therapeutic radiopharmaceutical, which destroys diseased tissues. 'Follow-up' is to monitor the success of treatment using the same diagnostic radiopharmaceutical employed in the original diagnosis of the disease.

Nuclear medicine is under-utilised in South Africa. Since a significant cause of this is limited undergraduate teaching, it is important that with revision of curricula at medical schools, the role of nuclear medicine should be emphasised and it should not be regarded purely as a postgraduate subject. Applied appropriately and cost-effectively is has an important role to play in patient management, but with the constraints placed on South Africa as a developing country, we are in danger of falling irrevocably behind rapid developments in the field. Therefore it is vital that nuclear medicine in South Africa continues to reflect these exciting international trends. We invite colleagues to visit the website of the South African Society of Nuclear Medicine at *www.sasnm.de.vu* for more information.

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Ethical standards

To the Editor: Discussions with various colleagues (GPs and specialists, including pathologists) show that a great deal is lacking in the behaviour towards, and relationships between, colleagues. It wasn't so in days gone by and the present state of affairs must be corrected.

Pathologists complain that the request forms they receive often omit essential information, e.g. age, sex of patient and suspected diagnosis, and that there is altogether a complete lack of clinical information. An example would be a request for a thyroid profile, without telling the pathologist that the patient is on Eltroxin. How can s/he be expected to interpret results under those circumstances?

This reflects the lack of concern specialists speak of. They seldom receive a letter of referral when a GP refers someone. They need to know why there is a referral, what relevant history has been elicited and what investigations and X-rays have been done. Above all, they need to receive either the results or copies of the results and reports to avoid duplication.

GPs say that if they refer a patient they rarely receive a report back and often never see the patient again as the specialist tells the patient to return in 3 months or so for another EEG or whatever. Alternatively, what often happens is that the specialist refers the patient to one or more other disciplines and the GP — the so-called gatekeeper — is not even informed of this, either by the original specialist, or by his colleagues who see the patient. Personally, I can recall sending a patient to a neurosurgeon who referred the patient to four other specialists. I found all this out from the patient much later.

The 'good old days' of specialised doctors being 'consultants' also disappeared years ago. Was it the advent of the Medical Schemes Act of 1967, or the fact that the Medical Council (now the Health Professions Council) issued an edict stating that it was the right of patients to see any doctor of their choice? Consequently, despite the medical aid injunction that all cases going to specialists must be on a GP's referral, patients in the urban environment all have their own gynae, paediatrician, ENT specialist, etc.

Let's get back to good conduct between colleagues, which at least will show respect for what the other person is doing.

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The Employment Equity Act — putting the record straight

To the Editor: The authors of the 'Personal View' entitled 'HIV testing and the Employment Equity Act — putting an end to the confusion'[1] have been tardy in responding to my first article on the topic,[2] and their information is misleading. It unkindly tries to position my letter published in 2000 as being 'against the EEA and its extremely powerful tools for equity, redress and social justice'.[1]

It was very clear (and this is re-emphasised) that the critique was focused and limited to Section 7(2) of the EEA, which was the only section about which the tripartite stakeholders in Nedlac were not consulted.[2] Furthermore, the attempt by the authors to single out the undersigned as the only party ever to have questioned the legal meaning of Section 7(2) is dishonest (or else a case of denial), as at least one if not all of the authors have been central to the debate and participated in surrounding actions to try to rectify the situation and the interpretation (including senior counsel legal opinion) of that section.

My original piece on the EEA[2] aimed at creating debate to end the confusion, or at least result in constructive efforts to correct it. The fact that it was published as a 'Personal View' was an editorial choice and unfortunate, reflecting the sensitivity of the issue and the reluctance to discuss or even confront it constructively at the time. The very late response from London *et al.*[1] may unfortunately revive the issue rather than put it to bed, as I believe the confusion surrounding section 7(2) of the EEA has been replaced with lenience and

resignation on the part of the health care profession. Many other documents are available that are clear on best practice, such as the International Labour Organisation (ILO) Code,[1] Department of Health guidelines, South African Medical Association (SAMA) guideline, etc.

Unclear legislation caused the confusion

If the provisions of Section 7(2) had been clear, there would have been no debate. The entire debate, widespread legal opinion and various discussions resulted from the fact that the drafting of Section 7(2) of the EEA was unclear and open to different interpretations, as set out in my article.[1]

Furthermore, I am deeply concerned as to why the authors regret the fact that 'debates that have taken place in confidential forums have now been placed in the public domain, a practice which does not bode well for encouraging negotiation and conciliation processes in policy development in the development of sound occupational health policy'.[2] It is precisely due to non-consultation and the addition of Section 7(2) only after the Nedlac process that the resultant confusion was generated. The authors create the impression that they were party to drafting Section 7(2), having been the consulted persons in the 'confidential forum' to discuss occupational health policy without open public debate and consultation.

It is quite correct to state that the EEA does not make it a criminal offence to conduct testing in violation of the Act — the reason is precisely due to the late addition of Section 7(2). The drafters of that section overlooked the requirement to add the penalty clause which should have been included in proper legislation, and would have been had it gone through the proper process.

Problem acknowledged by all parties

I personally sought legal opinion widely from diverse sources, including academics, legal practitioners (including senior counsel) and medical and legal associations. Referring to my

article as 'mischievous and totally unfounded' sounds like denial, and is misleading and dishonest. It is an attempt to belittle the widespread confusion and discussions that took place on Section 7(2) in many different forums including Nedlac, SASOM, the Chamber of Mines of South Africa, Business South Africa, the National Union of Mineworkers, the South African Labour Law Association, the Department of Labour, the Portfolio Committee on Labour and many others. It was certainly not one single 'personal view'. The possibility of a declaratory order was mooted in many forums. In Nedlac, business was urged to approach the Labour Court to get clarification, as according to government officials an amendment would have taken at least 2 years to effect. I did refer to this in my original article. I do not believe that my view alone prompted government to consider an amendment; as stated, I only gave voice to the widespread confusion.

Further confirmation and acknowledgement of the different possible interpretations of Section 7(2) is the fact that the tripartite drafters of the Code of Good Practice, during consultation in Nedlac, were requested to clarify the meaning and interpretation of Section 7(2) in the Code, which led to a specific footnote included in the Code.

The Advisory Council in terms of the Occupational Health and Safety Act No. 85 of 1993 and the Compensation Board in terms of the Compensation for Occupational Injuries and Diseases Act No. 130 of 1993 received documentation based on legal opinion sought from Mr P Benjamin (one of the co-authors) on addressing the issue of testing and eligibility for compensation.[1] However, the authors now acknowledge the fact that the EEA is supreme, as pointed out in my article.[2]

London *et al.* state that the EEA should be interpreted to mean that voluntary informed consent overrides Section 7(2) and does not require application for Labour Court permission. If this was such a simplistic case of interpretation then pre-employment testing could be done once informed permission was obtained, which is certainly not what the drafters of the EEA had in mind.

Widespread confusion caused damage to HIV prevention efforts

It would be dishonest to ignore or underestimate the significant damage caused by Section 7(2). It prevented many initiatives from getting off the ground, while others were stifled due to uncertainty and the different legal opinions expressed on the intention and meaning of the section. Many employers halted the development of clinics, motivated by health care practitioners, to expand sexual disease treatment and voluntary counselling and testing. Expressed legal opinion was that it would have been unlawful to provide testing facilities without Labour Court permission.

London *et al.* state that there is already immense confusion among health workers as to when HIV testing is allowed and how such testing may take place. This is exactly why we did not need any further confusion but rather proper, considered and circumspect drafting of legislation on such a significant issue.

Conclusion

I would be one of the first to agree that 'Given the immensity of the HIV epidemic facing South Africa, we cannot afford to give mixed messages', hence my extreme frustration and belief that Section 7(2) was a calamity. I was certainly not the only party struggling to interpret the section — I merely gave voice to the prevailing confusion, which the drafters of the Act were not prepared to respond to despite requests from various sources to do so.

Perhaps Section 7(2) was meant to have been a 'hallmark achievement, a legal landmark' and as such above any criticism. Of course we all appreciate what the Act 'intended' to achieve and prescribe, but unfortunately it did not achieve this clearly and caused confusion and harm. The legislation should have focused primarily on preventing discrimination or the abuse of knowledge of the results of an HIV test, not on preventing an HIV test as a tool for well-intended diagnostic purposes and treatment. Sadly, the medical profession was certainly not widely consulted, as the correspondence referred to[1] has reflected.

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1. London L, Benjamin P, Bass DH. HIV testing and the Employment Equity Act — putting an end to the confusion (Personal View). *S Afr Med J* 2002; **92**: 199-201.
2. La Grange MAC. The Employment Equity Act — another HIV calamity (Personal View). *S Afr Med J* 2000; **90**: 773-775.