---00---
| Choice of Program | 2. | **Leratong** has black board | 4 | 11/11/11 |

<table>
<thead>
<tr>
<th>Program</th>
<th>Co-op</th>
<th>Academic</th>
<th>Nursing</th>
<th>Teaching</th>
</tr>
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<tr>
<td>1</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>2</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>3</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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</table>

The cost of attending this program has to be taken into account.

The overall program is designed to prepare students for careers in health services. The program includes coursework in anatomy, physiology, and pathology, as well as clinical rotations in various healthcare settings. Students are required to complete a minimum of 1,000 hours of clinical experience during their program. The program is accredited by the South African Medical Council (SAMC).

The program is open to students who have completed their high school education and have a minimum of 50% in their final year of school. There are no specific prerequisites for the program, but students are encouraged to have a strong interest in the healthcare field.

The duration of the program is 3 years, and the program is conducted in English.

For more information, please contact the program coordinator at the following email address: info@leratong.co.za.
**Union Rileys**

Kay Bennett, Ridgeworth

Feak and slice large onions, and separate the rings. Heat 2 pints ghee 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.

---00---

**Oud Fami**

**French Pastries - 1802**

<table>
<thead>
<tr>
<th>Pastries</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eggs</td>
<td>2</td>
</tr>
<tr>
<td>Butter</td>
<td>2 cupbs</td>
</tr>
<tr>
<td>Flour</td>
<td>2 cups</td>
</tr>
</tbody>
</table>

Beat the eggs thoroughly, sugar and flour, and then a couple of minutes, quicken for 25 min sugar, or oil an egg, next between them. T. at any time.

---00---

**Spitzkop - 1850**

<table>
<thead>
<tr>
<th>Ingredients</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young milk</td>
<td>1 cupbs</td>
</tr>
<tr>
<td>Brown bread</td>
<td>2 cups</td>
</tr>
<tr>
<td>Mincemeat</td>
<td>1/2 cupbs</td>
</tr>
</tbody>
</table>

Put the milk through melted butter. Goi chopped parsley on till 1/2 done, then till well done. S. instant.

---00---

**Blum Pudding**

<table>
<thead>
<tr>
<th>Ingredients</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sugar</td>
<td>2 cups</td>
</tr>
<tr>
<td>Biscuit</td>
<td>1/2 cupbs</td>
</tr>
<tr>
<td>Brown bread</td>
<td>1 cupbs</td>
</tr>
<tr>
<td>Sultanas</td>
<td>1 cupbs</td>
</tr>
</tbody>
</table>

Mix all ingredients together well, tie in a pudding cloth, and boil for three hours. Serve with hot butter sauce. This recipe was used at Christmas dinner in 1810 by my mother and grand. The sauce is made 1 cup of flour and 1 cup of sultanas browned instead of 2 cups of flour. Very successful.

---00---

**Mutton Roast Shoulder of 1850**

<table>
<thead>
<tr>
<th>Ingredients</th>
<th>Quantity</th>
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</thead>
<tbody>
<tr>
<td>Shoulder of mutton</td>
<td>1 piece</td>
</tr>
<tr>
<td>Dripping</td>
<td>1 cupbs</td>
</tr>
<tr>
<td>Salt</td>
<td>1 cupbs</td>
</tr>
<tr>
<td>Flour</td>
<td>1 cupbs</td>
</tr>
</tbody>
</table>

Put the joint to a bright clear fire, flour well. Mutton contin-
Put the pot in a preheated oven. Pour in oil. Snip the ghee. Add the garlic, ginger, and onion to the pot. Stir-fry until the onion is soft. Add the bell peppers, zucchini, and mushrooms. Stir-fry until the vegetables are tender. Add the tofu, bamboo shoots, and water. Cover and simmer for 15 minutes. Serve over rice.
Bare staff situation

is being investigated

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THE SHOW 30.10.74

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May Bennett, Agla

EIGN FINDS
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 Mosheh.

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 Mosheh, Mr Motloung, Mrs T G Phahleng, Dr Grove and Mr Mpiyakha Kumalo.
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 women, some younger than myself, fighting expertly for someone else's life.

They do this 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, though they feel a personal sense of loss, and if 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 R180 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 strung, 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 the whole 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 eight nurses and one ward sister responsible for four medical wards in the old General Hospital.

I left them there at 9am. By the next morning, my eyes were red from sleeplessness — and a massive dose of depression.

Work began that night with the usual duties. The ward sister on duty took the 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 were 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 mirroring their favourite moods, being friendly.

It looked as though life was going slowly by with hourly checks, hourly tempersiko's, hourly worries about the patient…

At 10pm I went to the life struggle in Ward 3. A phonecall, a sister downstairs. A patient whose evening had passed without its events had passed without leaving a mark.

...
HIST WITH THE NURSES... AND SALUTES...

night price t for

with the angels who each life

SUDDENLY DEATH!

The sister with five years' experience (and a salary that probably leaves her with $500 a month) has never learned to bear herself against a death, each little old man, each moan- ing and demanding woman patient, is precious to her.

Each ward that Wednesday day 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 diet was affecting her badly, needed attention. The sister called again, she decided to wake the house- man who was trying to catch 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 3.30am 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 directed nurses to those for forever. He nev- er 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 tele- phone 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 he could, and persuaded him to have a hot drink or two. The nurse helped out with some more patients around the hospital wards.

"I felt so useless," she said afterwards.

The medical ward under Sister Doddy had had their share of drama. But the sister herself and the medical ward also had a busy night to report. She and her staff had spent the night trying to restrain a schizophrenic woman who had probably had no 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 back routines", the emptying of bedpans and bottles, the ferrying of patients to the toilet, the dispensing of nib- bly night medication.

The nurses seemed to have a new lease of life with the sunrise - home and sleep were well and only one ward would have a death to fill in. All 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 barrow in the hospital.

They tidied up the corner where they had waited the night with coffee and put back cases that had gone astray, examined stockings that had bed sores, etc. In the emergency, at 7am, 12 nurses were sent into the hospital, they were on their way to bed.

I am told now what nursing is all about. It is fascinating, it is challeng- ing - but I can echo the words of one "regular" pa- tient, Mr Neville Tamuri.

"There are no other people like nurses in the world, they are unbelievable - but stone mad to do it for no wealth - and as far as I am concerned no wage."
Debate rages on plan for sperm bank

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 1979, 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 Herenomde 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, Dr. 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

"..."
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<td>M</td>
<td>F</td>
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<td>0-1</td>
<td>1.47</td>
<td>0.76</td>
<td>0.60</td>
<td>0.03</td>
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<td>0.04</td>
<td>0.02</td>
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**Oriental Analysis**

By the incorporation of various cultural and religious elements, this structure reflects a harmonious blend of traditional and modern influences. The design is symmetrical, with the central axis serving as a focal point. The use of materials such as stone and wood adds to the aesthetic appeal and durability of the structure.

**Directions of the House**

- East: 0.17 0.08
- West: 0.10 0.21
- North: 0.00 0.00
- South: 0.01 0.01

This structure is surrounded by lush greenery, providing a serene and peaceful environment. The layout of the garden complements the architectural style, enhancing the overall experience of the visitors.
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."
Bara has a black board now

BARAGWANATH HOSPITAL had a party in the doctors' quarters for dinner to mark the inauguration of the first all-black board since the inception of the Baragwanath Hospital Board in 1938.

The public relations officer for the hospital, Mr L. Paul, said that he believed 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 alternately fill the time. They must meet once every two months.

Mr W. M. Matese, chairman of the Baragwanath Hospital Board, said in his address: "I, as chairman of the first all-black hospital board, will do my best to solve the problems of the entire hospital, the personnel and the community that patronises it."

Mr Matese will influence the public to stop smoking and drinking and to exercise. This does not mean that they must be athletes or gymnasts, but there are simple exercises one can do.

Mr Matese, chairman of the first ever all-black hospital board, said that he believed the board would act in an advisory capacity to the superintendent and the Director of Hospital Services in the Transvaal.

Mr Matese also mentioned that the Baragwanath Hospital Choir was under the baton of Mrs Pauline Moloi, and the Baragwanath Hospital Black Brass Band played items.

Dr W. M. Matese, chairman of the first all-black Baragwanath Hospital Board, said: "I will influence the public to stop smoking and drinking and to exercise."
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 clinic. 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 Mbabana 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

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 tech-
niques 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 develop-
ments inside. The building
will face north and south.

Air-conditioning had not been
provided for in the design of the
building, because ade-
quate precautions had been
taken to protect it from sun.

But where medical require-
ments demanded air-condi-
tioning, it would be supplied.

Tenders would be called for
during June and July next
year, and the contract peri-
od will be about three years.

Other projects included in the
R10 000 000 hospital develop-
ment are: an extension by
300 beds to the nurses' home, extensions to the
PABX telephone exchange
system, modernising of the
casually department, alter-
ations to three vacant black
wards to house a new ortho-
paedic workshop and arti-
ficial limb factory, a new de-
partment to house sonar and
body scanner X-ray equip-
ment, and a new emergency
electricity plant.

An emergency water supply
and water reticulation sys-
tem 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

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.
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 16-17). This means that at least one person died while waiting for treatment every day of the long weekend.

They are Mr Gilbert Tholele (33), of Zone 1, Miphokol; Mr. Victor Ndloko, of Zone 1, Meadowlands; Mr Eric Ngubeni (21), of Zone 1, Meadowlands; and Mr Veli Chauke (19), of Zone 1, Chawela.

Relatives and friends claim that the victims died before doctors could attend to them while waiting at casualty.

The hospital has rejected the claims.

The Deputy-Superintendent of Baragwanath, Dr Chris van der Heever, confirmed that Mr Tholele died in the casualty section. He said he died while doctors were examining him.

Dr van der Heever said that according to his records, Mr Ndloko 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.

POST 26/12/79 98
Private medical costs up

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. R. 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 R25 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.
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 hospitals?

Food in the hospital kitchen. That domestic working in the stains room as well as with the baby’s bottles.

Who decides on the removal of (or transfer of) such workers? The chief of the kitchen. This is the chef’s domain. The matron? Or does the decision rest with hospital management? And who is in hospital management?

I have my own experience as a patient in a private (R300 a day) hospital provided small samples. When I returned, the chef housekeeper on one of her duties, informed me that my room had not been cleaned for two days: she explained that she was aware of this, but hastened to take action as soon as she had received the complaint.

Some male cleaners are members of gangs, who may go to the trouble of supervising staff. Her report to the hospital management had resulted in a shuffling of personnel. We may well expect hospital hierarchies: What is the calibre of your domestic staff?

The same hospital had a dispute over fitted carpeting in the patients’ lavatories. On the side that the sick were unsteady on their feet, there was a discolored spot. One of the cleaners, a man in uniform, had laid the blame on the carpet.

Some of the floor covering material is necessary to be avoided without regard to its efficiency.

In one hospital it was decided to switch from one brand of cleanser to a cheaper one. The new brand was ineffective. The cleaners are responsible for the cleanliness of the kitchen. They have not been listened to. Who, on the hospital staff, asks what to buy? Is it the Medical Superintendent, who has a knowledge of bacteriology and microbiology, or is it the matron or is it the patient?”

Food poisoning by motor vehicle exhaust gas” is a code used in South Africa. (In C.D. 8th revision), see Ref. 13.

ENGINEERING

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 resulting quality was unsatisfactory and water is done by unskilled labour without adequate supervision and the results are inferior.

One may enquire from hospital authorities whether their staff are all free from overt disease. Considering a kitchen worker with a skin ailment is found handling food.

One delegate made the point that 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 at the cost of lives.

Florence Nightingale’s policy

Isabel 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 depends on the attention given to the tiniest, often dull, but always vital, small 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 dirt from the hearth before the door, put a window in the middle of the wall which opens, and drain, clean and line wash your vats?’

BERYL CONLAN
Hospitals therefore of necessity, carry a formidable responsibility in ensuring that suitable preventative measures are carried out to minimize 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 emphasized by the more than 300 delegates to the Sterilisation and Disinfection Society's symposium on 'Non-occipital 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, Thelier 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 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 patient's 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 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 R38 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.
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.”

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 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 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.