Occupational HEALTH

SOUTHERN AFRICA

A CANNON MEDICAL MEDIA PUBLICATION

Official Journal of the SA Society of Occupational Health Nurses (SASOHN) and the SA Society of Occupational Medicine (SASOM)

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Vol 4 No 3 May/June 1998

ISSN 1024-6274

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IndustroMed experienced phenomenal growth in 1997, not only in those areas where their advertising has been pitched, like mobile audiometry and total onsite occupational health services, but also in the field of consulting.

Particular interest has come from the long-distance transport industry as well as the heavy lifting services. Opencast mining from both within and outside the country has made substantial use of the service.

The degree of earnestness with which worker health is regarded differs vastly from group to group, organisation to organisation and from company to company, and even within various sectors of the same company. Generally, however, the importance attached to occupational health is on the wax and the degree of window-dressing is decreasing.

The bugbear of mobile audiometry remains the inhospitable hours of work in order to comply with legal restrictions, while the vast distance covered by the mobile units is another variable with which to contend.

Mainly because of the above-mentioned factors, franchising the service has become a distinct option, and the first franchise units will be operational in 1998.

For further information, please contact Neill Hattingh, at (011) 432-3578.

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For further information, please contact Shelly, at 082 464-8280.

Directory of Occupational Hygienists

continued on next page

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Guest EDITORIAL

Occupational health remains a challenging and rewarding occupation There is so much to learn about environmental health risks and how to prevent occupational disease that one should never be able to complain of boredom.

Many professionals are still trying to get to grips with all the legislation which has been promulgated during the past 5 years! I believe that legislation should be regarded as a valuable "rule-book" or guideline on what needs to be done to safeguard employees from risks to injury and disease and also to give structure to planned programmes of prevention in the workplace. It can also be used to convince management of the necessity for change - an employer guilty of an offence under the Occupational Health and Safety Act faces quite hefty fines as well as the possibility of a gaol sentence.

The Regulations for Hazardous Chemical Substances (R1179) have been written in an easy-to-understand format. When designing any medical surveillance programme, these regulations must be referred to.

The starting point for any programme should be a Risk Assessment. Without the information provided by the risk assessment any programme will be based on guesswork , not specific and perhaps even a waste of money and time.

Two important issues relating to risk assessment come to mind:

- The concept of teamwork in the workplace must be emphasised. Occupational health practitioners (OHP) should have close contact with occupational hygienists to understand the health risks in the working environment, receive reports, discuss health issues and motivate for change.
- Occupational health practitioners should extend their view to incorporate a better understanding of the "shop floor" as part of their responsibility. Too many OHPs spend all their time in the medical centre and never move out to observe the conditions that employees are exposed to. This knowledge has reference for the visiting medical practitioner (OHMP) as well. Occupational health nurses should ensure that a plant visit is scheduled as part of the doctor's duties on a regular basis.

In this way the doctor supports any planned programme and can assist to motivate management for any policy changes, additions to the budget, etc. and the employees will know that the medical staff understand conditions on the shop floor.

Of course having an intimate knowledge of working conditions makes it easier for the medical staff to understand the inherent requirements of the various jobs - especially at pre-placement level. Botha gives much food for thought in a well-written article on *Pre-placement examination and the Labour Relations Act 66 of 1995*. The most important question at this level of professional contact should be *Can the person do the job? and be a productive employee*. Prevention of discrimination starts with the proper planning and design of job content, which includes medical criteria based on the issues mentioned above.

Epilepsy is a disease which may have to be dealt with at pre-placement level. Kies makes it very clear that each case should be dealt with on merit but makes the important point that over 70% of persons with epilepsy may be rendered seizure free and should be allowed to perform any job without discrimination. There are many unemployed epileptics in the community who have been discriminated against in the past and denied employment because of predjudice and the stigma of the disease.

Smoking remains a battle-ground between the smokers and nonsmokers and even between manufacturers (tobacco industry) and health officials and professionals. Saloojee talks about the hazards of smoking and the nasty effects which have been well-documented over the years. Smokers insist that they have rights (to smoke!). This addiction is one of the most difficult to give up as the effects are not as directly devastating on family and other social relationships. In the working environment, smoking compounds the effects on the lungs of dusty and polluted environments. Every OHP should take a strong stand against smoking and smoking at work. Smoke-free workplaces should be encouraged. The Department of Health has issued a very helpful booklet "Toward a smoke-free workplace" to assist in setting up a smoking policy at work. Personally I cannot understand OHPs who smoke and have to counsel employees on healthy life-styles.

We look forward to the "new" NCOH and the role it will play in occupational health in SA at national level. These changes may take some time to implement - requiring extra manpower, financial resources and organisation.

After three-and-a-half years, this journal is more than 70% subscribed - a fine testimony to the continued support of the readers and to the fact that the journal satisfies its readers with the content and standards of articles.

Next issue we welcome the occupational hygienists to the 'family'.



Brenda Webster
GUEST EDITOR

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Tobacco-free workplaces and the law

When introducing a policy to restrict smoking in the workplace, employers must remember that both smokers and nonsmokers have freedoms and rights. Smokers want to be free to smoke when and where they choose. On the other hand, nonsmokers want to be free to breathe clean, tobacco-free air. Given this potential conflict between the two groups, it is the law that will finally determine which rights and freedoms shall prevail. It is therefore appropriate to survey the laws governing tobacco use in the workplace.

Smokers' rights

Some smokers claim that they have a constitutional right to smoke. The question therefore arises: Can an employee insist on smoking in the workplace? The answer is no. There is no constitutional right to smoke and an employee only has a right to smoke if his or her contract of employment specifically grants the employee that right.

If a right to smoke exists, then it has to be found in the 'custom and practice' of the workplace. It has been argued that if an employee accepts employment in a workplace where smoking is permitted, then the employee has an implied contractual right to smoke. In this event, the introduction of a no-smoking policy would be an unfair labour practice because the employer was unilaterally amending the terms and conditions of service.

This issue has not yet surfaced in our courts but, according to expert legal opinion, a smoking policy would not constitute an unfair labour practice. The employer would be able to show that passive smoking is harmful to nonsmokers, and this would be reasonable and fair grounds for changing the custom and practice of the workplace.

Although the introduction of new rules on smoking is not a breach of contract, the manner in which the new rules are introduced may, however, amount to a breach of contract. The English Industrial Tribunal suggested three steps as a fair method of introducing new rules, namely

- an employer should discuss the new rule in advance with the staff in a sensitive and sympathetic way;
- an employer should give proper notice of the change of rules; and
- an employer ought to attempt to seek alternative measures for those who cannot desist from their habit overnight, either by moving them into an office where smoking is allowed, or allowing smoking in some parts of the building or even outside.

Nonsmokers' rights

Section 24 of the Constitution states: "Everyone has the right to an environment that is not harmful to their health or well-being". This includes the right of protection against environmental dangers over which the individual has no control. In contrast to the right to smoke, nonsmokers clearly have a constitutional right to a tobacco-free environment.

A nonsmoking employee need not suffer passive smoking passively. An employee who finds that his or her employer has failed to resolve complaints about smoking at work has several legal options available:

- The employee may, under common law, obtain a court interdict against the employer obliging the company to take remedial action.
- The employee may resign and claim constructive dismissal, premised on the fact that the employer's conduct has been unreasonable.
- The employee may sue the employer for damage suffered to his/her health as a result of the employer permitting smoking in the workplace.

There have thus far been no such cases in this country, but whether an employer could be held liable for negligence would depend on several factors such as the following:

- Did the employer know or ought he to know about the dangers of passive smoking?
- What did he do about smoking in the workplace?
- Was the employee's health harmed as a result of exposure to tobacco smoke in the workplace?
- Did the employee cause the damage to his health or at least contribute to it, e.g. spending time in smoky bars, living with a partner who smoked?

In terms of convincing evidence, the courts would look no further than independent scientific reports. Once satisfied that passive smoking was a likely cause of ill health (on the balance of probabilities), the burden of proof would then shift to the defendant (the employer) to prove that the cause was not linked to environmental tobacco smoke at the workplace.

Several such claims have already succeeded in

Western Europe, the USA, Canada, and Australia. For example, in May 1993, a jury in Australia awarded a nonsmoker A$85 000 in damages against her employer for not protecting her from secondhand smoke. The jury accepted the employee's case that exposure to tobacco smoke in her office exacerbated her asthma and led to respiratory complications.

Employers' responsibilities

An employer has a duty under both common law and the Occupational Health and Safety Act No 85 of 1993 (OSHA) to protect the health of his/her employees.

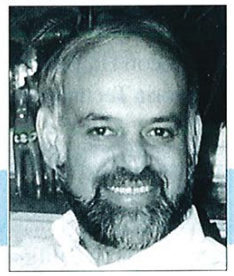
In common law: "Employers have a duty to protect their employees against known hazards." The OHSA states: "Every employer shall provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of his employees."

Employers who fail to take action are vulnerable to legal actions. They may be guilty of negligence (a civil issue) or guilty of a criminal offence under the Occupational Health and Safety Act. In addition to the actions an employee can take, in the case of a breach of OHSA, an OHSA Inspector can also prosecute an employer.

Conclusion

The Tobacco Products Control Act No 83 of 1993, enshrines the principle that every citizen has the right to tobacco-free air in indoor public places. The Department of Health is proposing to amend this Act to ensure that it protects employees from the harms of passive smoking in the workplace. However, regardless of the extent to which the new Act will cover the problem of smoking at work, it is best for employers to be in advance of legal developments.

Employers have a statutory duty to take reasonable steps to protect their employee's health and safety, including the provision and maintenance of safe workplaces. Injury from passive smoking is reasonably foreseeable and therefore employers are obliged to take steps to control this hazard.



YUSSUF SALOOJEE
GUEST EDITOR

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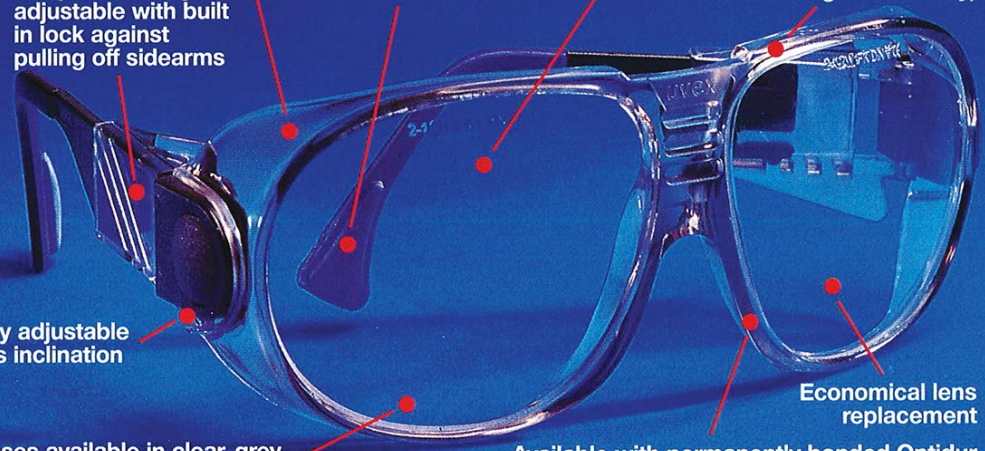
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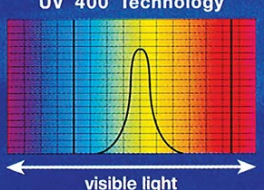
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OHASA joins the journal

The editorial board is pleased to announce that the Occupational Hygiene Association of Southern Africa (OHASA) will be utilizing the journal, *Occupational Health Southern Africa*, as its official publication in conjunction with the two existing societies from the July/August issue.
Mr Leon Harmse from the Pretoria Technikon will join the editorial board as the representative of OHASA.

Occupational health really has two pillars, occupational hygiene and occupational medicine, and the two complement each other closely although they are separate disciplines. Doctors and nurses have always worked closely together in industry and with the addition of occupational hygienists, it is likely this will be of benefit to workers' health. The journal is one area where this integrated approach will also benefit the readers and members of the three societies.

We welcome OHASA "on board" and hope it will be a mutually beneficial association.

Mike Baker
Editor

Prizes for articles on biological monitoring

The SASOM Scientific Committee for Biological Monitoring (SSCBM) is again pleased to announce R1 000 (2 x R500) prizes for the best two articles published in the journal.

The SSCBM criteria are as follows:

1. An original article on Biological Monitoring from South Africa
2. Data not older than 3 years
3. The SSCBM may withdraw the prize if insufficient quality publications are submitted.
4. The final decision rests with the SSCBM and the editorial board of *Occupational Health Southern Africa*
5. Cash prizes will be announced and presented at the SASOM AGM, 1998.
6. Articles published during the 12-month period will be entered for the competition.

For further information contact the SASOM national office at (012) 664-1460.

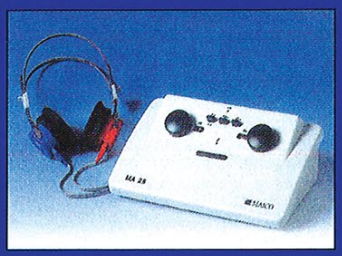
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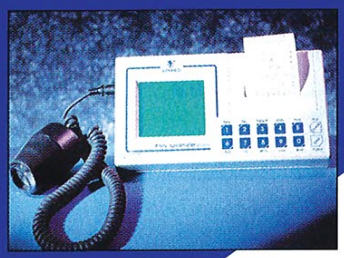
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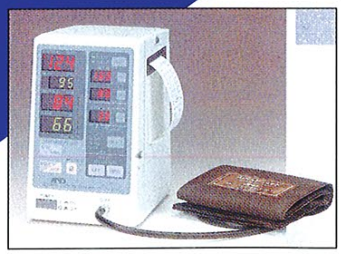
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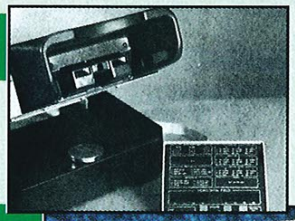
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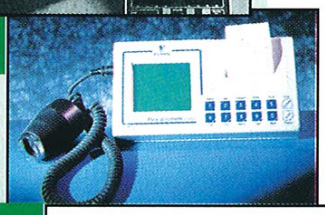
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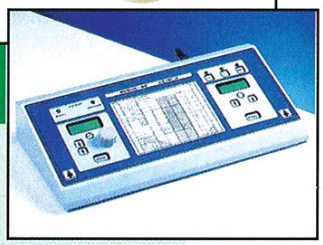
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M A

Calendar of Congresses and Conferences

June			
14 - 17	Futuresafe '98	Sydney, New South Wales, Australia	Dianne Speakman, National Safety Council of Australia Limited Tel:(02) 9313 4799 Fax: (02) 9313 5494
23 - 25	Occupational Health in the third millennium	Moscow, Russia	The Secretariat RAMS Institute of Occupational Health, 31, Prospect Budennogo, 105275, Moscow, Russia Tel: +7 095 365 02 09 Fax: + 7 095 366 05 83 E-mail: Izemerov@orc.ru.
28 - 3 July	12th World AIDS Conference	Geneva, Switzerland	Anette Lifors, Conference Manager, Congrex (Sweden) AB, PO Box 5619 11486 Stockholm, Sweden Tel: +46 8 612 6900 Fax: 46 8 612 6292 E-mail: anette@congrex.se
July			
6 -10	The Society of Occupational Medicine Annual Scientific Meeting	Oxford, England	Dr Murray Roberts, Dairy Cottage, ICL Beaumount, Burghfield Road, Old Widsor, Berks RG7 4JD, England
August			
24 - 26	First International ICOH Conference on Psychosocial Factors at Work	Copenhagen, Denmark	Ole Teller, The Danish Working Environment Fund, Vermundsgade 38, DK-2100 Copenhagen, Denmark Tel: +45 39 16 05 00 Fax: +45 39 16 05 80 e-mail: AMFUDD@inet.uni-c.DK
September			
8 - 11	Medichem 1998: New Horizons - Old concerns	Cape Town, South Africa	Medichem 1998, Occupational & Environmental Health in the Chemical Industry, PO Box 781811, 2146, Sandton, South Africa. Tel: 27 11 780 3600 Fax: 27 11 884 6932 email: Medichem@Sandton.Senchem.co.za
9 - 11	Global Ergonomics Conference	Cape Town, South Africa	Deborah McTeer, Postgraduate Conference Division, University of Cape Town Medical School, Observatory 7925, South Africa Tel: +27 21 406 6348 Fax: +27 21 448-6263 email: deborah@medicine.uct.ac.za
21 - 25	PRESMUS-ISEOH '98 3rd International Scientific Conference on Prevention of Work-related Musculoskeletal Disorders 13th International Symposium on Epidemiology in Occupational Health	Helsinki, Finland	Ms Mirja Kallio, Finnish Institute of Occupational Health, Topeliuksekatu 41 a A, FIN-00250 Helsinki, Finland Tel: 358 9 47 471 Fax: 358 9 4747 548 e-mail:mkal@occuphealth.fi
23 - 25	The 4th International Symposium on Biological Monitoring in Occupational Health	Seoul, Korea	Se-Hoon Lee, MD, Secretary General, Biological Monitoring, c/o Dept. of Preventive Medicine College of Medicine, Catholic University of Korea 505 Banpodong, Sochoku, Seoul 137-701, Korea Tel: +82 2 590 1236 Fax: +82 2 532 3820
October			
6 - 8	The 2nd Emergency Services Exhibition	Kyalami, Johannesburg	Debbie Turncliff, Tel: (011) 466-2299 Fax: (011) 466-1318
13 - 15	Safety, Health and Environment "98 Exhibition	Gallagher Estate, Midrand	Joan De Beurges, PO Box 652495, Benmore, 2010. Tel: (011) 444-3937 or 444-7954 or Fax: (011) 444-7987 E-mail:raisa@iafrica.com
November			
22 - 27	Noise Effects '98 7th International Congress on Noise as a Public Health Problem	Sydney, New South Wales, Australia	Congress Secretariat, Noise Effects '98, GPO Box 128 Sydney, NSW 2001, Australia Tel: 612 9262 2277 Fax: 61 2 9262 2323 e-mail: tourhosts@tourhosts.com.au

To advertise conferences, please contact Jenny Anderson, tel: (011) 791-2615 fax: (011) 791-2618

Approval of audiometrists

Approval of audiometry facilities lies with the Department of Labour, but once a National Council for industrial Audiometrists is elected the Department of Labour will no longer be involved in this function.

An interim council has been established to examine the scope and role of the industrial audiometrist. This council is based in the Gauteng region, but it is hoped that similar bodies will be established in other areas.

- The functions of the interim audiometry council are as follows:
- To identify all the role-players.
- To provide information.
- To co-ordinate the election of members for the National Council for Industrial Audiometrists.

Discussions were held with various groups to find a suitable institute for the registration of audiometrists. With all the information gathered, it looks like registration with OHSAP will be the most suitable.

For further information please contact
Sr PM Venter
Sasol Synthetic Fuels
Occupational Health
Private Bag X1000
Secunda
2302
tel no: (017) 610-3555

Medichem 1998 Exhibition

"New Horizons.... Old Concerns"

Date: 7-10 September 1998

Venue: Cape Sun Inter-Continental Hotel, Cape Town

Sector: Chemical, mining and general industry. The exhibition is open to all interested professionals (by invitation).

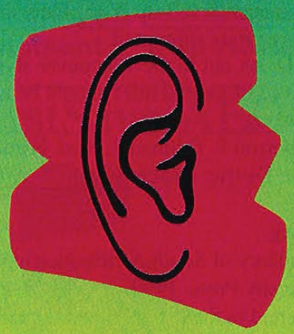
Exhibitor categories: PPE, occupational and environmental hygiene, computers, occupational H & S services, rescue and emergency services/ equipment, waste disposal, training, analytical equipment, books/literature.

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Specialist radiologist now at NCOH

Professor Albert Solomon has joined the National Centre for Occupational Health (NCOH). He is a specialist radiologist, an expert in occupational lung disease and an inspiring teacher. It is hoped to use his skills to support occupational lung disease radiology. To achieve this, a series of training sessions on topics such as Pulmonary TB recognition and the ILO Classification of Radiographs of the Pneumoconioses is planned - details will follow. Regular X-ray meetings have already started, at which radiographs and CT scans can be presented. These meetings will give practitioners the chance to discuss cases. The meetings are to be held at 09:30 every second Tuesday, as of 7 April 1998. The venue is the Old Medical School, 25 Hospital Street, Johannesburg. Please phone **Ms Clara Molefe or Ms Rosina du Preez, (011) 720-5734, to confirm that a meeting will be held** (in case the meeting has to be cancelled for some reason). Professor Solomon is also available for individual consultations by arrangement. Please phone him to make an appointment. Besides individual cases he can advise on quality control and other technical issues (this is a free service). X-rays can also be sent to the NCOH for a second opinion.

Please contact David Rees (e-mail david@ncoh.pwv.gov.za) or Marianne Felix (e-mail marianne@ncoh.pwv.gov.za) at the NCOH if you want more information.

Radiographic course

The NCOH, in collaboration with NIOSH, has organised a four-day radiographic course to read chest radiographs using ILO classification for pneumoconioses. It will be held at the National Centre for Occupational Health from 27 to 30 July 1998. At the end of the course, people will be able to sit the B reader examination on 31 July 1998.

For further details, please contact Dr Felix or Ms Du Preez at telephone (011) 720-5734, facsimile (011) 720-6608, or e-mail marianne@ncoh.pwv.gov.za

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References should be set out in the Vancouver style and only approved abbreviations of journal titles should be used.

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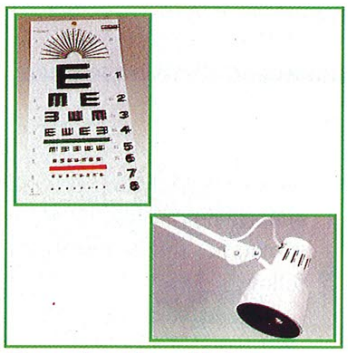
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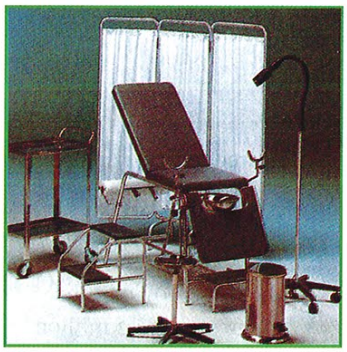
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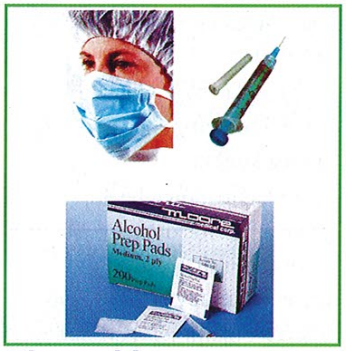
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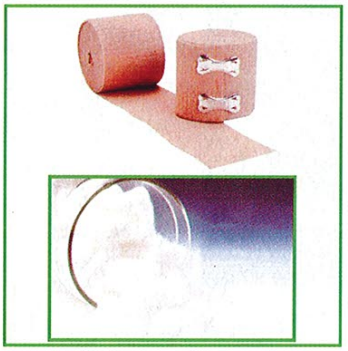
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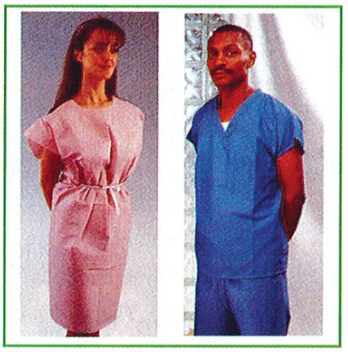
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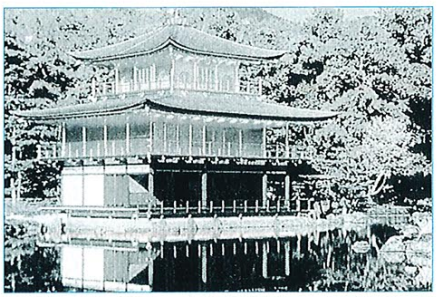
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ICORD Conference 1997

Kyoto Japan

The 9th International Conference on Occupational Respiratory disease was held on 13-16 October 1997 in Kyoto, Japan. ICORD is an official ILO- (International Labour Organisation) and ICOH (International Commission on Occupational Health) accredited conference.

Kyoto is a beautiful old city, once the capital of Japan, and regarded as the Cape Town of the country with 1,5 million citizens.

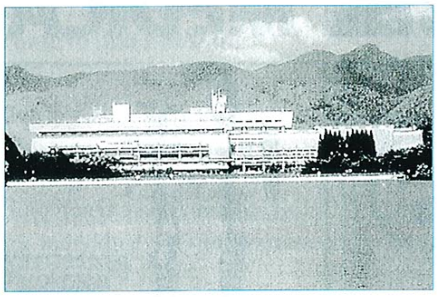


Typical shrine- The golden pavilion

The conference was attended by some 3 000 delegates from all over the world but predominantly by, as could have been expected, Japanese occupational practitioners with unpronounceable names. Their command of the English language was poor, which made communication difficult. Papers were often read in English by Japanese, thus eliminating the translators, but owing to their abnormal phrasing it was sometimes impossible to follow.

The drive at the conference was to strive for improved monitoring of dust, fumes and gas levels in the workplace and the response to this in the form of surveillance programmes. Many workshops and discussions covered topics such as silicosis, asbestosis, coal workers' pneumoconiosis and the use of modern diagnostic tools in the form of ultra-modern scanners and computer programs.

A paper read on engineering, environment and pneumoconiosis clearly pointed out the value of stricter control over surveillance programmes, dust control and employee awareness of risk factors. Applying the above to the Japanese industry where 300 000 workers have been followed up, suspected pneumoconiosis cases have dropped from 33 percent in 1983 to 7 percent in 1996 and definite cases from 13 percent in the same time.



Conference venue, Kyoto

Emphasis on preventative measures prescribed in the Ministerial ordinance for prevention of pneumoconiosis included the following:

- Wet process substitution
- Enclosure of dust emission at source
- Local exhaust ventilation
- Dilution by general ventilation
- Periodical environmental measures and evaluation of dusty workplace
- Facility maintenance, cleaning and good housekeeping
- Occupational health education for dusty workers utilizing respiratory protective devices.

Occupational asthma was one of the key issues discussed at the congress. The following few learning points are highlighted:

- Focus on respiratory function tests in the diagnosis of asthma indicated not only the use of parameters such as forced expiratory volume in 1 second (FEV 1) and forced vital capacity (FVC) but careful analysis of FEF 25-75% and FEF 50% (forced expiratory flow at 50 percent of vital capacity) to be used as a helpful tool. A decrease of more than 10 percent in FEV 1 and more than 25 percent in FEF 50 after exposure needs further investigations into the possiblity of industrial asthma.
- Three different workplaces - sanding, moulding and packing in the wood industries - were used as comparison in the development of industrial asthma. Meranti allergen skin tests IgE levels, FEV, FVC and FEF 25-75 were used as measures. The prevalence of industrial asthma was much higher in the sanding area (8 percent) in comparison to the packing area (1,76 percent). It is of interest to notice that symptoms of asthma generally only develop after several years of employment in the wood industry.
- In the clothing, spinning industry where employees are exposed to cotton, jute and hemp fibres, exposure to dust of more than 1mg/m^3 and less than 1mg/m^3 lead to development of byssinosis in 62,3 percent and 8,5 percent respectively; again clearly stating the value of good housekeeping.

Dr Andre van Blerk
Modderfontein Hospital

Special Feature Cover

Epilepsy

Occupational HEALTH
SOUTHERN AFRICA



Epilepsy and employment

Dr Bryan Kies
Senior Specialist Neurologist, Groote Schuur Hospital, Cape Town

Occupational Health SA 1998; Vol 4, No 3: 14-16

Abstract

More than 1% of South Africans have epilepsy. With optimal medical treatment, more than 70% of persons with epilepsy may be rendered seizure free, are by law permitted to drive, and should be allowed to perform any job without discrimination. Where epilepsy is suboptimally controlled, every case must be assessed on its merits. Often medical treatment may be adjusted to improve control. Where this is not achievable, the individual should not be allowed to drive or engage in activities where injuries could occur. Less than 20% of persons with epilepsy will not cope with a regular job, and in such circumstances sheltered employment should be considered.

Introduction

In epilepsy there is a temporary disturbance of neuronal function, resulting in a wide variety of clinical manifestations, with a tendency to recur if untreated. The disturbance in neuronal function may result in altered consciousness (but not necessarily), motor manifestations (e.g. jerking of limbs), sensory phenomena (including an aura of smell or taste), or behavioural manifestations. These phenomena may be very brief (e.g. seconds in absence) or last for more than ten minutes in generalised tonic clonic seizures.

In a tonic clonic seizure there may be a warning (e.g. aura of taste or smell), followed by loss of consciousness (during which a variety of motor manifestations may occur), followed by a period of confusion. During this seizure type there is the greatest risk of injury. In other types of epilepsy, e.g. focal seizures where consciousness is preserved, and seizures which only occur during sleep, the risks of injury in the workplace do not exist.

Epilepsy may be due to a wide range of conditions, e.g. secondary to head injury, infections of the nervous system, hereditary factors or the cause may be unknown.

A single epileptic seizure may never recur (and by definition this is not epilepsy), or may recur at a wide range of intervals depending on the severity and precipitating factors such as suboptimal treatment, alcohol abuse, sleep deprivation and stress.

If epilepsy is associated with head trauma or another physical condition, the limitation caused by such a pathological process is usually the limiting factor regarding employment capabilities, rather than the epilepsy *per se*.

Prevalence of epilepsy

The South African National Epilepsy League (SANEL) estimates the prevalence of epilepsy at more than 1%. This concurs with Shorvon's finding that epilepsy is up to twice as prevalent in developing countries as in developed countries.[1] Chandra[2] has attributed the higher prevalence of epilepsy in developing countries to high rates of infection, trauma and malnutrition.

The medical treatment of epilepsy

With optimal medical therapy, more than 70% of persons with epilepsy can be rendered seizure free.[3] It means that these people should be able to lead normal lives and undertake regular employment. The minority of persons with epilepsy (less than 30%) who may not be seizure free may have their seizures greatly reduced with medical management. However, until they are seizure free, certain restrictions are placed on these individuals, to avoid possible injuries.

The fine tuning of medical treatment, with dose adjustments, measurements of anti-epileptic drug levels in certain circumstances, the use of new generation anti-epileptic drugs and the possibility of epilepsy surgery in specific situations,[4] greatly improves the prognosis for persons with epilepsy.

In addition to optimised drug treatment, the management includes advice about avoiding excess alcohol, limiting psychosocial stress and vocational opportunities.



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Ref.1. Chadwick D. J. Neurol. Neurosurg. Psychiatry 1994; 57:264-277

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Employing people with epilepsy

People with epilepsy face discrimination in the workplace. Employers discriminate against them because of the stigma associated with epilepsy, misconceptions about the medical and social aspects of epilepsy, unfounded fears of legal and medical liabilities, and the misconception that people with epilepsy are not as productive as other people.[5] Fraser's international survey revealed unemployment rates of 15 to 50% for people with epilepsy.[6] A norm of 20% of people with epilepsy who cannot cope in the open labour market is accepted internationally. However, surveys commissioned by SANEL in Soweto and in deprived communities in Gauteng revealed unemployment rates of 91% and 79% respectively.

Kies, in a survey of employers found that there was much ignorance about epilepsy, injury was a major concern of employers and 26% indicated that they would not employ an individual with epilepsy.[7]

Legal aspects of driving

The ability to drive may be included in some job descriptions. South African law states that a person may only drive if epilepsy is "controlled". British law specifies that an individual should be seizure free for two years before driving a car is permitted. We in South Africa have been guided by this requirement. However, leniency would be in order if seizures only occurred during sleep, or if consciousness is not disturbed during a seizure, or if an aura always gives the individual sufficient time to get into a safe position.

Guidelines for employment

The Employment Commission of the International Bureau for Epilepsy has issued principles for good practice when employing people with epilepsy.[8] It covers aspects of health care, job suitability, recruitment and assistance at work.

If epilepsy is well controlled (i.e. seizure free for at least two years, on or off treatment), such an individual is legally permitted to drive a car, so should be eligible to occupy any position. Not to employ such a person on the basis of epilepsy would be unfair discrimination.

If epilepsy is not well controlled, many aspects must be considered. Every situation must be evaluated on its merit. The individual should be offered the services of medical specialists who very often will be able to optimise treatment as outlined above, and render the employee seizure free.

While the individual is at risk of getting the odd seizure, strict precautions should be taken to avoid injury. Such an employee should not be allowed to drive, operate dangerous mechanical equipment or work at heights. Education of fellow workers is required to cope with the possibility of a seizure occurring at the workplace.

Persons with poorly controlled epilepsy pose a special problem. Some may be able to cope with a modified work environment. But if seizures are very frequent despite all attempts at medical intervention, or if associated with other disabilities, e.g. neurological deficit secondary to head trauma, sheltered employment may be the only option.

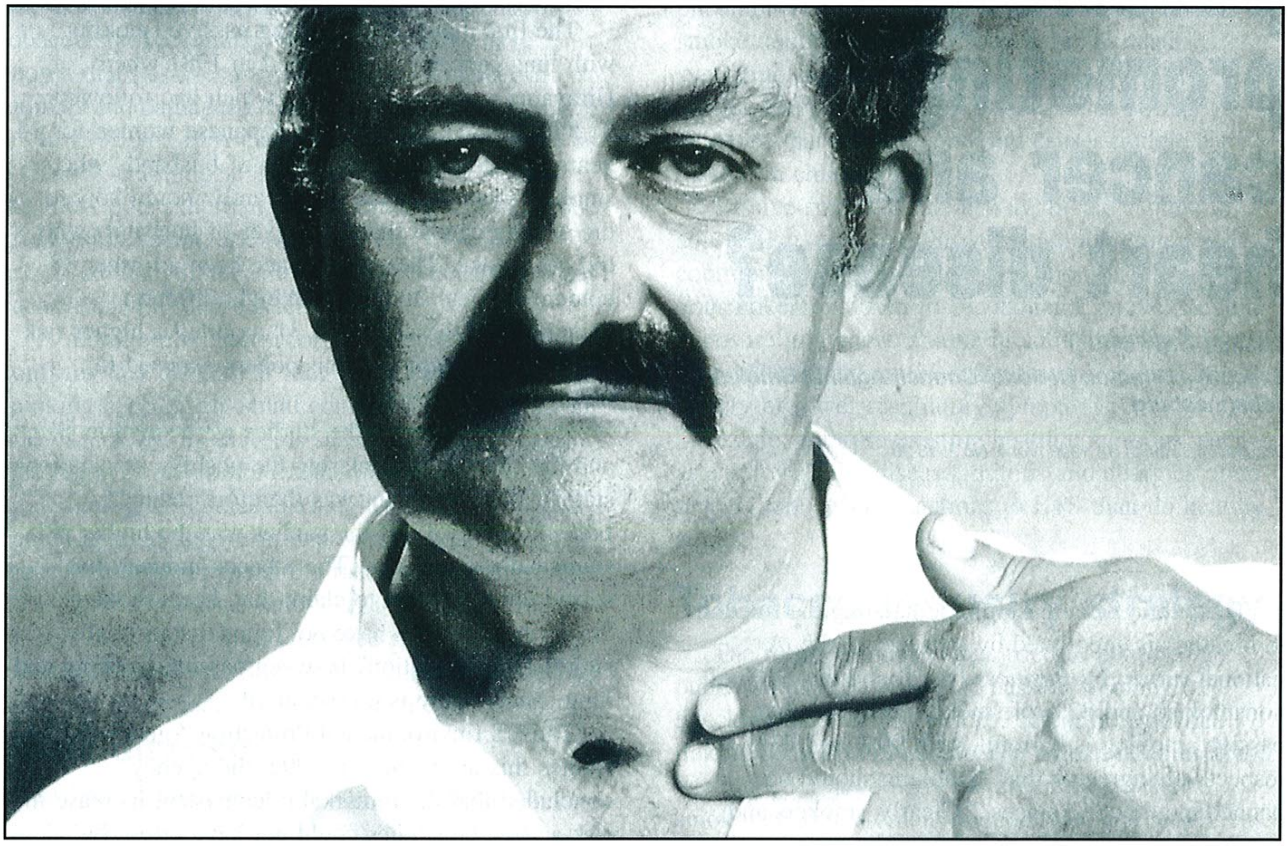
Conclusion

Epilepsy is common, and potentially treatable. With optimised medical management, more than 70% of persons with epilepsy can be rendered seizure free, and be able to enjoy regular employment. Where perfect control of epilepsy is not achievable, precautions against injury, and modifications in the workplace should still enable most persons with epilepsy to gain regular employment.

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8. *Employing people with Epilepsy - Principles for good practice. Epilepsia 30(4):411- 412.*

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Are you passively promoting cancer and heart disease?

Yussuf Saloojee,
Executive Director, National Council Against Smoking Johannesburg

Occupational Health SA 1998; Vol 4, No 3: 18-20

The public is increasingly demanding the freedom to breathe air unpolluted by tobacco smoke. A national survey by *Business Day* found that 94% of nonsmokers and 82% of smokers believed that passive smoking is harmful, with 90% and 73% respectively agreeing that "Smoking should be banned in all public places."[1] Clearly, smokers and nonsmokers alike agree that the public have a right to clean tobacco-free indoor air and that this right should be enforced by law.

Yet fewer than 40% of South African workplaces have a smoking policy.[2] Most employers still view smoking as a purely personal matter. They continue to place the needs of a minority of smokers above the health of the nonsmoking majority. Instead of actively managing change by introducing smoking policies which will be supported by their employees, they have been passive or even resisted change and thereby endangered the health and safety of the entire workforce.

For workers, passive smoking is a special problem, as the workplace has been identified as a major source of involuntary exposure to other people's tobacco smoke. Protection of their right to clean air is not a question of aesthetics or "personal choice" but a principle of public health.

Recently, new evidence has emerged on the link between environmental tobacco smoke (ETS) and ill health, and of the tobacco industry's efforts to cast doubts on the scientific data, which are briefly reviewed here.

The health effects of passive smoking

Lung cancer

The first major study linking passive smoking with lung cancer was published in 1981 when Hirayama reported on a study which had followed 91 540 married, nonsmoking Japanese women for 14 years.[3] He found that the wives of husbands who smoked cigarettes were significantly more likely to die of lung cancer than the wives of husbands who did not smoke. There have since been a further 38 epidemiological studies, from eight different countries. Of these studies, 31 reported a higher risk of lung cancer among nonsmokers exposed to involuntary smoking.

However, many of the studies were small in size, and the chances of declaring the positive associations statistically significant was therefore reduced. Indeed, in only 12 of the studies was the higher risk statistically significant. The tobacco industry has seized upon this fact to claim that, because the "majority of studies have not found a statistically significant association" between passive smoking and lung cancer, there is no risk at all.

The US Environmental Protection Agency (EPA) refutes this argument.[4] In 1992, the agency concluded that the remarkably consistent increase in risk across the studies could not have arisen by chance. It estimated that there was a one in ten thousand probability that 9 out of 30 (then-available) studies would find a significant association between passive smoking and lung cancer; and a one in a billion probability that 14 out of 14 studies would show a positive dose-response relationship. That is, increasing exposure to secondhand tobacco smoke resulted in increased risk of cancer.

The agency stated that it was unprecedented for such a pattern of results to be seen in epidemiology studies of cancer from environmental levels of a pollutant. It concluded that the evidence is clear and consistent: - passive smoking is a cause of lung cancer in adults who do not smoke.[5] This finding was based on the total weight of evidence and not based on the epidemiological data alone. This evidence includes several important facts.

First, it is indisputable that cigarette use causes lung cancer in smokers, and there is no evidence that there is a threshold below which tobacco smoke will not cause cancer. Second, ETS smoke contains up to 50 carcinogenic compounds. A smouldering cigarette releases over 4 000 chemicals into the air as

particles and gases. This smoke contains poisons such as hydrogen cyanide, sulphur dioxide and carbon monoxide, and carcinogens such as benzo(a)pyrene, formaldehyde and 4-aminobiphenyl. Third, nonsmokers absorb significant amounts of tobacco smoke. Finally, laboratory studies have shown that passive smoking can cause cancer in animals and damages DNA.

In 1992, the EPA classified secondhand smoke as a Class A carcinogen. This category includes only the most potent human cancer-causing agents, such as asbestos, radon, and benzene. The EPA also estimated that passive smoking kills 3 000 Americans each year with lung cancer.

A more recent analysis of the epidemiological data confirms that the risk of lung cancer from passive smoking is relatively small compared to the risk from direct smoking but that it is statistically significant. Hackshaw *et al.*[6] combined the data from 37 epidemiological studies in a single meta-analysis and concluded that long-term exposure to other people's tobacco smoke increased the risk of lung cancer by 26% (95% confidence interval 8% to 49%). This is far less than the 10-fold increased risk faced by smokers themselves. But it is far higher than society faces for other cancer-causing chemicals.

Heart disease

In 1981, Hirayama also found a link between passive smoking and heart disease. However, by 1986 the US Surgeon General was unable to draw any firm conclusions about this relationship because of a lack of confirmatory studies.

In 1997, from a meta-analysis of 19 studies, Law *et al.*[7] determined that the risk of heart attack or death from coronary heart disease is around 23% higher in nonsmokers who live with a smoker compared with unexposed nonsmokers (95% confidence interval 14% to 33%). This is a surprisingly high risk, given that smokers only have a twofold higher risk of a coronary event than nonsmokers. Data from clinical studies suggest various mechanisms which may explain the higher risk in exposed nonsmokers. Nonlinear increases in platelet aggregation, and an acceleration of atherosclerosis may mainly account for the effects of secondhand smoke on the heart.

Other diseases

Several studies have found that exposure of mothers to ETS during pregnancy was associated with lower birth weights. The size of the effect is small (30-40 g in most studies) and may not be clinically significant. But there is evidence that the effect may be greater in socially disadvantaged subgroups.[8]

A large number of studies have found that smoking in the presence of children is a cause of serious respiratory illness (such as bronchitis and pneumonia) and asthmatic attacks. Mothers who smoke double the risk of sudden infant death syndrome, and if both parents smoke the risk is almost four times greater. There is also strong evidence that parental smoking causes middle ear disease in children.[9]

Passive smoking can also aggravate asthma in adults. Eye, nose and throat irritation are the most commonly reported symptoms among adult nonsmokers exposed to secondhand smoke. Regular exposure to tobacco smoke in adults has been reported to increase the risk of occurrence of a variety of lower respiratory symptoms.[10]

Adults with pre-existing health conditions, such as cardiovascular disease, rhinitis and allergies often report more severe reactions to ETS than do healthy adults.

Tobacco industry strategy

The tobacco industry has tried to confuse the public about the dangers of passive smoking by attacking the credibility of the scientific evidence linking ETS with ill health. The industry claims that it has funded a large body of research on passive smoking and that "many independent and respected scientists" support the industry's position that passive smoking does not cause disease.

The facade that "independent" scientists support the industry's position on passive smoking was blown apart when a memo written by Dr Sharon Boyce of BAT was leaked, last year.[11] The memo, dated February 1988, described a meeting in London between representatives of several major tobacco companies. The memo sets out details of a worldwide strategy to "coordinate and pay so many scientists on an international basis to keep the environmental tobacco smoke controversy alive." The scientists were not to conduct neutral research but to provide propaganda - they were "to produce research or stimulate controversy" that could be used to advantage by "public affairs people in the relevant countries."

This document clearly shows how the tobacco industry has tried to distort science and create the illusion of controversy about well-established facts. By claiming that there is a "controversy" and that the "evidence is not in", the industry hopes to provide politicians and business with an excuse for not introducing policies regulating smoking in public places.

Clean-air policies at work

Actions to eliminate exposure to environmental tobacco smoke are long overdue. The ideal policy is one which guarantees the right of nonsmokers to breathe tobacco-smoke-free air while, wherever possible, taking account of the needs of smokers. However, where there is a clash between nonsmokers' rights and smokers' needs, the rights of the nonsmoker must take precedence.

There are three main policy alternatives, each of which has advantages and disadvantages:

• A total ban on smoking in all company buildings and vehicles

This policy offers total protection for all employees from second hand smoke, and is the easiest to administer. To reduce the discomfort some smokers may experience, they may have to be allowed to smoke outside company buildings.

• Allow smoking only in physically separated and separately ventilated nonwork areas

This choice brings most of the advantages of a totally smoke-free policy and allows some accommodation for smoking. Creating smoking areas may, however, involve considerable expenditures.

• Limit smoking to nonwork areas, such as sections of cafeterias or lounges

Depending upon ventilation patterns, nonsmokers will still have some exposure to smoke, and it penalizes the nonsmokers who may wish to use those nonwork areas.

Conclusion

Environmental tobacco smoke is a public health hazard that should not be dismissed because the act of smoking is familiar or because some of the risks are long term. Harm to health can be prevented and employers have a responsibility to safeguard the health of their employees.

Employers often anticipate resistance to new smoking policies. In fact, in most companies where smoking policies are enacted, the majority of workers usually support it, and patterns of acceptance and compliance readily emerge. Ongoing tensions between smokers and nonsmokers are also alleviated and company morale and productivity are improved.

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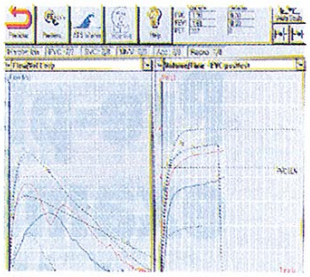
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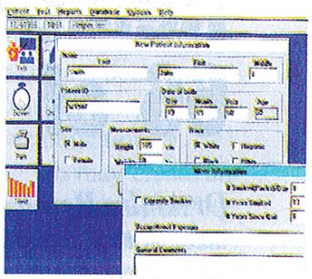
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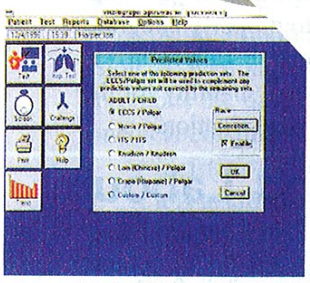
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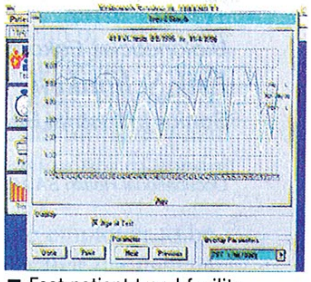
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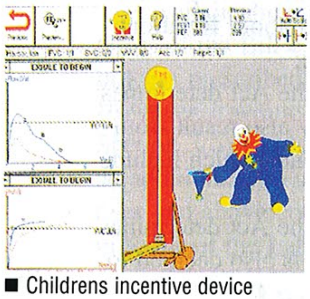
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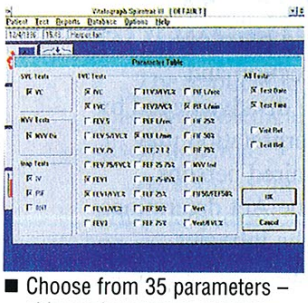


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Pre-placement examination and the Labour Relations Act 66 of 1995

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Occupational Health SA 1998; Vol 4, No 3: 22-25

Abstract

The new Labour Relations Act and the Constitution's Bill of Rights have a marked effect on the hitherto unprotected position of job applicants. Employers suddenly find themselves in a position where they can be subjected to litigation by unsuccessful job applicants on the basis of unfair discrimination.

This new development impacts on various aspects of recruitment not least of which is the medical screening of applicants. Occupational health professionals share in the responsibility to guard against practices that may cause such a liability on medical grounds. It is therefore imperative that they are familiar with the possible legal repercussions of their activities as it relates to pre-placement medical testing.

Introduction

Since the introduction of the new Labour Relations Act, the position regarding pre-placement examination has changed drastically. The matter is no longer that of a purely medical opinion but has become a potential legal minefield requiring a multidisciplinary approach. Potential role-players may include

- medical personnel;
- industrial relations and legal practitioners;
- human resources practitioners;
- safety risk management functionaries.

This list is not exhaustive and the involvement of any specific discipline will depend on the particular circumstances of a case.

A new approach is needed when dealing with pre-placement examinations. Failure to properly integrate the pre-placement medical examination with legal requirements may give rise to a costly liability for the employer on the basis of unfair discrimination.

Constitutional and Labour Law requirements

The Constitution in its Bill of Rights guarantees, *inter alia,* the freedom of trade, occupation and profession as well as the right to fair labour practices.

The following sections of the Labour Relations Act No. 66 of 1995 are applicable:

- Schedule 7, item 2(1)(a) of the Act determines that an unfair labour practice may also result from any unfair discrimination on grounds which include disability.
- Schedule 7, item 2(2)(a) of the Act determines that an applicant for employment is also deemed to be an employee for purposes of the Act.
- Schedule 7, item 2(2)(b) of the Act allows an employer to implement policies and practices designed to achieve adequate protection and advancement of people previously disadvantaged by unfair discrimination. A broad interpretation may include disabled or medically impaired persons.
- Schedule 7, item 2(2)(a) of the Act determines that any discrimination based on the inherent requirements for a particular job does not constitute unfair discrimination.
- Schedule 7, item 3(3) of the Act determines that labour disputes regarding unfair discrimination will be referred to the Commission for Conciliation, Mediation and Arbitration for conciliation. If unresolved, the matter will be referred to the Labour Court for final determination.
- Schedule 7, item 2(2)(a) of the Act determines

that the Labour Court, in such cases, may make any award it deems appropriate, including an award for compensation.

In addition to existing legislation, the proposed Employment Equity Bill also contains a number of provisions designed to prevent unfair discrimination against employees on the basis of their medical condition:

• Chapter II, Section 5(1) of the Bill, echoes the Labour Relations Act in its prohibition of unfair discrimination on grounds that include disability.

• Section 5(2) of the Bill also qualifies unfair discrimination (as to the Labour Relations Act) to exclude positive measure consistent with the purpose of the Bill as well as discrimination based on the inherent requirement of a job.

· More important for the purpose of this discussion, is Section 5(4) in the Bill, which expressly prohibits the medical testing of an employee for any medical condition unless

· legislation requires or permits the testing; or

· it is justifiable to do so in light of medical facts, employment conditions, the fair distribution of employee benefits or the inherent requirements of a job.

• Section 5(5) of the Bill also defines applicants for employment as employees.

• Adjudication of unfair discrimination disputes in terms of the Bill concurs procedurally with the process prescribed by the Labour Relations Act. However, it would appear that this Bill, in terms of Section 3(6), envisages the possibility of presenting an additional and separate claim for compensation over and above compensation that may be awarded in terms of the Labour Relations Act.

Interpretation and application

The applicable question is "When will the pre-placement medical examination give rise to unfair discrimination?"

As soon as the Employment Equity Act takes effect, any medical examination in contravention of Section 5(4) thereof, will obviously substantiate a claim of unfair discrimination. The issue may be even more problematic where a medical examination is in fact admissible in terms of the said Act.

In this regard it is important to bear in mind that discrimination, based on the inherent requirement of a particular job, does not constitute unfair discrimination. By implication, **unfair** discrimination (from a medical or health point of view) will therefore exist where an applicant, on medical grounds, is found to be unsuitable for a particular position whilst his particular disability or affliction does not significantly diminish the applicant's ability to perform the work.

In other words, where the applicant's medical condition does not impact on any inherent requirement for the specific job and the applicant is nevertheless unsuccessful as a direct result of his medical condition, the employer's failure to appoint the applicant will constitute an act of unfair discrimination.

The risk of unfair discrimination therefore also lies in the decision of appointment (or rather the decision not to appoint) based on the applicant's health - not only in the medical examination *per se*. However, any particular medical examination or medical requirement for a specific job may create an impression of discrimination on grounds of disability.

This impression (albeit possibly incorrect) may well constitute the *prima facie* evidence needed by an unsuccessful job applicant to proceed to court, where the onus will be on the employer to prove that he did not unfairly discriminate against the applicant. There is unfortunately precious little that an employer can do to avoid this *prima facie* claim of discrimination where a disabled or impaired applicant is unsuccessful, following a medical evaluation. This will be the case even if the applicant's health ultimately had no bearing whatsoever on the decision not to appoint the specific applicant.

It is therefore imperative for the employer to be able to conclusively show, not only that the medical examination was in compliance with the Employment Equity Act, but also that the decision not to appoint the applicant was either

• not based on the applicant's medical condition at all; or

• based on an inherent requirement of the job that the applicant, given his specific medical impairment, is unable to perform.

The employer's task will be infinitely more difficult if included in the medical examination are tests for afflictions or conditions that, even if present, cannot significantly impact on the inherent requirements of the job.

This does not mean that such tests *per se* will necessarily be indicative of a discriminatory practice as there may well be other considerations, such as admission to a medical aid or pension fund scheme, which justify their inclusion in a pre-placement medical examination.

There seems to some authority for the view that wider considerations with regard to pre-placement medical examinations, such as the potential liability for medical aid or pension fund schemes, have no

• Physical demands

➢Strength, climbing and/or balancing, stooping, kneeling and crouching, reaching, handling, sight, speech and hearing.

Certain biokinetic activities can enhance the pre-placement process in terms of the following:

• Setting physical norms of specific job categories (occupational risk exposure profile) and the assessment of the applicant

• Physical selection for work placement

• Advice on work adaptations in the event of job reservation for disabled employees as result of a practice designed to protect/advance previously disadvantaged persons.

The evaluation of the inherent physical requirements of a job would in our opinion hardly be complete without the input of an occupational therapist.

Conclusion

This development in our labour law will, no doubt, give rise to a number of medical, legal and even moral dilemmas. The screening and (non?) appointment of HIV-positive applicants is but one case in point.

Most HIV-positive candidates will be otherwise healthy and be able to perform the physical tasks associated with most jobs, at least until full-blown AIDS develops - which may not be for many years after appointment. During this time the person would be able to be a productive employee and there is much to be said for the argument that any discrimination on an applicant's HIV "status" would be unfair.

On the other hand, would it be fair to expect of an employer to invest in an employee, admit him to scheme benefits and take the risk that the employee may very well fall seriously ill within a short period of time after appointment?

In the absence of sufficient and definitive case law, employers are still sailing mainly uncharted waters as far as pre-placement medical evaluation in relation to unfair discrimination is concerned. At present this issue is still raising more questions than answers. It is clear however, that employers run the risk of costly legal action if they dare put a foot wrong in this regard. Proper planning and design of job content and relevant medical criteria, even before a post is advertised, would surely go a long way in guarding against this type of liability.

However, the emphasis should not be on "fancy footwork" for the sole purpose of avoiding possible legal liability. The protection afforded by the legislation will hopefully serve to ensure consideration to a great many potentially productive employees who have so far been unfairly excluded from the labour market. Ignorance and prejudice had previously robbed competent and talented persons of an opportunity to contribute their labour simply because of some or other - often insignificant - disability or medical condition. Employers should focus on talent and competency rather than the physical packaging wherein it appears.

This will not only go some way to address injustices of the past, but will no doubt be beneficial to our economy and society as a whole. The potential for contribution in this regard by the various occupational health professionals is huge and the importance of their role cannot be overstated.

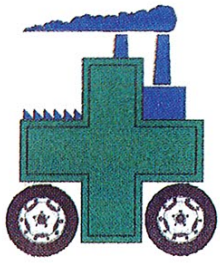
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3. *Cox et al. supra: p3*

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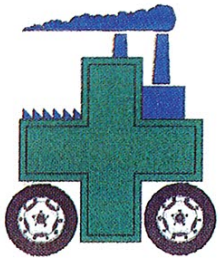
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Doctors' responsibility to job applicants

Dr Terry Geddes
ICS, Johannesburg

Occupational Health SA 1998; Vol 4, No 3: 26

Two recent legal cases in the UK concerning doctors carrying out medical assessments on prospective employees have been followed with much interest by those in the occupational health field.

In a nutshell, the two cases are as follows:

1. A television executive had been recruited by an American company subject to a satisfactory medical examination.[1] The pre-employment medical examination had been carried out by a London-based doctor with years of appropriate experience and he had found abnormal blood results suggestive of excess alcohol intake. Further blood tests confirmed the initial results and after discussion with a gastroenterologist and the firm's CMO in America the doctor recommended that the executive not be employed. The executive had meanwhile resigned from his existing job and sued the doctor for negligence (the plaintiff's stance being that the results did not support the view of his level of alcohol consumption), which had caused him severe financial loss.

The high court upheld that there was a "duty of care" to the plaintiff, although it accepted that there was a difference between the role of a doctor carrying out such an examination for a third party with specific employment requirements and the traditional therapeutic role between a doctor and a patient. Certainly it was the doctor's duty to judge the patient by reference to the company's requirements, but in doing so he had to exercise reasonable care.

The so-called *Bolam* principle, which has been used in British courts for several decades in deciding medical negligence cases, was upheld: whilst a medical practitioner in his dealings with a patient, whether by way of diagnosis or treatment, acts in a manner which would find favour with a substantial proportion, albeit a minority of his colleagues (competent in the relevant branch of medicine), he is unlikely to be found negligent.

The court found in favour of the doctor

2. A West-Indian-born cashier with sickle-cell anaemia applied for a job with a national building society.[2] On the questionnaire she disclosed a five-week absence as a result of sickle-cell anaemia and a chest infection within the last two years. She also ticked boxes on the questionnaire indicating previous attacks of asthma and bronchitis.

The GP who had a part-time contract as medical advisor to the building society advised the company not to employ the candidate on the basis of the replies in the questionnaire. She did not examine the candidate nor consult with her GP.

The cashier launched a race discrimination claim against the building society and when that failed, sued the doctor for negligence.

The Court of Appeal judges ruled that the doctor owed no "duty of care" to the cashier and could not therefore be sued. Even if she had owed such a duty, her actions would not have breached it. The building society was not obliged to employ the cashier and provided it did not unlawfully discriminate against her on improper grounds, "it could adopt whatever criteria for employment it liked, however capricious, and could apply or disapply its own criteria at will".

Proximity was also held to be an important factor in the original hearing - the fact that the knowledge had been gleaned from a questionnaire suggested to the court that there was insufficient proximity between the applicant and the doctor to give rise to a duty of care.

Interestingly, the Court of Appeal judges went further and repudiated the high court ruling mentioned in the first case and said that occupational health doctors owed no duty of care to job applicants.

These two cases are fascinating but there is no certainty that courts in this country, given current legislation, would reach similar judgements.

For an occupational medicine practitioner, the exercise of reasonable care is clearly essential and the first case stressed the importance of good medical notes and records made at the time of the examination. In the event of litigation, it will be almost impossible to defend a particular course of action without such documentation.

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An evaluation of compliance with noise and hearing conservation regulations in industry

JE Ric-Hansen
NOSA, Natal Coastal Region

Occupational Health SA 1998; Vol 4, No 3: 28-31

Introduction

According to the Health Care Trust,[1] a total of 30,000 factories exists in South Africa, and of the 1 600 000 workers in these factories, "at least 250 000 are exposed to dangerous noise levels". This is significant because the "health effects of noise span a multitude of bodily and mental reactions".[2] Although regulations to protect the worker from the hazards associated with noise at the workplace have been promulgated,[3,4] little is actually known about employers' adherence to these laws.

Since the occupational health nurse is often responsible for the health care of hundreds of workers, he or she is uniquely placed to ensure industry's adherence to the legislation aimed at minimising the dangers of noise at work. A study into the implementation of the Noise and Hearing Conservation Regulation 7 of the Environmental Regulations for Workplaces in industry was conducted in 1995 and, as far as the author was able to establish, data of this nature is limited.

Aims

- To assess industries' compliance with certain of the requirements of the Noise and Hearing Conservation Regulations of the Occupational Health and Safety Act, No 85 of 1993. (OHSA)
- To determine the prevalence of noise-induced hearing loss in industry.

Target population

The target population for this study was occupation health nurses working in occupational health units in industry in KwaZulu/Natal.

Methodology

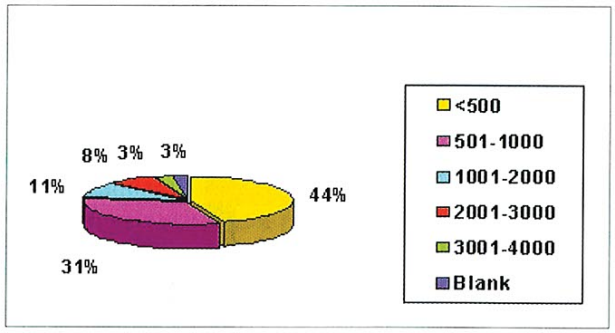
The study consisted of a descriptive survey using a questionnaire to collect data.

The industries were identified by using the list of clinics with drug permits from the Department of Health. From this list were extracted those industries which were likely to have a noise problem. Questionnaires were mailed to 125 occupational health clinics, of which 42 (33%) were returned. Four of these questionnaires were blank, and therefore 38 (30%) of the returned questionnaires were usable.

Results

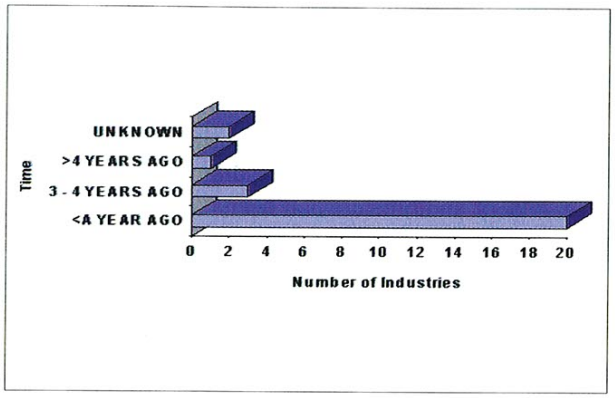
The poor response rate was disappointing, but it is felt the findings do still give worthwhile information. A total of 29 008 employees was employed in these 38 industries, of which 14 341 employees had audiograms carried out in 1995. The questionnaire did not identify what proportion of the employees were actually working in the noise zones; however, it did establish that 49% of the total workforce were tested.

Demographic information



This showed that the survey covered small, intermediate and large industries and is thus representative of industry as a whole.

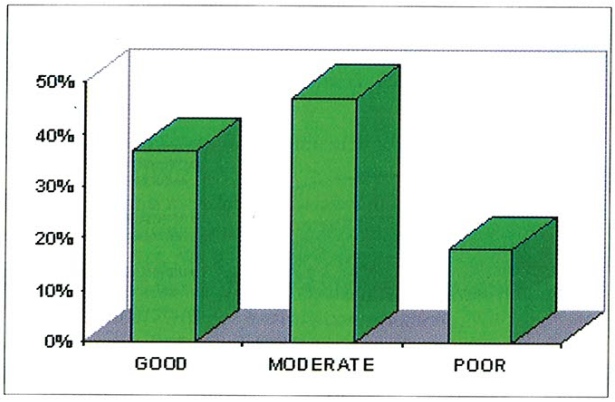
Noise surveys



From the questionnaire it could not be determined whether these surveys were conducted every 1-2 years or whether they were **only** conducted in the last 1-2 years.

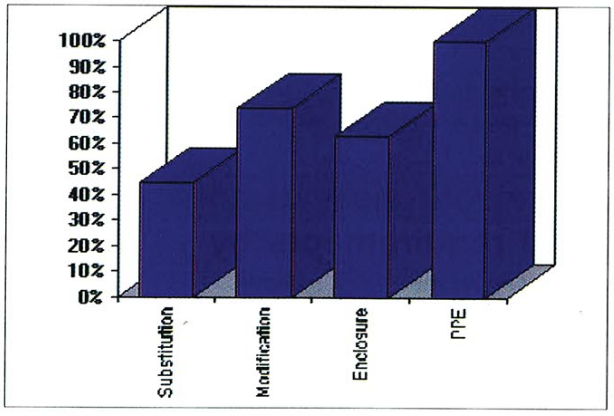
The SABS 083-1983 code of practice advises that repeat noise measurements should be made at intervals not exceeding two years

Compliance with personal protective equipment



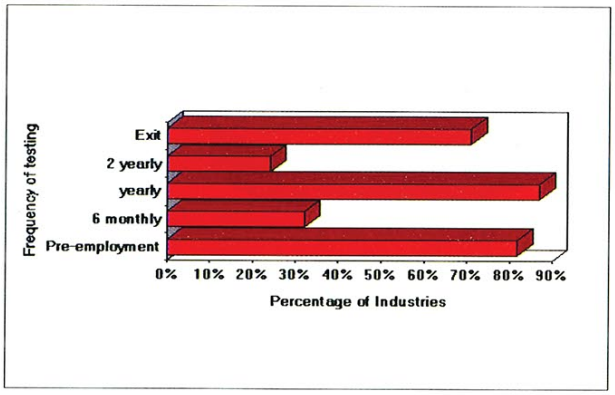
This figure shows the Occupational Health Nurses' perception of compliance of personal protective equipment (PPE) in the industry she or he works in. A total of 64% does not comply fully with the wearing of PPE.

Methods of reducing noise



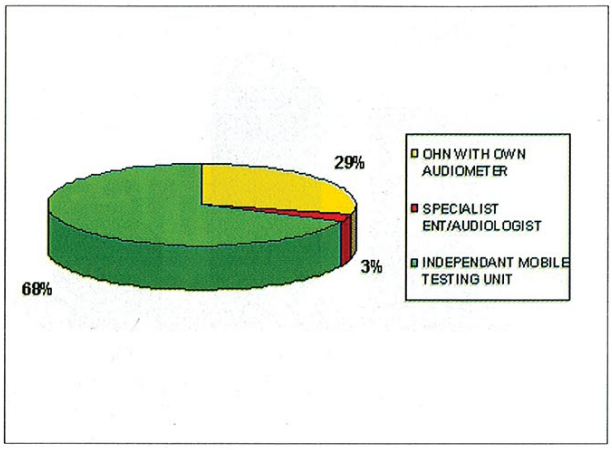
It was interesting to note that, although all the companies issued PPE, a significant percentage were also committed to reducing noise by other means as well.

Frequency of audiometric testing



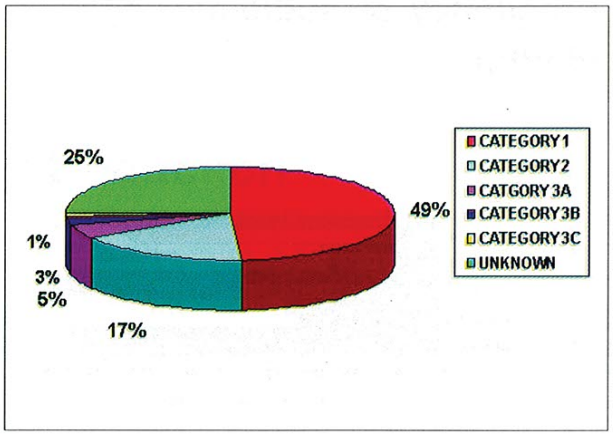
The frequency of audiometry in this graph was not related to the actual noise exposure levels as per the SABS 083-1983 code of practice.

Categories of health-care workers conducting audiograms



It was noted that only the larger industries used their own occupational health nurse (OHN) and audiometer.

Categorisation of audiograms



These categorization results are very similar to a previous study which showed only about half the working population tested had normal hearing.[6]

It was interesting to note that at the time the research was conducted, there was no legislation stipulating categorisation. On 17 April1996, the Department of Labour published a document requiring that the audiogram of a person undergoing audiometric examination be categorised by an audiometrist, but to date this has not been linked with legislation.[5] Some teaching institutions do not include this requirement in the audiometry courses they hold.

Other results

• It was interesting to note that 25% of all employees tested were referred for diagnostic audiograms, of which 3% were classified as medically related and 4% as noise-induced hearing loss.

• An approved inspection authority was used by 84% of factories for noise measurement.

• 79% of audiometers had been calibrated within the last year.

• 71% of audiometric booths had been calibrated within the last year.

• 55% used a type 4 audiometer as specified by SABS 083-1983.

• 57% measured the frequencies 500 Hz to 8kHz as specified by SABS 083-1983.

• Only 18% of Occupational Health Nurses (OHNs) and Audiologists were approved by the Department of Labour as specified by Regulation 7(10)a of the Environmental Regulations of the OHS Act.

Conclusions

• The findings of this study showed firstly that this sample of industry does not fully comply with Section 7 of the Environmental regulations of the Occupational Health and Safety Act and the SABS 083-1983 Code of Practice. Compliance with those aspects surveyed varied from only 18% of OHNs and audiologists gainined approval from the Department of Labour to 100% for the issue of personal protective equipment for those working in noise zones.

The possible reasons for this can be categorised as follows:

Perceived costs of adherence to legal requirements by employers

These include the costs of noise surveys which can be expensive and which seldom assist the employer on how to reduce the noise levels, engineering costs to reduce noise at source and audiometric costs, especially ear, nose and throat specialist consultations.

Insufficient inspection by Department of Labour to enforce legislation

At the time of the survey in KwaZulu/Natal, there were only 28 factory inspectors who had to cover a very large geographical area. Of these, 11 were engineering inspectors and 17 were environmental inspectors.

Inadequate audiometric training

Training programmes have lagged behind newer developments and do not always include all the aspects the OHN needs to be familiar with, especially in order to interpret audiograms, to categorise audiograms and to decide which employees should be put forward for compensation.

• Secondly, this survey showed that 4% of employees tested did have noise-induced deafness. The severity of this group and the number that received compensation was not ascertained.

Conclusion

There is no doubt that further specific research is required in the whole area of hearing conservation in industry to seek methods to improve compliance. Simple guidelines also need to be drawn up for employers, occupational health nurses and audiometrists.

The advent of instruction 168 under the Compensation for Occupational Injuries and Diseases Act which has lowered the entry level for compensation for noise induced deafness will result in more employees being notified and hence the assessments to employers will increase. However, no monetary reward can make up for hearing loss in employees, the majority of which can be prevented.

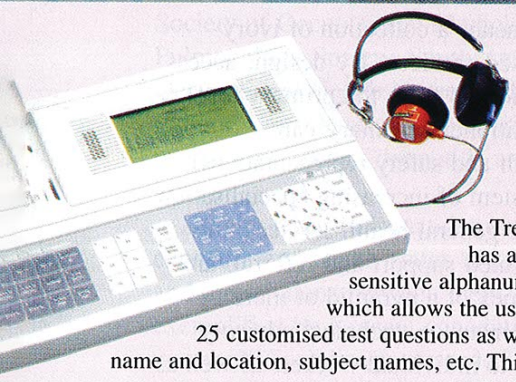
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4. *Code of Practice for the measurement and assessment of occupational noise for hearing conservation, 1989 Amendment, SABS 083-1983.*
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Acknowledgements and thanks

- ***Geoff Stanyer of Electroserve, who sponsored the printing and posting of the questionnaires.***
- ***NS Gwele, who assisted with the pilot study and questionnaires.***
- ***L Grainger, who assisted with the final presentation of this research.***

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The new National Centre for Occupational Health (NCOH)

David Rees
National Centre for Occupational Health
Johannesburg

Occupational Health SA 1998; Vol 4, No 3:32-35

Introduction

A new National Centre for Occupational Health (NCOH) was established in mid-1997. The fundamental changes to the NCOH were made with a clear purpose: to ensure that the functions of the NCOH support the development and provision of effective occupational health services in South Africa. Such services are irrefutably necessary: the Committee of Inquiry into a National Health and Safety Council in South Africa[1] has estimated that occupational disease and injury cost South Africa about R17 billion in 1996; and many expect that the increasing globalization of world markets will fuel demands for uniform occupational health standards, even in poorer countries.

South Africa needs to improve its occupational health services. To do this, the capacity in the public sector health services will have to be entrained because the informal and small business sectors, the agricultural and public sectors, migrant workers and retired, unemployed or casual workers are unlikely to have access to services unless the state takes some responsibility; and because some specific services are not profitable because of economies of scale, or simply because of what they are - research for instance. This is the context in which the Committee of the Minister of Health on Occupational Health planned. Its report was released in 1996[2] and, considering the vast number of South Africans unserved by workplace-based services, the plan is unambitious, aiming to establish only a skeletal infrastructure and to link the district health services to support and more specialised referral services. The support and referral services are to be provided by regional Occupational Health Units and by the NCOH.

The Committee's comprehensive plan necessarily called forth a new NCOH, but another factor informed the redesign: the best scenario for national functions is that they should serve the widest range of clients, including the enforcement agencies. Restructuring aimed to provide services concordant with this intention. The restructuring of the NCOH was done through a consultative process involving a wide range of individuals and agencies. We were fortunate to have Professor Jonny Myers, Head: Community Health, UCT and Dr Jukka Takala, Chief Occupational Safety and Health, ILO as consultants to assist us. A report is available.[3]

Functions of the new National Centre for Occupational Health (NCOH)

The NCOH has two major tasks:

- To provide support and referral services which contribute to the provision of effective occupational health services.
- To provide the statutory autopsy service required by the Occupational Diseases in Mines and Works Act (ODMWAct).

Support and referral services

These are by no means a collection of ivory-tower, super-specialised services. By design, access to most of these services is from the primary level (e.g. workplace practitioners, primary care practitioners, or health and safety representatives) and not through a system of increasing specialisation as is the case with the general health services: the services, although termed support and referral, are generally not at the apex of a pyramid of more general services. For instance, technical advisory services are available to individual workers as well as occupational health professionals. As services are developed at provincial and regional levels, the support and referral services of the NCOH will have to evolve to produce a rational system.

Table I presents the support and referral functions of the NCOH. They fall into five main areas: advisory services; research, surveillance and

health hazard evaluations (field surveys relating exposure and health outcomes); technical information dissemination; training; and specialised laboratory services. The services were selected to be consistent with national activity. In general, this means that they should be supportive of nascent provincial and subprovincial structures; fill gaps in scientific and technical capacity; and they should be services which cannot be provided in every province because of lack of specific skills (e.g. occupational toxicology), specific equipment or infrastructure, or because cost dictates that they should be provided centrally.

Advisory services are mostly consultations on specific problems or issues. These include individual patients, a pathology consultation service, development of research protocols and strategies for hazard control and the monitoring of groups of workers. An important aspect of our consultative function is policy formulation, usually on more technical matters. An example would be assisting with the design of a detailed strategy to implement the ILO/WHO International Programme on Global Elimination of Silicosis.

Research projects are epidemiologic and laboratory-based. Collaborative, multidisciplinary projects are becoming more common: tuberculosis in gold miners; the long-term effects of DDT exposure; neurobehavioural effects of manganese exposure; immunological changes in grain mill workers and asthma in pine sawmills are examples. (A list of current research projects is available from Dr M Gulumian, NCOH.)

SORDSA[4] exemplifies the surveillance function. SORDSA is a three-year project, guided by a board of directors representing the NCOH, South African Society of Occupational Medicine, South African Pulmonology Society, South African Society of Occupational Health Nurses and the Department of Labour. Consideration is to be given to surveillance projects on contact dermatitis and musculoskeletal injury.

Health hazard evaluations are assessments of exposure and health status of groups of workers, and the relations between them. This function is exemplified by a recent vanadium project,[5] which was multidisciplinary, exceeded the capacity of subnational structures, novel, but most important, patently problem-solving in intent. A health hazard evaluation of the microelectronics industry is planned for 1998.

A Technical Advisory Service has been established to provide technical information aimed at improving practice. Table I expands on this function.

Training is focussed on practitioners (from health and safety representatives to specialised professionals). The presentation of intensive issue-specific sessions is seen as an important development. The recent contact dermatitis workshops are examples of this activity.

Laboratory functions do not compete with the private sector, but rather fill gaps in occupational toxicology, hygiene and medicine laboratory capacity, and establish ad hoc capacity for specific projects of national interest. A recent development is the occupational allergy service - the putative allergen and the patient's blood can be sent for tests of sensitisation to the Immunology and Microbiology Section, NCOH.

International programmes have been developed with the World Health Organisation, National Institute of Occupational Safety and Health (NIOSH), USA and the Health and Safety Laboratory, UK.

Statutory autopsy service

The Occupational Diseases in Mines and Works Act makes provision for an autopsy evaluation of all deceased miners to determine eligibility for compensation. The Pathology Directorate of the NCOH performs these medico-legal evaluations which are both diagnostic and impairment-setting. The autopsy service generates information for a database called PATHAUT. This, together with biological and exposure/work histories, forms a unique national resource. This resource is utilised nationally and internationally and has contributed significantly to the understanding of occupational lung diseases. New genetic techniques have increased its value.

Structures

The NCOH is a component of the Chief Directorate: Environmental and Occupational Health of the Department of Health. The Chief Directorate includes the Chief Director, the Directorate: Environmental Health, Administrative Support Services, the National Centre for Occupational Health (NCOH) and the Medical Bureau for Occupational Diseases (MBOD).

The sections of the NCOH are shown in Figure 1.

Conclusion

The new NCOH is designed to be an integral part of our occupational health system. There are going to be difficulties in delivering all the services effectively. Chief among them are the following:

Table 1: Supprot and referral functions of the NCOH

Functions	Explanation
1. Advisory services	Consultancy,medico-legal and general functioning as a neutral independent source of expertise
2. Research, surveillance and health hazard evaluations (field surveys)	**Research** • Contribute to coordination & priority setting. • Conduct a set of national research programmes inappropriate at other levels: Industry/occupation wide issues in occupational epidemiology, medicine, hygiene & toxicology. Standard setting PATHAUT[a] Health services research and evaluation **Surveillance** • Develop model surveillance schemes for key occupational conditions • Assist in the identification of valid indicators of occupational health practice, health services performance indicators and human and other resources indicators. Assist in the collection of data on these indicators. **Health hazard evaluations.** • Selected priority evaluations where these cannot be done regionally.
3. Technical information dissemination	**Proactive** • Production of standards, guidelines and protocols: Specialised laboratory procedures Occupational hygiene Clinical occupational medicine Occupational health services Toxicology Management systems Compensation procedures (impairment & certification) • Collaborative proactive campaigns to improve practice in key industries or sectors. **Reactive** ILO-CIS/National reference library/International databases available to a wide range of users and linked into national systems. Network of practitioners to support information dissemination.
4. Training	• Build capacity in collaboration with training institutions. • Provide specialised training where this is of limited availability elsewhere (e.g. occupational epidemiology,occupational toxicology, occupational hygiene, occupational medicine).
5. Specialised laboratory	• Private, regional and provincial laboratories will have to provide the vast bulk of assessments. • National laboratory capacity to focus on filling gaps, i.e. conduct priority laboratory-based analyses and assessments where these are of limited availability elsewhere.
6. Other	• Formulate concrete programmes to support developments in the provinces • International liaison to develop agreements which build capacity at national and subnational levels.

[a] PATHAUT is described in the text in the section on Statutory Autopsy Services.

• Progress is being made to an interdepartmental national occupational health and safety system, but in the interim we do not have a national occupational health and safety policy. This impedes development of services because of uncertainty over the future roles of our national agencies and because the customer-base of these agencies is unspecified: will NCOH laboratory capacity serve a single system or will individual government departments develop capacity? Also, some functions presuppose a provincial infrastructure which is still to be developed. The NCOH will have to evolve along with the development of national policy and provincial infrastructure.

• Underdevelopment of occupational health services generally means that expectations on the resources that do exist can be unrealistic and unfocussed. The NCOH will, of course, have to prioritise with all the fallout associated with this.

• Resources are limited and public service conditions do not promote the recruitment and retention of excellent scientists and practitioners.

In our favour is a sense of purpose and a core of dedicated and expert staff committed to better occupational health practice.

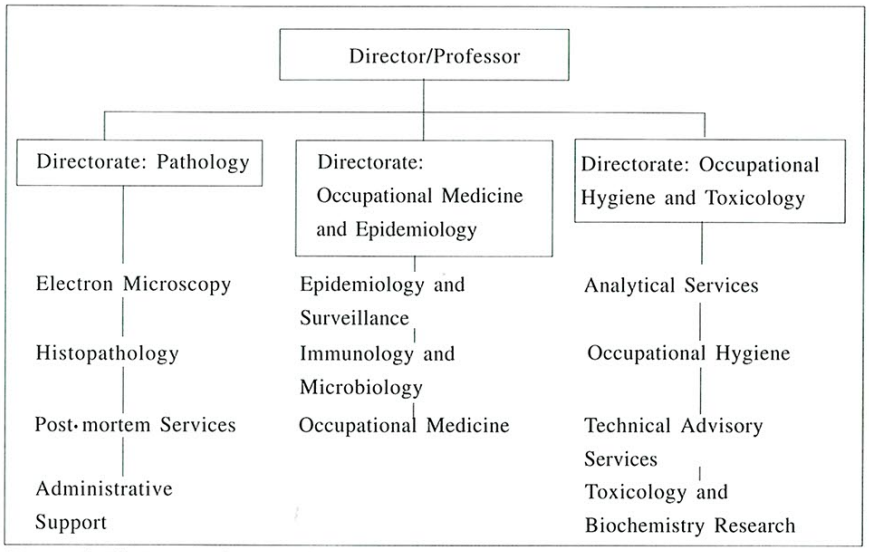


Figure 1: The National Centre for Occupational Health (NCOH)

Note: the documents referred to are available from Ms Engela Venter, NCOH, P O Box 4788, Johannesburg 2000; Fax (011) 720-6608 or e-mail info@ncoh.pwv.gov.za.

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New regulations for environmental impact assessments

Helen Fawkes
Risk Management South Africa (Pty) Ltd, Johannesburg

Occupational Health SA 1998; Vol 4, No 3: 36-37

Environmental Impact Assessment (EIA) Regulations were published under the Environment Conservation Act on 5 September 1997. South Africa now has, for the first time, a firm legal base from which to evaluate the environmental impacts of development proposals. The Regulations include a list of activities which will in future be subject to the EIA process.

EIAs take place within the overall framework of Integrated Environmental Management (IEM). The aim of IEM is to ensure that environmental considerations are incorporated into the planning and implementation process of new developments.

The Regulations will have important implications for industry, planners, and developers, as well as for the government, to whom the regulations also apply. The regulations will, in the case of certain specified projects, force those who could previously ignore environmental concerns, to consider the environmental impacts of their activities.

The EIA Process

The EIA process outlined in the regulations includes four main components:

An initial application

All initial applications must be sent to the Provincial Authorities of the Department of Environment Affairs and Tourism (DEAT) on the prescribed form. The application will then be referred to the appropriate level of authority. All levels of government will be involved in the EIA process.

Scoping report

This report details the results of a preliminary investigation into the impacts of a proposed development. The report must include details of consultation with interested parties, and must identify the main issues of concern.

EIA report

An EIA report may be required if the authorities feel that the scoping report indicates an EIA is warranted. The level of detail of this report will depend on the nature and extent of the development proposal, its complexity, the sensitivity of the environment, and issues identified during the scoping process.

Record of Decision report

This is prepared by the authorities. The report indicates the decision made with regard to the development, and the reasons for it.

Applicants can appeal

The regulations also permit the applicant to lodge an appeal within 30 days of the decision being made. Grounds for the appeal must be provided.

Regulations to be phased in

The application of the regulations to various activities has been phased in, in a 4-stage implementation programme. Some "high impact" activities were covered with immediate effect, while others were covered from 5 January, 2 March and 1 April 1998 respectively. Table I provides details of the activities, and implementation dates.

Independent consultants must be appointed

In terms of the new regulations, independent consultants must be appointed to conduct environmental impact assessments. The Department of Water Affairs has a list of approved consultants in the field of Integrated Environmental Management (IEM). This list can be used when sourcing consultants to conduct EIAs.

Table I: Activities and implementation dates

Regulations apply from 8 September 1997 to

- the construction or upgrading of
  - facilities for commercial electricity generation and supply;
  - nuclear reactors and installations for the production, enrichment, reprocessing and disposal of nuclear fuels and wastes;
  - roads, railways, airfields and associated structures outside the borders of town planning schemes;
  - marinas, harbours and all structures below the high water mark of the sea;
  - cableways and associated structures;
  - racing tracks for motor-powered vehicles and horse racing, excluding indoor tracks;
  - public and private resorts and associated infrastructure;
- the reclamation of land below the high-water mark of the sea and in inland water including wetlands.

Regulations apply from 5 January 1998 to

- the construction or upgrading of
  - structures associated with communication networks, other than telecommunication lines and cables, as well as access roads leading to these structures;
  - buildings and structures for industrial and military manufacturing and storage of explosives or ammunition or for testing or disposal of such explosives or ammunition;
- the concentration of livestock in a confined structure for the purpose of mass commercial production;
- the intensive husbandry of, or importation of, any plant or animal that has been declared a weed or an invasive species;
- the release of any organism outside its natural area of distribution that is to be used for biological pest control;
- the genetic modification of any organism with the purpose of fundamentally changing the inherent characteristics of that organism.

Regulations apply from 2 March 1998 to

- the construction or upgrading of
  - transportation routes and structures, and manufacturing, storage, handling or processing facilities for any substance which is dangerous or hazardous and is controlled by national legislation;
  - canals and channels, including diversions of the normal flow of water in a river bed and water transfer schemes between water catchments and impoundments;
  - dams, levees or weirs affecting the flow of a river;
  - reservoirs for public water supply;
  - schemes for the abstraction or utilisation of ground or surface water for bulk supply purposes;
  - sewage treatment plants and associated infrastructure;
- the disposal of waste in terms of section 20 of the Environment Conservation Act, 1989;
- scheduled processes listed in the Second Schedule to the Atmospheric Pollution Prevention Act, 1965.

Regulations apply from 1 April 1998 to

- the change of land use from
  - residential use to industrial or commercial use;*
  - light industrial to heavy industrial;*
  - agricultural or undetermined use to any other land use; and
  - use for nature conservation or zoned open space to any other land use.

* These two activities have been deleted (apparently temporarily) from the list by the Minister, in Government Notice no R448 of 27 March 1998, as capacity building still needs to take place within the appropriate government departments.

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Gill Harrower



Sister Gill Harrower started her Occupational Health nursing career when she joined Unilever SA in January 1975. In 1976 she enrolled for the pilot course in OH and qualified with distinction. During this period she was very involved in expanding Unilever's off-site clinics into viable, worthwhile and professional Medical Centres. In 1982 she was appointed sister-in-charge of Unilever Boksburg site where she currently leads the medical team. Her role involves communication forums with management, as well as liaising with the union on all aspects of health and safety. During her time with Unilever she has been secretary of the Occupational Health Nurses Group, Southern Transvaal. In November 1995 she received the South African Society of Occupational Health Nurses honorary life membership award.

Gill Harrower matriculated at the Girl's High School, Queenstown, in 1958 and she started her nursing career at Rondebosch College Hospital and Groote Schuur, finishing at Frontier Hospital, Queenstown, as a silver medallist in her final year.

Gill married her husband, John, a sheep and cattle farmer in December 1962. Their early married years were spent on a farm and besides having four children (two boys and two girls), Gill was also the "unpaid" district medical advisor to the surrounding farming community - learning cultural beliefs, traditional customs and becoming proficient in the Xhosa language.

In 1972, the Harrower family moved to Benoni, where Gill nursed at the Glynwood Hospital. She applied for the position as occupational health nurse with Unilever in 1975. In 1976, she enrolled for the pilot course in occupational health and qualified with distinction. Gill is currently doing a course on Advanced Life Support as she feels that basic first aid is not sufficient in life-threatening emergencies and is certainly not the required level of care expected from trained professionals. She believes that the independent OHN should make every effort to be able to give maximum care to employees entrusted to her professional care.

She has also received the following recognition:

- Lennon Achievement Award 1985
- EMA and Advanced Life Support 1989
- Special recognition certificate in 1993
- AIDS/HIV Care Group and trainee 1995
- AIDS/HIV Counsellor 1996
- Winner NOSA Hygiene Personality of the Year in 1989, 1991 and 1996.

She has also attended congresses on OHN in Dublin and Ireland in 1984, Montreal and Canada in 1990 and Pan Africa in Cairo and Egypt in 1994.

The emphasis throughout her Occupational Health career has been on care and compassion in the field of nursing. Amongst the most rewarding events over the years has been the formulation of an HIV+/AIDS support group offering counselling, empathy, training and extensive education to every employee, including contractors. Worlds AIDS Day has a prominent role on the site and is well supported. A Substance Abuse Group has also been formed and with care and nurturing amazing results are being achieved.

To ensure that all employees, including senior management, are fully aware of the scope of the services, Health Expos have been introduced as annual events. The entire spectrum of OH nursing is then experienced, including the participation of outside services, e.g. podiatry, dieticians, traumatologists, diabetic educators, optometry, audiometry and dentistry.

Networking is also one of Gill's priority issues. Carefully selected and specific services are invited to the factory, and become very much an integral part of the system, causing minimal absence from the work environment and the assurance of quality supervised care to the patients. This type of service has generated tremendous interest amongst the workforce and the one-day diabetic workshops, cholesterol clinics and podiatry visits are overwhelmingly supported and extremely stimulating for employees and staff.

For many years Gill, together with Unilever, has been committed to hosting more than 200 postgraduate students annually. Their aim is to instill within them a deep professional responsibility for the well-being and health of workers in industry and to inspire them to take up the exciting challenge offered in the field of Occupational Health Nursing.

In a sentence, Gill Harrower is the embodiment of professionalism, dedication and caring.

Gill has recently moved to a townhouse and hobbies include gardening, creating a Japanese-style garden and hiking. She has three delightful little granddaughters and two ageing spoilt bull terriers.

To the editor

Post-traumatic stress syndrome and benefits under COIDA

Definition: Post-traumatic stress disorder (PTSD) is a specific anxiety disorder that occurs when a person has experienced or witnessed a very traumatic event. The person's reaction to this event involves intense fear, helplessness or horror.

For professional nurses working in a 'safe' occupational health environment such as financial services companies, the 90s have brought a new set of challenges. Staff who work in offices where large amounts of cash are handled daily are now at greater risk of acts of violence and robbery, which will expose them to PTSD.

Other staff, those who transport cash for example, and also clients who are present when violence erupts, are at a similar risk, since more and more hold-ups and hijacks are reported daily in the press.

So where does the Compensation for Occupational Injuries and Diseases Act (COIDA) fit into the scenario? The question recently came to mind when one of the branch offices of the company I serve came under attack. One of the senior female employees was held hostage, with a gun pointed at her head. As a result of the incident, which happened on a Saturday, she was extremely distressed and needed urgent psychological counsel.

On the Monday following the incident, the woman was advised by her manager to see a psychologist for post-traumatic debriefing. She was also afterwards admitted to hospital for intensive counselling.

The obvious question is: who should pay the medical expenses?

It was my task to contact the office of the Compensation Commissioner and I was advised to submit a standard WC12 claim form, even though COIDA does not make provision for this. This, way I was told, the case would be considered.

With violent acts, especially those targeted at businesses, becoming more and more commonplace in our society, it is clear guidelines for compensation will have to be set. Ways will also have to be found to streamline the process of claiming compensation.

People traumatised by violence are suffering already. They should not be subjected to further stress by having to fight or defend their post-traumatic medical needs. Of course the business world can help, by ensuring that public liability insurance covers this type of event, for example, three to four days in hospital. Currently the ABSA Banking Group offers staff and clients four sessions of post-trauma debriefing. At a recent international trauma conference, it was emphasised that violent robberies are a worldwide phenomenon and that they are likely to continue in the foreseeable future. Even if this social ill cannot be cured overnight, we can at least prepare ourselves to deal with it in future.

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To the editor

Occupational medicine as a speciality

Occupational medicine practitioners have long lobbied for the formal recognition of their speciality. Their efforts may well be rewarded by the millennium.

In 1997, the Interim South African Medical and Dental Council (ISAMDC) recognised Occupational Health as a sub-speciality of community health.

That same year, the College of Medicine gave approval to the College of Community Health (CCH) to investigate the development of a four-year specialist qualification in Occupational Medicine.

Community health specialists who qualify as sub-specialists in Occupational Health initiated the establishment of an Occupational Medicine Group (OMG) in 1997. The group has prepared direct proposals of the course content, course structure and examination requirements for the four year speciality and the current six-year sub-speciality.

Initially I was sceptical of the CCH assisted by the OMG, spearheading the creation of a speciality for Occupational Medicine because specialities such as Pulmonology, Dermatology, Rheumatology, Orthopaedics and ENT, to name but a few, have a role to play in the development of such a speciality. However, it is clear that the OMG recognises the potential role of the various disciplines in the development of the Occupational Medicine speciality. Certainly, the draft proposal acknowledges the importance of these disciplines. Perhaps we can look forward to the creation of a speciality that relies on creative collaboration between the many relevant specialities.

Dr Marianne Felix
SASOM Executive Committee, Education and Training Portfolio.
NCOH
P O Box 4788
Johannesburg
2000

Editor's Note: If anyone would like to obtain a copy of the draft course content or examination requirements, please contact Professor Daan Kocks, Medunsa.

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To the editor

Onsite clinics

I read with dismay your article on STD management; the negative comments by a manager regarding using an onsite occupational health clinic for treatment.[1] On the whole, I do not believe that this is correct and would ask the author to substantiate her findings.

The survey was conducted telephonically among OHN in the Gauteng area: what was the sample size?

I agree that all OHNs and Doctors, as well as GPs outside OH practice need further training and that this should be an ongoing process.

At present the local authorities are withdrawing their services to industry. This leaves a large hole especially in respect of family planning and STD clinics. What does the Department of Health plan to do with the permit system? The regulations have been in the pipeline for more years than I care to remember. Surely it's time to stop playing to the gallery and let us get on with the job of delivering a quality service.

BW Hoggins
Occupational Health Nurse, Corobrik
P O Box 49
Germiston
1400

1. Occupational Health SA 1998; 4 (2):38-41

To the editor

WCA Tariff and Instruction 168

Permit me to comment on the "WCA Tariff" and "Instruction 168", discussed in an article on COIDA in the January/February issue of *Occupational Health Southern Africa.*

The WCA tariff for providers

The stated reason for the higher tariff is an urban legend. The main reason is found in section 76 of the Act, which in essence prohibits any amount in excess of the tariff being recovered from the patient. Another reason is the increased administrative workload on the doctor himself, who is expected to fill in the forms personally, thereby certifying the correctness of the diagnosis, and other content. Guaranteed access to medical care is simply not a consideration. Besides, what exactly makes the RAMS tariff a guideline or even remotely acceptable to doctors in private practice?

Instruction 168

The morbid interest in Instruction 168 remains incomprehensible. Surprise is expressed in the article that the content of this specific instruction was not communicated to occupational medical practitioners, audiologists, and ENT surgeons.

Instruction 168 is a directive on how to accept a claim of noise-induced hearing loss (NIHL), and how to determine permanent disability, where applicable. The contents should therefore be of interest only to people who perform these administrative tasks, and was duly distributed to these people.

Schedule 3 of COIDA recognises hearing impairment as an occupational disease. Sections 65 to 68 of COIDA address occupational diseases, and nowhere is it implied that any occupational disease, or NIHL in particular, should only be reported once permanent disability has occurred. Therefore occupational diseases and injuries should be reported when they are diagnosed.

The interest of occupational medical practitioners should thus be directed to how to make the diagnosis of NIHL and other occupational diseases. This information is found in medical textbooks, and not in Instruction 168, or any other office instruction, for that matter.

The parameters for compensation for many other disabilities have changed in the last nine years, and these were also not communicated to medical practitioners, for the simple reason that doctors diagnose and treat. They do not assess permanent disability percentages, and any attempt to do so should be discouraged.

As to the independent estimate of the total liability due to the implementation of Instruction 168, the medical aspects and nature of NIHL could not have featured in the calculation. The result of any projected estimate depends on the information used to make the calculation. This specific calculation apparently took for granted that each and every case of NIHL will be awarded 12% and more permanent disability in the future, and this is patently incorrect.

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To the editor

Merit rebates under COIDA

The merit rebates for the 1992-1994 cycle were paid out towards the end of 1997. Our company was very disappointed when the rebate was less than half of the expected amount according to our calculations (R115 939 instead of R269 670), especially as the money is "earmarked" by our company for the safety programme. On speaking to the office of the Commissioner, it appears that the medical expenses of the fund have increased substantially again, and thus the rebates have been reduced by more than 50% as opposed to the previous cycle, i.e. the maximum rebate you could now get was 22.4% as opposed to the 51% of the previous cycle.

I wish to refer to the article in which Baker[1] recommends that the merit rebate system be discontinued (as it is becoming of little financial value anyway) and that the focus by the office of the Commissioner should be on loading or reducing the annual premiums of companies according to their previous years' claims experience.

Sister Irene Thomas
Haggie Rand Ltd
P O Box 6554
Johannesburg
2000

1. *Baker MD. Is there a case to partially privatise the state compensation fund for occupational injuries and diseases. Occupational Health SA 1997;4:15-23.*

To the editor

HIV testing as a pre-employment practice in the food industry

It is well known that the diagnosis of the AIDS complex revolves around the development of opportunistic infections. These would include atypical pneumonias, soft tissue infections which would include boils, otitis externa, eczema and candidiasis. Episodes of bacterial enteritis are common. These symptoms particularly become more prevalent when the CD4 count drops below 250 and endemic when the CD4 count drops below 100.

It is recommended that HIV testing become routine for all food handlers, together with the CD4 count. If the CD4 count is below 250, these workers should be regularly monitored for symptoms of diarrhoea, cough and soft tissue infections.

Once these symptoms begin and the CD4 count is showing progressive deterioration, the worker would become unfit to handle food.

Fitness for other duties not related to the handling or production of food should not be affected.

I would appreciate comment on this issue.

Dr Greville Wood
P O Box 304
Pavilion
3611

To the editor

Occupational HealthSouthern Africa, March/April 1998 Issue

I would like to congratulate you on the above issue of the journal, especially the focus on drug abuse.

Despite the fact that drug abuse is growing rapidly, there is still much ignorance present in industry. I agree with Vivienne Pienaar when she states that policies, procedures and education should be in place. These are still lacking in many companies.

Very often the employee with an alcoholic problem is dealt with through disciplinary channels. Would the same company discipline the employee with severe depression or would the employee with the diagnosis of cancer be disciplined? This is where the real understanding of the problem becomes a necessity - realising that this person needs treatment and support in order for him to deal with this problem effectively. The person with the dependency problem needs to accept responsibility for the management of his problem - this he can only learn and integrate through specialised treatment.

Professionals have a major task educating decision makers in industry regarding this aspect.

Elize Smith
Alcohol and Drug Consultant
Elim Clinic
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1620

Disabled sport given tremendous boost

South African Druggists' Pharmacare Division announced that the generic brand Panamor, an anti-inflammatory medicine, is to be the title sponsor of the 1998 South African Disabled Table Tennis Open Championships and South African disabled table tennis in general.

Table tennis is the largest individual sport played by disabled athletes in South Africa and is second in popularity only to athletics at the World Paralympic Games. The Panamor sponsorship will benefit athletes through the supply of equipment at grassroots level, across all disabled communities. Ultimately, the winners of the 1998 Panamor South African Open will earn the right to travel to Paris and represent the country in the 1998 World Disabled Table Tennis Championships.

"All too often our disabled athletes are overlooked when it comes to sponsorship and this is one of the most important sponsorships in the history of South African disabled sport," said Andy Scott, Executive Director of South African Sports Association for Physically Disabled (SASAPD).

Lizette Hunt, Brand Manager of Panamor had this to say, "Panamor elected to become involved in disabled sports activities as part of Pharmacare's social commitment."

It is estimated that several thousand people are active in disabled table tennis throughout South Africa. From development through to competitive levels, the Panamor sponsorship will be used to secure much needed equipment for distribution throughout the country, and will also provide increased funding for tournaments and training camps.

"Anyone who thinks that this a Cinderella sport," says Scott, "would be more than welcome to challenge our local top players. In fact, I am sure Panamor would be pleased to organise a match for anyone who is prepared to take up the challenge! Several months of serious practice, several hours a day in advance, would defnitely help!" he cautions.

Panamor is widely used throughout the medical industry and is known for its effective treatment of post-traumatic conditions such as sprains and strains.

For further information, please contact Lizette Hunt, at (011) 239-3427.

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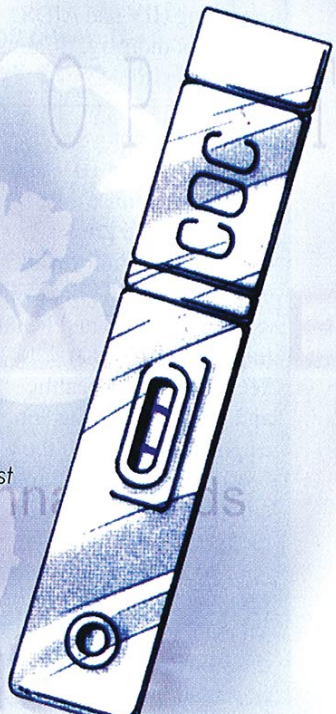
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For further information, please contact Ken Southcott at (011) 622-1743.

Living the consequences

This, booklet on managing HIV and AIDS addresses industry. It aims to minimise the stigma attached to HIV; to familiarise employees with concepts around HIV and AIDS; to minimise time spent on initial pre-test counselling; to inform all employees on the broader aspects of AIDS and health information in general; to keep employees healthy and productive for as long as possible; to reach the broader community through employees, by their taking the booklet home.

Health information sessions held at two of MONDI KRAFT's divisions proved that information of this nature is sought after. Employees indicated that they found the sections on viruses and bacteria most interesting as they could understand the transmission of the virus and the delayed onset of the disease far better.

The sessions last approximately three hours with enough time allowed for discussion and questions. It is most important to stress that these booklets should not be seen as a handout but rather as a support to a formal information session.

Training manuals and booklets are available from Jalinda van der Westhuizen at tel: (0351) 902-2104 fax: (0351) 97-3639 e-mail: JMDWESIH@MONDIKRAFT.COZA

The gloves are off!

The Trades Union Congress (TUC) and the National Asthma Campaign have joined forces in the United Kingdom to prevent the occurrence of asthma in National Health Service employees as a result of latex allergy. In a document entitled *Latex and Asthma: The Gloves are Off!*, the TUC lays the blame for latex-induced dermatitis and asthma and their sequelae at the door of those health services who are putting the health of employees at risk through the purchase of cheap, powdered surgical gloves with high levels of extractable latex protein.

The TUC notes that, although awareness of latex-induced allergies is rising, immediate financial pressures present health sector employers with an incentive to ignore the risks. As a result, the TUC/National Asthma Campaign is seeking progress in the following areas:

- Stronger legal protection for workers enshrined in an Approved Code of Practice making it absolutely clear to employers the steps they are legally required to take to prevent latex-induced asthma in their workers.
- More research to establish the number of sensitised individuals in the UK and the severity thereof, so that they may be treated more effectively.
- Information for health-care managers on the problem of latex allergy, so that they can undertake health and safety assessments in the workplace and institute measures to protect their staff.
- More information for people in contact with latex on the risks they face, how they can reduce the risks and early recognition and reporting of the symptoms of latex allergy.
- Proper labelling of gloves, so that supplies purchasers have full information about the protein levels in the gloves they are buying. (At present latex gloves

can contain widely different amounts of protein; the suggested 'safe' level of extractable protein is 10 micrograms per gram.)

• More widespread use of safety data sheets, which should be supplied to all managers and workers where latex gloves are used in the health service, so that all are aware of risks and the measures to be taken to control those risks.

• Identification of sensitised people by means of MedicAlert cards, so that they will not be treated in an emergency by personnel wearing latex gloves.

Unfortunately, the worst latex gloves are often the cheapest, and resources within health services are limited. The TUC document emphasises, however, that there is no cure for latex-induced asthma: those who become badly affected have to leave their jobs. Whilst low protein or washed powder-free gloves can help prevent the onset of asthma, for those already sensitised there is no alternative to working in a latex-free environment wearing more expensive nitrile or non-latex gloves.

Reference

Gallagher J. Latex and Asthma: The Gloves are Off! Preventing asthma in the NHS. TUC/National Asthma Campaign, November 1997.

For further information, contact Maggie Smock at (011) 314-3102.

Sanitary Solutions

In 1996, some colleagues met for lunch. Talk turned to needs in the toilet and washroom industry, and how these needs were not being met because people were so used to poor hygiene standards they accepted them as normal. In the ensuing months, one of the group, Lynda Bannister, kept recalling this conversation. So Lynda, who had previously been involved in this industry, approached Deeken Services for support in re-entering the market. ***Sanitary Solutions* was born!**

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So says Rupert Xaba, Training Manager at leading safety supplier, Campbell Gardwel, a company in safety and security group, Klipton.

"This is especially true for hearing protection, where absence of acute pain makes it difficult for workers to understand the benefits of wearing their earplugs. Hearing loss happens gradually and painlessly, unlike a damaged finger or blow to the head, which manifests immediately as pain. Unbeknown to many workers at risk of losing their hearing through their occupations, deafness is an extremely unpleasant disability."

Many companies adopt discipline as a means of enforcing the usage of hearing protection. Although this is perhaps a temporary solution, this cannot be sustained. The answer is creating a health and safety aware employee who will take responsibility for his health.

Campbell Gardwel recently opened the doors to a grassroots-level training programme aimed at the workforce to provide an insight into the importance of the correct usage of safety equipment.

In addition, the programme provides workers with recognisable, transportable skills in the form of certificates as proof of skills and knowledge in the field of workplace safety. This ties in directly with the new outcomes-based education policy now being implemented by the state, of which Campbell Gardwel is fully supportive.

"Occupational health and safety awareness can only be raised through a multi-pronged strategy adopted by companies. A strategy could comprise training modules, internal competitions and awards for the best health and safety practices," says Xaba. "Involving employees in the implementation of the health and safety strategy is the cornerstone to its success."

For further information, contact Rupert Xaba, Campbell Gardwel, at telephone (011) 613-2151.

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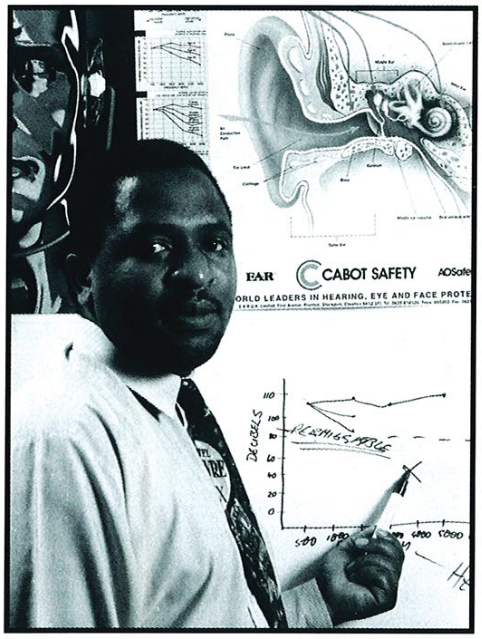
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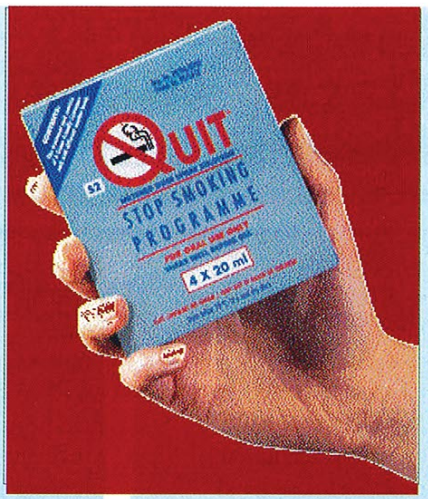
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