



Voluntary HIV testing and counselling at the workplace — entirely compatible with the Employment Equity Act

To the Editor: Previous debate in the *SAMJ*¹⁻³ drew attention to the problem (misperceived, in our view) of restrictions placed on workplace HIV prevention programmes by the provisions of the Employment Equity Act that prohibit HIV testing at the behest of employers without permission of the Labour Court.⁴ The Labour Court recently considered an application by a large employer in the fishing industry, supported by the employee's trade union, to conduct voluntary and anonymous testing for HIV.⁵ The ruling of the Labour Court⁶ found that voluntary counselling and testing (VCT), an essential element of public health measures to control HIV, would not require the Court's permission. Indeed, the court went further to include compulsory anonymous HIV testing as permitted without Labour Court oversight, provided that no discrimination could result from such testing. Central to the court's analysis, was the recognition that voluntary consent removes the testing from the ambit of the Act, and that no public interest is threatened by such a waiver of an individual employee's right to protective oversight by the Labour Court.

These findings are entirely consistent with guidelines emanating from the Department of Labour,⁷ the Department of Health,⁸ the Southern African Development Community⁹ and the World Health Organisation,¹⁰ all of whom recognise the important contribution that workplace HIV programmes can make to benefiting employees and the broader objective of HIV control, an opinion explicitly acknowledged by the Labour Court in arriving at its finding. We trust that this legal precedent finally puts to rest the debates circulating regarding the place of workplace voluntary counselling and testing programmes in the strategies available for the control of HIV, misinformation that, in our opinion, can only be of benefit to highly paid lawyers and industry consultants, rather than employees and employers willing to undertake HIV prevention activities. The message should now go out loudly and clearly from the public health community — the Employment Equity Act does NOT prevent the adoption of well-planned non-discriminatory HIV prevention programmes that include VCT, and that ensure that participants are able to give informed consent and to make decisions that benefit their own health and well-being.

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Breast cancer management in the new millennium — a multidisciplinary approach

To the Editor: Breast cancer is the most common cancer in women worldwide. In South Africa about 5 000 new patients are diagnosed every year.

Breast cancer is a chronic and unpredictable disease. Over the past three decades, advances in the knowledge of breast cancer biology and its different behavioural patterns have enabled the medical profession to change the management of this disease. Until the 1970s breast cancer was regarded a loco-regional disease, with mastectomy being the first treatment of choice for 'early' disease.

Although breast cancer was primarily diagnosed and treated by surgeons, it is now unacceptable for any single specialty to manage breast cancer without the input of the other role players. The roles of the breast radiologist (preoperative histological diagnosis and extent of disease spread), medical oncologist (preoperative, and adjuvant treatment, preventive hormonal and other), nuclear physician (sentinel node mapping and screening for metastases), breast and reconstructive surgeon and radiation oncologist are important in the preoperative workup of all patients. The mismanagement of breast cancer is eliminated in a multidisciplinary setting as advocated in leading breast care centres all over the world. No surgical procedure should be done at all (surgical excision biopsy included — core needle biopsy is preferable) before multidisciplinary consultation (in which the patient herself has a say and time for more consultation and second opinions). No patient should be hurriedly pushed into a decision.

It is only since 1992 that there has been a rapid worldwide decline in breast cancer mortality (in spite of increased incidence). The progressive advances in early detection using screening mammography, new techniques in breast surgery,



plastic surgery and radiotherapy, and finally, new systemic treatments (hormonal, chemotherapeutic and genetic) have contributed to many more lives, and breasts, saved.

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Ritalin — on the bandwagon?

To the Editor: The new Ritalin-LA (long acting) was launched at the beginning of this year at a roadshow throughout the country. As with many new drugs it became so popular that almost a month after the launch it was out of stock.

Unfortunately since then I have seen some very worrying tendencies appear on the horizon. It seems that Ritalin is increasingly being prescribed without thorough assessment. One such example involves 4-year-old boy who was put on Ritalin-LA 30 mg after a complaint by a nursery school teacher that he could not sit still. Another involves a girl aged 12 years with sudden regression in school performance and behaviour, who was put on Ritalin-LA 20 mg, without any response. A full evaluation revealed that she had been sexually abused.

Another worrying development is that more and more mothers are phoning to ask for advice after their child has been put on Ritalin and now has side-effects, with which the prescribing doctor does not know how to deal.

Ritalin is an excellent and wonderful drug for children who need it. However, it is my impression that the roadshow (unintentionally!) might have given the impression to doctors unfamiliar with the field of developmental paediatrics that the long-acting version is now a quick fix for concentration problems. The talk on attention deficit and the functioning of Ritalin was excellent, but it is important to realise that attention deficit disorder is only one block in the puzzle of developmental paediatrics and not the puzzle itself. It is therefore important to adopt a holistic approach in the case of the child presenting with concentration problems. This includes, over and above a full assessment of the main complaint, a thorough assessment of the child's emotional status, social abilities, learning problems, other co-morbid conditions that might co-exist, and extremely important, also educational and family psychodynamics. Only when all these factors are taken into account and fully assessed can a treatment protocol for each child be individualised and put into place. If we neglect our duty in this regard we are going back to the seventies when Ritalin was dished out right, left and centre — when stopped in those days at 12 years of age,

many children still could not read, write or socialise, and still struggled with behaviour problems and low self-esteem.

There is also a tendency for children to get referred from occupational or speech therapists, or even in some instances from the teacher, with the instruction that the child be put on Ritalin — and the doctor faithfully obeys.

Professor Johan Prinsloo once said: 'The most important thing for a doctor is to know when he does not know.' I know that this is general knowledge, but it is still important for any medical professional to have a sound knowledge of the functioning and side-effects of any medication that s/he uses and to have a thorough knowledge and understanding of the condition being treated. It is in the interests of all children with developmental problems that they, their families and schools can rely on correct diagnosis and continuous support. Treating these children is not a quick prescription, it is a lifelong commitment.

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Weak knees

To the Editor: SAMA online (27 February) reports the South African Medical Association (SAMA)'s comments on the pressure from the Board of Health Care Funders (BHC) to force medical practitioners to contribute to the BHC practitioner register. SAMA states that discussions with the BHC have been unsatisfactory in many ways and SAMA said that it wished to verify and clarify some aspects further.

However, SAMA then goes on to say that it recommends that all medical practitioners concede to the request, because 'otherwise they may not get paid'.

This weak capitulation is not what is expected of SAMA. It seems that SAMA has no appreciation of its powerful authority. A directive from SAMA to all medical practitioners, recommending that payment should be withheld, would stop short the BHC pressure immediately and so allow all necessary clarification.

Once a concession is made to the BHC demands, the precedent will be set, and become irreversible. After this the BHC will cock a snook at any attempts at further 'verification and clarification'.

This additional cost burden, which is of doubtful value to the individual practitioner, will then become yet another legacy of weak ineptitude to be inherited by our successors.