TRANSACTIONS

Volume [illegible]

Admission Ceremony May 2007

TRANSACTIONS

50 Years of Excellence 1955-2005

Contents

Volume 51 Number 2 Jul-Dec 2007

Front Cover

In support of contemporary Zulu telephone wire baskets
Artist: Ntombifuthi Magwasa, Nongoma, KwaZulu-Natal
Photographer: William Raats

Ntombifuthi wove her first basket in 1993, after being taught how to weave by her neighbor Anamaria Dlamini in Siyanda. She had a natural talent for the craft and soon developed an unusually complex sense of color and balance in her designs. Inspired by the colors of the wire and how the colors work together, she experiments constantly with new patterns and scale. She looks for inspiration in books, magazines, and in the colors and patterns she sees around her. Her designs range from traditional Zulu patterns to bold contemporary patterns that reflect a melding of Zulu and Ndebele traditions.

Photographs reproduced from the book, *Wired*, by David Arment and Mariska Fick-Jordaan, 2005, S/C Editions Santa Fe. ISBN 0-89013-449-9, with permission. © 2005 David Arment and Mariska Fick-Jordaan. The book is available from David Krut Publishers, (011) 880 4242 or info@davidkrutpublishing.com and local book shops in South Africa. Proceeds from the book will benefit the Wilson Education Foundation and educational development projects in South Africa

Editor
Prof Gboyega A Ogunbanjo

Letters to the Editor
Prof GA Ogunbanjo
E-mail: gao@intekom.co.za
Mail and faxes to Mrs Bernise Bothma

The Colleges of Medicine South Africa (CMSA)
Website: http://www.collegemedsa.ac.za

Administration
Chief Executive Officer (Cape Town)
Mrs Bernise Bothma
E-mail: bernise.ceo@colmedsa.co.za

Western Cape Regional Office
Tel: (021) 689-9533
Fax: (021) 685-3766

The Colleges of Medicine of SA
17 Milner Road
RONDEBOSCH
7700

Academic Registrar (Johannesburg)
Mrs Ann Vorster
E-mail : alv@cmsa-jhb.co.za

Gauteng Regional Office
Tel: (011) 726-7037
Fax: (011) 726-4036

The Colleges of Medicine of SA
Private Bag X23
BRAAMFONTEIN
2017

Education: Administrative Secretary (Durban)
Mrs Anita Walker
E-mail: cmsa-edu@ukzn.co.za

KZN Regional Office
Tel: (031) 260-4438
Fax: (031) 260-4439

The Colleges of Medicine of SA
PO Box 17004
CONGELLA
4013

Production
Editor: Dr Douw GS Greeff
Manager: Me Caryl de Meillon
Medpharm Publications (Pty) Ltd

Publisher
Medpharm Publications (Pty) Ltd
PO Box 14804
Lyttelton Manor
Centurion
0157

Tel: (012) 664-7460
Fax: (012) 664-6276
E-mail: enquiries@medpharm.co.za

Designer
Ilze Garnett-Bennett
Medpharm Publications (Pty) Ltd

Printed by Intrepid Printers (Pty) Ltd

EDITORIAL

Prof Gboyega A. Ogunbanjo

Dear colleagues,

This edition of the Transactions is a 64-page bumper edition, which covers some of the presentations at the Durban symposium on logbooks/portfolios held in May 2007, and articles on the ethics of resuscitation and the "impaired practitioner". In addition, the May 2007 admission ceremony, list of successful candidates and annual reports of the various Colleges are presented.

The Durban symposium on logbooks/portfolios was a revelation in terms of the direction the Colleges of Medicine of South Africa (CMSA) would be pursuing on this issue. The symposium addressed four crucial questions namely:

a. Should we have logbooks?
b. Should the information have a gate-keeper function for entry into the qualifying exam?
c. How can the logbook be used as a formative assessment tool?
d. How can the logbook be used as an instrument of quality control related to the teaching and training programmes?

One of the significant areas of understanding was the differentiation of the logbook and portfolio. Dr. Walter Kloeck in his article –"**Where do logbooks fit in",** defines a logbook as "*a list of activities or things that were done*". While on the other hand, a Professional Performance Portfolio (PPP) is "*a collection of evidence that learning has taken place across a range of activities"*. He mentions the value of a professional performance portfolio which relates to the principles of adult-based, learner-centered education, and promotes deep learning through encouraging the development and tracking of personal progress. The article further gives examples of what could be included in the PPP but cautions that before implementing a performance portfolio, objectives, learning outcomes, content and criteria for assessment should be set jointly between the educational institution, examining body and prospective candidate.

The article on **"Quality assurance – Striving for consistency with the Colleges of Medicine of South Africa"** by Dr. A Hurribance introduces the concept of quality assurance as a primary instrument for evaluating performance and accountability in higher education systems. He elucidates the importance of Total Quality Management (TQM) in higher education institutions as having three generic approaches namely client focus, staff focus and service agreement. In the implementation of the TQM by the CMSA, the proposal is to register as a Higher Education institution with the Commission for Higher Education and the Department of Education. This article concludes with the suggestion to establish internal quality assurance systems by means of self-evaluation, external quality audits for improvements and preparation of the constituent Colleges for accreditation.

The abridged report by Prof MF Jeebhay from the International **Assessment Tool for Occupational Medicine** (ATOM) workshop held in Barcelona from November 9 to 10, 2006 provides information on a project to develop common assessment methodologies among a number of countries. Actions for the Occupational Medicine Division of the CMSA arising from the workshop include ongoing review of current Occupational Medicine regulations, finalization of the scope of practice document, exam regulations, and development of a databank on assessment tools. *The full report is available on the CMSA website*.

The KM Seedat lecture delivered by Prof D Hellenberg at the 13th National Family Practitioners Conference in Mthatha on the "**Future of the Family Practitioner in South Africa**" has been included to highlight the problems facing the family practitioner in this country. The lecture is in the format of a SWOT analysis and offers recommendations based on lessons from countries that have been through similar restructuring processes in their health systems.

Finally, the article on the "**Impaired practitioner**" by Dhai A *et al* which was initially published in the South African Medical Journal, is reprinted in our journal with their kind permission. The article gives a concise summary on the scope of the problem and how the Health Professions Council of South Africa deals with reported cases. It is interesting to note that over 50% of the reported cases were related to substance abuse. The focus of the HPCSA is non-punitive but rehabilitative, comprising of comprehensive medical and psychiatric assessment as well as treatment and active long-term follow up.

Future editions of the Transactions will have a regular column dedicated to the links between CMSA and sister Colleges in Africa. Enjoy this copy of the Transactions and have a restful Christmas and festive period.

Prof. Gboyega A Ogunbanjo
Editor: Transactions
Email: gao@intekom.co.za

NB: The journal welcomes well-written original and review articles for publication.

ADMISSION CEREMONY
10 May 2007

The admission ceremony was held in the Students' Union Hall, on the Edgewood campus of the University of KwaZulu-Natal, Pinetown.

At the opening of the ceremony the President, Professor Zephne van der Spuy asked the audience to observe a moment's silence for prayer and meditation.

The President announced that she would proceed with the admission to the CMSA of the new diplomates, certificants, members and fellows.

The new Diplomates, Certificants and Members were individually announced and congratulated.

The Honorary Registrar - Examinations and Credentials, Dr Jeanine Vellema announced the candidates, in order to be congratulated by the President. The Honorary Registrar – Education, Professor Bilkish Cassim individually hooded the new Fellows. The Honorary Treasurer, Professor Tuviah Zabow handed each graduate a scroll containing the Credo of the CMSA.

Twelve medalists were congratulated by the President on their outstanding performances in the CMSA examinations.

Two Honorary Fellows were admitted. Professor Pierre Foëx to the College of Anaesthetists – citation written and read by Professor Arthur Rantloane. Doctor Basil Jaffe to the College of Family Practitioners – citation written and read by Professor Gboyega Ogunbanjo.

The President admitted 174 Fellows, 5 Members, 242 Diplomates and 25 Certificants.

Professor Jack Moodley delivered the oration.

The National Anthem was sung, there after the President led the recent graduates out of the hall. Refreshments were served to the new graduates and their families.

MEDALISTS 2007

Libero Fatti Medal
FC Cardio(SA) Final

Rishendran Naidoo

J M Edelstein Medal
FC Orth(SA) Final

Karl Frielingsdorf

S A Society of Otorhinolaryncology Medal
FC ORL(SA) Final

Johan Grobbelaar

Leslie Rabinowitz Medal
FC Paed(SA) Part I
and Robert McDonald Medal
FC Paed(SA) Part II

Judy Nicole Rothberg

Novartis Medal
FC Psych(SA) Part II

Hendrik Sebastiaan Temmingh

RECOMMENDATION FOR MEDALS 2007

Josse Kaye Medal
FC Rad Diag(SA) Part II

Shalendra Kumar Misser

Frederic Luvuno Medal
FCS(SA) Primary

Sumayyah Ebrahim

Trubshaw Medal
FCS(SA) Primary

Colin Ian McGuire

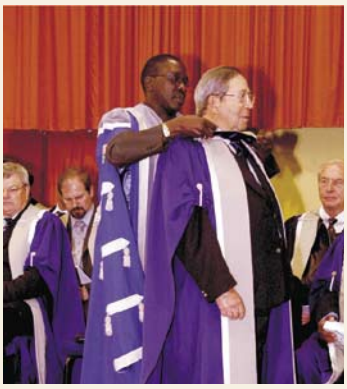
Brebner Award
FCS(SA) Intermediate

Lesley Marcia Maude Nunn

SASA John Couper Medal
DA(SA)

Kim de Vasconcellos

CITATION
HONORARY FELLOWSHIP
DR BASIL JAFFE
COLLEGE OF FAMILY PRACTITIONERS



Dr Jaffe entered general practice in 1949, soon after graduating with MBChB from the University of Cape Town. He has been significantly involved in the development of Family Medicine in South Africa ever since. In 1962, Dr Jaffe was appointed as a Member of the Cape of Good Hope Faculty of the British (later Royal) College of General Practitioners. Seven years later, on creation of the South African College of General Practitioners (SACGP), he was awarded membership. A year later, when the SACGP joined the College of Physicians, Surgeons and Gynaecologists of South Africa as the Faculty of General Practice, Dr Jaffe was made an Associate Founder of what then became The College of Medicine of South Africa. He remained an active member of the Faculty, which subsequently became the College of Family Practitioners and served as Chairman for one triennium. In 2005 he was awarded life membership. In 1982, he was elected as an Honorary Life Member of the National General Practitioner Group of the South African Medical Association for services to general practice.

In 1980, Dr Jaffe was the founding Chairman of the Academy of Family Practice/ Primary Care. This organisation emerged out of conflict with the then College of Medicine Council over autonomy and equality of general practitioners within the College. The College was supportive of the establishment of the Academy, even agreeing to the transfer of funds from the Faculty to the new body. The Academy also continued to support the activities of the College of Medicine, recognising it as the examining body for this discipline. In fact, the Faculty Committee consisted of the same people as the Council of the proposed Academy. Many of the initial aims of the Academy have been achieved and it has now merged with FaMEC (the consortium of all eight departments of Family Medicine at South African universities) to complete the unity of academic Family Medicine in South Africa. Over subsequent years, the Colleges of Medicine of South Africa, as it is now known, have continued to be the recognised national examining body and the College of Family Practitioners is now on the threshold of being able to provide a Fellowship examination. There is a lot of support from the academic departments for using this as our national endpoint examination for post-graduate Family Medicine training.

Dr Jaffe's initial leadership of the Academy helped it to become a non-partisan body that was inclusive of all types of general practitioners in South Africa, united by the common goal of improvement of the quality of care provided to the population of South Africa who accessed primary care whether that be in the private or public sector, urban or rural. One can only wonder where Family Medicine would have been in South Africa and the Colleges of Medicine today if it had not been for the courage of Dr Jaffe and his band of "freedom fighters"!

More than thirty years ago, in 1975, at a special ceremony before the biennial congress of the Medical Association, held in conjunction with a regional congress of the World Organisation of Family Doctors, Dr Jaffe read the citation to bestow an Honorary Fellowship of the College of Medicine in the Faculty of Family Practice on Pat Byrne from Manchester (then the President of the Royal College of General Practitioners). After completion of the congress another ceremony was held at which (amongst others), Dr Jaffe was elected as a Fellow of the Royal College of General Practitioners.

It is surely now time that his own College bestows a similar honour on Dr Jaffe for his very long and significant contributions to the development of the discipline of Family Medicine in South Africa. His contributions have helped to bring us to the point where we are today, at the beginning of being recognised as a specialty, with an examination for a Fellowship, on a par with all other specialist disciplines.

Madam President, it is a great honour for me to present Dr Basil Jaffe for admission to Honorary Fellowship of the College of Family Practitioners of South Africa.

Author: Prof Gboyega Ogunbanjo

CITATION
HONORARY FELLOWSHIP
PROF PIERRE FOËX
COLLEGE OF ANAAESTHETISTS

Professor Pierre Foëx has been a long time friend and supporter of anaesthesia in South Africa. He was the Nuffield Professor of Anaesthesia at Oxford from 1991 to 2002 and is currently Emeritus Professor of Anaesthesia at Oxford, as well as an honorary consultant anaesthetist at the Oxford NHS Trust. He is also an elected founding Fellow of the Academy of Medical Sciences. From July 1999 until the present time, he has been the civilian advisor in Anaesthetics to the Royal Air Force.

Pierre was a member of the Council of the Royal College of Anaesthetists from 1996 to 2002 and a College examiner from 1988 to 1999. He also has a Fellowship from the Australian and New Zealand College of Anaesthetists, as well as being a Fellow of the Faculty of Anaesthetists, Royal College of Surgeons UK. He ob-

tained the degree, Doctor of Medicine at the University of Geneva in 1965 and a Doctor of Philosophy from Oxford in 1973.
His main area of interest and research in anaesthesia has been cardiovascular and he has published extensively. In addition to 3 books and over 95 book chapters he has more than 150 peer reviewed publications. His clinical research in anaesthesia includes the prophylactic use and protective effects of beta blockers, and statins in surgical patients; the prevalence of silent ischaemia in surgical patients; hypertension as a risk factor as well as cardiovascular drugs and their interactions with anaesthesia.

In 2003, Prof Foëx was awarded the prestigious Royal College of Anaesthetists gold medal - an academic recognition by his peers. He has extensive involvement in under- and postgraduate teaching and has also been involved as an external research assessor in Hong Kong, Australia and New Zealand. In addition, he has given six eponymous lectures in Canada, the United States of America and the United Kingdom.

Pierre has attracted many Research Fellows to his department over the years. Seven of these currently hold chairs in their departments (two in anaesthesia in South Africa). He has also supervised eighteen PhDs and numerous MScs.

He has been a member of the editorial board of numerous international anaesthesia journals, including his current involvement on the editorial boards of Current Anaesthesiology Reports and the Canadian Journal of Anaesthesiology.

He is happily married to Anne-Lise for many years.

Madam President, it is my pleasure to present Prof Pierre Foëx to you for admission to Honorary Fellowship of the College of Anaesthetists of South Africa.

Author: Prof Arthur Rantloane

INSTRUCTIONS FOR AUTHORS

1. Manuscripts

1.1 All copies should be typewritten using double spacing with wide margins.
1.2 In addition to the hard copy, material should also, if possible, be sent on disk (in text only format) to facilitate and expedite the setting of the manuscript.
1.3 Abbreviations should be spelt out when first used in the text. Scientific measurements should be expressed in SI units throughout, with two exceptions; blood pressure should be given in mmHg and haemoglobin as g/dl.
1.4 All numerals should be written as such (i.e. not spelt out) except at the beginning of a sentence.
1.5 Tables, references and legends for illustrations should be typed on separate sheets and should be clearly identified. Tables should carry Roman numerals, thus: I, II, III, etc. and illustrations should have Arabic numerals, thus 1,2,3, etc.
1.6 The author's contact details should be given on the title page, i.e. telephone, cellphone, fax numbers and e-mail address.

2. Figures

2.1 Figures consist of all material which cannot be set in type, such as photographs, line drawings, etc. (Tables are not included in this classification and should not be submitted as photographs).
Photographs should be glossy prints, not mounted, untrimmed and unmarked. Where possible, all illustrations should be of the same size, using the same scale.
2.2 Figures' numbers should be clearly marked with a sticker on the back and the top of the illustration should be indicated.
2.3 Where identification of a patient is possible from a photograph the author must submit consent to publication signed by the patient, or the parent or guardian in the case of a minor.

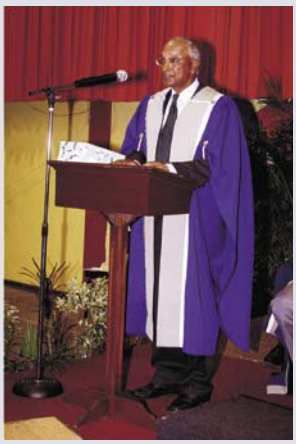
3. References

3.1 References should be inserted in the text as superior numbers and should be listed at the end of the article in numerical order.
3.2 References should be set out in the Vancouver style and the abbreviations of journals should conform to those used in *Index Medicus*. Names and initials of all authors should be given unless there are more than six, in which case the first three names should be given followed by 'et al'. First and last page numbers should be given.

Article references:
- Price NC. Importance of asking about glaucoma. BMJ 1983; 286: 349-350.

Book references:
- Jeffcoate N. Principles of Gynaecology. 4th ed. London: Butterworths, 1975: 96.
- Weinstein L, Swartz MN. Pathogenic properties of invading micro-organisms. In: Sodeman WA jun, Sodeman WA, eds. Pathologic Physiology: Mechanisms of Disease. Philadelphia: WB Saunders, 1974: 457-472.

3.3 'Unpublished observations' and 'personal communications' may be cited in the text, but not as references.



The President, Senators, Members of the Colleges of Medicine, Colleagues, New Graduates, Ladies and Gentlemen

The Colleges of Medicine is a prestigious, internationally recognized body, and is looked upon with great esteem by the general public in South Africa. This recognition is well deserved as the Colleges consist of Members with intellectual capital that is unrivalled in this country. Further, the Colleges cut across University boundaries and includes influential representatives of the private sector.

Therefore, the Colleges have the capacity to take a broader role than that of just an examining body. Its broader role should include issues associated with health care, health services and continuing health professional education and training in this country, and the continent.

Health issues are intertwined with health professional education and examinations, and require the involvement of academics, civil society and political will, if South Africa is to achieve the Millennium Development Goals set for 2015. One of these goals is to reduce maternal mortality, which is still extremely high in our country, despite the wealth of expertise available.

I would like to use my experience as the Chairperson of the National Committee on Confidential Enquiries into Maternal Deaths to challenge the Colleges of Medicine to address what I understand to be the current issues facing the training of doctors, nurses and support staff in South Africa.

In general terms, there is a wide-spread perception in the country that the quality of both post- and under-graduate medical training is deteriorating. The Colleges may wish to take a forward-looking view to verify if this is a fact. The process of verification would require a thorough examination of the quality of teaching, examinations, qualifications of senior staff who conduct the teaching, the research capability of senior staff, and the increasing resource limitations imposed by the Provincial Authorities, amongst other issues.

I would now like to expand on some of the challenges that the Colleges should be involved in:

The shortage of health professionals (including doctors, nurses and support staff) in the country is due to a combination of factors viz. employee dissatisfaction, poor planning, greater provision of services in rural areas, an increasing young population and the spectre of treating large numbers of HIV patients with co-infections. The latter leads to “heavy service workloads” and subsequent “knock-down effects” such as lack of time for appropriate training and education, and a drop in the standard of health services. In simple terms, registrars in training are being asked to provide more service without requisite time for training.

The effects of staff shortage are also reflected in frequent absenteeism of health professionals, possibly from mental and physical stress of the “heavy service loads”, adding to further deteriorating effects on training.

The Colleges of Medicine should engage with government in respect to retention of staff in the public sector and the country as a whole by promoting the creation of enabling work environments, appropriate staffing norms, salaries commensurate with the private sector, and the establishment of shared patient care with private practitioners, so that registrars obtain sufficient time for appropriate training. This may help in preventing the migration of doctors or entice those who work overseas to return. Partial training in the private sector may also broaden the skills of registrars.

Training and education should also be appropriate. The recent Saving Mothers Report on Maternal Mortality has shown that lack of resuscitation skills accounted for 22% of all avoidable factors in maternal deaths. The Colleges of Medicine must promote focussed courses on resuscitative skills in all disciplines and examine in this field, to make sure that all medical practitioners become skilled in dealing with medical emergencies at all levels of health care.

Training in the public sector is also affected by the lack of modernisation of tertiary services and the appropriate “patient mix” needed for post-graduate education. Training, certainly in the Obstetrics and Gynaecology field, is deficient in equipment for appropriate education in endoscopic techniques, fetal surgery and assisted reproduction, amongst others. Furthermore, not only is equipment lacking, but trainers themselves may lack the skills to teach in these fields. This has implications for sub-specialization.

There is obviously a need for sub-specialization because the better the primary health care system, the more likely it is for patients with unusual conditions to be referred up the health chain. However, if we do not have well equipped, well-managed tertiary academic facilities, modern equipment and qualified trainers to educate sub-specialists, the standard of care for patients requiring tertiary care will probably not be of an acceptable standard. It should also be recognized that if we do produce large numbers of sub-specialists, there may be insufficient funds, equipment or drugs for sub-specialists to gain the necessary clinical experience. Furthermore, it is important to note that individuals, who return with expertise gained from international job opportunities, may not remain in the country if there is no equipment, drugs and theatre facilities to practice their skills. This applies not only to clinicians, but to researchers and laboratory personnel.

The Colleges of Medicine should also consider spreading its expertise to other African countries without Colleges, by facilitating the training and examining of postgraduate students from these countries in a manner that it does not cause a brain-drain from these countries. Furthermore, countries to our North can teach us much about “mid-service level workers / assistant physicians”. Mozambique has a shortage of doctors and has introduced doctor assistants. Such trained assistants perform caesarean sections and other procedures. There is now good published evidence that their introduction has reduced perinatal and maternal morbidity and mortality, good measures of the quality of health services in a country. It has also been shown that trained assistants are less likely to leave rural areas or emigrate.

The Colleges of Medicine should also interact with civil society, although it is an examining body, through comments, statements, and position papers on common issues affecting the public at large. This would influence politicians and opinion leaders in the health field.

The Colleges for example, should find a way of addressing the increasing spread of unscientific remedies throughout the continent, especially in South Africa, for a range of diseases, in particular HIV/AIDS. The Colleges stand for the promotion of scientific learning and therefore cannot do otherwise.

Positive staff-student relationships are important in education and training. Local provincial experience indicates a breakdown in teacher-student relationships, the Colleges should ensure that any action from such breakdowns will be seen to be fair and equitable and not seen to prejudice any single group.

Finally, these challenges, amongst others, must be addressed together with the National Departments of Health and Education, the Health Professions Council of South Africa, and the Universities, so that a common understanding of strategies to improve health professional education in South Africa can be developed and sustained to provide quality health care to all citizens.

Prof Jack Moodley

LIST OF SUCCESSFUL CANDIDATES

MARCH/MAY 2007

Fellowship of the College of Anaesthetists of South Africa:

FCA(SA)

ARCACHE Michelle Jeanne	UCT
BASAJJASUBI Patrick	
BEHARI Raveen	
BUGWANDEEN Shikanth Rabikaran	
BUITENDAG Ernest	UKZN
BURKE Jonathan Lewis	US
DAVIES Gareth Leon	UCT
DONCASTER Ivan William	UP
DOORGAPERSHAD Rajiv Dharmsi	UKZN
EITNER Louis	UCT
FERIS Nicolaas Johannes	UKZN
HODGES Owen	UCT
KATZMAN Gary	WITS
LERM Elze	US
MADURAI Jo-Anne Olivia	UKZN
MAHARAJ Karishma	WITS
MATHIE Karryn Gail	
MAYET Shafeeqa	WITS
MAYET Atiyah	UCT
MCDONALD Dennis John	UP
MILBRANDT Ralf	UP
MRARA Busisiwe	WITS
PIOVESAN Simone Nova	UCT
POONIPERSHAD Ashveer	UKZN
RETIEF Francois Wilhelm	US
SAVAGE Stephen Cedric	UCT
TAYOB Imraan	WITS
THOM George	US
VAN DYK Dominique	UCT
VOIGT Mariana	UP
WOEBER David Walter James	UKZN

Fellowship of the College of Dermatologists of South Africa:

FC Derm(SA)

MAYEKISO Avela Zukiswa	WITS
MOOSA Laeeka	WITS
NAIDOO Ugeshnie	UKZN

Fellowship of the College of Emergency Medicine of South Africa:

FCEM(SA)

KROPMAN Annemarie Jeanine	UCT

Fellowship of the College of Forensic Pathologists of South Africa:

FC For Path(SA)

KRYSZTOFIAK Bozena	UKZN

Fellowship of the College of Maxillofacial & Oral Surgeons of South Africa:

FCMFOS(SA)

OTTO Stephanus Daniel	UWC

Fellowship of the College of Neurologists of South Africa:

FC Neurol(SA)

BURGER Izak Daniel Petrus	UKZN

Fellowship of the College of Neurosurgeons of South Africa:

FC Neurosurg(SA)

JACOBSOHN Marthinus Jacobus Dewalt	UCT
RÖTHEMEYER Sally Jones	UCT

Fellowship of the College of Obstetricians & Gynaecologists of South Africa:

FCOG(SA)

ABELS Peter Ryan	US
BOLTON Elizabeth	UP
BRITS Lizl	US
DLAMINI Nonhlanhla Isabel	UKZN
FIRMIN Carl Joseph	
GUNGUWO Taurai	
HERBST Unine	UP
HORAK Tracey Anne	UCT
MABENGE Mfundiso Samson	UP
MADU Ikechukwu Steven	WITS
MISRA Rajesh Kumar	UKZN
MOTHUPI George Mohobo	UL
MOTSHEGARE Lebogang Prudence	WITS
MYAMYA Nobuhle Eunice	
NDHLOVU Jackson	UP
RAMOGALE Makgobane Repo	UKZN
SHAIK Mohamed Zameer	UP
SMITH Melanie	US
VAN ZYL Henriette	UCT
WIDMER Tania	US

Fellowship of the College of Ophthalmologists of South Africa:

FC Ophth(SA)

BEATTY James William	US
DU TOIT Daniel Stephanus	UP
GUGLIELMETTI Stefano	WITS
KRUSE Carl-Heinz	UKZN
MATLALA Jacob Baile	UL
MOODLEY Kapilar Radhaic Rishnan	UKZN
THOMPSON Shaun Mark	UL
VALLY Zaeed	UKZN

Fellowship of the College of Orthopaedic Surgeons of South Africa:

FC Orth(SA)

HLOPHE Vincent Vusie	UKZN
LAUBSCHER Pieter Heckroodt	UP
MAPEKULA Bandile	
MAREE Michelle Nerine	UCT
MGELE Xolisa	
RAMNARAIN Avesh	UKZN
STORM Martin	US
VISSER Mart-Mari	UP

Fellowship of the College of Otorhinolaryngologists of South Africa:

FCORL(SA)

BASSON Herman	UL

GLIKSMAN Alastair	WITS
MCKENZIE Bruce John	US
MULWAFU Wakis Katepela	UCT
SRIKEWAL Salesh	UKZN

Fellowship of the College of Paediatricians of South Africa:

FC Paed(SA)

BANOO Zohra Bibi	UKZN
BHOOLA Roopesh Nagin	UKZN
DE QUINTAL Helder Alfredo	UCT
DU TOIT Marlé	US
GREEFF Stephanie	UKZN
JOHN Camilla Thurshee	UKZN
MAPONYA Nosipho Kholofelo	UP
MAREE Freda	US
MEKGOE Omphile Tshegofatso	WITS
MOLLENTZE Michelle	UP
NAIR Sathiaseelan Parmersivan	WITS
SNYMAN Philippus Johannes	UP
SOKO Paul Boisie	UCT
THOMAS Reenu	WITS
VAN EYSSEN Ann Louise	UCT
VAN WYK Lizelle	US

Fellowship of the College of Pathologists of South Africa:

Anatomical - FC Path(SA) Anat

BHANA Babita Dhirajlal	WITS
GAYAPARSAD Keshree	UP
HEAN Debra Lynne Duff	WITS

Fellowship of the College of Pathologists of South Africa:

Chemical - FC Path(SA) Chem

FRANTZEN Lani	UP
GOVENDER Radha	UP

Fellowship of the College of Pathologists of South Africa:

Haematology - FC Path(SA) Haem

IZAAKS Sonya Elizabeth	
PARASNATH Sharlene	UKZN

Fellowship of the College of Pathologists of South Africa:

Microbiology - FC Path(SA) Micro

BEYLIS Cleo Natalie	WITS
HAFFEJEE Sumayya	UCT

Fellowship of the College of Pathologists of South Africa:

Virology - FC Path(SA) Viro

KYAW Thanda	UL

Fellowship of the College of Physicians of South Africa:

FCP(SA)

ANGEL Gavin David	WITS
BALTON Charlene Chandrika	WITS
BAYAT Zaheer	WITS
BERA Mumtaz	
BOTHA Julia Dorothea	WITS
BURGER Trevlyn Felicity	WITS
CHATHURY Vironica Bhojnath	
JOBO Richard Diamont	UL
KENYON Christopher Richard	UCT
KHAN Yonus	
KHAN Rahim	
KREUSCH Adrian Michael	WITS
LEBOHO Moloko Victor	UCT
LORGE Gareth Richard	WITS
MIA Haroon	
MKHWANAZI Makhosini Lanlelot	
NAHRWAR Shahroch Patrick Ehile	US
NAMARIKA Dan Christopher	
RAMDIAL Shevern Vishwalall	
SHADDOCK Erica Jeanie	WITS
THOMAS Vinod	
WADEE Ayesha	WITS
WADEE Ashraf Suliman	WITS

Fellowship of the College of Plastic Surgeons of South Africa:

FC Plast Surg(SA)

ADAMS Kevin George	UCT

Fellowship of the College of Psychiatrists of South Africa:

FC Psych(SA)

BEAUMONT Charl Gregory	WITS
CRUICKSHANK Lindsay	
DHANSAY Khalid	US
HARLIES Anthony Benjamin	WITS
KHANYILE Sibongile Angela	UKZN
KOTZE Carla	UP
MOOLMAN Jeanné	UCT
NAUDE Hilletjie Elizabeth	UP
PILLAY Anben	WITS
RAGHUBIR Latisha	WITS

Fellowship of the College of Public Health Medicine of South Africa:

FCPHM(SA)

ADONIS Leegale Franscesca	
WEBER Ingrid Brigitte	UP

Fellowship of the College of Diagnostic Radiologists of South Africa:

FC Rad Diag(SA)

BURROWS David Alexander	UKZN
CRAWFORD Bronwen Anne	WITS
JANSE VAN RENSBURG Allinda Salome	UP
PARSONS Jacobus Johannes	US
PORTEOUS Rory	UKZN
REDDY Sugania	WITS

Fellowship of the College of Radiation Oncologists of South Africa:

FC Rad Onc(SA)

ASSEFA WOLDEGEORGIS Mathewos	WITS
JAMES Jo-Ann Averyl	UKZN
KANYIKE Daniel Mukasa	WITS
MSADABWE Susan Citonje	WITS
NAICKER Niroshini	
RAY Suddhasattwa	WITS

Fellowship of the College of Surgeons of South Africa:

FCS(SA)

BHYAT Ahmed	UCT
BISETTY Tuendra Venketasloo	
CAIRNS Alan Hugh	WITS
COETZEE Gysbert Jacobus Nicolaas	US
HASAN Fayyazul	WITS

IBIROGBA Sheriff Babatunde	UCT
ISLAM Jahangirul	UKZN
LUKASIEWICZ Marek Jan	
MARR Ian Alexander	UCT
NAIDOO Yogananda Govindasamy	
NEL Morné	UCT
PADAYACHY Vinesh	UKZN
RAHAMAN Wahab Farouk	UKZN
RAJCOOMAR Suvan Pooran	UKZN
RAMNARAIN Anupa	
REDDY Pramod	UKZN

Fellowship of the College of Urologists of South Africa:

FC Urol(SA)

DEBEIL Yvan Louis	UFS
FISHER Megan	US
MUNKS Dean Grant	UKZN

Membership of the College of Family Practitioners of South Africa:

MCFP(SA)

MAISTRY Venktaskumar Kunniah	UKZN
RAILTON Jean Pamela	US
SEMENYA Matshehla Mary-Anne Lebogang	WITS
SIRKAR Surendra	UKZN
YUTAR Jacqueline	WITS

Certicicate in Cardiology of the College of Paediatricians of South Africa:

Cert Cardiology(SA) Paediatricians

ZÜHLKE Liesl Joanna	UCT

Certificate in Cardiology of the College of Physicians of South Africa:

Cert Cardiology(SA) Physicians

BUSHIDI Mbuyu	
HANSA Cassim Ismail	UCT
MAKANJEE Bhavanesh	UCT
OOSTHUYSEN Wessels Marthinus	UFS
SLECZKA-SZPAK Barbara Alina	WITS

Certificate in Child Psychiatry of the College of Psychiatrists of South Africa:

Cert Child Psychiatry(SA)

DHANSAY Yumna
PARUK Saeeda

Certificate in Critical Care of the College of Physicians of South Africa:

Cert Critical Care(SA) Physicians

TILLEY John Steven

Certificate in Endocrinology & Metabolism of the College of Physicians of South Africa:

Cert Endocrinology & Metabolism(SA)

HOUGH Cregory Arthur
ISIAVWE Afokoghene Rita

Certificate in Gastroenterology of the College of Physicians of South Africa:

Cert Gastroenterology(SA) Physicians

NAIDOO Vasudevan Govindsamy	UKZN

Certificate in Medical Oncology of the College of Paediatricians of South Africa:

Cert Medical Oncology(SA) - Paediatricians

HENDRICKS Marc Gerald	UCT
STEFAN Daniela Cristina	

Certificate in Nephrology of the College of Paediatricians of South Africa:

– Cert Nephrology(SA) Paediatricians

LEVY Cecil Steven	WITS

Certificate in Nephrology of the College of Physicians of South Africa:

Cert Nephrology(SA) Physicians

EZEKIEL Linda Margaret Kokolamuka	
HARIPARSHAD Sudesh Premchund	UKZN
MABUBULA Edward	WITS
SCHUBERT Claudia	US

Certificate in Paediatric Neurology of the College of Paediatricians of South Africa:

Cert Paediatric Neurology(SA)

RAPITI Pamela	
WILSON Dorcas	WITS

Certificate in Paediatric Surgery of the College of Surgery of South Africa:

Cert Paediatric Surg(SA)

SIMANGO Itayi Freeman	WSU

Certificate in Pulmonology of the College of Physicians of South Africa:

Cert Pulmonology(SA) Physicians

KALLA Ismail Sikander	WITS

Certificate in Rheumatology of the College of Physicians of South Africa:

Cert Rheumatology(SA) Physicians

ICKINGER Claudia

Certificate in Vascular Surgery of the College of Surgeons of South Africa:

Cert Vascular Surgery(SA)

ANDERSON Duncan William	UCT

Higher Diploma in Internal Medicine of the College of Physicians of South Africa:

H Dip Int Med(SA)

CHIKANDA Cephas

Higher Diploma in Orthopaedics of the College of Orthopaedic Surgeons of South Africa:

H Dip Orth(SA)

NAIDOO Navendran Dhanapalan	
ONGARO Neford	NAIROBI
SATHYAPAL Sunil	

Diploma in Allergology of the College of Family Practitioners of South Africa:

Dip Allerg(SA)

KRIEL Magdalena Marilee	
MURRAY Carien Helena	
TERBLANCHE Albertha Jacomina	UP

Diploma in Anaesthetics of the College of Anaesthetists of South Africa:

DA(SA)

ABASS Kashif
BAILEY D'Oliveira Natachia
BALLIM Nishaat Ahmed
BERGH Kobus
BEUKES Johann Gerhard
BEUKES Errol Gerhard
BLOM Linda Karen
DANIELL Reinette
DE JAGER Carel Pieter
DONKIN Ian Edward
EKSTEEN Elizma
FELDMAN Nigel Elliott
FOURIE Petrus Daniël Roux
GOUNDER Morgan
HADEBE Sandile Diplomat
HANAUER Catherine
HEYNEKE Matthys Gerhard
JIMÉNEZ GUERRA Idalberto
JITHOO Sandhya
JOHNS Tony
JOUBERT Regina Catharina
JURGENS Martha Elizabeth
KEENAN Michelle
KISTAMURTHY Dheshnee
KRÜGER Hendrik Lodewyk
LANDSBERG Hester Cecilia
LOOTS Pieter Hendrik
MATLALA Ntsopa Samuel
MELONAS Basil Frank
MKHABELA Ramatsemela Mumsy
MOKGALAKA Dorcas Ntsebeng
MOLEFE Beaulah Hlumuzi UL
MORKEL Floris Johannes Wouter
MORKEL Hendrik Wade
MTUKUSHE Bukhosi
NAIR Ratheesh Surendran
NGEMA Lorraine Siphiwe
OKAISABOR Olusegun Aideloje
PEENS Erus Johannes
PICKEN Guy
PIETERSE Jacobus
PILLAY Narainsamy Vijendharen
PUTTER Elita
RAJKUMAAR Kamini
RANDEREE Shabnam
REDFERN Geraldine Ann
ROOS Anna-Mart
SAFFIN Andrew Peter
SEELE Ruth Magdalene
SHAIKH Mohmed Iqbal
SHAIKH Abdulsamad Ibrahim
STRAUSS Amelia Ledivia
TLALE Seobi
TSOKO Nomathamsanqa Nowa
VAN ZYL Lucette
WENTZEL Marli
WIID Catharina Maria

Diploma in Child Health of the College of Paediatricians of South Africa:

DCH(SA)

ALBERTYN Pamela Elizabeth
AULD Francis Andrew WITS
CHIBABHAI Vindana
DE JAGER Christelle
DENGA Mpho Dianah
GOVENDER Prashini
ISMAIL Mugammad Taib
JACOBSON Candice Ivanna
KHAN Muhammed Uzayr
KOK Elmien
LEDGER Michael Ryan
MADIHLABA Legodimo Iren
MAGNI Bridget
MAITISA Norah UL
MOODLEY Samantha
MORARE Mamotshabo Rebecca
MUKANSI Meriam Muhanyisi
MUNIR Safdar WSU
MYBURGH Elisabeth Lydia
NETSHIMBONI Rendani
O'RYAN Samantha
PELO Matsela Patience
PRINSLOO Elmarie Susan
PURCHASE Susan Elizabeth
RAMABOEA Ngwako Innocent
RAMCHARAN Amith UKZN
SIBIYA Nandi Sihle
SMIT Morné
TALAKGALE Kwena Tilly
VENTER Christien

Diploma in Forensic Medicine of the College of Forensic Pathologists of South Africa:

Dip For Med(SA) - Clin

RAMIAH Leslie Dhayanandham

Diploma in Forensic Medicine of the College of Forensic Pathologists of South Africa:

Dip For Med(SA) – Clin/Path

BERLYN Timothy David
MOODLEY Clive James
NKOSI Sobantu Andrew

Diploma in Forensic Medicine of the College of Forensic Pathologists of South Africa:

Dip For Med(SA) - Path

CHUMBA David Kiprop
KGOETE Kgolane Yvonne
MACHARIA Benson Ndegua
MAINGI Sylvester Mulli NAIROBI
MBITHI Makau NAIROBI
MBUUKO Ng'ali NAIROBI
NALYANYA Walter Wekesa
NDIANGUI Francis Maina
NGULUNGU Titus NAIROBI
NJERU Dorothy Gicuku NAIROBI
NKONDO Tinyiko Zelda
WASIKE-SIMINYU Jane

Diploma in HIV Management of the College of Family Practitioners of South Africa:

Dip HIV Man(SA)

ADEBANJO Adefolarin Babafemi	US
AHMED Farhana	
AKONI Samuel Oluyomi	UL
ALABI Olubunmi Onome	
ASSELMAN Valerie	
BARNABAS Shaun Lawrence	UCT
BATUBENGA Muela Muana	UP
BEJA Samuel	
BHAYROO Schené	
BISHOP Leesa Anne	
BLACK John Maule	
BOLHAAR Martine Genéviéve	
BONDONGA Abobi	
BUNJIRA Kenneth	
CAMANOR Sia Wata	
CHAKA Brian	
CHIMATIRA Raymond	
CHISHA Percival Sume	
CHONCO Fundisiwe Magambushe	
DAURAMANZI Masimba	
DIBAKOANE Anna Khumo	UKZN
DUBE Blessing	
ESSA Imraan Ebrahim	
FRIGATI Lisa Jane	
GINSBERG Philip	
GRAHAM Nicola Kim	
IFEBUZOR Deciderius Chika	UL
KARANGWA Osee-Robert	
KAUNDA Nathalie Chimwemwe	
KEMP Donald Harold Maxwell	
LAHER Fatima	
LEBINA Limakatso	
LEGOABE Zandile Lulama	
LITTLE Melanie Clare	
LOUW Frederick Christoffer	
MABUNDA Harry Lionel	UP
MABUYANGWE Patience Lindi	
MAHARAJ Jayneetha	
MAHARAJ Sundesh Kripanath	
MAKATU Sbongile	
MALAKA Hangwani Joyce	
MANZINI Prince Charlie	
MAPELE Apamu Jacques	
MASUKA Nyasha	
MATHIBA Ruth Sisinyana	
MCNALLY Matthew James Nicholaas	
MJAMEKWENA Siyambulela	
MLAWANDA Ganizani	
MNGQIBISA Rosie	
MOGOTSI Keddinnetse Sarah	
MOLAPO Ramolapo Antony	
MOODLEY Neermala	
MOSHE Mamokgethi Christina	UL
MULENGA Peter	
MUNGAI Brenda Nyambura	
MURTAZA Amir	
NASH Jennifer Leroux	
NDAMASE Loyiso	
NGUBENI Nozipho Sweetness	
NKABINDE Mkhulu Simon	
NYATONDO Kapera Tafadzwa Justin	
OLADOYINBO Olarotimi Samuel	US
OMARI Kalenga	
OMOTAYO David Adebanjo	US
PFAFF Colin Anthony	
PHIRI Almakio	
RINGANAYI Hebert	
RISTIC Biljana	
ROGERS Patrick John	
SAMSON-AKPAN Ufok Sonny	WITS
SEBELEBELE Anna Mahlodi	
SHONHIWA Shepherd Ushe	
SUTHERLAND Taryn	
TERREBLANCHE Owen Dale	
THULKANAM Dasakumaran Derek	
TIAM Appolinaire	WITS
TOM Penelope	
UHOMOIBHI John Omo-Osagie	
VAN STADEN Jacobus Daniël	
VEZI Thabile Desiree Dann	
YOGOLELO Willy Bulambo	
ZISIS Dafni	WITS
ZONDI Khanyisile Victoria	

Diploma in Mental Health of the College of Psychiatrists of South Africa:

DMH(SA)

EBRAHIM IQBAL Zaaheda
HARRIS Michael Graham
MOODLEY Aneshree
MORGAN Maxine Alvean
PRINSLOO Bernice
SESHOKA Thupana Naphtally
SIBISI Gladness Nelisiwe
SIDDI GANIE Ismat
SINGH Swasti

Diploma in Obstetrics of the College of Obstetricians and Gynaecologists of South Africa:

Dip Obst(SA)

ADAMS Clarisse	
BERNHARDT Gina Leanne	
BHUIYAN Salah Uddin	
BOSHOMANE John Malose	UL
BUGA Edward Chandia	
CHUNDER Alisha	
CLOETE Alrése	
CRONJE Yolande	US
DIETRICH Liesl Bertha Kay	
FLEET Jane	
HANDTRACK Claudia	
JORDAN Victoria	
KRICK Daniela	
KUNENE Sifiso Justice	
MHLONGO Sigwili Bright	
MWAMBI Mwamba Kabeya Christophe	
NAIDOO Rubendren	
NARASIMOOLOO Ronelle	UKZN
NDJAPA NDAMKOU Constant	UKZN
NKOSI Patrick Thamsanqa Dominic	
ORISAKWE Emeka Edwards	
PINNAMARAJU Suryanarayana Raju	
PRETORIUS Mercia	
SCHEEPERS Pamela Anne	
SIKO Peter Rapula	
VAN DER LINDE Erich Prinsloo	

Diploma in Ophthalmology of the College of Ophthalmologists of South Africa:

Dip Ophth(SA)

BAWA Sachin
CURTIS Elizabeth Louise
JOSEPH Dylan Arthur
LEE Claudine Nandi
MAKAKASE Makata Gedion

Diploma in Primary Emergency Care of the College of Emergency Medicine of South Africa:

Dip PEC(SA)

ADAM Ahmed	
CASEY Michelle Elizabeth	
D'ANDREA Patrick Andrew	
DE HAAN Sebastian Hein Scott-Waring	US
DORUYTER Alexander Govert George	
ELLIOTT Mary-Ann	WITS
HOFFELDT Anriëtte	
LAUBSCHER Anchen	
LEE Howard Chi-Hung	
RUDOLPH Adriana Josina	
SNYMAN Hendrik-Willem	
TUDOR Jacoba	
VAN ASWEGEN Elizna	

Part I of the Fellowship of the College of Anaesthetists of South Africa:

FCA(SA) Part I

BISHOP David Gray	
BRANNIGAN Lliam Barrett	WITS
CORBETT Caroline Beth	WITS
DE BEURS Jaco	UKZN
DUBE Sandile Sikphosomuzi	UCT
FOURIE Etian	
HAUS Nikolas Jason	
LYELL Margot Heléne	WSU
MORFORD Michael Bruce	WITS
MUKADDAM Hizir	
NGWENYA Nhlanhla Samuel	WITS
PADIACHY Dineshree Natasha	WITS
RICHARDSON Peter Brian	
RORKE Nicolette Francis	UKZN
SADZIK Jakub	
SCHMIDT Joan Annette	UKZN
SITHEBE Zanele Constance	WITS
VAN HEERDEN Helga	
VATHARAJH Yogashree	
VENTER Stephen Jonathan	

Part I of the Fellowship of the College of Dermatologists of South Africa:

FC Derm(SA) Part I

BROWNE Ilsphi	UCT
JAIKARUN Sarvesh	UKZN
MOTSEPE Christine Didintle	UCT
SKENJANA Andiswa	UKZN

Part I of the Fellowship of the College of Emergency Medicine of South Africa:

FCEM(SA) Part I

PARKER Abdul Aziz	US
GOLDSTEIN Lara Nicole	

Part I of the Fellowship of the College of Forensic Pathologists of South Africa:

FC For Path(SA) Part I

DU TOIT- PRINSLOO Lorraine	UP
HATTINGH Christa	UKZN
MOENG Shirley Faith Angela Portia	WITS
WALRAVEN Sonata	UCT

Part I of the Fellowship of the College of Neurologists of South Africa:

FC Neurol(SA) Part I

BATEMAN Kathleen Jane	UCT
BHANJAN Ashleigh	UKZN
CILLIERS Frederik Jacobus	UFS
JIVAN Kalpesh Deraji	WITS
ZATJIRUA Vaja	US

Part I of the Fellowship of the College of Nuclear Physicians of South Africa:

FCNP(SA) Part I

MALAN Nico	WITS
PURBHOO Khushica	WITS
STEYN Rachelle Elizabeth	UCT

Part I of the Fellowship of the College of Obstetricians & Gynaecologists of South Africa:

FCOG(SA) Part I

BOSHOFF Idalette	UP
CEBEKHULU Sylvia Nnaniki	UL
DEHINBO Tunde Bank Titus	UKZN
FOOLCHAND Serantha	
GREEN Beulah Emelyne	UP
MANGENA Mapula	UP
NENE Laura Nana Zozo	
NGUEKENG Etienne	WITS
RICHARDSON Katherine Jane	UCT
WALMSLEY Linda Joanne	

Part I of the Fellowship of the College of Ophthalmologists of South Africa:

FC Ophth(SA) Part I

APHANE Maduoe
ASVAT Akiel
CRONJE Pieter Roelof
DU BRUYN Magritha
HEYDENRYCH Leonard Goussard
JUGADOE Bhavna
KOK Andries Gerhardus
MOHAMED Nabiel
MSUTHWANA Simanga Elias Geoffrey
VAN ZYL Cornelis Johannes Petrus Gerhardus

Part I of the Fellowship of the College of Paediatricians of South Africa:

FC Paed(SA) Part I

APPEL Ilse Nadine	
BUDREE Shrish	
HANNI Tabea Mathilde	WITS
KERAAN Qaunitah	
KERBELKER Tamara Charmian	
KHAN Riaz Rashid	
LAMB Gregory Vincent	UKZN

MOONSAMY Glenda	UKZN
NAICKER Thirona	UKZN
NAIDOO Visva	UKZN
NAIDOO Lerusha	UKZN
ROWE Biance	WITS
THWALA Mgcini Desmond	WITS
VAN DER MERWE Sarah Katrina	WITS

Part I of the Fellowship of the College of Pathologists of South Africa:

Anatomical – FC Path(SA) Anat Part I

CHOTEY Nivesh Ashok	UKZN
WU Hye-Tsi	UCT

Part I of the Fellowship of the College of Pathologists of South Africa:

Haematology – FC Path(SA) Haem Part I

HOOSEN Siddeeq	UKZN
NTOBONGWANA Monalisa	UCT

Part I of the Fellowship of the College of Physicians of South Africa:

FCP(SA) Part I

BRÖNN Karen	US
CASSIM Farhana	UKZN
CHOHAN Muhammad Yusuf	WITS
CHOTHIA Mogamat Yazied	US
CUPIDO Clint Shane	
DEETLEFS Eduan	UCT
DISSANAYAKE Arjuna	WITS
FREERCKS Robert Jeremy	UCT
FRIEDRICKSEN David Vaughan	US
JIVAN Daksha	WITS
LATIEF Yosef	US
LOMBARD Bianca	WITS
MAHARAJ Vishal Rameshchand	
MANAVALAN Tindo George Devassy	UCT
MORKAR Jatin	US
MORLEY Julta Claire	US
MOSES Agnes	WITS
MOWLANA Abdurasiet	US
NAICKER Poobalan Pragalathan	WITS
NAIDOO Balram	UKZN
NQEBELELE Nolubabalo Unati	WITS
NTUSI Ntobeko Bubele Ayanda	UCT
NYO Myat Tun Lin	
PANDIE Shaheen	UCT
PATEL Anupa	WITS
PETER Jonathan Grant	UCT
PIORKOWSKI Adam	US
RAY Roanne	WITS
RICHTER Erné	US
SARDIWALLA Zahir	WITS
SYMONS Gregory John	
WEINREICH Carsten Joachim Bernd	UCT

Part I of the Fellowship of the College of Psychiatrists of South Africa:

FC Psych(SA) Part I

COSSIE Qhama Zomani	UCT

Part I of the Fellowship of the College of Diagnostic Radiologists of South Africa:

FC Rad Diag(SA) Part I

ABDURAHMAN Nuraan	
AYIWOROH Joseph Kampalayire	WITS
BELLEW Neil	
CUPIDO Brindley David	
DAVIES Scott Stanley	UP
GOUSE Mohamed Riaz	WITS
HARTLEY Tharbit	
JANSE VAN RENSBURG Pieter	UFS
KHOURY Bryan Darryl	
KUYS Willem Cornelis	
MAHOMED Nasreen	WITS
MALATJI Phaku Nhlanhla	WTS
MFEKETHO Mlungisi Vincent	UCT
MODY Kalpesh Girish	UKZN
MTHEMBU Mamokete Nontuthuko Ruth	
NGEMA Zemfundo Portia	
PILLAY Tanyia	WITS
PILLAY Megantheran	UKZN
REDDY Leeshana	
RUDAKEMWA Emmanuel	WITS
VALLI OMAR Moaaz	WITS
VISAGIE Ruan Louw	UKZN
VOLKER Ryan Damon	WITS

Part I of the Fellowship of the College of Radiation Oncologists of South Africa:

FC Rad Onc(SA) Part I

FRÖHLING Rainer Edgar	
LOHLUN Kim Nicole	WITS
LUUTU Israel	WITS
PARKER Mohamed Imran	UCT

Primary Examination of the Fellowship of the College of Surgeons of South Africa:

FCS(SA) Primary

ALLORTO Nikki Leigh	
ANSARI Sajid	WITS
ARNOLD John Phillip	UKZN
BLAKE Craig Andrew	
BLIGNAUT Stephanus Johannes	UKZN
BOONZAIER Glen Frank	UKZN
BUGWANDIN Santosh	UKZN
CASSIM Farzana	
COETZEE Pieter	
CONSTANTINIDIS Anna	
ENICKER Basil Claude	UKZN
FERREIRA Nando	UKZN
GHOOR Saajida	UP
GOVINDASAMY Janeshree	
HARRICHANDPARSAD Rohen	UKZN
HOOGENDYK Charles August	
IMBANGU Nangulah Ailly Vistorina	UCT
JACKSON Brandon Spencer	
JACOBS Christopher Richard	UKZN
JOGIAT Zaheer	
KHOZA Maria Ramaesela	
KHUBONI Sanele Justice	

KOSHY Jithan Jacob	UNZA
LAING Grant	
LAMPRECHT Jan-Hendrik Adriaan	
LOUW Arnold Howard	
LUTCHMINARAIN Nithin Nundkissoor	UKZN
MAGAN Avesh Tugadish	
MAHARAJH Suhani	
MAKATA Kalipa Philip	WSU
MANN Carol Ann	
MBATHA Bongani Calvin	
MBUYANE Tommy	WITS
MELARIRI Herbert Ikechukwu	UCT
MJOLI Ntethelelo Spiritus Amadeus	
MOHAMMED Feroza	
MOOLMAN Johan Adriaan	
MOTEBEJANE Mogwale Samson	
MSHUDULU Lumkile Wilfred	UKZN
NAUDE Petrus Hendrik	
OSMAN Mohammed Riaz	UKZN
PADAYACHEE Eneshra	UKZN
PEENS-HOUGH Hyla	
PETERS Franciscus Martinus	
PIETRZAK Jurek Rafal Tomasz	
PILLAY Desigan	
POTGIETER Johan Wilhelm Theodorus	UFS
PUCJLOWSKI Tamaryn Anne	
RAMUSHU Leah Dimakatjo	
RIEMER Bryan Lawrence	
SENDEGEYA Augustin	WITS
SENEKAL Jannien	
SEPTEMBER Gareth Rudolph	
SHEZI Emmanuel Happy-Boy	
SKINNER David Lee	
SMITH Murray James	
STANDER Hanrich Johan	
STEINBERG Isabelle	
STRUWIG Daniel	WITS
SULIMAN Mohammed	
THIEBAUT Wilna	
TSHIDIBI Kalombo Didier	
TWALA Makhaya Owen	
VAN HEERDEN Hester Margaretha	
VAN ZYL Willem Jacobus Smit	
VERSTER Corneels Thomas	

Primary Examination incl Neuroanatomy of the Fellowship of the College of Surgeons of South Africa:

FCS(SA) Primary incl Neuroanatomy

ANSARI Sajid	WITS
CONSTANTINIDIS Anna	
HARRICHANDPARSAD Rohen	UKZN

Primary Examination of the Fellowship of the College of Urologists of South Africa:

FC Urol(SA) Primary

DU TOIT Kenneth

WOLDEAB Wondwossen Ergete

Intermediate Examination of the Fellowship of the College of Maxillofacial & Oral Surgeons of South Africa:

FCMFOS(SA) Intermediate

MUTHRAY Enesh	WITS

Intermediate Examination of the Fellowship of the College of Surgeons of South Africa:

FCS(SA) Intermediate

ALEXANDER Gerard Roderick	UKZN
BALAKRISHNAN Theogren	UKZN
BICK Simon Millard	
BUGWANDIN Satish	UKZN
DU TOIT Russel Roland	WITS
DUBE Butini Andries	WITS
FURAHA Charles	WITS
GERBER Stefan Bradley	
GREYLING Jan Frederik	
GROTTE Anders Christian	UCT
HATFIELD Paul Adrian	UKZN
HOOSEN Ismail Goolam Mahomed	UKZN
JENKIN Aimee Thelma	
LANDMAN Nicolette	UCT
LATCHMANAN Neshalan Perumal	
MANGRAY Hansraj	
MASEKO Emmanuel Makhosonke	
MATHABE Kgomotso Minah	
MJOLI Dennis Monde Thamsanqa	UKZN
MOODLEY Morvendhran	UKZN
MOOPANAR Manogran	UKZN
MUNGHERERA Andrew Robert Were	
NADAR Vernian	UKZN
NAIDOO Surendra	UKZN
PEER Shazia	UKZN
PHILIP Sunu John	WITS
REDDY Jenendhiran	UKZN
REDMAN Laura Anne	UKZN
ROCHER Antoine Gideon Louw	UKZN
RUGNATH Avin Kissopersad	UKZN
SHAIK Muhammed Zaki	UKZN
SIMMONS Dina Yaeli	
SMIT Rian Wilfred	
TUDOR Andrew Glyn	UKZN
UHUNAMURE Bright Osa	
ZWANEPOEL Pieter	

FELLOWSHIP BY PEER REVIEW

BETANCOURT Orlando Alonso	College of Psychiatrists
JORDAAN Gerhard	College of Psychiatrists
BRITZ Hermina Christina	College of Emergency Medicine
VAN LOGGERENBERG Charl Jacques	College of Emergency Medicine

Annual Report of the Senate of The Colleges of Medicine of South Africa for the period 1st June 2006 to 31st May 2007

The second Annual Report of the Seventeenth Senate gives an account of the business of Senate during the financial year 1st June 2006 to 31st May 2007. The report will customarily be presented in two sections - the financial statements and matters pertaining to the appreciation of the state of affairs of the CMSA, its business and profit and loss will be published separately and the rest of the activities appear hereunder.

The annual reports received from Presidents and/or Secretaries of constituent Colleges, giving an account of their activities during the same period, are published separately.

IN MEMORIAM

Notification was sadly received of the death of the following members during the past year and the President and Senate extend condolences to their families.

Honorary Fellows

DEWHURST, Christopher John
HOFFENBERG, Raymond (Bill)
PEEL, John
VILJOEN, Marais

Fellow *ad eundem*

BREYTENBACH, Hermanus Steyn

Founders

ABEL, Solomon
MEYER, Jan Abraham
RABINOWITZ, Leslie

Associate Founders

ARNDT, Theodore Carl Heinrich
BEDFORD, Michael Charles
BERNSTEIN, Henry
DAVIS, Meldrum John Finnamore
EPSTEIN, Edward
EVANS, William Benjamin David Iorwerth
GORDON GRANT, Michael Cameron
HEYDENRYCH, Desmond Johan
RETIEF, Degenes Jacobus
SALKINDER, Joe
WATSON, Ian France

Fellows

CONRADIE, Ryno Verster
CRAUSE, Leon
DE KOCK, Machiel Adriaan
ELLIS, Peter
GOUWELOOS, Johannes Simon
HUMAN, Randolph Russell
KHAI, Cope Khan
MacFARLANE, Campbell
PASCOE, Francis Danby
POTGIETER, Louis
SEOPELA, Semakaleng Simon
SKINNER, Donald Pape
SNOWDOWNE, Robert Blackstock
VAN HEERDEN, Willem Martens

Member

NEL, Jan Jacobus Petrus

Diplomate

JELLIMAN, Erika Susan

NEW OFFICERS ELECTED FOR THE CMSA

President

Prof Zephne van der Spuy of Cape Town became the second woman to serve The Colleges of Medicine of South Arica in its highest office when she was elected as its President in October 2006 and officially resumed this office at the Senate meeting in Durban on 10 May 2007. Prof van der Spuy will remain in office until May 2010.

Vice Presidents

Prof Anil Madaree (Durban) who was elected as the Senior Vice President and Prof Gboyega Ogunbanjo (Pretoria), elected as the Vice President, also resumed office on 10 May 2007 and will serve in that capacity until May 2010.

Honorary Registrars

Finance and General Purposes Committee

Senate regretfully received the resignation of Prof Bongani Mayosi as Honorary Registrar due to the additional responsibilities that came with his appointment to the post of Professor and Head of the Department of Medicine, University of Cape Town.

Prof Usuf Chikte (Stellenbosch) was appointed to replace him for the remainder of the current triennium of Senate ending in October 2008.

Education Committee

With the election of Prof Anil Madaree to the Vice Presidency of the CMSA, the office of Honorary Registrar in Durban became vacant. Prof Bilkish Cassim was duly elected as Honorary Registrar of the Education Committee and will also serve in that office until the end of the current triennium in October 2008.

NEW OFFICERS ELECTED FOR CONSTITUENT COLLEGES

College of Obstetricians and Gynaecologists

In terms of the Articles of Association and By-laws, the President CMSA does not represent any of the constituent Colleges. Should the President of a constituent College therefore be elected as President of the CMSA, he/she has to relinquish that office with immediate effect.

Prof Jay Bagratee, Professor of Obstetrics and Gynaecology, University of KwaZulu-Natal, was therefore duly elected to succeed Prof Zephne van der Spuy as President of the College of Obstetricians and Gynaecologists when she vacated that office upon her election to the CMSA Presidency. He will remain in office for the remainder of the current term of office of Council ending in October 2008.

College of Radiologists

Prof Alan Scher resigned as President of the College of Radiologists and as their representative on Senate, due to his increased commitments abroad. Dr Duncan Royston simultaneously resigned as Secretary because he found it increasingly difficult to attend their College meetings.

The following were duly elected to replace Prof Scher and Dr Royston:

President	:	Dr Ashwin Hurribunce
Secretary	:	Prof Savvas Andronikou
Senate representative	:	Prof Steve Beningfield

They will also remain in office until the elections in October 2008.

CMSA PENSION FUND

The current fund has been terminated and members have been transferred to a defined contribution umbrella fund. Existing members were given an immediate benefit enhancement of 12.5%, payable out of the surplus, but the remaining 2.5% was retained as a margin and credited to the existing members as an ongoing additional contribution that would give them an enhancement targeted at retirement.

MODIFIED CMSA WEBSITE

http://www.collegemedsa.ac.za

The new CMSA website is now up and running. The site is more user-friendly and allows the three offices to publish important documentation directly. This will also facilitate the publication of examination time tables, results, etc.

CONSTITUTIONS

Articles of Association and By-laws of the CMSA

The CMSA Constitution has been reprinted, distributed and has been published on the website.

Constitutions of Constituent Colleges

The constituent College Constitutions have been updated by their respective Councils and are also available on the website.

MEMBERSHIP BENEFITS

At its meeting in May 2007, Senate defined the following "Top Ten" benefits for members of The Colleges of Medicine of South Africa:

Qualifications – the Core Business of the CMSA

- As examining body, the CMSA provides a national qualification and determines the quality and standards of specialties.
- CMSA qualifications are internationally respected.
- The CMSA accredites Fellows to practice their specialties locally and globally.
- Formal links exist with sister Colleges and Academies.
- The international recognition and maintenance of standards.
- Regulation of training and registration.
- International reciprocity.
- External moderating at examinations.

Transactions

Receipt of the Journal biannually.

Newsletter

Publication of the monthly newsletter on the web site. Also conveying to interested persons the challenges and successes of the CMSA.

CMSA Website and E-mail Access

- A resourceful and user-friendly website.
- On the educational front, providing authoritative, independent and excellent commentaries on topical medical matters.
- Availability to all members of the CMSA with internet access and to the public.
- E-mail access to members using links.
- Access to on-line journals.
- An international page on available courses and congresses worldwide.
- CPD programmes would be incorporated on the website.
- Publication of Clinical Practice Guidelines.
- Advocacy role for Patients and Doctors.

Education and Training

- Research methodology courses.
- Training of University Educators.
- Regular clinical updates.
- Visiting CMSA lecturers.
- Medico-legal issues and quality CME activities.
- Exploring the possibility of becoming a training body and applying for training courses.

A voice in influencing health policy

Raising health matters with Government.

Registrars joining the CMSA as "Affiliates"

- Question still being addressed as to whether their membership should be free or whether a nominal fee should be charged as recommended by SARA.
- Whether medical students should join the CMSA.
- The rights of Affiliates will entail participation in deliberations at CMSA Senate and standing committee meetings and the receipt of Transactions.

The Hire of CMSA facilities for functions

Credit Card Discounts to CMSA Members for various Financial Transactions of Educational Value

Online library access: MELISA

LIONEL B GOLDSCHMIDT LIBRARY

Books authored by CMSA members continues to form the core section in the library. Among other donations received during the year, special mention must be made of Dr OAA Bock's generous donation of books, mainly on the history of medicine, which greatly enhances the quality of our collection. A bust of the late Dr Arthur Landau, past President of the CMSA, was also gratefully received and placed in the library.

The current book stock is now recorded on Libwin, a Library computer program, while recent donations still need to be processed

EXAMINATION RELATED MATTERS

Successful Candidates

The names of candidates who pass the biannual CMSA examinations appear in each issue of Transactions. The results are also published on the web page: *http://www.collegemedsa.ac.za*

National Equivalence Examination

This matter is now handled by a sub-committee of the Medical and Dental Professions Board of the HPCSA.

Conversion of MFGP(SA)/MCFP(SA) to FCFP(SA)
First FCFP(SA) Examination

A considerable number of holders of the MFGP(SA) or MCFP(SA) applied for conversion of their Membership qualification to a Fellowship (the FCFP(SA)). This meant that some had to reinstate

their membership and pay all arrear subscriptions in order to qualify for the conversion and had to return their original certificates. The names of these new Fellows appear elsewhere in these Transactions.

The first FCFP(SA) examination according to the new regulations can only be offered with effect from September/October 2010, when the first set of family medicine registrars complete their minimum mandatory training period before sitting for the examination. This means that the last MCFP(SA) examination will be offered in March/May 2010.

Name of Certificate Examinations
It was considered appropriate to change the name of the 'Certificate' examination to 'Sub-specialty Certificate' with immediate effect.

Change of Examination Format

FCS Orth(SA) Intermediate
The College of Orthopaedic Surgeons will be running a combined intermediate examination. Candidates will write the first paper of the FCS(SA) Intermediate, but the second paper will be the FC Orth(SA) Intermediate paper which will only be on Orthopaedics.

Cert Nephrology(SA)
It was agreed that the oral component of this examination would be replaced with an OSCE.

Formation of a Committee for Critical Care
Senate agreed that a committee for Critical Care be formed, that will be responsible for nominating panels of examiners for the Cert Critical Care(SA) examination and for updating the regulations. The following constituent Colleges will be represented on this committee: Surgeons, Anaesthetists, Paediatricians, Physicians, Obstetricians and Gynaecologists, Neurosurgeons, Emergency Medicine and Cardiothoracic Surgeons.

Medals
Institution of a GlaxoKlineSmith Medal
A new medal has been accepted, to be known as the GlaxoKline-Smith Medal. The medal will be awarded to the best candidate in the FCA(SA) Part I Physiology examination.

Medal Recipients
The recipients of medals during the period under review were:

Bloemfontein: 19 October 2006

Anette Swanepoel
(Novartis Medal : FC Neurol(SA)

Durban: 10 May 2007

Rishendran Naidoo
(Libero Fatti Medal : FC Cardio(SA) Final
Karl Frielingsdorf
(J M Edelstein Medal : FC Orth(SA) Final)
Johan Grobbelaar
(S A Society of Otorhinolaryngology Medal : FCORL(SA) Final)
Judy Nicole Rothberg
(Leslie Rabinowitz Medal : FC Paed(SA) Part I)
(Robert McDonald Medal : FC Paed(SA) Part II
Hendrik Sebastian Temmingh
(Novartis Medal : FC Psych(SA) Part II
Shalendra Kumar Misser
(Josse Kaye Medal : FC Rad Diag(SA) Part II
Sumayyah Ebrahim
(Frederic Luvuno Medal : FCS(SA) Primary)
Colin Iain McGuire
(Trubshaw Medal : FCS(SA) Primary)
Lesley Marcia Maude Nunn
(Brebner Award : FCS(SA) Intermediate)

Fellowship by Peer Review
The following were successfully considered for Fellowship by peer review since the last report:

College of Anaesthetists
LEVIN, Andrew Ian

College of Emergency Medicine
BRITZ, H C
VAN LOGGERENBERG, C J

College of Obstetricians and Gynaecologists
POPIS, M

College of Pathologists
JANSE VAN RENSBURG, M N

College of Psychiatrists
BETANCOURT, O A
JORDAAN, G

College of Public Health Medicine
(Division of Occupational Medicine)
BLIGNAUT, C
CARSTENS, S E
SMITH, F C A

Accreditation of Hospital Training Posts
The following hospitals were accredited during the year under review:

H Dip Int Med(SA)
Eerste River Hospital

H Dip Orth(SA)
Letaba Hospital

DCH(SA)
Stanger Hospital

Dip Ophth(SA)
Good Shepherd Hospital
Madadeni Hospital

Dip HIV Man(SA)
Lower Umfolozi District War Memorial Hospital
Hottentots-Holland Hospital

Dip Obst(SA)
Mokopane Hospital

Dip PEC(SA)
ARWYP Medical Centre
Highveld Medi-Clinic
Mamelodi Hospital
Tambo Memorial Hospital
Welkom Medi-Clinic

Examination Results
In future when the final pass lists are sent to the Deans of the

Faculties of Health Sciences, a final mark sheet will be included for each of the examinations for which they had candidates. The final mark sheet will not include candidate's names, only their examination numbers. Heads of Departments can then obtain the results for their candidates only, from their Deans. The final mark sheet will show the mark obtained for each question in each paper, but an attached Excel spreadsheet will indicate the marks obtained by candidates in each question.

Workshops in 2007 on *"Training of Examiners"*
It was pointed out at the strategic planning meeting of the CMSA in August 2006 that most doctors entered their careers as trained clinicians and were then expected to be teachers and examiners. Very few received formal training in either examination assessment or medical education techniques. It was felt that the CMSA could contribute significantly to the education and assessment processes in South Africa by setting up workshops for training of examiners in Cape Town, Durban and Johannesburg. This was supported by Senate and arrangements have been initiated to get this off the ground together with the relevant parties.

Cert Nephrology(SA): replacement of the oral with an OSCE
The Cert Nephrology(SA) oral examination has been replaced with an OSCE.

Establishment of Clinical Pharmacology as a Specialty
The fully supported proposal has been submitted to the HPCSA for approval.

SCHOLARSHIPS AND AWARDS

Phyllis Knocker/Bradlow Award : 2006
The name of the award winner has not been released and details, also about the relevant research project, will consequently appear in the next report.

K M Browse Research Scholarship : 2006/2007
Dr Marc Combrinck was the recipient of the Browse Scholarship for his proposed study: *"To test whether (i) serum reductive capacity and (ii) systemic inflammatory markers are related to the severity of Parkinson's disease in a cross-sectional, observational study"*.

Maurice Weinbren Award in Radiology : 2006
Not awarded.

R W S Cheetham Award : 2006
The Cheetham award was given to Dr M Y K Moosa for his published article entitled *A review of multi-spousal relationships – psychosocial effects and therapy".*

M S Bell Scholarship : 2006
The Bell Scholarship was awarded to the following best registrar representations at the South African Society of Psychiatists Congress:
Dr Urvashi Vasant (University of KwaZulu-Natal); and
Dr Fatima Seedat (University of Pretoria).

EDUCATIONAL MATTERS

News Bulletins

CMSA Bulletin
The College news bulletin has been further developed. Members are invited to visit this page for information about congresses, workshops, educational matters, etc. Any news items will be welcomed.

Newsletters of the College of Psychiatrists and the College of Public Health Medicine
These Colleges are to be congratulated on their initiative to keep their members informed via this medium.

Workshop on the Use of Logbooks held in Durban on Friday 11 May 2007
The workshop was a highly successful exercise attended by CMSA Senators and members of the Faculty of Health Sciences of the University of KwaZulu-Natal. Prof Leana Uys, Deputy Vice-Chancellor and Head of the College of Health Sciences, also attended the workshop and participated in the discussions. The speakers, Dr Walter Kloeck, Prof Gerhard Lindeque, Prof Sandie Thomson and Dr Ashwin Hurribunce, gave excellent presentations, addressing all four questions posed, namely:

- Should there be a Log Book?
- Should the Log Book/Portfolio have a gate keeping function to the examination?
- Should the Log Book/Portfolio have a formative assessment role?
- Portfolios as a Quality Control Tool.

These have been encapsulated in a summary with recommendations which would be sent to all the constituent Colleges. A general discussion took place on the summary and various suggestions were made which would be considered.

Details of the presentations appear in the CMSA News Bulletin on the website : http://www.collegemedsa.ac.za.

Information Booklet
A CMSA information booklet will soon be available at the various Faculties of Health Sciences for graduating students.

The Health Professions Council of South Africa

Registrars' Contract
The draft contract prepared by Prof John Robbs in his capacity as Chairman of the CMSA Education Committee is still with the HPCSA.

CMSA Representative
In terms of CMSA policy that representatives on external bodies should be members of the Senate, Prof John Robbs (Chairman of the Education Committee) is now the representative of the CMSA on the Subcommittee for Postgraduate Training and Education (Medical) of the Medical and Dental Professions Board of the HPCSA.

Continuing Professional Development: CPD
The new HPCSA system for the processing of CPD applications has been instituted. No problems have been experienced.

Educational Development Programme : Transkei and East London
Only one educational visit was undertaken during the past year, i.e. from 17 – 20 August 2006, when Profs M McCullogh and A Ndondo presented a programme on *"Updates in Paediatric Nephrology and Paediatric Neurology"*.

A full programme has been planned for the second half of 2007

Professorships and Lectureships

Arthur Landau Lectureship
Lecturer

Professor Stephen Hough delivered his lecture *"A Rational Approach to the Treatment of Osteoporosis: is it Possible?"* in Johannesburg, Durban, Cape Town and Bloemfontein during the latter half of 2006.

Funding by the College of Physicians
It is recorded with sincere appreciation that the College of Physicians has agreed to subsidise lectures in the four main centres on an ongoing basis in order to allow the funds in the lectureship account to accumulate.

Francois P Fouché Lectureship
Professor Anton Schepers, the FP Fouché Lecturer for 2006, delivered his lecture, entitled *"In Search of the Truth"* at the SAOA Congress held in Durban on 6 September 2006.

JC Coetzee Lectureship and the K M Seedat Memorial Lectureship
As there was no Family Practitioners' Congress held in South Africa during the past year, the next JC Coetzee and KM Seedat lecturers will be appointed during 2008.

Margaret Orford Memorial Lectureship
If funds permit, the next lecturer will be appointed for 2008.

The JN Jacobson and WLS Jacobson Lectureship
Although two lecturers were appointed for 2006 namely Dr CA Hurribunce and Professor A Andronikou, Prof Andronikou withdrew from his appointment. Dr Hurribunce will deliver his lectures during the latter half of 2007.

Peter Gordon-Smith Lectureship
As reported earlier, the purpose of this lectureship will be to uphold the theme of the golden jubilee year, viz. the enhancement and promotion of academic healthcare in Africa. The Education Committee is currently preparing the guidelines for consideration by Senate.

Sir Arthur Sims Commonwealth Professorship
Professor Guy Maddern, FRACS gave a talk on *"Changes to surgical training in Australia and New Zealand"* on 26 January 2007 in the Steve Biko Lecture Theatre, Nelson R Mandela School of Medicine. He also participated in various departmental meetings at Ngwelazana, IALCH and Medical School. His lecture on 27 January 2007 entitled *"Who should undergo metastatic colorectal liver resection"* was video-linked to other centres throughout the country.

Robert McDonald Rural Paediatric Fund
During October 2006, funds were awarded to the Department of Paediatrics, Pietermaritzburg Metropolitan Hospitals Complex to bring Sr Jane Booth from Red Cross War Memorial Children's Hospital to Pietermaritzburg to assist with the establishment of a home based tracheotomy programme.

J C COETZEE PROJECTS (OBSTETRICS AND GYNAECOLOGY)
The JC Coetzee fund is supported by the JC Coetzee Trust which is a body external to the College of Obstetricians and Gynaecologists and is administered by the CMSA. Dr JC Coetzee was a rural general practitioner who later specialised in Obstetrics and Gynaecology. Throughout his career he remained sensitive to the needs of rural practitioners and was particularly concerned about the provision of continuing medical education in areas which did not have easy access to local teaching facilities.

He provided funds in his Will for the provision of educational activities in Obstetrics and Gynaecology for rural practitioners both in South Africa and beyond our borders.

The projects which are funded through the JC Coetzee Trust are broadly divided into three groups. When the original bequest was made, there was considerable debate how to utilise this maximally and this programme was devised through the College for the JC Coetzee Trust. The aim of the Trust Fund is to provide educational input, support in rural areas and also to provide input into sub-Saharan Africa. In the past permission has been given to run CME courses in metropolitan areas, provided they are aimed at primary care physicians.

Essentially this programme concentrates on three main areas of input.

J C Coetzee Refresher Courses
These courses are aimed at obstetrician/gynaecologists, family practitioners, midwives and other healthcare workers who are involved in Women's Health. These courses are usually organised in an area which does not have a Faculty of Health Sciences, although family practitioner refresher courses have been organised within academic centres. This particular programme enjoys the most input from the College of Obstetricians and Gynaecologists (COG(CMSA)) and from Departments of Obstetrics and Gynaecology in South Africa.

Several visits have been undertaken and funded through this programme during the period under review. The plans for 2007 are already well advanced. Requests for funding have been reviewed and submitted by a number of the Universities and these activities will continue in 2007.

University of Pretoria
Very successful courses were run during the past year and were well attended. The programmes were presented by Professor Peter McDonald, Prof Greta Dreyer, Dr Hendrik Lombaard and Dr Leon Snyman in the following centres.

Polokwane: 8 June 2006

Topics addressed:

HIV Update	(Prof McDonald)
Diabetes in Pregnancy	(Dr Lombaard)
Ectopic Pregnancy	(Dr Snyman)
Vaginal Infections	(Prof McDonald)
PET Management	(Dr Lombaard)
Caesarean Section on Request	(Prof McDonald)
HRT	(Dr Snyman)
Fetal Monitoring	(Dr Lombaard)
Cervical Screening	(Dr Snyman)

The feedback from this course was extremely good and requests have been made for the course to be repeated.

Rustenburg: 21 September 2006

Topics addressed:

Management of the pregnant HIV Infected patient	(Prof McDonald)
Cervical Smears	(Dr Snyman)
HPV Testing and Vaccines	(Prof Dreyer)
Ante Partum Haemorrhage	(Prof MacDonald)
PID and Bartholin's Abscesses and Cysts	(Prof Dreyer)

Diagnosis and Management of Unruptured Ectopic Pregnancies	(Dr Snyman)
Female Sexual Dysfunction	(Dr Snyman)
Caesarean Section in S A	(Prof MacDonald)

University of Stellenbosch
Zithulele : 25 to 30 June 2006

Prof Gerhard Theron, who undertook this visit, reported that he did several ward rounds, gave lectures to the nursing staff on antenatal care, the first and second stages of labour and the correct use of the partogram and had several informal discussions with doctors. An external cephalic version discussion was arranged, with demonstration on a patient.

An educational day was arranged for all nurses working in primary health care facilities in the Umtata and Nqanduli districts held at the Vidgesville Primary Health Care Centre, which was very well attended. Lectures included all the topics discussed at Zithulele.

University of Cape Town
Monthly visits to Port Elizabeth and East London have continued. The norm has been for each of these visits to be undertaken by one or two specialists from the Department of Obstetrics and Gynaecology of the University of Cape Town. Specialised clinical services such as advanced ultrasound scanning or oncological surgery are also provided depending on the skills and the pre-arrangements with the visiting lecturer.

The visitors arrive in Port Elizabeth on a Wednesday afternoon, participate in academic activities in the Department of Obstetrics and Gynaecology at Dora Nginza Hospital. These include ward rounds and case presentations. The evening is spent at a CME presentation for senior staff from the hospital and private practitioners.

On the Thursday morning a teaching labour ward round takes place followed by clinical teaching and case presentations. There is an opportunity for registrar staff to gain personal tuition.

On Thursday afternoon the lecturers travel to East London and undertake clinical ward rounds and case discussions followed by lectures to junior staff in the Postgraduate Centre at Frere Hospital. In the evening a meeting is organised with local specialists and senior members of the hospital staff. This usually takes the form of a lecture and discussion session.

On the Friday morning the visitors visit the Cecilia Makiwane Hospital where they attend a perinatal mortality meeting and participate in teaching ward rounds in both Obstetrics and Gynaecology. They usually return to Cape Town early on Friday afternoon.

The opinions of the staff at the centres in both Port Elizabeth and East London are canvassed every year and the visits for the coming year and the frequency of the visits are determined according to this feedback.

The latest feedback included a request that the visits should continue in 2007 and that the clinical expertise was particularly valued.

The visiting lecturers and their lecture topics are documented.

24 – 26 May 2006
Dr C Stewart : The depressed pregnant patient
Dr G Miles : Surgery pelvic organ prolapse: current evidence

7 – 9 June 2006
Dr G Draper : Evidence to aid the use of injectable contraception
: The investigation and management of SGA fetus

26 – 28 July 2006
Prof S Fawcus : 11 Stories of postpartum haemorrhage
: Morbidity adherent placenta

Dr M Matjila : Recurrent pregnancy

23 – 25 August 2006
Prof L Denny : HPV vaccines
Dr S Dyer : Endometriosis update

27 – 29 September 2006
Prof J Anthony : Confidential enquiries into maternal mortality 2002 – 2004
Dr T T Matebese : Puberty

18 – 20 October 2006
Dr G Petro : Water birthing

Dr M Moss : Instrumental Vaginal Delivery
: Contraception in the Older Woman

22 – 24 November 2006
Dr M Besser : PMPCT revisited
: Infertility and HIV care

21 – 23 February 2007
Prof Z M v d Spuy : Reproductive health during the menopause transition
: Non-reproductive consequences of polycystic ovary syndrome

28 – 30 March 2007
Dr O Olarogun : Laparoscopic Management of Endometriosis
Dr N Sigcu : Antenatal Screening

The JC Coetzee Medical Development Programme to Sub-Saharan Africa
This programme affords the COG(CMSA) the opportunity of either providing lecturers or examiners to Faculties elsewhere in Africa or allows us to bring colleagues to South Africa for training courses. The programme may include developing specific skills in a facility elsewhere in Africa or running an educational course in a Faculty in Africa. It also allows us to identify colleagues in Africa who require special training and supporting them during their stay in South Africa.

The JC Coetzee Lectureship
This biennial lectureship is delivered at a congress organised by the College of Family Practitioners. The lecturer has to be from the discipline of Obstetrics and Gynaecology but the choice of lecturer is left to the organisers of the congress. Prof Franco Guidozzi was the last J C Coetzee lecturer at the National Congress of Family Practitioners in 2005.

THE AFRICAN DEVELOPMENT INITIATIVE AND FORMATION OF A FEDERATION OF AFRICAN COLLEGES OF MEDICINE
This initiative was mooted generally to address some of the Mille-

nium Development Goals in the area of Health and the challenges in sub-Saharan Africa identified by President Lizo Mazwai when he took up the office of President. The final impetus came from the Golden Jubilee Celebrations in 2005, which served as a spring board for the concept.

The objectives of the initiative are to forge stronger academic links and share in matters of common interest pertaining to Academic Medicine in Africa. Some of these areas will include:

1. Human Resource Development for Health.
2. Academic activities such as conferencing and examinations.
3. Challenges in service delivery in the light of the brain drain from Africa.
4. The impact of socio-economic conditions on disease patterns and how to collectively and strategically meet these challenges.

Prof Lizo Mazwai, in his capacity as President, attended a meeting of the College of Surgeons of East, Central and Southern Africa (COSECSA) in Blantyre, Malawi in November 2006 (facilitated by the RCS (Edin). The meeting afforded him the opportunity to meet with colleagues and introduce the idea.

It became evident that, though the idea of a Federation was desirable, certain logistics would make the start difficult due to some of the challenges of Africa, e.g. geographical spread, communication and language and transnational and international political dynamics. The issues of governance, secretariat and headquarters, for example, could stall the formation of the Federation if a top-down approach was followed. The impression was that the Federation should develop in an evolutionary, bottom-up approach.

Prof Mazwai's recommendation to Senate, therefore, was that the initial approach should be an informal "Association of Colleges" one, on the basis of collaboration in various fields such as education and training. Examples already existed of Pan African Associations, e.g. Surgeons (PAAS) and Paediatric Surgeons (PAAPS).

It was agreed in principle that members of the African Colleges would be invited to examine, or observe, at examinations of the CMSA. The suggestion was that the constituent Colleges could consider inviting perhaps one examiner per year and this is being pursued. A strategy is being developed on how to proceed and procure the required funding.

It was also agreed that interaction between the constituent Colleges of the CMSA and the African Colleges would be encouraged. A good example cited was the interaction of the College of Surgeons (CMSA) with representatives of the Ghanaian College of Physicians and Surgeons. Their interest was mainly for examiners to participate in their College examinations. This has now been extended with a further visit being planned for November 2007 which would include, amongst others, the College of Obstetricians and Gynaecologists and College of Paediatricians.

An invitation will be extended to the President of COSECSA, Prof Krikor Ertzingatsian, to attend the CMSA activities in Johannesburg in October 2007 as they are keenly interested in learning about the CMSA's statutes, rules and regulations on how to run examinations, admission ceremonies, etc.

ASSOCIATION OF MEMBERS

KwaZulu-Natal

The medico-legal ethics lectures continue to be popular. Scenarios from the April 2006 meeting, with comments from medical specialists and a legal expert, were published in the August 2006 CMSA News Bulletin.
Meetings were held as follows:

13 September 2006
"Whistleblowing – impaired or unethical behaviour of colleagues"

8 November 2006
"Super-cession (patient pinching)"

28 February 2007
"The role of journalism in the responsible reporting of health issues"

12 April 2007
HIV-AIDS issues.

Functions for Committee Members and Candidates

A cocktail party for successful candidates in the March-May 2006 examinations was held on 2 June 2006 which was well attended and appreciated by all concerned.

On 3 November 2006 a final end of year combined function was held for all committee members and successful candidates in the August-October 2006 examinations.

Western Cape

The first function was held at the College office in Rondebosch on 21 November 2006 and was attended by almost 180 members and their partners. Prof Solly Benatar gave a thought provoking and challenging talk on *"What is Happening to Professionalism in Medicine in South Africa"*, after which Prof Zephne van der Spuy welcomed candidates who were successful in the 2006 examinations. The evening was concluded with cocktails.

It was agreed that this would be the norm for the future and Dr André Venter has been invited to give the next talk, on HIV/AIDS related matters at a function on 20 November 2007.

CMSA PROPERTIES

Grant-in-Aid in Respect of Rates : 17 Milner Road, Rondebosch

The Cape Town City Council has again approved the CMSA's application for a grant-in-aid in lieu of rates. R46 124 was granted for the 2006/2007 financial year.

Development of Durban Property : 12 Glastonbury Place, Congella

During the past year the Colleges of Medicine Foundation (CMF) and the CMSA jointly agreed to make bridging finance available for the purchase of two properties adjacent to the existing College building (Nos 14 and 16 Glastonbury Place). An architectural plan was presented to the Board of Trustees of the CMF and to the CMSA Senate in May 2007.

At the Trustees meeting in May, Prof Y K Seedat gave first option to the CMSA for the purchase of his premises (No 10 Glastonbury Place) with the promise that the proceeds of the sale would be used for a research scholarship to be administered by the CMSA. Prof Seedat's offer was accepted with sincere appreciation.

A more definite proposal, incorporating all four sites (10 – 16 Glastonbury Place) will be presented to Senate for consideration in October 2007.

TAX IMPLICATIONS OF THE CHANGE OF RELATIONSHIP BETWEEN THE COLLEGES OF MEDICINE OF SOUTH AFRICA (CMSA) AND THE COLLEGES OF MEDICINE FOUNDATION (CMF)

The Tax Executive of Edward Nathan Sonnenbergs, Mr Mansoor Parker, was asked to guide the CMSA Senate and members of the Board of Trustees of the CMF on certain matters where uncertainties existed. These are recorded hereunder in "question" and "answer" format:

Q Would Transfer Duty become payable if the CMF property was transferred to the CMSA or would the tax exemptions granted to the CMSA apply?

A Should the CMF property be transferred to the CMSA, transfer duty would not be payable *provided that the property was acquired by the CMSA for the purpose of carrying on one or more of its approved public benefit activities.*

Q What would the position be in respect of Capital Gains Tax?

A *If the transfer of the CMF property was made as a donation which resulted in liability for CGT, the Foundation would be exempt from the payment of such CGT as the recipient (CMSA) was an approved public benefit organisation. Thus, if as mentioned above, the transfer of the Foundation's property was a donation or transferred at less than market value, donations tax would not be payable.*

Q Would the fact that the CMSA would be renting out this property affect its tax exemption status?

A *The rental of property was regarded as a trade for income tax purposes and accordingly the CMSA would be obliged to pay income tax upon the rental receipts unless the receipts could be brought within any one of the exemptions contained in items (aa), (bb), (cc) and (dd) of section 10(1)(cN). The rental income received by the CMSA would be fully taxable at a rate of 29%.*

Q If there were any reservations about this point, what would the position be as far as Transfer Duty and Capital Gains Tax were concerned, if the property was transferred to the CMF to administer?

A *Since the Foundation was not exempt from the payment of tax, if the property were to be transferred to it to administer, transfer duty would be levied on the value of the property and would be payable by the Foundation. Therefore the transfer of the property to the Foundation would have to be at market value so as to avoid any prejudice on the side of the CMSA.*

The CMSA would not be liable for the payment of capital gains tax as public benefit organisations were also exempt from CGT on the disposal of an asset provided that the public benefit organisation did not use the asset in carrying on any business undertaking or trading activity or substantially the whole of the asset was directed at a purpose other than carrying on a business undertaking or trading activity. If the CMSA rented out the property prior to transferring same to the Foundation, the CMSA would be considered to have conducted a business undertaking and would be liable for the payment of CGT on the subsequent transfer of the CMF property to the Foundation.

LINKS WITH OTHER PROFESSIONAL BODIES

Health Professions Council of South Africa

Prof Thanyani Mariba, Chairman of the Medical and Dental Professions Board, continues to make himself available to attend CMSA Senate meetings. This greatly facilitates discussion on important matters of mutual interest.

As recorded before, the CMSA enjoys representation on the Subcommittee for Postgraduate Training and Education (Medical) of the Medical and Dental Professions Board of the HPCSA. Prof John Robbs has just been elected to represent the CMSA on the Board.

National Department of Health

Interactions between the CMSA and the Department of National Health, particularly through the good offices of Dr Percy Mahlati, Deputy Director General Human Resource Planning, Development and Management, have been continuing.

At the strategic planning meeting of the CMSA in August 2006 in Cape Town, attended by Dr Mahlati, the issue of current and future relationships between the CMSA and the Department of National Health was further debated. The sentiment expressed as a resolution was that the CMSA should have a more formal and structured relationship with the Department of Health. To achieve this goal, a CMSA steering committee was formed with the President tasked to write to the Director General, Mr Thamsanqa Mseleku, to open dialogue that would see realisation of this objective. Proposals were submitted by the CMSA for consideration at a meeting that took place in the office of the Director General on 4 October 2006, attended by members of the CMSA steering committee, Mr Mseleku and Dr Mahlati.

The College's mission to be acknowledged as an authoritative body of medical and dental professionals who could be a resource to Government, is becoming a reality. An example of this is the request by Dr Percy Mahlati that the CMSA and its Specialist Groups participate in a workshop scheduled to take place on 3 August 2007, when critical aspects of the implementation of the HRH Planning Framework will receive attention.

National Department of Education

A formal and structured relationship is now also sought with the Department of National Education, similar to the relationship that exists with the Department of National Health and a letter has, therefore, been addressed to the Director General, Mr Duncan Hindle, informing him that the CMSA would welcome the opportunity, as a stakeholder, to comment on legislation and policy matters and participate at National Department of Education fora. Mr Hindle has also been invited to attend CMSA Senate meetings, or to nominate a designated representative to attend on his behalf.

RELATIONS WITH SISTER COLLEGES AND ACADEMIES

Contact with Sister Colleges and Academies remain of extreme importance and every effort is made by the CMSA to attend their conferences and meetings. Intercollegiate relationships were fostered at the following meetings where the CMSA was represented:

40th Malaysia-Singapore Congress of Medicine : 24 to 27 August 2006, Sunway Pyramid Convention Centre, Petaling Jaya, Selangor

Representative: Prof Lizo Mazwai (President)

The Royal College of Physicians and Surgeons of Canada : Annual Conference to be held in Ottawa from 28 – 30 September 2006
Representative: Prof Lizo Mazwai (President)

Academy of Medicine, Hong Kong hosting the IACAP Meeting and an International Congress in collaboration with the Royal College of Surgeons of Edinburgh (the closure of their Quincentenary Celebrations) : 10 – 13 October 2006
Representative: Prof Lizo Mazwai (President)

International Liaison Committee of Presidents (ILCP) of the English Speaking Colleges of Pathologists to be hosted by the College of American Pathologists in October 2006
Representative: Prof Simon Nayler (President C PATH)

Royal College of Surgeons in Ireland : Charter Day Dinner held on 17 February 2007
Representative: Prof Lizo Mazwai (President)

Recognition
Sponsorship of the overseas visits by the Colleges of Medicine Foundation is customarily acknowledged.

THE CMSA ACTING AS HOST TO OVERSEAS COLLEGES AND ACADEMIES
Joint Conference of the Royal College of Physicians and the College of Physicians (CMSA): 22-24 February 2007
The President of the College of Physicians, Prof Ken Huddle, hosted this joint meeting at the Vineyard Hotel. The arrangements were ably convened by Prof Janet Seggie and delegates commented on the very high standard of the academic programme.

It was an honour for the President of the CMSA, Prof Lizo Mazwai, to admit Prof Ian Gilmore, President of the Royal College, to Honorary Fellowship of the College of Physicians of South Africa at a special conferral ceremony at the Congress Dinner held at Kirstenbosch.

ACKNOWLEDGEMENTS
Senate wishes to place on record its gratitude of the immeasurable contributions of honorary officers, examiners, trustees, councillors of constituent Colleges and committee members who continue to serve the CMSA on an ongoing basis despite numerous other commitments.

A word of thanks also to members of the CMSA and others who actively participated in the vast number of activities that took place during this past year, and particularly to those who contributed to the success of the projects referred to in this report.

Finally, it is always an immense pleasure for Senate to acknowledge the loyal and dedicated service of the full-time staff of our College who render a vital service far beyond the normal call of duty.

Bernise Bothma
CEO

LOST MEMBERS

The office of the CMSA is keen to establish the whereabouts of the following “lost members”. Any information that could be of assistance should please be submitted to:

The Chief Executive Officer
The Colleges of Medicine of South Africa
17 Milner Road
7700 RONDEBOSCH
South Africa
Tel: (021) 689-9533
Fax: (021) 685-3766
E-Mail: cmsa-adm@iafrica.com
Internet: http://www.collegemed.ac.za

Block, Joseph *(College of Neurosurgeons)*
Block, Sidney *(College of Family Practitioners)*
Bresler, Pieter Benjamin *(College of Public Health Medicine)*
Drew, James du Preez *(College of Anaesthetists)*
Gibson, John Hartley *(College of Obstetricians and Gynaecologists)*
Hill, John William *(College of Physicians)*
Kornell, Simon *(College of Physicians)*
Leigh, Werner Eberhard Julius *(College of Family Practitioners)*
Matus, Szlejma *(College of Radiologists)*
Ndimande, Benjamin Gregory Paschalis *(College of Anaesthetists)*
Oduwole, Olusesan Odusami *(College of Anaesthetists)*
Phillips, Kenneth David *(College of Family Practitioners)*
Raubenheimer, Arthur Arnold *(College of Obstetricians and Gynaecologists)*
Richmond, George *(College of Physicians)*
Sartorius, Kurt *(College of Public Health Medicine)*
Sesel, John Ruby *(College of Radiologists)*
Shaw, Keith Meares *(College of Surgeons)*
Smith, Robin Errol *(College of Paediatricians)*
Van den Aardweg, Machteld Sonja *(College of Surgeons)*
Van Wyk, Hester Catharina *(College of Surgeons)*

Information as at 20 June 2007

COLLEGE OF CARDIO-THORACIC SURGEONS

Over the last two years the curriculum within the College of Cardiothoracic Surgeons has been applied and our impression is that recent candidates have had a reasonably good knowledge base using the new revised curriculum which was on the CMSA website and which we will be adding to the newly revamped website.

Problems that are increasingly confronting our candidates is the relative lack of operative and clinical exposure due to the severely curtailed activities in tertiary medicine in most of the academic centres in the country. Because of this, and because of many complaints received by candidates, we have as yet to implement the logbook requirement, as candidates will struggle to fulfil international minimum criteria for their operative logbook. This problem is not unique to our College and has been addressed by a recent CMSA workshop in May 2007 which focused on the whole question of logbooks and portfolios for all future candidates in the CMSA. The Senators from our College who attended this meeting found it very worthwhile and our College Council will be meeting in the near future to discuss the implementation and the use of a candidate's portfolio (rather than just a logbook), not only as a gatekeeper function but also as an adjunct to the evaluation of candidates for the FC Cardio(SA) examination.

It has also become evident to many members of the Cardiothoracic surgical community in South Africa that we have too many Cardiothoracic Surgeons in South Africa and too many registrars in training at present for the realistic need (not the ideal need) for Cardiothoracic surgery in South Africa. The exact way to deal with this problem is difficult because an academic unit requires the services of registrars for ongoing teaching, training and research. No department will voluntarily give up a registrar training post. This is a challenge which our College and the academic Cardiothoracic community will be facing.

Prof Garth Brink
President

COLLEGE OF FAMILY PRACTITIONERS

In the past year, family medicine as a discipline in South Africa experienced progressive changes in its recognition as a speciality. Within The Colleges of Medicine of South Africa (CMSA), all holders of its membership qualification (MFGP(SA) or MCFP(SA)) in good standing with the CMSA were given the opportunity to convert from '*Members*' to '*Fellows*' of the College of Family Practitioners - FCFP(SA) following a majority CMSA Senate decision taken in Oct 2005. Members who have not yet applied for the conversion can contact the Cape Town office as soon as possible as the cut-off date for the conversion is 31 January 2008. Thereafter only newly qualified members will convert immediately after their examinations upon application.

Secondly, family medicine was officially named as a speciality in the Government Gazette No. R. 69 of 2 February 2007, signed by the honourable Minister of Health – Dr Manto Tshabalala-Msimang for comments. The closure date for comments was 2 March 2007 and no submission opposed the content of the gazette as reliably informed. The final draft gazette was published on 17 August 2007 (No. R. 712) confirming Family Medicine as a new medical speciality in South Africa.

The first FCFP(SA) examination according to the new regulations can only start with the September/October 2010 examination, when the first set of family medicine registrars complete their minimum mandatory training period before sitting for the examination. This means that the last MCFP(SA) examination will be offered in March/May 2010. With these developments, the College of Family Practitioners of South Africa - CFP(CMSA) can now commence the award of Fellowships according to the criteria for the various categories of Fellowship within the CMSA. The CFP Council is busy assessing the first set of Fellowships by *peer review* for recommendation to the CMSA review committee.

In addition, a new CFP(SA) examinations committee was constituted comprising its Council members and Heads of Departments of Family Medicine to streamline the assessment process as we move towards a national equivalence examination for the speciality. During the transition phase from the MCFP(SA) to FCFP(SA) examinations, it was agreed that the setting of papers will be done jointly at the CFP Council annual meetings, which should coincide with the examination periods. The new MCFP(SA) examination format which commenced at the March/May 2007 examination is as follows:

a. **Written examination:** These comprise Multiple Choice Questions (MCQs), Modified Essay Questions (MEQs) and Critical Review questions based on a journal article. The long essay paper has been withdrawn.

b. **Clinical examination:** These comprise an Objective Structured Clinical Examination (OSCE) with the previous management interview incorporated within the OSCE, and Patient Consultations (at least 3 ambulatory cases per candidate). The oral (viva voce) has also been withdrawn as it is too subjective for reliability.

The CFP President attended the Fellowship examination of the Faculty of Family Medicine of the West African College of Physicians (FWACP) in Ibadan, Nigeria as an observer in October 2006 and the reciprocal future visit by their chief examiner, Dr Modupe Ladipo will take place at the May 2008 clinical examinations in Cape Town. In addition, Prof Ogunbanjo was elected by the CMSA Senate as one of its Vice-Presidents for the triennium (2007 - 2010).

Finally, Dr Basil Jaffe was awarded an Honorary Fellowship of the College of Family Practitioners of South Africa for his contributions to the College and family medicine at large at the CMSA graduation ceremony held in Cape Town in May 2007.

Prof Gboyega Ogunbanjo
President

COLLEGE OF MAXILLO-FACIAL AND ORAL SURGEONS

Two candidates received the Fellowship this year and the medal of the Society of MFOS (SA) was awarded to Dr CB Pearl. The number of candidates entering for the Fellowship is increasing, but pass rates for the primary examinations are poor, hence the small number of candidates for the intermediate and final exami-

nations. There is slow progress towards implementing a national equivalence examination.

The Annual General Meeting of the College of Maxillo-Facial and Oral Surgeons (CMSA) was held as usual at the time of the meeting of the South African Society of Maxillo-Facial and Oral Surgeons in August, 2006, in Port Elizabeth. No increase in the levy was implemented this year.

On behalf of the Council of the College of MFOS, I wish to thank the staff at both the Cape Town and Johannesburg offices for their ongoing assistance.

Prof Madeline Lownie
President

COLLEGE OF NEUROLOGISTS

All 9 members of the Council of the College of Neurologists met for the annual meeting of the College in Johannesburg on 9 March 2007. We thank Pfizer Pharmaceuticals who have sponsored the travel arrangements and venue for this meeting over the last 4 years.

The syllabus for the FC Neurol(SA) Part 1 examination was revised and it was agreed that the aspects of neuro-anatomy, neurophysiology, neuropathology, neurogenetics, neuro-immunology and biostatistics would not include clinical aspects. It was also agreed that the conduct of the Part 2 examination should be standardised and would include 1 long case and 3 examiner-directed short cases and 15 OSCE stations comprising 5 EEGs, 5 EMGs and 5 radiology stations. All candidates who commence their training in 2008 will be required to submit logbooks confirming that they have had adequate experience in neuro-physiological examinations before they are eligible to write the Part 2 examination.

We are encouraging all South African registered specialist neurologists who have been practicing for more than 10 years and are not Fellows of the College of Neurologists, to make themselves available for consideration for Fellowship by peer review. These are mainly senior colleagues who may have been registered because of MMed qualifications or because of the grandfather clause.

On other matters, we agreed that in the College of Psychiatrists examinations, the Neurologists would continue to play a supportive role but that the College of Psychiatrists should be primarily responsible for the organisation of the examination and the selection of patients.

The National Department of Health and the HPCSA have now approved the Diploma in Sleep Medicine. Our President, Prof Pierre Bill, was invited by the President of the World Federation of Neurology to attend a meeting, together with representatives from other African countries, and from Europe and the USA, to initiate a WFN project to assist the development of neurology in Africa, through projects such as the establishment of a WFN Neurology Traveling Fellowship for Africa, accelerating the training of supernumerary registrars in neurology in South Africa, with free access to journals and teaching material to neurologists in Africa.
It was agreed that one of the most important functions of our College is to maintain high international and academic standards, so it is vital that we continue our efforts to ensure that the College of Neurologists sustains this vital function.

Prof B M Kies
Secretary

COLLEGE OF NEUROSURGEONS

Successful FC Neurosurg(SA) Final examinations were held for the first time at University of Limpopo (Medunsa Campus) in September 2006. This was due to the unavailability of Bloemfontein, where all the other constituent College examinations were held. The examiners were:

Dr N Govender	KwaZulu-Natal
Prof H B Hartzenberg	Stellenbosch
Prof S Mokgogong	University of Limpopo
Dr S S Nadvi	KwaZulu-Natal

The May 2007 FC Neurosurg(SA) Final examinations were held in Durban. The following examined:

Dr M du Trevou	KwaZulu-Natal
Dr N D Fisher-Jeffes	Cape Town
Prof R Gopal	Johannesburg
Dr S S Nadvi	KwaZulu-Natal

The format of the FC Neurosurg(SA) Final examinations has been standardised. In the future a log book for neurosurgery is likely to be compulsory. In principle, Heads of Departments have agreed to introduce a research component into the final neurosurgical examination, with candidates being encouraged to submit at least one scientific publication to a peer-reviewed journal.

A formal OSCE component in the FC Neurosurg(SA) Final examination, while being a useful addition, was abandoned for the moment due to logistical problems.

The next full sitting of the Council of the College of Neurosurgeons will be in August 2008.

Dr Samir Nadvi
Secretary

COLLEGE OF NUCLEAR PHYSICIANS

The College of Nuclear Physicians (CNP) has grown and can proudly report that the FCNP(SA) Part II is now written by all universities with accredited nuclear medicine departments. For a small College like ours, this is a milestone and will help us to maintain and advance the high quality and standards of Nuclear Medicine in South Africa.

The College of Nuclear Physicians has to date admitted twelve Fellows, most of them since 2004.

A pilot study of the FCNP log book/student profile will commence in the near future, as soon as the various Heads of Departments

have agreed on the content. The Council of the CNP is presently busy with the development of the new regulations which will modify the Part I requirements and syllabus.

Prof Annare Ellmann
President

Prof Mike Sathekge
Secretary

COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

On behalf of the members of our College I would like to congratulate the immediate past president of our College, Professor Zephne van der Spuy, on her election as President of The Colleges of Medicine of South Africa (CMSA). We are indeed honoured and thank her for her tireless efforts in the activities of the College of Obstetricians and Gynaecologists (COG).

The COG has remained at the forefront of educational changes over the past decade and this is in no small measure due to the committed Councillors from all the Universities around the country. The challenges of postgraduate training and assessment have been constantly reviewed by Council. The FCOG(SA) Part 1 remains as a written examination comprising 3 papers based on the basic sciences. Paper 3 in this examination, which replaced the viva voce held previously, is structured as short questions similar to the viva questions, except that the candidate answers in the written format. In this present day of evidence-based medicine an understanding of statistical analysis and interpretation of clinical research is mandatory and therefore the COG expects its trainees to be competent in this area. This area is also assessed in the Part 1, so enabling our trainees to have the foundations prior to commencing their dissertations. We encourage our trainees preparing for the FCOG(Sa) Part I examination to attend research methodology courses.

The registrars (trainees in a 4-year programme) are required to submit a logbook and dissertation prior to the Part 2 examination. The logbook, which details the clinical experience of the registrar, is regularly reviewed by Heads of Departments and supervising Consultants so that areas of deficiency are timeously noted and appropriate measures taken to assist the registrars in fulfilling certain minimum requirements as requested by the College. This is especially pertinent in the areas of vaginal and endoscopic surgery. The logbook remains valid for 3 years. The research component in the form of commentaries/ dissertations has remained mandatory in the COG. Until the September 2007 examination, 2 commentaries are acceptable; however from 2008 a single research project at MMed dissertation level will be accepted. In meeting the goal of a national equivalence examination, the dissertation or research component will help meet the requirements of awarding the MMed by the Universities to those trainees who have successfully completed their Part 2 examination. The clinical component of the Part 2 examination is assessed using both the OSCE and OSPE formats. Feedback from examination candidates over the years that these formats have been employed, confirms the fairness and objectivity of our examination.

The format of the clinical component of the Dip Obst(SA) changed from a single clinical case plus OSCE, to 6 clinical scenarios in OSPE format plus OSCE from the September 2003 examination. Similarly, this format has been unanimously accepted by all examination candidates. We would like to encourage primary care physicians in private practice and medical officers working in small district hospitals to attempt the Dip Obst(SA). Candidates for this examination may obtain the requirements for part-time training in obstetrics from the CMSA.

Our College would like to record its appreciation towards the examiners, universities and hospitals that have allowed us the facilities to examine our candidates. In addition, the organisation and assistance provided by the support staff of these host departments and non-examining Fellows of our College is acknowledged.

Examiners in 2006/2007

September/October 2006

Part I Examination	
Prof G Dreyer (Convenor)	UP
Dr P J Swart	UP
Dr C M J Stewart	UCT
Dr N H Mbatani	UCT
Dr H A Rhemtula	Wits
Dr R Schackis	Wits
Dr R Maharaj	UKZN
Dr P Steyn	US
Part II Examination	
Prof H S Cronjé (Convenor)	UFS
Prof E J Coetzee	UCT
Prof A B Koller	Wits
Prof A P MacDonald	UP
Prof R E Mhlanga	UKZN
Prof D W Steyn	US
Prof S Levin	Wits
Dr A Alperstein	UCT
Dip Obst(SA)	
Prof P H Wessels (Convenor)	UFS
Prof J S Bagratee	UKZN
Prof G A B Buga	WSU
Dr J B F Cilliers	UFS
Dr J D Nortjé	UFS
Dr G Pedro	UCT

March/May 2007

Part I Examination	
Prof E J Buchmann (Convenor)	Wits
Dr F H van der Merwe	US
Dr N Mbatani	UCT
Dr S R Ramphal	UKZN
Dr H A Rhemtula	Wits
Dr J M du Plessis	UFS
Dr L C Snyman	UP
Dr A N M Muse	UL
Part II Examination	
Prof J S Bagratee (Convenor)	UKZN
Dr L Govender	UKZN
Prof S Monokoane	UL
Prof B G Lindeque	UP
Prof G B Theron	US
Dr T Smith	Wits
Prof Z M van der Spuy	UCT
Prof P H Wessels	UFS
Dip Obst(SA)	
Prof R E Mhlanga (Convenor)	UKZN
Dr M J Titus	UKZN
Dr W W Edridge	Wits

Dr P Godi	Rob Ferreira
Prof D W Steyn	US
Dr NF Moran	UKZN

Our College, through the CMSA, administers the J C Coetzee Fund which has been established by an endowment by the late Dr J C Coetzee. The main purpose of this fund is to provide educational programmes for rural doctors. CME courses for health professionals in Limpopo, Southern KwaZulu-Natal and the Eastern Cape have been run by the various University academic departments. The CMSA has also extended this Fund to enable collaboration with colleagues from sub-Saharan Africa. Doctors from Malawi and Tanzania have received support from the Fund and a colleague of ours from Kenya will be supported in training in Oncology in 2007.

The HPCSA has already recognised three of our four subspecialities (Reproductive Medicine, Oncology and Feto-maternal Medicine) and the first candidates should be entering for their certificate examination in 2008. Our Council has made it a priority to assist in the process of establishing urogynaecology as a subspeciality in South Africa.

May I take the opportunity to express our gratitude to the South African Society of Obstetricians and Gynaecologists (SASOG) for the annual funding of the education meetings of our College.

Our Council has co-opted one member each from the University of the Free State and Walter Sisulu University this year.

On behalf of our Council, I wish to record my appreciation to Mrs Bernise Bothma, Mrs Ann Vorster and Mrs Anita Walker and their staff in the three offices around the country.

Prof JS Bagratee
President

COLLEGE OF ORTHOPAEDIC SURGEONS

During the past year the College, together with Heads of university departments, had several fruitful meetings regarding the MMed Intermediate (Part II) and the FC Orth(SA) Intermediate. It was noted that the College intermediate examination lacked orthopaedic content when compared to the MMed intermediate syllabus The syllabus of the College intermediate was revised to include basic principles of fracture treatment, biomechanics and tumours. The CMSA Examinations and Credentials Committee approved the revised submission of the orthopaedic intermediate syllabus. The new format of the examination will come into effect in October 2008.

The South African Orthopaedic Association annual congress was held in Durban last year and included outstanding registrar presentations and instructional courses. The F P Fouché lecture *"In Search of the Truth"* was delivered by Prof Anton Scheepers.

The college was active in the outreach programme last year in Southern and West Africa. In December 2006 the AO course on fracture management in Malawi was well attended with delegates from as far as West Africa. In addition, several workshops were conducted by Mr Paul Demmer on non operative treatment of fractures. Subspeciality orthopaedic training for one in South Africa was arranged for four newly qualified orthopaedic surgeons from the region. In addition a senior orthopaedic resident from Mozambique spent a year in South Africa prior to their specialist examinations. The East Central Southern African Orthopaedic Association congress will be held in Pemba, Mozambique on the 6-7 August 2007.

The recent Fellowship examinations were well organised and of a high standard. The failure rate among well prepared candidates who entered for the first time was 20%. However the failure rate was between 60% - 80% among repeat candidates.

The College acknowledges the support of the members, examiners, Mrs Bernise Bothma and Mrs Ann Vorster.

Prof Teddy Govender
President

COLLEGE OF PAEDIATRICIANS

The past year has been an eventful one for the College of Paediatricians. The Council has been very active in implementing changes to the Diploma as well as the Fellowship examinations. We had a full day Council meeting at the Paediatric Congress in September 2006 as well as two teleconferences in the past year, and keep in regular email contact with one another. The strength of the Council lies in its representivity and the wide range of skills and experience of the Councillors, together with an extremely dedicated and hard-working President in Professor Haroon Salojee.
The main efforts of the College continue to focus on increasing the organisation and level of professionalism of the College examinations. Key developments in this area, over the past year, include:

- Establishment of examiner panels well in advance of the examinations, with a blend of experienced and new examiners, aiming for representivity and a process that allows for review of the papers.
- The DCH(SA) has been reviewed and significant changes to its structure, eligibility criteria and conduct have been finalised. We hope that this will mean that more doctors are able to write the examination, which will ultimately translate into better medical care for children in South Africa.
- The FC Paed (SA) Part I was the subject of a workshop in Johannesburg in April 2006. Since then the structure of the examination has changed considerably. The examination has been blueprinted to ensure coverage of as many important areas as possible, and the paper undergoes review by an examination review panel prior to being finalised. We are currently working on establishing a bank of multiple choice questions, which will be introduced from March 2008.
- The FC Paed(SA) Part II has undergone considerable improvement. The results for the past examinations show significantly better pass rates. An FC Paed(SA) II Indaba is planned for October to coincide with the clinical examinations in Gauteng.
- The College Council intends to become more involved in the subspecialty Certificate examinations.

The College website continues to offer valuable resources in continuing medical education and examination-related support material. Thanks to Alan Rothberg for his continuing enthusiastic input and hard work.

And last but certainly not least: the College of Paediatricians turns 40 this year! We are extremely proud of our College and its history, and wish to honour its Founders and Associate Founders. Alan Rothberg is the coordinator of a wonderful event which will be held in October in Gauteng.

I wish to pay tribute to our President, Haroon Salojee, for his dedication and inspiring leadership. I would also like to thank all the Councillors who are working so hard to ensure that our examinations are fair and appropriate, while continuing to uphold the high standards of Paediatrics in South Africa. Thank you too to all the CMSA administrative staff for their excellent support and willingness to be of assistance at all times.

Dr Sharon Kling
Secretary

COLLEGE OF PATHOLOGISTS

The past year has been a busy one for the College of Pathologists with particular emphasis on the conduct of the examinations, revision of curricula of the various pathology disciplines and fostering relationships with our international colleagues in the pathology disciplines.

The College continues to conduct Fellowship examinations in seven pathology disciplines, which include Anatomical Pathology, Chemical Pathology, Clinical Pathology, Haematology, Microbiology and Virology. No examination has been convened for Oral Pathology as yet, this is a fairly newly introduced specialty at CMSA level. More recently, Certificate examinations were conducted in the subspecialty of Clinical Haematology.

The conduct of the examinations, and the outcomes have been satisfactory. The Council is extremely grateful for the time, effort and dedication our Fellows put into these examinations. Several observers have been invited to attend and observe the examinations in order to widen and refresh the examination panels, whilst several more experienced examiners have retired or left the country.

The prestigious Coulter Medal for 2006 was awarded to Dr van der Watt (FCPath Chem Path), who was the most distinguished Fellow in all the Pathology disciplines in 2006.

Revision of the various pathology discipline curricula is currently in progress, with most disciplines having concluded the process. The issue of formative assessment, and portfolios and logbooks is an ongoing one and the president was on the discussion panel at the workshop on this issue held in May in Durban. Logbooks have now been introduced in some Departments of Haematology and Anatomical Pathology in the various accredited Pathology training institutions.

The College continues to foster relationships with its counterparts abroad. The President was invited to participate in a meeting of the International Liaison Committee of Presidents of the Colleges of Pathologists (ILCP) held in Washington, USA, in October 2006. Other attendees included the Presidents and Presidents-elect of the College of American Pathologists, the Royal College of Pathologists, The Royal College of Pathologists of Australasia and of Hong Kong. The College of Pathologists (CMSA) is now a member of this organisation and will continue to attend to represent the interests of the discipline in this forum. The next meeting will be held in Dublin in September 2007, and we are scheduled to host this prestigious meeting in 2008.

On the African continent, the College continues to expand and establish new relationships. A recent request from the Qatar College of Pathologists for recognition of training is under discussion.

On the local front, the College continues to participate in the various forums discussing the issues of training of Pathologists and seeking solutions to address the critical shortage of these professionals.

Professor Sir James Underwood honoured our College by graciously accepting an Honorary Fellowship which was finally conferred at the graduation ceremony in Bloemfontein in October 2006. Nolan Janse van Rensburg was awarded Fellowship by peer review, in the discipline of microbiology.

It is with sadness and a sense of loss that we report the untimely death of the two Fellows of the College of Pathologists who passed away in the last year. Professor Nelson Muthuphei was a past Councillor of the College of Pathologists and had convened the FC Path (Anatomical Pathology) examinations. He was also past President of the Federation of the South African Societies of Pathology and Academic Head of the Department of Anatomical Pathology at the University of Limpopo. Dr Simon Seopela was an Anatomical Pathologist in private practice with Ampath Laboratories at the time of his death.

We wish to thank the administrative staff of the CMSA, the Councilors of the College of Pathologists and all examiners for their hard work and support during the past year.

Prof Simon Nayler
President

Dr Johnny Mahlangu
Secretary

COLLEGE OF PHYSICIANS

The College of Physicians (CP) presents its annual report for the year 1 June 2006 to 31 May 2007, having met on two occasions on 16 October 2006 in Bloemfontein and 7 May 2007 in Durban.

The following items were under discussion:

Examinations

The Part I Basic Science examination and Part II Clinical examination are working well. Marking has been in symbols and percentages. The format of the Part II examination was reviewed and the Objective Test, extended to 3 hours.

The curriculum has been reviewed and information on the curriculum, marking systems and the examination process is available on the CMSA website. The FCP(SA) regulations have been approved by the Examinations and Credentials Committee: Proposal: Part I may be written earlier, especially with the 2 year internship and community service taking effect shortly; Part II may be taken 2¾ years after commencement of training.

The Registrar Portfolio has been updated and will permit formative assessment of trainees; stipulates the minimum number of procedures to be done and records other aspects of training such as presentations, teaching, research projects. The portfolio and curriculum are now compatible and has been implemented in January 2007. The continuous assessment form has been modified and needs to be completed by the Unit Head at the end of each block.

The Higher Diploma in Medicine continues to attract a small number of candidates; insufficient recognition is being given to individuals with this qualification and this needs to be addressed.

Subspeciality examinations have become compulsory from 1 January 2002 and are proceeding well. Nephrology has decided to abandon the costly viva and replace it with an objective test that could be written in the centres where the trainees are based.

Medal winners

Asher Dubb Medal	: Dr N Goolam Mahyoodeen
M M Suzman Medal	: Dr A Klisiewicz
A Meyers Medal	: Dr B Allwood

Fellowship by peer review
This has been an on-going process.

Arthur Landau Lectureship
The Arthur Landau Lecturer for 2007 is Professor Umesh Lalloo. He will be visiting Bloemfontein, Cape Town, Durban and Johannesburg in the new financial year.

Links with Other Colleges
A combined meeting of the Royal College of Physicians and the CP(CMSA) was held in Cape Town on 22-24 February 2007, which was very enjoyable and successful. Links were established between the respective Colleges and with the Ghanaian College of Physicians and Surgeons. A meeting was held to discuss ways of assisting African countries with training of specialists and subspecialists.

Sarala Naicker
Secretary

COLLEGE OF PSYCHIATRISTS

Council Members during period under review were:
Prof. R Emsley (President)
Prof. S Seedat (Secretary)
Prof. C Allwood
Prof. O Alonso-Betancourt
Prof. S Kaliski
Prof. D Mkize
Prof. J Pretorius
Prof. S Rataemane
Prof. L Roos
Prof. M Vorster
Prof. D White
Prof. T Zabow

Meetings
The following meetings were held during the period 1 June 2006 to 31 May 2007:

19 July 2006	Teleconference
20 September 2006	Teleconference
06 December 2006	Teleconference
27 February 2007	Face to face meeting
18 April 2007	Teleconference

CPSYCH Regulations
The inclusion of the MMED dissertation requirement in the FC Psych II regulations was considered, amendments made to the existing regulations and sent out to Council members for their input. In September 2006, the Council then resolved that the change be approved. The revised regulations were then submitted. The requirement of a research dissertation for the Part II will only be applicable to all new registrars starting as from January 2007, who will then, at the earliest, sit their Part II in September 2009. It will not be a compulsory College requirement for registrars who are currently in the system. However, individual Heads of Department may enforce this as a departmental requirement for eligibility to the Part II.

Psychotherapy Logbook
The psychotherapy logbook, which was introduced in 2005, was extensively modified in 2006 and circulated to all Council members for their inputs. The revised version was submitted to the CMSA for posting in the College website.

Promotion of the DMH
The DMH proposal for doctors in rural areas was submitted to the CMSA and presented together with other proposals to the Discovery Foundation. It was suggested that a handbook of psychiatric management be selected and promoted as part of this endeavour. It was suggested that a list of 3 to 4 possible handbooks be compiled and sent out for independent review with the aim of selecting one of these. In early 2007, two texts were selected. Funding will be pursued in the near future to enable free distribution of these texts to community service doctors in the country.

Resignation of Council Member: Dr. J Saunders
Dr. Saunders informed the Council in July 2006 that she was no longer able to serve on the Council as she would be living overseas for a few years.

Proposals for other Sub-Specialties
In July 2006, Council members agreed that proposals for Forensic and Old Age Psychiatry be solicited. Prof. S Kaliski was approached and agreed to draft regulations for Forensic Psychiatry and Dr. F Potocnik for Old Age Psychiatry. Dr. Funeka Sokudela and the Forensic Psychiatry SIG (SASOP) are also working on a proposal in Forensic Psychiatry.
The matter of recognizing additional sub-specialties will be kept on the agenda for on-going discussion in the coming year.

Independent Observer
Prof. S Kaliski was recommended, and accepted this appointment, to serve as independent observer for the October 2006 examinations in Bloemfontein.
Dr. Farouk Randeree was recommended, and accepted this appointment, to serve as independent observer for the May 2007 examinations.

Representation of Examiners: FC Psych Part II examinations
The matter of whether there is adequate and fair representation of examiners from all institutions for the FCPsych Part II clinical/oral exams was discussed at the meeting held in February 2007. It was reported that across all three exams as a whole (DMH, FCPSYCH I, FCPSYCH II), an attempt was made to ensure representivity in respect of gender, race and institution.

It April 2007, it was decided that Prof. Mkize would select suitable young potential examiners to act as unofficial observers for the FC Psych Part II. He would also follow the same procedure for the DMH.

It was also decided that Council would be more proactive in identifying suitable colleagues in private practice who could serve as examiners for future examinations.

Examination Guidelines for Candidates: FCPSYCH, DMH, Cert Child Psychiatry
The CMSA requested that individual Colleges compile guidelines for candidates on format and conduct of the examinations.

Prof. Yusuf Moosa of the University of Witwatersrand was approached, and agreed, to assist the Council with this. His guidelines for candidates were circulated to Council members and will be tabled at a face-to-face Council meeting in November 2007.

MS Bell Award
Two awards of R2 500-00 each were made to two Registrars at the annual SASOP congress which was held in Swaziland in September 2006. The recipients were: Dr. Urvashi Vasant from the University of Kwazulu Natal and Dr. Fatima Seedat from the University of Pretoria.

Fellowship Ad Euendum
Dr. Tom Sutcliffe was nominated for a Fellowship Ad Euendum in September 2006. The Council was unanimous in its support of the nomination which would be ratified by the Senate in May.

Associate Membership and Fellowship by Peer Review
Dr Maricela Herrera was successfully nominated as an Associate and Prof Alonso-Betancourt and Dr Gerhard Jordaan were successfully nominated as Fellows by Peer Review.

Co-opted to Council: Prof. Sean Kaliski
In February 2007, it was proposed to co-opt Prof. Kaliski from the University of Cape Town to Council. This was unanimously accepted.

Prof Robin Emsley
President

COLLEGE OF RADIOLOGISTS

The College of Radiologist bid farewell to its past president Prof. Alan Scher and paid tribute to him for the contribution he made to the practice of radiology in the country in general, and specifically to academic radiology. At the same meeting, Dr Duncan Royston withdrew as the Secretary of the College. The vacancies in these critical posts was rapidly filled during a by-election that saw Dr Ashwin Hurribunce elected as President, Professor Savvas Andronikou as Secretary and Professor Steve Beningfield as the new Senate representative of the College on the CMSA Senate. The new executive team and Council set about its task by constituting three standing committees viz. the executive, examinations and education committees, supported by their respective charters that spell out their roles and objectives in the College.

In September 2006 councillors of the College participated on the Scientific Committee of the International Congress of Radiology at the invitation of the Radiological Society of South Africa (RSSA). Drs. Richard Tuft and Jan Labuscagne of the RSSA also gave their blessing for the 3rd annual College of Radiology pre-exam course to be held at the conference facility free of charge. In addition the 'See Right Through Me Imaging Atlas' an official collaborative publication of the College of Radiology and the Radiological Society produced by Andronikou, Wieselthaler, Kilborn and Lotz was funded and distributed free by the RSSA at the conference.

Early in 2007, the South African National Academic Radiology Think-tank was also formed. This vehicle, initiated by Stellenbosch University and championed by the College, includes the Departmental Heads of all the radiology training centres and the Radiological Society of South Africa, and will attend to issues of mutual and collective benefit of the profession. The first outcome of the Think-tank was a pilot program of four lectures delivered 'live' by videoconference to 10 academic radiology centres throughout South Africa. The College thanks Jan Lotz and Otto Shulze for their vision and for showing us the way. This program was a success and the College looks forward to a videoconference curriculum being prepared by the College education committee.

The education committee is a new body headed by Prof Andronikou and has no previous example to follow, yet we have a high expectation from the proposed activities. The College of Radiology pre-exam course [the 4rth annual] will be planned for August, a Think-tank meeting to finalise the videoconference programme will be held in July and a new College publication 'The ABC of Paediatric Surgical Imaging' is already underway by Andronikou, Theron, Ackermann, Alexander and Sidler. In addition the education committee will plan educational workshops in specialty areas, plan technical Workshops, provide accreditation for educational activities, foster a permanent association with the South African Journal of Radiology with a regular feature, create an outreach program to African radiology education bodies, pursue association with other national education bodies (Universities) and international bodies, promote research at all teaching institutions by providing teaching programs and support, aim at providing (in association with the RSSA) scholarships / fellowships/student exchange, promote and foster South African and African conferences in Radiology and promote new and experimental educational activities.

The examinations committee, headed by Dr Hurribunce, has developed a draft documentation that was circulated for comment and finalisation by Council. The areas that were addressed include revised Rules and Regulations (positioning for accreditation), Internal Guidelines (aimed to achieve equity, fairness and consistency in the conduct of examination) and a Performance Portfolio (aimed at providing a quality assured basis for formative development and assessment of candidate specialist radiologists).

During the latter half of the year, the executive committee will host a special Council strategic planning session where amongst other business of the College, a medium term strategy will be formulated that will confirm the rightful place of the College of Radiologist in the South African Radiological and Clinical landscape. The year would draw to a close with two examination events administered and managed successfully by the nominated centres.

Prof Savvas Andronikou
Secretary

COLLEGE OF SURGEONS

The past few years has seen several new developments, some of which are in the process of being finalized, and others which are still ongoing.

Most importantly is that we have had a thorough review of the curriculum. Professors Robbs and Thomson were responsible for updating the FCS Final curriculum, and Professor Thomson and Bizos revised the FCS Intermediate and FCS Primary curriculum, respectively. The new curriculum have incorporated the changes that have taken place in General Surgery in the last few years. The new curriculi are in their final versions and will be submitted to the E and C Committee.

Changes have also occurred in the examination process. The clinical component of the FCS Final examination is still weighted and has been enhanced by the introduction of the OCSE. The latter has now become established as an integral part of the examination process and seems to be a good surrogate of the over-

all outcomes of the examination. Registrars are required to submit their logbooks when applying to sit the FCS Final examination. The logbooks have been standardized and the quality of the submissions have improved significantly in recent years. The concept of the logbooks is still in evolution and the College remains undecided on how to critically use the logbooks. Importantly the College still needs to establish minimum numbers of procedures that registrars need to do or see before they are allowed o sit the FCS Final examination.

The College would also like to add a Research component to the examination process. Registrars will be required to have submitted their research in an MMed format to their local university. The format and standard of the research submissions will be at the discretion of the local universities. The College is hoping to have this process in place by the end of 2008.

One of the major challenges facing all surgical departments is the dwindling resources in the state sector, which impacts most significantly on theatre time. There is no doubt that registrars are doing fewer cases now than before, and this has led many to believe that it is impossible to train surgeons in four years. The logbook will therefore assume great importance to determine adequately of training. We also believe that formative in training assessment is necessary.

The College as in recent years established subspecialist training in several areas, including vascular, gastrointestinal and paediatric surgery.

Prof Del Kahn
President

Prof Sandie Thomson
Secretary

COLLEGE OF UROLOGISTS

In accordance with discussions at the College Council Meeting of 15 May 2006 the Constitution of the College of Urologists has been changed so that there will be 10 instead of 8 elected members of the Council. Provision was made for the co-option of a representative from each University Department of Urology, as well as members from the private sector who are actively contributing to registrar training, in order to ensure representation. The number of co-opted members will be limited to 5 in total.

A General Meeting of the Fellows of the College of Urologists was held on Wednesday 15 November 2006 at the Cape Town International Conference Centre, during the combined Congress of the SA Urological Association and the Societé Internationale d'Urologie.

In response to the directive from the Education Committee of the CMSA that the Regulations are to be updated regularly, a few problem areas were identified since the previous revision of the Regulations in 2005. There was lively discussion of these issues at the General Meeting. Among the consensus decisions were that the Primary and Intermediate Examinations should have to be passed within a limited time period, and that the different subjects may be taken or passed one at a time within this period.

There was considerable discussion about the new examination format and the marking system in percentages, which remains problematic, mainly because examiners tend to "regress to the mean" of giving 45% for a fail mark (instead of 25% or less) and 65% for a good mark (instead of 75% or more). Returning to the previous system of 5 symbols which are then translated into percentages may be a solution, although even with the previous system some examiners tended to vacillate by using "in-between" symbols such as S plus with arrow up (or down), and in this context giving percentages may be a better way of allowing flexibility.

Some speakers felt that the previous system of one long case and two short cases was better, but it was pointed out that prior to revision of the examination format the Colleges held several workshops where experts had presented scientific evidence that the reliability of examinations increases in proportion to the number of testing sessions and the area of the knowledge domain in which the candidate is tested.

There was again discussion about the Log Book, and whether specified numbers of certain procedures should be laid down as a requirement for admission to the examination, because in certain centres the candidates would have no exposure to certain procedures, and it may prove difficult to remedy a situation where the registrars would have to rotate to another centre or the private sector to obtain such exposure.

The CMSA hosted a symposium in Durban on 11 May 2007 to discuss the "Log Book issue", and this was attended by Profs. Chris Heyns and Alf Segone and dr Tjaart Fourie. Several problem areas were highlighted and different views and opinions were discussed. It is clear that, no matter what term is used in future, the "Log Book" issue itself will not simply go away, and a system will have to be established to provide continuous monitoring and assessment of the training process, to ensure that candidates are adequately prepared before taking the Final Examination and, more importantly, that they are appropriately trained to enter independent practice by the time they are awarded Fellowship of the College.

In consultation with the Council and the Panel of Examiners, the Regulations for the FC Urol SA were revised. Apart from a few editorial changes, the relevant amendments were:

1. The Final Examination must be passed within six years of passing the Intermediate and within nine years of passing the Primary. The reason for this is to prevent candidates taking an indefinite time from the Primary to the Final.
2. The scope of the syllabus for the Primary Examination in basic sciences (Anatomy, Physiology and Pathology) was clarified.
3. The regulation with regard to marking the Primary Examination was amended to clarify that the candidate does not have to pass both the written and the oral parts of the examination, but that they will each count 50%, and the final mark will be an aggregate of the marks for the written and oral parts.
4. In order to give credit for (a) Primary subject(s) passed, but to prevent the candidate from studying for only one and totally neglecting the other two; and to ensure that the candidate does not use credit gained for passing a single subject at a time to eventually obtain the Primary over an indefinite period, the following amendment was made: The candidate must take all three Primary subjects concurrently at the first attempt; if the candidate fails one or two of the subjects, credit will be given for the subject(s) passed, provided the candidate has obtained at least 45% in the subject(s) failed; the candidate must pass all three subjects within 18 months of passing the first subject, otherwise all credit for any subject(s) passed will lapse, and the candidate will have to re-take all three subjects concurrently at the next examination attempt.
5. With regard to the Intermediate, it was clarified that Part A is to be set by an examiner(s) from the College of Surgeons, and Part B is to be set by an examiner(s) from the College of Urologists, who must co-opt an examiner(s) with a specialist qualification in Anatomical Pathology (not necessarily a Fellow of the College of Pathologists). A written and oral examination on Part A is to be conducted by examiner(s) from the College of Surgeons, with examiner(s) from the College of Urologists as observer(s).

6. To clarify the situation that the General Surgery Intermediate is recognized as equivalent to the Urology Intermediate, the relevant regulation was amended as follows: Candidates who have passed the Intermediate examination of the College of Surgeons will be exempted from the Intermediate examination of the College of Urologists (parts A and B).
7. To prevent our College having to set up separate Part A (Surgery) and Part B (Urology) Intermediate examinations, candidates who have come via the General Surgery Primary will simply do the General Surgery Intermediate and then continue to the Urology Final, but those who have done a Urology Primary will then have to do the Urology Intermediate Parts A and B at the same examination, and will have to pass Part A to get credit for passing Part B. The candidate must attempt both Parts A and B concurrently (i.e. at the same examination), but will be given credit for passing Part A, provided the mark for Part B is not less than 45%; the candidate then has to pass Part B at the next examination, failing which the credit for passing Part A will be withdrawn. If the candidate fails Part A at the first attempt, no credit will be given for Part B, which will have to be retaken at the next examination.
8. A clause was added stating that the Final Examination may include questions on ethical issues related to the practice of Urology, to indicate that medical ethics will be regarded as an integral part of the syllabus and examination.

The Urology Registrars' Forum took place on 7 to 9 June at the Irene Country Lodge outside Pretoria. It was organized by Prof Alf Segone of Medunsa/University of Limpopo, and was generously sponsored by sanofi-aventis, with support from the South African Urological Association. This was the 7th biennial Registrars' Forum, and this meeting has clearly become a valuable and vital part of the training experience of our registrars. At the end of the Forum there was a discussion about changes to the format of future Forums, and a number of interesting proposals were made, which will hopefully be implemented by the organizers of the next Forum in collaboration with the Academic Committee of the SAUA.

In order to familiarise future candidates as well as examiners with the new format of the Final Examination, a formative OSCE ("training examination") was organized on the Saturday morning after the Registrars' Forum. There were 6 examiners, 10 candidates and 5 observers. At the end of the OSCE there was an hour's discussion where the examiners gave general feedback on their impressions, and candidates as well as observers had the opportunity to air their views. The purpose of this training exercise was to familiarise candidates with the examination format and to provide them with individual feedback on their state of preparedness for the examination. An interesting aspect of this OSCE was the close correlation between marks awarded by the examiner and by the observer for individual candidates – the more remarkable, because some of the observers were junior registrars, indicating that one does not necessarily need to know all the correct answers in order to know if the candidate is giving the correct answers! The general impression was that the training OSCE was felt to be a useful experience, and hopefully it will become an annual event, alternating in conjunction with the biennial SAUA Congress and the Registrars' Forum.

The Council of the College of Urologists consists of the following members: CF (Chris) Heyns (President), LJ (Lance) Coetzee (Secretary), RD (Dick) Barnes, TM (Trevor) Borchers, M (Mohamed) Haffejee, H (Haroun) Patel, S (Simon) Reif, AM (Alf) Segone, CA (Cindy) Zietsman (elected); ZB (Zoltan) Bereczky, MLS (Marthinus) de Kock, PH (Paul) Porteous, LT (Lybon) Rikhotso and S (Schalk) Wentzel (co-opted).

Prof Chris Heyns
President

Dr Lance Coetzee
Secretary

CMSA Life Members As at 31 May 2007

Aaron Cyril Leon
Abdulla Mohamed Abdul Latif
Abel Solomon
Abrahams Abduragiem
Abrahams Cyril
Abramowitz Israel
Ackermann Daniel J Joubert
Adam Anvir
Adams Edward Barry
Adler David Ivan
Adler Max
Adno Jacob
Africa Benjamin Jakobus
Aitken Robert James
Alexander Louis Leonard
Allan John Cameron
Allen Colin E Lewer
Allen Keith Lewer
Allie Abduraghiem
Allison John Graham
Anderson Donald Frederick
Anderson Joan
Anderson Mary Gwendoline
Anderton Edward Townsend
Andrew William Kelvin
Appleberg Michael
Armitage Bernard Albert
Arndt Theodore C Heinrich
Baigrie Robert D Hutchinson
Bailey Michael John
Baillie Peter
Baines Richard E Mackinnon
Baker Graeme Cecil
Baker Lynne Wilford
Baker Peter Michael
Barbezat Gilbert Olivier
Barlow John Brereton
Barnard Christiaan Neethling
Barnes Donal Richard
Barnetson Bruce James
Barrett Carl T Herzl
Barron David
Barry Michael Emmet
Baskind Eugene
Batchelor George Bryan
Bax Geoffrey Charles
Beatty David William
Becker Ryk Massyn
Bedford Michael Charles
Beemer Abraham Mayer
Benatar Victor
Benjamin Ephraim Sheftel
Bennett Margaret Betty
Bennett Michael Julian
Bensusan Arthur David
Berk Morris Eli
Berkowitz Hayman Solomon
Bernstein Alicia Sheila
Bernstein Henry
Bethlehem Brian H James
Bezuidenhout Daniel Johannes J
Beyer Elke Johanna Inge
Biddulph Sydney Lionel
Biebuyck Julien Francois
Binnewald Bertram R Arnim
Bird Allan Vivian
Blair Ronald Mc Allister
Blecher John Aubrey
Bleloch John Andrew
Bloch Cecil Emanuel
Bloch Hymen Joshua
Block Joseph
Block Sidney
Blum Lionel
Blyth Alan George
Bock Ortwin A Alwin
Bodenstab Albert TBH
Bok Louis Botha
Booth John Vivian
Bosman Christopher Kay
Botha Daniel Johannes
Botha Jean René
Botha Louis Johannes
Bothwell Thomas Hamilton
Boulle Trevor Paul
Bowie Malcolm David
Bradlow Bertram Abraham
Braude Basil
Bremer Paul MacKenzie
Bremner Cedric Gordon
Brenner Dietrich Karl
Briedé Wilhelmus M Hendrik
Brink Andries Jacob
Brink Stefanie
Brock-Utne John Gerhard
Brokensha Brian David
Broude Abraham Mendel
Brown Alexander Annan
Brown Helen Annan
Brown Raymond Solomon
Buch Julius
Buchan Terry
Bull Arthur Barclay
Burger Thomas Francois
Burgin Solomon
Burns Derrick Graham
Burton Dudley Walton
Butcher Nigel Ross
Butler George Parker
Buys Anna Catherina
Byrne James Peter
Caldwell Michael William
Carim Abdool Samad
Catterall Robert Desmond
Catzel Pincus
Cavvadas Aikaterine
Chait Jack
Charles David Michael
Charlewood Godfrey Phillips
Charlton Robert William
Charnock Frederick Niven
Cheetham Richard W Spencer
Chenik Gerald Samson
Chetty Dhevaraj Vasudeva
Chitters Max
Chouler Florence Joan Gordon
Cilliers Leon
Cilliers Pieter Hendrik Krynauw
Cinman Arnold Clive
Claassens Hermanus JH
Clausen Lavinia
Cluver John Arthur
Clyde Jack Howard
Coetzee Daniël
Coetzee Louis Frederik
Coetzer Hendrik Martin
Cochrane Raymond Ivan
Cohen David
Cohen Harvey
Cohen Lionel
Cohen Morris Michael
Coller Julian Somerset
Combrink Johanna Ida Lilly
Comfort Peter Thomas
Conradie Marthinus T Steyn
Cooke Paul Anthony
Coote Nigel Penley
Coovadia Hoosen Mahomed
Cort Alexander
Cowie Robert Lawrence
Cowley John Godfrey
Cowley Ronald
Cowlin John Albert
Cox Herbert Walter
Coxon John Duncan
Craig Cecil John Tainton
Crichton Eric Derk
Crosley Anthony Ian
Croucamp Petrus C Hendrik
Dall George
Dalrymple Desmond Ross
Danchin Jack Errol
Dando Raymond Victor
Daneel Alexander Bertin
Daubenton François
Daubenton François (Snr)
Daubenton John David
Davey Dennis Albert
Davidson Aaron
Davies David
Davies Michael Ross Quail
Davis Charles Pierre
Davis Meldrum J Finnamore
Dawes Marion Elizabeth
Daynes William Guy
De Klerk Daniel Johannes Janse
De Kock Johannes Hendrikus
De Kock Machiel Adriaan
De Villiers Jacquez Charl
De Villiers Jan Naude
De Villiers Pieter Ackerman
De Wet Jacobus Johannes
Dean Joseph G Kerfoot
Denis-Lester Leslie
Dent David Marshall
Dennehy Patrick J Pearce
Dickie-Clark William Findlay
Dommisse George Frederick
Dornfest Franklyn David
Douglas-Henry Dorothea
Dove Ephraim
Dove Jechiel
Dowdle Eugene B Davey
Dower Peter Rory
Dreyer Wynand Pieter
Dubb Seymour
Duckworth William Calvert
Duncan Harold James
Du Plessis Daniel Jacob
Du Plessis Hendrik Pienaar
Du Plessis Hennie Lodewia
Du Plessis Hercules Gerhardus
Du Plessis Willem Hendrik
Durham Francis James
Du Toit Guilluame Tom
Du Toit Johan Jakob
Du Toit Johan Loots
Du Toit Pierre F Mulvihal
Duursma Rienk Willem
Dykman Cornelis Derksen
Eales Lennox
Eathorne Allan James
Edelstein Harold
Edelstein Wolfe
Edge Kenneth Roger
Edge William E Basil
Ehrlich Hyman
Eksteen Jurgen Kotze
Engelbrecht Jacobus Adriaan
Enslin Ronald
Epstein Edward
Erasmus Frederick Rudolph
Etellin Pierre Anthony
Evans Warwick Llewellyn
Evans William Benjamin David I
Eyre Jane
Faiman Israel Osser
Fainsinger Maurice Haig
Fehler Boris Michael
Feldman Max Bernard
Fergusson David J Guillemard
Findlay Cornelius Delfos
Fine Julius
Fine Stuart Hamilton
Fischer Gustav Fichardt
Fisher-Jeffes Donald Leonard
Fleishman Solomon Joel
Flynn Michael Anthony
Fontein Batholomeus T Petrus
Foord Charles John
Forman Robert
Förtsch Hagen E Armin
Foster Nathaniel E George
Fourie Christian F Gilsen
Frankel Freddy Harold
Frank Joachim Roelof
Franks Maurice
Freedman Jeffrey
Freeman Arthur Arnold
Freiman Ida
Friedberg David
Friedland Benjamin Percival
Friedman Isidore
Friedman Sydney
Friedmann Allan Isodore
Frost Cyril
Fuller Denis Norden
Futeran Gerald
Galatis Chrisostomos
Gani Akbar
Gasson Charles H Reginald
Gasson John Edward
Gaylis Hyman
Geere Jacobus Johannes
Geerling Rudolf
Geffen Heime
Geldenhuys Frans Gert
Gentin Benjamin
Gerber Johan Abraham
Gibson John Hartley
Gillis Lynn Sinclair
Gillmer Ralph Ellis
Ginsberg Hilde
Girdwood Donald Hampden
Glazer Harry
Glen Alan Murray
Gluckman Jonathan
Glyn Thomas Raymond
Goeller Errol Andrew
Goetz Robert Johannes
Goldberg Solomon
Goldstein Bertie
Gollach Benjamin Leonard
Goodley Robert Henry
Goodman Hillel Tuvia
Gordon Grant M Cameron
Gordon Isidor
Gordon Vivian Nathan
Gordon Walter
Gordon-Smith Derek Peter
Gorvy Victor
Govender Perisamy
Neelapithambaran
Gowans Ronald
Graham John Donald
Graham Kathleen Mary
Grant John F Cardross
Grayce Isaac
Grek Isaac Joseph
Grieve James Muir
Griffiths Joan McElwee
Griffiths Seaton Bythyl
Grobler Johannes Lodewikus
Grobler Marthinus
Grundill Wilfrid
Grusiner Wolf
Haarburger Oswald Maximillian
Hacking Edgar Bolton
Haffejee Ismail Ebrahim
Hamelberg Henri Jacques
Hamilton Clarence Gawn
Hamilton Donald Graham
Hamilton Ritchie Douglas Archibald
Hangelbroek Peter
Hansen Denys Arthur
Hansen John D Lindsell
Harris Ian Michael
Harris Michael
Harrison Derek Haddrell
Harrison Gaisford Gerald
Hassan Mohamed Saeed
Haupt Frank Johannes Groot
Haynes Donovan Russell
Heese Hans de Villiers
Hefer Adam Gottlieb
Helfet Arthur Jacob
Helman Isaac
Henderson Linda Grantham
Henderson Rex Scott
Hendrix Robert J Maria
Henning Alwyn J Harvard
Henson Soloman
Hersch Sidney Julius
Hersman Doris
Heselson Jack
Heymann Seymour Charles
Heyns Anthon du Plessis
Hift Walter
Hill John William
Hill Paul Villiers
Hillock Andrew John
Hilson Don
Hirschowitz Jack Sydney
Hirschson Herman
Hitchcock Peter John
Hoffmann David Allen
Hoffmann Vivian Jack
Hofmeyr Francis Edward
Hofmeyr Nicholas Gall
Holloway Alison Mary
Horrowitz Stephen Dan
Hossy Sidney Charles
Hovis Arthur Jehiel
Howell Michael E Oram
Hugo André Paul
Hugo Pierre Andre
Human Randolph Russell
Hundleby Christopher J Bretherton
Hurwitz Mervyn Bernard
Hurwitz Solomon Simon
Huskisson Ian Douglas
Hyslop Robert James
Immelman Edward John
Ichim Camelia Vasilica
Ichim Liviu
Ingle Pauline Cornwell
Isaacson Charles
Ismail Mahomed Hoosen Hajee
Israelstam Dennis Manfred
Jacob Hilderbrand Hamilton
Jacobs Miguel Adrian
Jacobs Peter
Jacobson Isaac
Jaffe Basil
Jammy Joel Tobias
Jan Farida
Jansen van Rensburg Martinus
Jassat Essop Essak
Jeppe Carl L Biccard
Jersky Jechiel
Jöckel Wolfgang Heinrich
Joel-Cohen Sidney
Joffe Leonard
Johnson Sylvia
Jones Cecil Stanley
Jonker Edmund
Jooste Jacobus Letterstedt
Jordaan James Charles
Jordaan Robert
Joubert James Rattray
Kaiser Walter
Kalley Harold Aaron
Kaplan Cyril Jacob
Kaplan Harry
Karlsson Eric Lennart
Karstaedt Abraham Lemel
Katz Arnold
Katz Hymie
Kaufman Morris Louis
Kay Sholem
Keen Edward Norman
Keet Robert Arthur
Keeton Godfrey Roy
Kemp Donald Harold Maxwell
Kenyon Michael Robert
Kerr Edward Matson
Kew Michael Charles
Key Jillian Jane Aston
Kinsley Robin Howard
Kirsch Ralph Emmanuel
Kisner Cyril David
Klein Herman
Klein Hymie Ronald
Klenerman Pauline
Klevansky Hyman
Kling Kenneth George
Klopper Johannes Frederick
Kloppers Phillippus Johannes
Klugman Leon Hyam
Knobel John
Knocker Phyllis A Hendrika
Knoetze Gerald Casparus
Knox Lance O'Neil
Kok Hendrick Willem Lindley
Koopowitz Joseph Ivan
Kornell Simon
Kotton Bernard
Kotzé Johannes van Zyl
Koz Gabriel
Kramer Michael Sherman
Krengel Biniomin
Kretzmar Noel
Krige Christiaan Frederick
Krige Louis Edmund
Kriseman Michael Maurice
Krogh Lex
Kussel Jack Josiah
Kussman Barry David
Labuschagne Izak
Lachman Sydney Joshua
Laing John Gordon Dacomb
Lake Walter Thomas
Lampert Jack Arthur
Landsberg Pieter Guillaume
Landsman Gerald Bernard
Lantermans Elizabeth Cornelia
Lapinsky Gerald Bert
Lasich Angelo John
Laubscher Willem M Lötter
Lautenbach Earle E Gerard
Lawrence Henry Martin
Lawson Hugh Hill
Leary Peter Michael
Leary William P Pepperrell
Leask Anthony Raymond
Lebona Aaron David
Leeb Julius
Leeming John A Lamprey
Leigh Werner E Julius
Lejuste Michel JL Remi
Lemmer Eric Richard
Lemmer Johan
Le Roex René Denyssen
Le Roux Desmond Raubenheimer
Le Roux Petrus A Jacobus
Lessing Abrahim J Petrus
Levin Joseph
Levin Solomon Elias
Levy Reginald Bernard
Levy Wallace Michael
Levy Walter Jack
Lewin Ethel
Lewis Henry Montague
L'Heureux Renton
Liebenberg Nicolaas Dreyer
Linde Stuart Allen
Linscott Rosemary Marguerite
Lipschitz David
Lipschitz Robert
Lipsitz Max
Lipworth Edward
Lissoos Irving
Lloyd David Allden
Lochner Jan de Villiers
Lodemann Heide Katharina
Loening Walter E Karl
Loot Sayyed M Hosain
Losken Hans Wolfgang
Losman Elma
Lotzof Samuel
Loubser Johannes Samuel
Louw Adriaan Jacobus
Louw John Xavier
MacEwan Ian Campbell
MacGregor James MacWilliam
MacKenzie Donald Bernard
MacLeod Ian Nevis
Maggs Roderick Frank
Mahomed Abdullah Eshaak
Mair Michael John Hayes
Maitin Charles Thabo
Malan Atties Fourie
Malan Christina
Malan Gerard
Maliza Andile
Malkiel-Shapiro Boris
Mangold Fritz Theodor
Mann Noël Myddelton
Mann Solly
Marais Johannes Stephanus
Marchand Paul Edmond
Maresky Abraham Leib
Maresky Leon Solomon
Margolis Frank
Margolis Kenneth
Marivate Martin
Markman Philip
Marks Charles
Masey George R Frederick
Mason Eric Ivor Henry
Massey Patricia J Helen
Matus Szlejma
Mauff Alfred Carl
May Abraham Bernard
Maytham Dermine
McDonald Robert
McIntosh Robert Roy
McKenzie Malcolm Bett
McPhee Michael Henry
Mears Jasper W Walter
Meer Farooq Moosa
Meeran Mooideen Kader
Melvill Roger Laidman
Melville Ronald George
Mendel Sonnie Ivan
Mendelow Harry
Mendelsohn Leonard Meyer
Meyer Anthonie Christoffel
Meyer Bernhardt Heinrich
Meyer Cornelius Martinus
Meyer David
Meyer Eric Theodore
Meyer Jan Abraham
Meyer Julius
Meyer Roland Martin
Meyers Anthony Molyneux
Meyersohn Sidney Jacob
Meyerson Louis
Michael Aaron Michel
Michaelides Basil Andrew
Michalowsky Aubrey Michael
Michelow Maurice Cecil
Midgley Franklin John
Mieny Carel Johannes
Miles Anthony Ernest
Millar Robert Norman Scott
Miller Samuel
Milne Frank John
Milner Selwyn
Mirkin Wilfred Hyman
Misnuner Zelik
Mitchell Peter John
Mokhobo Kubeni Patrick
Molapo Jonathan Lepoqa
Möller Carl Theodorus
Molteno Christopher David
Moodley Jagidesa
Moola Yousoof Mahomed
Moosa Abdool-Sattar
Morley Eric Clyde
Morris Charles David Wilkie
Morris Derrick Ryder
Morris Edel
Morrison Gavin
Movsowitz Leon
Mullan Bertram Strancham
Muller Hendrik
Mulligan Terence P Simpson
Mundy Raymond
Murray Neil Laird
Myburgh Johannes Albertus
Myers Leonard
Naidoo Lutchman Perumal
Nanabhay Sayed Suliman
Nash Eleanor Scarborough
Naude Johannes Hendrik
Naylor Aubrey Chalkley
Neifeld Hyman
Nel Elias Albertus
Nel Jan Gideon
Nel Pieter Daniel
Nel Rhoderic William Arthur
Nel Wilhelm Stephanus
Neser Francois Nicholas
Nestadt Allan
Newbury Claude Edward
Nicholson John Campbell
Noble Clive Allister
Noll Brian Julian
Norman-Smith Jack
Norwich Isadore
Novis Bernard
Nurick Ivan James
Obel Israel Woolf Promund
Okreglicki Andrzej Michael
Olinsky Anthony
Oliver Johannes Andries
Opie William Henry
Orelowitz Manney Sidney
Osler Henry Ingram
Ospovat Norman Theodore
Padayatchi Perumal
Palmer Philip Edward Stephen
Palmer Raymond Ivor
Paradisgarten Hymie Charles
Parkes John Ryan
Parsons Arthur Charles
Pascoe Francis Danby
Patel Prabhakant Lalloo
Pearlman Theodore
Pein Jack
Pein Nathaniel Kemsley
Perdikis Phoebus
Perk David
Peters Ralph Leslie

Philcox Derek Vincent
Phillips Gerald Isaac
Phillips Louisa Marilyn
Piesold Gerald A Ferdinand
Pieterse Holland Frederik
Pillay George Permall
Pillay Rathinasabapathy Arumugam
Pillay Thiagarajan Sundragasen
Pillay Veerasamy K Govinda
Planer Meyer
Plit Michael
Polakow Raphaely
Politzky Nathan
Pollak Ottilie
Polley Neville Alfred
Pompe van Meerdervoort Hjalmar Frans
Porter Christopher Michael
Posel Max Michael
Potgieter Louis
Pretorius Davis H Schalk
Pretorius Jack
Price Samuel Nathaniel
Prinsloo Simon Lodewyk
Procter Desmond S Collacott
Prowse Clive Morley
Pudifin Dennis James
Quan Tim
Quantock Owen Peter
Quinlan Desmond Kluge
Quirke Peter Dathy Grace
Rabinowitz Albert
Rabinowitz Leslie
Radford Geoffrey
Raftopulos Paris
Rankin Anthony Mottram
Ransome Olliver James
Rayman Ashley
Rebstein Stephen Eric
Reichman Leslie
Reichman Percy
Reid Frederick Payne
Renton Maurice Ashley
Retief Daniel Hugo
Retief Degenes Jacobus
Retief Francois J Petrus
Retief Francois Pieter
Reynders Johannes Jurgens
Reyneke Philippus Johannes
Rice Gordon Clarke
Richey Allan Frank Whitfield
Richmond George
Ritchken Harry David
Roberts William A Brooksbank
Roberts William Michael
Robertson Thomas Chalmers
Robinson Brian Stanley
Rode Heinz
Roman Horatius E Hereward
Rome Paul
Roos Nicolaas Jacobus
Roose Patricia Garfield
Rosenberg Basil
Rosenberg Edwin Robert
Rosenthal Elijah
Rosin Isodore Roland
Ross Bremner Lloyd
Rossouw Dennis Pieter
Rossouw Johan Tertius
Rothschild Emil E Aaron
Roux Daniel Jacobus
Rudolph Isidore
Russell John Tait
Rutovitz Isaac Jacob
Ryan Raymond
Sacks Selig
Sacks Sidney
Sacks William
Safro Ivor Lawrence
Salkinder Joe
Samson Ian David
Samson John Monteith
Sandeman John Charles
Sanders Eric John
Sanders Hannah-Reeve
Sandison Alexander Gorrie
Saner Robert Godfrey
Sapire David Warren
Sarkin Theodore Leonard
Sartorius Kurt Honbaum
Saunders Stuart John
Saxe Norma Phyllis
Schaetzing Albrecht Eberhard
Schepers Nicolaas Jacobus
Schneider Tobias
Schneier Felix Theodore
Scholtz Roelof
Schutte Philippus Johannes
Schwär Theodor Gottfried
Schwarz Kurt
Scott James Graham
Scott Quentin John
Scott Walter Fleming
Scragg Joan Noelle
Seaward Percival Douglas
Sedgwick Jerome
Seedat Yackoob Kassim
Sellars Sean Liam
Senior Boris
Sesel John Ruby
Shapiro Benjamin Leon
Shapiro Max Phillip
Shapiro Norman
Sharpe Jean Mary
Sher Gerald
Sher Joseph Norman
Sher Mary Ann
Shété Charudutt Dattatraya
Shulman Louis
Shweni Phila Michael
Siew Shirley
Silberman Reuben
Silbert Maurice Vivian
Simons George Arthur
Simonsz Christiaan G Adolph
Simpson Thomas Victor
Simson Ian Wark
Singer Martin
Sischy Benjamin
Skinner Donald Pape
Sliom Cyril Meyer
Smalberger Johannes Marthinus ` (Snr)
Smith Alan Nathaniel
Smith John Alaister
Smith Lionel Shelsley
Smith Michael Ewart
Smith Petrus Nicolaas
Smulian Hubert Godfrey
Smythe Patrick Montrose
Sneider Paul
Snyman Hendrick G Abraham
Solomon Herman Israel
Somera Satiadev
Sonnendecker Ernest W Walter
Spilg Harold
Spitz Mendel
Stein Aaron (Archie)
Stein Abraham
Stein Leo
Stein Lionel
Stein Mannie
Stern Ferdinand
Stewart-Wynne Edward George
Steyn Dora Nell
Steyn Gerbrandt
Steyn Izak Stefanus
Stronkhorst Johannes Hendrikus
Styger Viktor
Suliman Abdoorahaman Ebrahim
Sur Monalisa
Sur Ranjan Kumar
Sutin Gerald Joseph
Suzman Moses Myer
Svensson Lars Georg
Swanepoel André
Swart Barend Hermanus
Swartz Jack
Tang Kenneth
Tarboton Peter Vaughan
Taylor Robert Kay Nixon
Te Groen Frans Wilhelmus
Te Groen Lutherus H Treub
Teeger Arnold
Terblanche John
Terespolsky Percy Samuel
Thaning Niels-Otto
Thatcher Geoffrey Newton
Theron Francis
Theron Jakobus L Luttig
Thomson Alan J George
Thomson Peter Drummond
Thompson Roderick Mark McGregor
Thorburn Kentigern
Thornington Roger Edgar
Thorp Marc Alexander
Tobias Ralph Lulu
Toker Eugene
Tomlinson John R Dacomb
Treisman Oswald Selwyn
Trichard Louis C G Lennox
Trope Robert Allan
Trott Edmund Lorimer
Trubshaw William H Daines
Tucker Robert D St George
Tucker Ronald B Kidger
Turner Peter James
Ungerer Matthys Johannes
Utian Hessel Lionel
Van Coeverden de Groot Herman A
Van Coller Beulah Marie
Van den Berg Andries D Petrus
Van den Bergh Cornelius Jacob
Van den Ende Jan
Van der Merwe Jan Abraham
Van der Riet John Werendly
Van der Riet Ryno le Seur
Van der Spuy Johan Wilhelm
Van der Walt Johannes Joachim
Van der Wat Jacobus JH Botha
Van Dongen Leon G Raymond
Van Drimmelen Pieter
Van Gelderen Cyril Jack
Van Graan Nico Jacobus
Van Greunen Francois
Van Hasselt Carel Hugh
Van Helsdingen Jacobus O Tertius
Van Huyssteen Hendrik Roelof (Snr)
Van Leenhoff Johannes Willem
Van Niekerk Christopher
Van Niekerk Gilbert André
Van Niekerk Willem Abraham
Van Rensburg L C Jansen
Van Rooyen Adriaan J Louw
Van Schalkwyk Colin Henri
Van Schalkwyk Herman Eben
Van Wyk Eugene Muller
Van Wyk Frederick A Kelly
Van Zyl Jakobus J Wynand
Venter Pieter Ferdinand
Victor Arthur
Viljoen Ignatius Michael
Viljoen Theunis Gabriel
Visser Daniel
Vogelpoel Louis
Von Wielligh Gysbertus Johannes
Vooght Terence Edward
Vorster Carl Theodorus
Vosloo Arnoldus Johannes
Wade Harry
Wahl Jacobus Johannes
Walker David Anthony
Walker Dennis Hamilton
Walker John Douglas
Walker Lindsay Hamilton
Walls Ronald Stewart
Walsh James Clifford
Warren George St Leger
Watson Ian France
Wayburne Samuel
Webber Bruce Leonard
Weinberg Eugene Godfrey
Weingartz Felix Kruger
Welsh Ian Bransby
Welsh Neville Hepburn
Welsh Robert I Hepburn
Wessels Cornelius Johannes
Westaway Joan Lorraine
Whiffler Kurt
White Ian William Craig
Whitfield Leslie Edwin
Whiting David Ashby
Wienand Adolf Johann
Wiggelinkhuizen Jan
Williams Margaret Ethel
Williams Robert Edward
Wilson Peter James
Wilson William
Wilton Thomas Derrick
Winship William Sinclair
Wise Roy Oliver
Wium Peter Pet
Wolfsdorf Jack
Wood Frank Henry
Wootton John Barry Leif
Wranz Peter Anthony Bernhard
Wright Ian James Spencer
Wright Michael
Wunsh Louis
Wykerd Hermanus Claassens
Wylde Ronald Burns
Youngleson John Henry
Yudaken Israel Reuwen
Zaacks Philip Louis
Zent Clive Steven
Zent Roy
Zieff Solly
Zion Monty Mordecai

Deceased

Honorary Fellows

The Colleges of Medicine of South Africa As at 6 June 2007

Abrahamse Leonard George (CMSA) (1991) Cape Town, SA
Acquaye Joseph Kpakpo (CP) (2004) Accra, Ghana
Adams Aileen Kirkpatrick (CA) (1987) London, UK
Adamson Fryhofer Sandra (CP) (2003) Atlanta, USA
Akande Oluwole (COG) (2002) Ibadan, Nigeria
Alberti Kurt George MM (CP) (1998) London, UK
Anderson Edward William (C PSYCH) (1964) Frant, UK
Arulkumaran Sabaratnam (COG) (2005) London,UK
Asmal Kader (CMSA) (2003) Cape Town, SA
Atkins Hedley John Barnard (CS) (1968) London, UK
Azubuike Jonathan C (C PAED) (2005) Enugu, Nigeria
Ballantyne John Chalmers (C ORL) (1989) London,UK
Baltzan Richard (CP) (2001) Saskatoon, Canada
Barlow Charles Sydney (CS) (1970) Johannesburg, SA
Becklake Margaret R (CP) (1994) Montreal, Canada
Benatar Solomon Robert (CP) (2001) Cape Town, SA
Bird Alan Charles (C OPHTH) (2006) London, UK
Blaisdell F William (CS) (1986) California, USA
Bortz Edward L (COG (1957) Pennsylvania, USA
Bothwell Thomas Hamilton (CP) (1994) Johannesburg, SA
Bouchier Ian Arthur Dennis (CP) (1992) Edinburgh, UK
Boulter Patrick Stewart (CS) (1961) Cumbria, UK
Boix-Ochoa José (CS) (2006) Barcelona, Spain
Bradlow Emanuel Percy (CMSA) (1980) Johannesburg, SA
Brain Walter Russell (C NEUROL) (1957) London, UK
Brebner Innes Wares (CS) (1961) Halfway House, SA
Breen James Langhorn (COG) (1984) New Jersey, USA
Brock John Fleming (CP) (1973) Cape Town, SA
Brown Thomas C K (Kester) (CA) (2002) Victoria, Australia
Browse Norman (CS) (1996) London, UK
Bruce John (CS) (1962) Edinburgh, UK
Burger Henry (CP) (1984) Victoria, Australia
Burgess John H (CP) (1991) Westmount, Canada
Byrne Patrick Sarsfield (CFP) (1975) Manchester, UK
Calder Andrew (COG) (2005) Edinburgh, UK
Calnan Charles Dermod (C DERM) (1970) London, UK
Cameron Donald Patrick (CP) (1998) Queensland, Australia
Caruso Vincent (C PATH) (2005) NSW, Australia
Chalmers Iain Geoffrey (COG) (2001) Oxford, UK
Chisholm Geoffrey Duncan (C UROL) (1990) Edinburgh, UK
Clark Douglas Henderson (CS) (1979) Glasgow, UK
Clayton Stanley George (COG) (1975) Surrey, UK
Clewlow Warren (CMSA) (2006) Sandton, SA
Conti Charles Richard (CP) (1991) Florida, USA
Courtemanche Albert Douglas (CS) (1991) Ottawa, Canada
Couture Jean (CS) (1979) Quebec, Canada
Cowley John Godfrey (CMSA) (1989) Johannesburg, SA
Cox John (C PSYCH) (2000) London, UK
Craib William Hofmeyer (CP) (1974) Somerset East, SA
Crichton Eric Cuthbert (COG) (1963) Cape Town, SA
Cunningham Anthony Andrew (CA) (2004) Dublin, Ireland
Cywes Sidney (CS) (1998) Cape Town, SA
Dacie John Vivian (C PATH) (1973) London, UK
Dall George (CMSA) (1989) Cape Town, SA
Dart Raymond Arthur (CMSA) (1984) Johannesburg, SA
Daubenton François (Snr) (COG) (1986) Cape Town, SA
De Beer Johannes (CMSA) (1978) Pretoria, SA
De Klerk Frederick Willem (CMSA) (1994) Cape Town, SA
De Laey Jean-Jacques (C OPHTH) (2000) Gent, Belgium
Denny-Brown Derek Ernest (CP) (1971) Boston, USA
Deschênes Luc (CS) (1998) Quebec, Canada
De Swiet Michael (COG) (2004) London, UK
Deutman August (C OPHTH) (2000) Nijmegen, Netherl.
De Villiers Henri Paul (CMSA) (1993) Johannesburg, SA
Dewar Frederick Plummer (C ORTH) (1982) Ontario, Canada
Dewhurst Christopher John (COG (1978) London, UK
Dickson Wright Arthur (CS) (1960) London, UK
Diederichs Nico (CMSA) (1977) Pretoria, SA
Dinsdale Henry B (CP) (1996) Ontario, Canada
Donald Ian (COG) (1967) Essex, UK
Dott Norman McOmish (CS) (1975) Edinburgh, UK
Douglas Donald MacLeod (CS) (1972) Dundee, UK
Douglas Neil James (CP) (2005) Edinburgh, UK
Doyle J Stephen (CP) (1994) Dublin, Ireland
Drake Charles George (CS) (1972) Ontario, Canada
Drife James Owen (COG) (2002) Leeds, UK
Dubb Asher (CP) (1998) Johannesburg, SA
Dudley Hugh Arnold Freeman (CS) (1987) London, UK
Duff Francis Arthur Joseph M (CS) (1972) Dublin, Ireland
Dunlop Derrick (CP) (1978) Edinburgh, UK
Du Plessis Daniel Jakob (CS) (1982) Johannesburg, SA
Du Toit Guillaume Tom (C ORTH) (1982) Johannesburg, SA
Elkington Andrew R (C OPHTH) (1997) Hampshire, UK
Elliot Guy Abercrombie (CP) (1968) Cape Town, SA
English Terence Alexander H (CS) (1991) London, UK
Fabb Wesley Earl (CFP) (1975) Victoria, Australia
Farooqui Muhammad S (CP) (2001) Karachi, Pakistan
Fitzpatrick John Michael (C UROL) (2002) Dublin, Ireland
Foëx Pierre (CA) (2007) Oxford, UK
Forman Frank (CP) (1970) Tel Aviv, Israel
Foulds Wallace Stewart (C OPHTH) (1992) Glasgow, UK
Galasko Charles S B (C ORTH) (2003) Cheshire, UK
Gear James Henderson S (CMSA) (1990) Johannesburg, SA
Geldenhuys Frans Gert (COG) (1987) Pretoria, SA
Genest Jacques (CP) (1970) Montreal, Canada
Gillingham Francis J (C NEUROS) (1981) Edinburgh, UK
Gilmore Ian Thomas (CP) (2007) London, UK
Giwa-Osagie Osato O F (COG) (2005) Lagos
Gluckman Henry (CP) (1983) Johannesburg, SA
Gordon Isidor (C FOR PATH) (1984) Durban, SA
Gordon-Smith Derek Peter (CMSA) (1993) Johannesburg, SA
Greenberger Norton J (CP) (1991) Massachusetts USA
Guillebaud John (COG) (2004) Oxford, UK
Hamilton Andrew M P (C OPHTH) (2001) Middlesex,UK
Hamilton Stewart (CS) (2005) Alberta, Canada
Hanlon C Rollins (CS) (1988) Chicago, USA
Hanrahan John Chadwick (CS) (1992) Peppermint Gr. WA
Harrison Donald F N (C ORL) (1988) London, UK
Harwood-Nash Derek C (C RAD) (1991) Toronto, Canada
Hederman William Patrick (CS) (1992) Dublin, Ireland
Hennessy Thomas Patrick J (CS) (1997) Dublin, Ireland
Hoffenberg Raymond (CP) (1956) Queensland, Austr.
Hollins Sheila (C PSYCH) (2005) London, UK
Hudson Alan Roy (C NEUROS) (1992) Ontario, Canada
Hume Robert (CS) (1992) Glasgow, UK
Huskisson Ian Douglas (CMSA) (1997) Cape Town, SA
Hutton Peter (CA) (2003) Birmingham, UK
Idezuki Yaso (CS) (1992) Saitama, Japan
Illingworth Charles Frederic W (CS) (1965) Glasgow, UK
Jaffe Basil (CFP) (2007) Cape Town, SA
Jansen Ernest George (CP) (1959) Pretoria, SA
Janssen Paul Adriaan Jan (CMSA) (1989) Beerse, Belgium
Jeffcoate Thomas Norman A (COG) (1972) Liverpool, UK
Joubert Peter Gowar (CMSA) (1999) Johannesburg, SA
Kathrada Ismail (CMSA) (1998) Durban, SA
Kay Andrew Watt (CS) (1972) Glasgow, UK
Keogh Brian (CP) (1998) Dublin, Ireland
Kerr David Nicol Sharp (CP) (1992) London, UK
Keys Derek Lyle (CMSA) (1993) Johannesburg, SA
Knocker Phyllis Amelia H (CMSA) (1988) Johannesburg, SA
Kok Ordino Victor Steyn (CA) (1975) Pretoria, SA
Krige Christiaan Frederik (COG) (1966) Johannesburg, SA
Kuku Sonny F (CP) (2001) Lagos, Nigeria
Landau Arthur (CP) (1981) Cape Town, SA
Langer Bernard (CS) (2001) Ontario, Canada
Leffall LaSalle D (CS) (1996) Washington, USA
Lemmer Johan (CD) (2006) Sandton, SA
Leon Alan Henry (CMSA) (1978) Cape Town, SA
Levett Michael John (CMSA) (1999) Cape Town, SA
Levin Lawrence Scott (C PLAST) (2006) North Carolina, USA
Loewenthal John (CS) (1972) NSW, Australia
Looi Lai Meng (C PATH) (2005) Kuala Lump. Malaysia
Lorimer Andrew Ross (CP) (2004) Glasgow, UK
Louw Jan Hendrik (CS) (1980) Cape Town SA
Luke Egerton M F (CP) (2001) Merseyside, UK
Luntz Maurice Harold (C OPHTH) (1999) New York, USA
MacKay Colin (CS) (1998) Glasgow, UK
MacKenzie Walter Campbell (CS) (1975) Alberta, Canada
McDonald John W David (CP) (2004) Ontario, Canada
McLean Peter (CS) (1998) Dublin, Ireland
MacLean Lloyd Douglas (CS) (1996) Quebec, Canada
MacSween Roderick N M (C PATH) (1998) London, UK
Mandela Nelson Rohlihlala (CMSA) (1995) Johannesburg, SA
Maran Arnold George D (CS) (1998) Edinburgh, UK
McKenna Terence Joseph (CP) (2005) Dun Laoghaire, Dublin
Meakins Jonathan Larmonth (CS) (2004) Oxford, UK
Mensah George A (CP) (2005) Georgia, USA
Mercer Walter (C ORTH) (1956) Edinburgh, UK
Meursing Anneke Elina Elvira (CA) (2003) Blantyre, Malawi
Middlemiss John Howard (C RAD) (1975) London, UK
Mieny Carel Johannes (CMSA) (1996) Pretoria, SA
Mokgokong Ephraim T (COG) (2006) Medunsa, SA
Molteno Anthony C B (C OPHTH) (2001) Otago, New Zealand
Morrell David Francis (CMSA) (2004) Kenton on Sea, SA
Mortimer Robin Hampton (CP) (2004) NSW, Australia
Murley Reginald Sydney (CS) (1979) London, UK
Mushin William Woolf (CA) (1962) Wales, UK
Myburgh Johannes Albertus (CMSA) (1991) Johanneburg, SA
Myers Eugene Nicholas (C ORL) (1989) Pennsylvania, USA
Nel Cornelius Johann C (CMSA) (1998) Bloemfontein, SA
Newman Philip Harker (C ORTH) (1982) Suffolk, UK
O'Brien Bernard McCarthy (C PLAST) (1992) Victoria, Australia
O'Donnell Barry (CS) (2001) Dublin, Ireland
Oh Teik Ewe (CA) (2003) Perth, West Australia
O'Higgins Niall (CS) (2005) Dublin, Ireland
Oliver Thomas Keyser (Jnr) (C PAED) (1980) North Carolina, USA
Ong Guan-Bee (CS) (1976) Mid-Lev. Hong Kong
Oppenheimer Harry Frederick (CP) (1968) Johanneburg, SA
Organ Claude H (Jnr) (CS) (1986) California, USA
Pasnau Robert O (C PSYCH) (1988) California, USA
Patel Naren (COG) (1997) Dunkeld, Scotland
Peel John (COG) (1968) Salisbury, UK
Petrie James Colquhoun (CP) (1998) Edinburgh, UK

	Pinker George (COG) (1991)	London, UK
#	Platt Harry (CS) (1957)	Manchester, UK
#	Porritt Arthur (CS) (1962)	Wellington, N Zealand
	Prys-Roberts Cedric (CA) (1996)	Bristol, UK
	Ramphele Mamphela Aletta (CMSA) (2005)	Cape Town, SA
	Reeve Thomas Smith (CS) (1991)	NSW, Australia
	Retief Daniel Hugo (CD) (1995)	Alabama, USA
#	Rhoads Jonathan Evans (CS) (1972)	Philadelphia, USA
	Rice Donald Ingram (CFP) (1975)	Ontario, Canada
	Richmond John (CP) (1991)	Edinburgh, UK
	Rickham Peter Paul (CS) (1992)	Altendorf, Switzerl.
#	Robson Kenneth (CP) (1969)	London, UK
#	Rosenheim Max Leonard (CP) (1972)	London, UK
	Rosholt Aanon Michael (CMSA) (1980)	Johanneburg, SA
	Roth Martin (C PSYCH) (1973)	Cambridge, UK
	Rudowski Witold (CS) (1990)	Warsaw, Poland
#	Rupert Antony Edward (CP) (1968)	Stellenbosch, CT
#	Rutledge Felix Noah (COG) (1990)	Texas, USA
#	Saint Charles Frederick Morris (CS) (1967)	Cape Town, SA
	Salter Robert B (C ORTH) (1973)	Ontario, Canada
	Saunders Stuart John (CMSA) (1989)	Cape Town, SA
	Schulz Eleonora Joy (C DERM) (2006)	Pretoria, SA
	Seedat Yackoob Kassim (CMSA) (1962)	Durban, SA
#	Sellors Thomas Holmes (CS) (1972)	London, UK
	Sewell Jill (CP) (2005)	Victoria, Australia
	Shaw Keith Meares (CS) (1979)	Dublin, Ireland
	Shear Mervyn (CD) (1999); (C PATH) (2004)	Cape Town, SA
	Shields Robert (CS) (1991)	Liverpool, UK
	Shires George Thomas (CS) (1979)	Nevada, USA
	Siker Ephraim S (CA) (1983)	Pennsylvania, USA
	Sims Andrew C Peter (C PSYCH) (1997)	Leeds, UK
	Slaney Geoffrey (CS) (1986)	London, UK
	Smith Edward Durham (CS) (1990)	Victoria, Australia
	Smith John Allan Raymond (CS) (2005)	Sheffield, UK
#	Smith Marlow Rodney (CS) (1976)	London, UK
#	Smythe Patrick Montrose (C PAED) (1988)	Durban, SA
	Soothill Peter William (COG) (2004)	Bristol, UK
	Sparks Bruce Louis W (CFP) (2006)	Parktown, SA
	Spitz Lewis (CS) (2005)	London, UK
#	Stallworthy John Arthur (COG) (1964)	Oxford, UK
#	Staz Julius (CD) (1989)	Cape Town, SA
	Steer Phillip James (COG) (2004)	London, UK
#	Straffon Ralph A (CS) (1992)	Ohio, USA
	Strong John Anderson (CP) (1982)	Edinburgh, UK
	Strunin Leo (CA) (2000)	London, UK
#	Swart Charles Robberts (CP) (1963)	Brandfort, SA
	Sweetnam Sir Rodney (CS) (1998)	London, UK
	Sykes Malcolm Keith (CA) (1989)	Oxford, UK
	Tan Ser-Kiat (CS) (1998)	Singapore
	Tan Walter Tiang Lee (CP) (2001)	Singapore
#	Taylor Selwyn Francis (CS) (1978)	London, UK
#	Te Groen Lutherus Johannes (COG) (1963)	Pretoria, SA
	Terblanche John (CMSA) (1995)	Cape Town, SA
	Thomas William Ernest Ghinn (CS) (2006)	Sheffield, UK
	Thomson George Edmund (CP) (1996)	New York, USA
	Tobias Phillip (CMSA) (1998)	Johannesburg, SA
	Todd Ian P (CS) (1987)	London, UK
#	Townsend Sydney Lance (COG) (1972)	Victoria, Australia
	Tracy Graham Douglas (CS) (1979)	NSW, Australia
	Trunkey Donald Dean (CS) (1990)	Oregon, USA
	Tucker Ronald BK (CMSA) (1997)	Cape Town, SA
	Turnberg Leslie Arnold (CP) (1995)	Johannesburg, SA
	Turner-Warwick Margaret (CP) (1991)	London, UK
	Underwood James C E (C PATH) (2006)	Sheffield, UK
#	Van der Horst Johannes G (CP) (1974)	Cape Town, SA
	Van Heerden Jonathan A (CS) (1989)	S Carolina, USA
	Vaughan Ralph S (CA) (2003)	Cardiff, UK
	Viljoen Marais (CMSA) (1981)	Pretoria, SA
	Visser Gerard (COG) (1964)	Utrecht, Netherlands
#	Walt Alexander J (CS) (1989)	Michigan, USA
	Wijesiriwardena Bandula C (CP) (2005)	Kalubowila, Sri Lanka
#	Wilkinson Andrew Wood (CS) (1979)	Edinburgh, UK
#	Wrigley Arthur Joseph (COG) (1957)	Cheshire, UK
	Yeoh Poh-Hong (CS) (1998)	Kuala Lump, Malaysia

Fellows Ad Eundem

The Colleges of Medicine of South Africa As at May 2006

Breytenbach Hermanus (CMFOS) (2001)	Stellenbosch
Cleaton-Jones Peter Eiddon (CD) (2005)	Johannesburg
Gear John Spencer Sutherland (CPHM) (2005)	Still Bay
Gevers Wieland (CP) (2001)	Rosebank, Cape Town
Lemmer Johan (CD) (2003)	Johannesburg
Makgoba Malegapuru W (CP) (2003)	Durban
Ncayiyana Daniel JM (CMSA) (2002)	Durban
Padayachee Gopalan N (CPHM) (2004)	Cape Town
Price Max Rodney (CPHM) (2004)	Cape Town
Saffer Seelig David (C NEURO) (2004)	Johannesburg
Van Reenen Johannes F (C DENT) (2003)	George
Van Selm Justin Leander (C OPHTH) (2005)	Plettenberg Bay
Welsh Neville Hepburn (C OPHTH) (2006)	Lydenburg

Conversion of MFGP(SA) to FCFP(SA)

The Colleges of Medicine of South Africa As at 7 August 2007

ABBAS	Mohamed Rafiq		9979
ADAM	Anvir		2003
ADEGBULU	Adekunle	Kayode	10211
ADEKEYE	Olufemi	Abidemi	9698
ADI	Ikechukwu	Okwunna	12835
AFOLAYAN	Benjamin	Kayode	9456
AGGET	Michael	John	2947
AIMUAN	Francis		12396
AKINGBA	Kayode	Omotayo	13835
AKINSETE	Folajimi	Vincent	9457
ALDERTON	Norman		2994
ANANTH	Swamiji		4888
ANDREWS	Steven	Murray	8988
ARMSTRONG	Robert	John	2948
ARNOLD	Hadjie	Moegamat	3567
AYIBIOWU	Ogunroti		10744
AZIH	Charles	Ikechi	13836
BAISE	Gershan		2221
BAKARE	Mobolaji	Babatope	11229
BALA-MBAMBISA	Rita	Rhona	4286
BAMFORD	Elizabeth	Fiona	8341
BASSANINO	Mauro		7405
BAWA	Ebrahim		8275
BAWASA	Kemal		4975
BAYAT	Mahomed		7406
BEZUIDENHOUT	Lizette		6476
BHANA	Jasvanti		8276
BHARATH	Rusraj	Bickram	5166
BHORAT	As'Ad	Ebrahim	10213
BIERSTEKER	Moira		11231
BODIAT	Zahiera	Adam	12593
BRINK	Garth	Kuys	2500
BUCHEL	Elwin	Herbert	2583
BURGER	Gerrit	Erasmus	5137
BUTTERS	Rodney	Colin	6355
CARIM	Abdool	Samad	2007
CASSIM	Amina		11726
CASSIMJEE	Mohammed	Hoosen	5696
CAUDWELL	Rowena	Mary	7847
CHETTY	Ananthan		8278
CHOULER	Charles	Alexander	8088
CHRISTIANS	Felicia		9192
CHU	Henson		10986
CLOETE	Johannes	Hermanus	4167
COBB	Hugh	Jeffrey	7282
COHEN	Karen		9750
CONNELL	Martin	Anthony	7849
COOVADIA	Mohamed Rafiq	Abdool	2008
CORNELL	Jonathan	Martin	8279
DALZIEL	Grant	James	2794
DANGOR	Faiza		10214
DANIEL	Antia	Offiong	10846
DARLISON	Michael	Tatlow	2584
DE BRUIJN	Benjamin	Matthys	2308
DE VILLIERS	Francois	Pierre	3307
DE VILLIERS	Marthinus	Johannes	3569
DHANSAY	Jalaluddin		3348
DICK	Colin	Mark	6652
DOHERTY	Olanrewaju	Joseph	10577
DULABH	Rohit		8281
DUNGWA	Norman		8282
DUTT	Purnima		10987
EBRAHIM	Essop	Moosa	2795
EBRAHIM	Ismail		2010
ELLIS	Christopher	Guy	3938
ENSLIN	Ronald		2229
ERASMUS	Phillip	Daniel	2309
ERUMEDA	Neetha	Joe	13170
EVANS	Herbert	Campbell	3716
FADAYOMI	Victor	Taye	10988
FAYERS	Colin	Matthew	5697
FERNANDES	Osvaldo	Tomas	8090
FOTHERINGHAM	Elspeth	Margaret	6117
FOSTER	Criispin	Barry	3688
FRANCIS	James	Uzoma	11523
FREDERICKS	Rodney	Enver	74
FURMAN	Saville	Nathan	2699
GAGIANO	Johannes	Francois	4118
GLISSON	Jacqueline	Grace	11729
GOKAL	Jayantilal	Ratilal	5606
GOONDIWALA	Zainab		10216
GOVENDER	Indiran		12594
GOVENDER	Manivanan		10746
GOVENDER	Perisamy	Neelapithambaran	2385
GOVENDER	Visvanathan		7408
GREEFF	Oppel	Bernhardt	3255
GREVLER	Bernard	Zion	2672
GREYLING	Jacobus	Arnoldus	2587
GUNST	Colette		9536
GUTTENBERG	Graham	Roy	4432
GWYTHER	Elizabeth	Margaret	7409
HAASBROEK	Leonard	Johannes	2012
HEITNER	René		2015
HELLENBERG	Derek	Adriaan	6482
HELMAN	Isaac		2233
HEYER	Adele	Salome	9725
HILL	Jan	Houldsworth	8092
HILL	Paul	Villiers	1718
HOFFMANN	David	Allen	2235
HOOSAIN	Rehana		7410
IRINOYE	Idowu	Olusoga	9702
JADWAT	Fazeela		7633
JADWAT	Ismail	Ahmed	7634
JEAREY	Peta	Lynn	7521
JUGNUNDAN	Olusoga		5626
KABONGO	Cila	Dominique	12291
KAKA	Aisha		9462
KAMFER	Alison	Clare	5168
KAPLAN	Neville	Lewis	2018
KAREEM	Jimoh	Adekunle	12836
KATHAWAROO	Sherwin		9463
KAZUM	Oladele	Johnson	12837
KEMP	Donald	Harold	2019
KIGGUNDU	Fredrick		9464
KOTZE	Johannes	Van Zyl	2020
KOTZEE	Theunis	Johannes	10224
LALLOO	Suraya		4168
LANDSBERG	Pieter	Guillaume	2591
LEMMER	Lourens	Badenhorst	2022
LEGODI	Sannie	Marcus	10748
LESLIE	Kayode		13474
LINDH	Eva	Barbara	8293
LISON	Solomon	Mordehai	6280
LLOYD	Mariana	Magdalena	12838
LOEST	Hellmut	Claudius	3571
LOMBARD	Adrian	Patrick	7042
LOOT	Sayyed	Mahmood	5258
LUBBINGE	Aaltina	Willemien	7636
MABUNDA	Harry	Lionel	9465
MAELANE	Kgadi	Petrus	3479
MAFANYA	Matshezandile	Gcinikhanya	6484
MAHOMED	Faiza		8294
MAHOMED	Mahomed	Faruk	5700
MAKHAMBENI	Peter	Robert	2800
MALAN	Gerard		2024
MALINGA	Thembinko	Dunstan	5774
MALUSI	Sityhilelo		10821
MANGA	Sashikant	Mohan	4978
MANGERA	Ismail		2025
MARIVATE	Russell		2593
MARONEY	Roy	Thomas	9195
MARX	Anna	Barbara	8285
MATHEW	Kunnumpurathu	James	10749
MBETE	Jamangile		4549
MBOKAZI	Aquira	Jibha	10503
McDONALD	Michael	Charles	3573
McINTOSH	Belinda	Mary	11842
McINTOSH	Cleve	Derek	11843
McIVER	Colleen	Lesley	7240
MEYER	David		3575
MHLAMBI	Sibusiso	Dumisani	4848
MITHAL	Yuvaraj		9466
MOHAMED	Hidayatullah		8095
MOODLEY	Arumugam	Varadarajooloo	8991
MOODLEY	Keymanthri		8555
MOODLEY	Magaseelan	Munsami	8297
MOOLA	Mahomed	Iqbal	4514
MOOSA	Abdool	Sattar	2239
MOOSA	Aziz	Ahmed	7637
MOTOJESI	Ayo	Aderele	10877
MSAULI	Lawrence	Menzeleleli	4979
MUDELY	Devandran		4980
MUDINGAYI	Kabuya		12292
MUKADAM	Mahomed	Abdul	3480
MUSAH	Christopher	Audu	11525
MUSOKE	Frederick	Nkuke	8556
MYBURGH	Glorette		8096
NAIDOO	Balgopal		7640
NAIDOO	Gonaseela	Varadarajulu	7853
NAIDOO	Lutchman	Perumal	2389
NAIDOO	Mergan		10750
NAIDOO	Neetheananthan		2901
NAIDOO	Premla Roshni		9469
NAIDOO	Salendra	Dhasarathun	5261
NAIDOO	Soornarain	Subramoney	7641
NAIDU	Komala		10992
NAIR	Krishna	Mannadiar	8300
NGCWABE	Mxolisi		3482
NKURUNZIZA	Paul Lingu		8992
NWAKA	Bernard	Chukweumeka	13171
OBIDIKE	Chinaka	Patrick	12029
ODUGBEMI	Oluwole	David	7196
OFFIAH	Francis	Obiora	9470
OGUNBANJO	Gboyega	Adebola	7642
OGUNOJEMITE	Babs	Justin	12840
OLUFEMI	Ademola	Olusegun	9472
ONGOLE	Joven	Jebio	11526
ONWUKWE	Victor	Nnanna	13837
OOSTHUIZEN	Fredrick	Pollard	3465
OSEGBUE	Emmanuel	Ubaka	13172
OWO	Owo	Ikwa	13838
OWOLABI	Olufemi	Tunde	10353
OYEDOKUN	Taofiq	Olusegun	10506
OYEKANMI	Abayomi	Olajide	9984
OYENAIKE	Abisoye	Nosiru	11527
PADAYATCHI	Perumal		2034
PARR	Guy	Wyndham	4515
PATEL	Bhavna		8993
PATEL	Pradipkumar	Chimanbhai	7045
PATEL	Rajesh	Hira	7854
PAULSE	Barry	Richard	9985
PEMBA	Elijah	Ntsikelela	4381
PIENAAR	Daniël		5262
PILLAY	Perumal	Salven	8605
PILLAY	Rajandara	Savabathy	7643
PITCHER	James	Sydney	4433
PLANT	Christine	Margaret	5339
POLAKOW	Everard	Stanley	2997
PRENTICE	Bernard	Ross	2140
PRINSLOO	Simon	Lodewyk	2036
PROUDFOOT	Ian	Graham	4836
PUPUMA	Donald	Duma	10221
QUAN	Tim		1550
RABINOWITZ	Clive		5263
RAJAH	Leila		9475
RAMJEE	Anil		9986
RAMSUBAG	Arvind		9704
RAPITI	Ellappen	Venketsami	5265
RATHAKRISHNAN	Sakuntaladavi		9476
RICHARDS	Neil	Robert	9252
RITCHIE	Roy		4516
ROUX	Louisa	Marina	3704
RUGNATH	Thirjbahadur		9705
SABAN	Mogamad	Sadick	7644
SCHLESINGER	Joanna	Leigh	9493
SELAHLE	Moditsana	Abel	7645
SETZER	Michael		7414
SKAKAL	Ingrid	Elizabeth	7855
SMIT	Michael	Robert	3670
SMITH	James	Leslie	3104
SMITH	Timothy	Michael	3336
SNYMAN	Adam	Johannes	2142
SOLARSH	Stanley	Monash	2807
SOMERA	Satiadev		2246
SONI	Ellesh	Narbharam	7646
STANDER	Dudley		3483
STYGER	Viktor		2038
SWIEGERS	Wotan	Reynier	2998
TAMALE	John	Roland	9068
TRUSCOTT	Andrew	Garside	3259
UMUNNA	Olufunmilola	Yeside	13475
UNTERSLAK	Rodney	Leslie	4434
VAITHILINGAM	Karthikesan	Asaka	7416
VAN DEN BERGH	Cornelius	Jacob	2040
VAN DEVENTER	Claire		8308
VAN GREUNEN	Andries	Edward	3484
VAN SELM	Christopher	Denys	2133
VALLABH	Bhadrish	Kantilal	5793
VARUGHESE	George		9701
VISSER	Errol	Pierre	5961
WAJA	Zinath		8310
WELCH	Kirsten	Magaret	6697
WESSELS	Marlene		12293
WHITTAKER	David	Ernest	2991
WOKE	Felix	Ikechi	12595
WONG	Chi	Mun	9563
ZIEFF	Dayle	Suzanne	12031

FEES AND CHARGES

(Applicable 1 June 2006 to 31 May 2007)

PAYABLE BY MEMBERS OF THE CMSA:

Annual Subscriptions

Local:

Associate Founders, Associates, Fellows, Members and Certificants:	R550
Diplomates:	R325
Overseas (all categories of members):	R550
Retired members:	R62

Assessment Fee: Fellowship by Peer Review: R800
Registration Fee: Associates: R520
Fellows, Members, Certificants and Diplomates: R350
(The registration fee for Fellows, Members, Certificants and Diplomates forms part of the examination fee)

Voluntary Constituent College Levy: R60

Purchase or Hire of Gowns and Hoods

(The charge for the hire of gowns by new Fellows, Members, Certificants and Diplomates is included in their registration fees)

For occasional hire:

Gown and hood:	R110
Gown only:	R80
Hood only:	R40
Purchase of hoods:	R200

PAYABLE BY THE CMSA:

Subsistence Allowance (in addition to accommodation only) per day or part thereof, actually spent on CMSA business

Senators, examiners and staff (local):	R196/day
CMSA delegates (overseas):	$190/day

Honorarium (local subsistence)
Local examiners: R180 per day less PAYE of R45: R135/day

Remuneration for Setting FCS(SA) Part 1 Papers: R280

Remuneration for Assessment of Case Books and Commentaries: R200

Remuneration Invigilating:

(not applicable to salaried personnel of the CMSA)

Full day:	R330
Half day:	R175

Remuneration for Secretarial Assistance:

(not applicable to salaried personnel of the CMSA)
The following sliding scale applies:

Hours worked	Remuneration		
Up to 8 hours	R30 per hour	08 – 10 hours	R300
11 – 15 hours	R425	16 – 20 hours	R570
21 – 25 hours	R650	26 – 30 hours	R740
31 – 35 hours	R830	36 – 40 hours	R950
41 – 45 hours	R1 045	46 – 50 hours	R1 100

There is a ceiling of R1 100 as persons providing secretarial assistance to the CMSA receive a salary from their employers.

Claims in respect of secretarial assistance rendered at the time of the examinations have to be supported by a special recommendation for payment signed by the examination Convener.

RATE OF REMUNERATION FOR LABORATORY TECHNOLOGISTS/TECHNICIANS

The current rate of remuneration is R70 per hour.

Claims for reimbursement of laboratory technologists/technicians who assist during CMSA examinations also have to be supported by a special recommendation for payment signed by the examination Convener.

COST OF PAST EXAMINATION QUESTION PAPERS
Per set of 6 papers (covering a period of 3 years): R50

Reimbursement for Travelling on CMSA business: R2,46/km

ADDITIONAL FUNDING FOR EXAMINER'S MEETINGS

Additional funds have been made available to allow for examination meetings and examination preparation so as to increase the efficacy of the process. These funds have been allocated from budget surplus and does not influence the examination expenses or fee structure. No examination fee increase is proposed.
- Prof Tuviah Zabow; HONORARY TREASURER

CMSA MEMBERSHIP PRIVILEGES

LIFE MEMBERSHIP

Members who have remained in good standing with the CMSA for thirty years since registration and who have reached the age of sixty-five years qualify for life membership, but must apply to the CMSA office in Rondebosch.

They can also become life members by paying a sum equal to twenty annual subscriptions at the rate applicable at the date of such payment, less an amount equal to five annual subscriptions if they have already paid for five years or longer.

RETIREMENT OPTIONS

The names of members who have retired from active practice will, upon receipt of notification by the CMSA office in Rondebosch, be transferred to the list of "retired members".

The CMSA offers two options in this category:

First Option

The payment of a small subscription which will entitle the member to all privileges, including voting rights at Senate or constituent College elections. If they continue to pay this small subscription they will, most importantly, qualify for life membership when this is due.

Second Option

No further financial obligations to the CMSA, no voting rights and unfortunately no life membership in years to come.

Members in either of the "retired membership" categories continue to receive the Transactions of the CMSA and other important Collegiate matter.

WAIVING OF ANNUAL SUBSCRIPTIONS

Payment of annual subscriptions is waived in respect of those who have attained the age of seventy years and members in this category retain their voting rights.

Those who have reached the age of seventy years must advise the CMSA Office in Rondebosch accordingly as subscriptions are not waived automatically.

Symposium on logbooks/portfolios held Durban, May 2007

The concept of logbooks as a record of training evolved at least a decade ago in the United Kingdom. This has been embraced by most postgraduate medical colleges worldwide and by the CMSA approximately 4years ago. There is however universal uncertainty as to how the information obtained from logbooks should be used. Four major questions were addressed at the symposium:

1. Should we have logbooks at all?
2. Should the information have a gatekeeper function for entry into the qualifying exam?
3. How can the logbook be used as a formative assessment tool?
4. How can the logbook be used as an instrument of quality control related to the teaching and training programmes?

Dr Walter Kloeck (College of Emergency Medicine) addressed the first question. He developed the theme that there should be some record of training. This should not be purely a logbook of procedures but represent a professional portfolio comprising all activities that occur during the registrar's training. This includes records of academic contributions, presentations, publications, surgical and technical procedures, as well as exposure to the field of training in general. After discussions this principle was unanimously accepted at the symposium.

Professor G Lindeque (College of Obstetricians and Gynaecologists) addressed the question of the gate keeping function, and made a cogent argument in favour of this. However, the problem will be not to use "thumb suck" criteria. Minima would have to be established in terms of the various procedures and exposure to different modalities. Other issues include whether the candidate was the first operator, assistant, or observer in operative procedures. Currently a complicated formula exists and must be simplified. Clear definitions must be established and agreed to. After much discussion this was probably the most vexatious issue of all and certainly will require more debate within individual colleges.

Professor S R Thomson (College of Surgeons) addressed the formative assessment role of the portfolio. A plea was made for regular assessments at intervals of at least twice yearly or preferably at the end of each rotation which must be standardized for each college. Each college will need to develop their own criteria and format for reporting. What was stressed was the importance of discussion of each report with the trainee who should be counselled on his/her progress. Verification of the contents of the logbook was also a question for debate.

Programme directors (Heads of Departments) should have the final responsibility for "signing off" but reportage and counselling in each rotation should be the responsibility of the supervising consultant. There was considerable debate on this issue and there was support for the formation of some form of "external" adjudication of the final product. It was generally felt that an assessment score should be arrived at for the portfolio which would be factored into the final examination assessment.

Dr Ashwin Hurribunce (College of Radiologists) addressed the use of the portfolio as a quality assurance tool. He made a case for this being an essential part of quality control on adequacy of the training programmes and teaching. In the widest sense this portfolio should be used to assess the adequacy of the particular training programme. The candidate's input would be an essential part of the assessment. A major challenge however is to remove the spectre of "victimization"

He added that trainers are responsible for ensuring adequate exposure of candidates to the specialty.

In conclusion, this was a successful symposium. The degree of support and participation from the colleges was gratifying. The discussion panel, in addition to the speakers included participants from the laboratory and non-clinical disciplines as well as the Registrar body. Guidelines have been drawn up which will be circulated to all colleges for consideration and subsequent implementation.

Prof. John Robbs
UKZN, South Africa

WHERE DO LOGBOOKS FIT IN?

Walter G J Kloeck, FCEM(SA), DipPEC(SA)
Medical Director, Academy of Advanced Life Support
President, College of Emergency Medicine (CMSA)
*(*Adapted from the *AMEE Education Guides of the Association for Medical Education in Europe*[1,2,3]*)*

Definitions
"Logbooks" have been used both internationally and by the Colleges of Medicine of South Africa for many years. The educational value and credibility of Logbooks has however been questioned. What is the difference between a "Logbook" and a "Professional Performance Portfolio"? In order to answer the question *"Where do Logbooks fit in?"*, a few definitions are required.

- A **Logbook** is *"a list of activities or things that were done".*

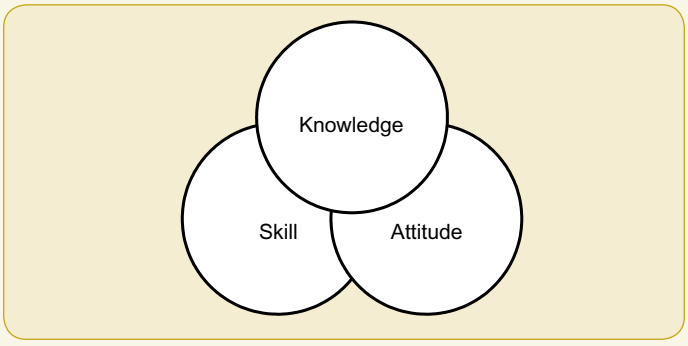
- A **Professional Performance Portfolio** is *"a collection of evidence that learning has taken place across a range of activities".*[4]

Based on the above definitions, *"Does the CMSA need Logbooks?"*. The simple answer would be "NO!". However, if the question is asked *"Do we need Professional Performance Portfolios?"*. The answer is undoubtedly "YES!".

In May 2004 the newly established College of Emergency Medicine, in designing a professional portfolio for their College, coined the phrase "CRITICAL" Performance Portfolio, an acronym for "**C**ertified **R**ecord of **I**n-service **T**raining **I**ncluding **C**ontinuous **A**ssessment and **L**earning".

Professional learning
Professional learning integrates the development and interaction of a candidate's knowledge, skill, and attitude[5] (Fig 1). Learning involves seeking new knowledge, which is evaluated against established practices, resulting in adaptations to one's performance.

Fig 1: Professional Learning



Gibbs[6] compared the concept of **"surface learning",** being "the *learning of a set of facts for regurgitation in a formal examination"* with **"deep learning"** which is *"understanding principles, ideas and concepts,* and *interpreting these with personal meaning".* Many current examination systems tend to evaluate knowledge and surface learning only.

Deep learning incorporates the following:
- Appreciation and recognition of the candidate's motivation and need to know.
- Promoting the concept that candidates become actively involved in their own learning process.
- Encouraging active interaction with peers, supervisors and other relevant professionals.
- Gaining knowledge as integrated wholes rather than in small, separate pieces.

The value and content of a performance portfolio
The educational rationale supporting the use of Professional Portfolios is based on the principles of adult-based, learner-centered education, and promotes deep learning by encouraging the development and tracking of personal progress.

Performance Portfolios:
- Encourage autonomous and reflective learning.
- Are based on the real experiences of the learner.
- Cater for a range of learning styles.
- Enable assessment within a framework of clear criteria and learning objectives.
- Provide evidence of learning from different sources.
- Provide for both formative and summative assessment.
- Provide the framework for life-long learning and continuing professional development.

The content of any portfolio is only as useful as the way in which the material is used. Portfolios do not assess whether a candidate can recall information and apply it in a specific, time-limited context. They do not grade or rank the candidate.

Examples of what can be included in a Professional Performance Portfolio are:
- Critical events involving patient care or contact
- Tutorial attendance
- A reflective journal or diary
- Learning plans
- Clinical experiences
- Exam preparation material
- Video recordings
- Audits and project work
- Critical review of articles
- Practical skills performed
- Feedback from supervisors

Introducing Performance Portfolios
Before implementing a Performance Portfolio, the requirements, ground rules, learning outcomes and objectives, content and criteria for assessment need to be established jointly between the educational institution, the examining body, and the prospective candidate.[1] These should ideally be discussed with the candidate, preferably at a face-to-face meeting, so that concerns, apprehensions, and personal benefits are addressed and expectations are clearly understood.

The following ground rules should be defined in advance:
- Who writes in it?
- Who sees what is written?
- What will happen to the written material?
- How much time should be spent on it?
- What parts will be assessed?
- How often will it be assessed?

Performance Portfolio Assessment (PPA)

It has been asked whether there really is a need for Portfolios to be assessed7? The educational benefits of evaluating Performance Portfolios are:

- To provide feedback to candidates.
- To motivate candidates and keep them focused.
- To enable candidates to identify and remedy deficiencies.
- To consolidate learning.
- To help candidates apply abstract principles to practical contexts.
- To assess the candidate's achievements.
- To assess the candidate's professional progress and development.
- To assess tutor and institutional effectiveness.

The validity of a Portfolio is determined by the extent to which it accurately documents those experiences that are indicators of mastery of the desired learning outcomes. In evaluating a Performance Portfolio, the following questions should be asked[8]: Is the evidence presented **valid** *(shows what it claims to show)* and is the evidence **sufficient** *(detailed enough to indicate that learning has indeed taken place)?*

The Criteria to be assessed must be:

- Explicit and known to both candidate and assessor.
- Linked to specific learning outcomes and objectives.
- Accompanied by written reflective explanations as to why each piece of evidence has been included.

Using a grid (Table 1), educational institutions and examining bodies must determine *at the onset* which components of the Portfolio will be:

1. For *personal* reflection only (kept private) (P)
2. For *discussion* with clinical supervisors (D)
3. For *assessment* by external examiners (A)

Table I: Determination of Components for Evaluation

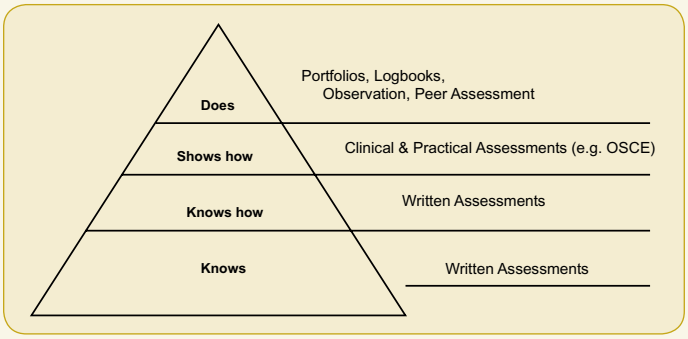
	1. Personal	2. Discussion	3. Assessment
• Critical events involving patient care or contact	P	D	A
• Tutorial attendance	P	D	A
• Reflective journal or diary	P	D	A
• Learning plans	P	D	A
• Clinical experiences	P	D	A
• Exam preparation material	P	D	A
• Video recordings	P	D	A
• Audits and project work	P	D	A
• Critical review of articles	P	D	A
• Practical skills	P	D	A
• Feedback from supervisors	P	D	A

(Circle P or D or A as appropriate)

The Learning Assessment Pyramid

Miller[9] described the concept of a *Learning Assessment Pyramid,* comparing common evaluation techniques with the assessment of learning. Written, Clinical and Practical Assessments determine a candidate's cognitive knowledge, and to a lesser degree, practical skills. What a candidate is *actually able to do* is assessed by Observation, Peer Assessment, Logbook, or Portfolio.

Fig 2: The Learning Assessment Pyramid



Learning Outcomes

Harden[10] described twelve Learning Outcomes required for the training of a competent and reflective medical practitioner. Table 2 provides a comparison of the role that various evaluation methods have with respect to assessing these twelve outcomes[2]. It can readily be seen that a Professional Performance Portfolio plays a significant role in the assessment of each of these Learning Outcomes.

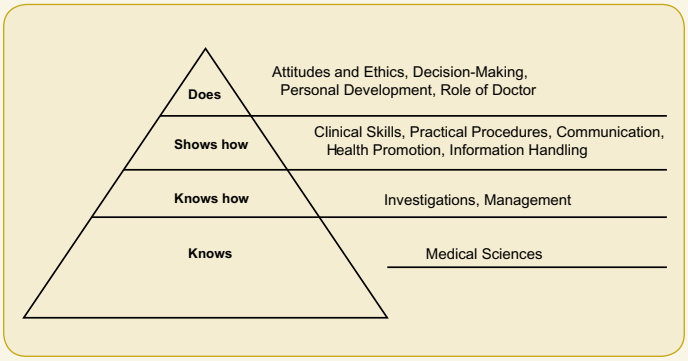
Table II: Comparison of Evaluation Methods in assessing the 12 Learning Outcomes

	LEARNING OUTCOMES	EMI	CRQ	OSCE	PPP
1.	Clinical skills	+++	+++	+++	++
2.	Practical procedures	++	++	+++	++
3.	Investigating a patient	++	++	+++	++
4.	Patient management	+++	+++	+++	++
5.	Health promotion and disease prevention	++	++	+++	++
6.	Communication skills	+	+	+++	+++
7.	Information handling	++	++	+	+++
8.	Understanding of basic, clinical and social sciences	+++	+++	+	+++
9.	Appropriate attitudes, ethical and legal responsibility	++	++	++	+++
10.	Decision making, clinical reasoning	+++	+++	+++	+++
11.	Role of the doctor	+	+	++	+++
12.	Personal development	+	+	++	+++

EMI = Extended Matching Items
OSCE = Objectively Structured Clinical Examination
CRQ = Constructed Response Questions
PPP = Professional Performance Portfolio

Correlating the 12 Learning Outcomes with the Learning Assessment Pyramid, several learning outcomes can best be assessed using a well designed Professional Portfolio[3].

Fig 3: The Learning Assessment Pyramid correlating with Learning Out-



comes

Conclusion

The era of evaluating mainly knowledge acquisition and factual recall has now passed. Professional performance qualities such as clinical judgment, problem solving, communication skills, attitudes, and professionalism are equally important, and deserves to be considered.

> "A Portfolio is a story of the development of the learner and his or her accomplishments"

- a story that deserves to be heard!

References

1. Snadden D *et al*. Portfolio-based learning and assessment. AMEE Education Guide No 11 (1999). Association for Medical Education in Europe.
2. Friedman M *et al*. Portfolios as a method of student assessment. AMEE Education Guide No 24 (2001). Association for Medical Education in Europe.
3. Shumway J *et al*. The assessment of learning outcomes. AMEE Education Guide No 25 (2003). Association for Medical Education in Europe.
4. Davis MH *et al*. Portfolio assessment in medical student's final examinations. Medical Teacher (2001) 23: 357-366.
5. Schon DA. Educating the reflective practitioner (1987). San Francisco, CA: Jossey-Bass.
6. Gibbs G. Improving the quality of student learning (1992). Bristol: Technical and Education Services Ltd.
7. Brown S *et al*. Assessing learners in higher education (1994). London: Kogan Page.
8. Simosko S. APL: a practical guide for professionals (1991). London: Kogan Page.
9. Miller GE. The assessment of clinical skills/competence/performance. Academic Medicine (1990) 65: S63-87.
10. Harden RM *et al*. Outcome-based education from competency to meta competency: a model for the specification of learning out-

1.	Fellows ties in navy blue with rows of CMSA shields, separated by gold stripes with jubilee emblem	R 110
2.	Informal ties (animals) with jubilee emblem	R 110
3.	Informal (long) ladies scarves (same design) in soft material	R 125
4.	Leather purse with material inlay (same design)	R 300
5.	Lapel pins (oval) in baked enamel with jubilee emblem on royal blue background	R 45
6.	Cuff-links (square) in baked enamel as above	R 60
7.	Key rings (oval) with jubilee emblem on royal blue background	R 48

Note:
There will be a "first day" envelope offered for sale to stamp collectors.
For further enquiries contact your closest branch:

Cape Town: Tel: (021) 689-9533, **Johannesburg:** Tel: (011) 726-7037, **Durban:** Tel: (031) 260-4438

Quality Assurance I: Striving for consistency within the Colleges of Medicine of South Africa (CMSA)

Ashwin C Hurribunce, MBChB, FC Rad(SA), MBA(UCT)
IQ Healthcare a Division of IQ South Africa
The IQ Business Group (Pty) Ltd

Correspondence to: Dr AC Hurribunce, e-mail: ahurribunce@iqgroup.net

Introduction

The concept of quality assurance, control and overall management has emerged as a primary instrument for evaluating performance and accountability in higher education systems around the world today. This conceptual position paper attempts to provide a framework about quality in the conduct of the core business of the CMSA. This is with the aim to develop a better and shared understanding of, and appropriate responses to the attainment of high quality. Whilst the paper presented by Professors V. Burch and R. Hift[1] provides extensive indication on how to attain quality in the assessment of candidates that engage the CMSA examinations process, it is devoid of the foundation and wider context that is required to sustain it.

Late in the 20th century, Kistan[2] observed that Government policies for quality assurance systems in different forms and with different names are functioning in several institutions in our country. At the policy level, quality assurance is about power and control of standards measured in terms of accountability. At the institutional level they are about candidate experience and achievement. With the growth of higher education, these micro-level (institutional) processes have become more visible, more important and more costly. In a variety of ways, the traditionally private lives of higher education institutions are being opened up to wider public scrutiny. And as a consequence, the Government is getting increasingly explicit through policy about what they want from higher education.

Definition of quality

Traditionally, the concept of quality has been associated with the notion of distinctiveness, of something special or high class. According to Harvey and Green[3] there are five broad approaches to quality. They see quality as exceptional, perfection, fitness for purpose, value for money and being transformative.

While quality is a widely used concept in industry where clearly definable products exist, the concept of quality is more difficult to define in higher education. There should rather be a notion of quality instead of a definition of quality.

The notion of quality embodies:

1. Being of exceptionally high standard;
2. The fitness for purpose concept requires an institution to formulate its missions and goals and is then evaluated against itself;
3. The quest for zero defect - here comparison is made to preset standards;
4. Value for money quality could be measured in terms of performance indicators like failure rates and examiner to candidate ratios.
5. Being transformative, where candidates are not being regarded as a finished product, but as a persons being transformed.
6. The ISO 9000 concept of quality i.e. quality evaluated against stakeholder satisfaction. This concept has been used by erstwhile technikons, partly because it does provide a good benchmark for industry, which employs especially their professionally trained graduates. The general trend in the debate goes that ISO 9000 is more applicable to institutions offering service-oriented training instead of subject-oriented teaching; however the principles that underpin this ISO construct can be appropriately adapted to suite the CMSA's needs.

A conceptualisation of quality with enough flexibility to embrace both generic aspects of educational provision and context specific ones is advocated in the Education White Paper 3: A Programme for the Transformation of Higher Education. Reference to quality here is made as: "maintaining and applying academic and educational standards, both in the sense of specific expectations and requirements that should be complied with and in the sense of excellence that should be aimed at. These expectations and ideals can differ from context to context, partly depending on the specific purposes pursued. Applying the principle of quality entails evaluating services and products against set standards, with a view to improvement, renewal or progress."

Total quality management (TQM) in higher education institutions[4]

Educational institutions have turned to TQM for many of the same reasons that businesses have instituted quality programmes. The move towards TQM in higher education can be attributed mainly to the escalating number of students, the lack of consistent leadership style, the increasing accountability to the public and changing attitudes towards higher education institutions.
Different writers have adopted various definitions of TQM. However in summary, there are three generic approaches to TQM. The first approach has a client focus, where the idea of service to candidates is fostered through staff training and development. The second has a staff focus, and is concerned to value and enhance the contribution of all members of staff to the effectiveness of the institution. The third approach takes a service agreement stance, and seeks to ensure conformity to specification at certain key measurable points of the educational process.

Further, TQM implies meeting the expectations of all the stakeholders in the educational system. The external stakeholders, such as the taxpayers, parents/guardians and potential employers, should be satisfied with the standards of the graduates, whereas the internal stakeholders, such as educators and candidates, should be satisfied with the teaching and learning process in the learning institutions e.g. schools. It targets the total process and output of the education system. It also requires quality assurance to ensure conformity to specification of standards set out by the institution in partnership with key external stakeholders. Lastly it is a management tool that emphasizes the means for measurement of performance and feedback.

In adopting TQM, educational administrators are trying constantly to pursue three cardinal objectives:

1. *Philosophy and mission* - this category includes principles that stress focusing on stakeholder needs in a never-ending search for quality.
2. *Organizational environment* - these principles establish norms and values that dictate the treatment of each individual in the organization.
3. *Process* - this category stresses the need for problem preven-

tion and early detection and tolerance for errors throughout the process rather than the identification of failures at the end of the process.

Proposed approach of TQM by the CMSA

The following description is a synthesis of key drivers of quality attainment in higher education institutions. In making this proposal cognisance is taken of the need for the CMSA to possibly formally register as a Higher Education institution with the Commission for Higher Education and the Department of Education as part of its quest to expand its role in South African society.
The proposed construct addresses three aspects: sustaining academic standards, the need for a system of guarantees, and a TQM excellence model.

Sustaining Academic Standards

The adapted framework described below was developed by the Higher Education Quality Control of the UK for use at institutional level in the initial stages of formulating a policy and an implementation strategy on academic standards.[5] It offers a useful approach with an acceptable conceptual underpinning that can be implemented, tested and developed for the CMSA. The framework is based on the following guiding principles, and is premised on the following definition of academic standards: explicit levels of academic attainment that are used to describe and measure academic requirements and achievements of individual candidates and group of candidates.

1. Academic standards may be best protected and enhanced through giving particular attention to:
   - candidate attainment and progression;
   - the quality of learning experiences programmed for candidates and the nature and levels of support provided for them;
   - the selection and admission of candidates;
   - the recruitment, selection, deployment and development of staff (core and support); and
   - institutional management and development.
2. The quality of provision significantly affects candidate attainment. It follows that in order to monitor or improve academic standards, service standards need to be maintained or improved.
3. Service standards may be established through a process of:
   - achieving general agreement on the expectations which users may reasonably have of the services provided to them;
   - converting the expectations, wherever possible, into standards of performance that may be measured and benchmarked.
4. Particular attention should be given to establishing threshold standards.

The tendency up to the present has been to mechanistically apply TQM and to focus on inputs and process, and to evaluate the institutional mechanisms developed for assuring quality, which serve as a proxy for academic standards. This is not surprising and should be avoided, given the conceptual and operational difficulties of measuring and benchmarking student attainment, both within and across institutions. This can only be managed within a universal framework of academic standards.

The aspects of academic standards that should be routinely addressed and could be described at a universal level are described in Table I:

Note that at the level of the CMSA as an institution, the Senate could represent the strategic level, the Senate Committees and the Administration the operational level, and the constituent

Table I: Higher education quality control and academic standards

LEVEL	FOCUS	MECHANISM
Strategic	Policy	Formulation Content Implementation
	Monitoring effectiveness	Sector feedback
	Comparability	Validating bodies Like institutions
Operational	Curriculum development, monitoring and review	Promulgating bodies
	Implementation of assessment arrangements	Performance assessment system
	Use of external referents	External examiners Professional bodies Others
	Staff qualification and experience	Selection Development
Tactical	Setting of standards	Teaching levels Stages of candidate learning Candidate achievements Research and scholarly activity Staff development
	Communication of standards	Staff Candidates
	Departure from standards	Measurement of success/failure Overcoming weakness and recognising success
	Comparability	Awareness of standards elsewhere Influence own standards

Colleges the tactical level of focus all harmonised to achieve the CMSA's objectives.

The need for a system of guarantees

Providing a guarantee requires specifying to whom the guarantee should be provided. This has been debated at length with much of the debate focusing on the appropriate way to view candidates. This debate often presents obstacles to applying TQM in education. It is clear from all the discussions that higher education serves multiple stakeholders that include candidates, parents, employers, graduates, alumni, taxpayers, legislators and society as a whole. It is also clear that candidates can be thought of in a number of different ways, including as the product-in-process, as co-producers in the learning process, as consumers of the service, and as stakeholders in at least some circumstances.
The benefit of a system of guarantees[6] is that it can be designed to accommodate multiple stakeholders and the various changing roles of candidates in the educational and qualification processes. The system of guarantees is focused primarily on three cardinal stakeholder groups: the candidates, the instructor/examiner of the learning programs that build on prerequisite standards, and the health sector that employs the graduates. Providing guarantees to these different stakeholders provides a balanced view of who the CMSA serves and accommodates multiple stakeholders. There is a time continuum that underpins this system of guarantees that serves to roughly depict which guarantee is directed to which cardinal stakeholder over time i.e. immediately upon completion (short term); within a few years upon completion (medium term); and well into the graduate's career (long term).

Stretching the benefits on a time continuum helps to accommodate the multiple and changing roles of the stakeholder groups - each guarantee proposed would translate into a specific results guarantee. A specific results guarantee warrants only specific performance aspects e.g. attaining requisite performance standards during examinations. Unconditional guarantees allow a stakeholder to invoke the guarantee if dissatisfied for any reason e.g. the examiner's performance in creating a reasonably conducive environment for the evaluation of candidates. Offering a series of specific results guarantees, as opposed to a single, unconditional guarantee, is critical to achieve balance and objectivity. Included in the system of guarantees is the provision of feedback. An example of the different examples of guarantees is provided in Table II.

Table II: Summary of what guarantees would cover

TIME	STAKEHOLDER		
	Candidate	College	Health Sector
Short term	Instructor/ examiner performance: delivery but not content or grade	Candidate performance: effort and participation	An reasonably accurate index of potential capacity
Medium term	Preparation for future events for which the event is a prerequisite	Preparation of candidates that completed prerequisite	Refinement of index potential into index competence
	Preparation for entry level employment	Contribution to building good standing	Preparation of graduates with skills necessary for entry level employment
Long term	Learning skills necessary for continuous learning, discounts on content updates (graduates)	Potential for global good standing and contribution to humanity	Learning skills necessary for continuous learning, discounts on content updates (alumni)

A higher education TQM excellence model (HETQMEX)

TQM has fast become the cornerstone of any strategy that aims to manage change effectively and to gain competitive advantage in many higher education institutions. In order to optimally leverage the advantages and benefits of TQM in higher education, a working model is required that links the myriad focus areas that impact on quality. Ho and Wearn[7] proposed such a model for higher education institutions. Their work has been based on the Osada's TQM model that uses the 5S's (roughly translated from Japanese): structurise - organise; systemise - neatness; sanitise - cleaning; standardise - standardisation; and self-discipline - discipline. The model depicted in table III has been suitable adapted from the original model for the CMSA environment.

Table III: An HETQMEX for the CMSA

FOCUS	PROCESS FLOW	COMMENT
Objective	Examination Quality Standards	These are the cornerstones against which the CMSA measures itself and is measured by any external validating body.
	↓	
Operations Management	5-S	The 5s's as described in the preceding text are the basic activities that everybody should be doing in order to have a total quality working environment.
	↓	
	Marketing and Examinations Quality Control	The 'marketing' consists of the right product at the right place, right promotion and right price. The examinations quality depends on information and decisions given correctly and promptly; is the prospectus or curriculum/syllabus user-friendly and consistent with the service delivered?
	↓	
Quality Management	Quality Control Circles	This is a small group of people that perform quality control. They also assist with developing quality-promoting initiatives that aim to improve the general environment.
	↓	
	ISO and National Standards	The SABS can help provide useful guidelines for the CMSA if it strives to approximate or fully achieve ISO standard certification. Contribution to the generation of national standards will ensure seamless application in the CMSA.
	↓	
	Total Preventative Maintenance	This is a formal system of maintenance that covers the entire life of the qualifications offered by the CMSA. This includes managing the relevant infrastructure and capabilities of the CMSA and partner institutions.
	↓	
	Total Quality Management	The following principles will ensure the successful implementation of TQM – leadership, continuous improvement, total involvement, ownership and teamwork.
	↓	

Conclusion

Just as the SAUVCA adopted an approach to attaining high quality in 1995, so should the CMSA follow suit in order to establish a quality management system. This system will assist it in establishing internal quality assurance systems by means of self-evaluation; undertake external quality audits for improvements (and at a later stage for accountability purposes); and prepare itself and its constituent Colleges for accreditation.

Whilst a broad international approach was used in this paper, it will be prudent to closely study the South African Excellence Model and extract any additional aspects that might assist with improving the context of quality management further.

The main objectives of quality assurance must not only be explicit but it must be widely accepted by all the CMSA's key role players and stakeholders. The Education White Paper and the Higher Education Act propose that quality assurance systems have at least two simultaneous components, namely public accountability and institutional improvement. At this stage in the transformation of the CMSA, it is largely the latter that deserves direct and immediate attention. It is envisaged that with each successful step taken in the attainment of high quality, public accountability would be served.

References

1. Burch, V and Hift, R. "Post-graduate assessment within the Colleges of Medicine of South Africa." *CMSA Symposium, Cape Town.* 2003.
2. Kistan, C. "Quality Assurance in South Africa." Quality Assurance in Education. Volume 7. Number 3. 1999. 125 133.
3. Harvey L, and Green, D. "Defining Quality." *Assessment and Evaluation in Higher Education.* Volume 18. Number 1. 1993. 11 27.
4. Kwan, PYK. "Application of TQM in Education." *International Journal of Educational Management.* Volume 10. Number 5. 1996. 25 35.
5. Williams, G. "Academic Standards in Higher Education." *Quality Assurance in Education.* Volume 3. Number 4. 1995. 35 43.
6. Lawrence, J.J. and McCollough, M.A. "Guaranteeing Higher Education." *Quality Assurance in Education.* Volume 9. Number 3. 2001. 139 152.
7. Ho, S.K. and Wearn, K. "A Higher Education TQM Excellence Model: HETQMEX." *Quality Assurance in Education.* Volume 4. Number 2. 1996. 35 42.
8. Osada, T. "The 5-S: Five Keys to a Total Quality Environment." *APO.* Japan. 1991.

Insignia for sale to CMSA Members

Please select the items you wish to purchase by ticking the applicable box and state the quantity.

			QTY
1.	**Ties** in navy blue, maroon or bottle green in the following designs:		
1.1	The CMSA Crest in colour as a single under-knot design	R 70	
1.2	Rows of CMSA shields separated by silver-grey stripes	R 70	
2.	**Silk ties** in navy blue only …………… ……….…………………	R 180	
3.	**SA Wildlife CMSA ties** …………………………………………	R 80	
4.	**Scarves** (60 x 60 cm) in two designs, with the full CMSA Crest as a centerpiece and shields on the corners, as follows:		
4.1	Design A : Background beige, with main colours navy blue, green and gold …………………………………….	R 90	
4.2	Design B : Background cream, with main colours navy blue, maroon and gold …………………………………..	R 90	
5.	**SA Wildlife CMSA scarves** ……………………………………..	R 160	
6.	**Cravats** in bottle green ……………………………………………	R 25	
7.	**Blazer badges** on black or navy blue background with the CMSA Crest hand-embroidered in full colour ………………………………	R 300	
8.	**Cuff-links** in sterling silver with the CMSA crest …….……………	R 350	
9.	**Cuff-links** in baked enamel with the CMSA Crest in colour, on a cream, gold or navy background …………………………………….	R 40	
10.	**Lapel badges/brooches** in baked enamel ………………………	R 15	
11.	**Key rings** in black/brown leather with the CMSA Crest in colour, in baked enamel on a cream, gold or navy background ………….	R 40	
12.	**Paper-weights**:		
12.1	Nickel-plated, with gold-plated CMSA Crest ……………	R 320	
12.2	Gold-plated, with gold-plated CMSA Crest ………………	R 350	
13.	**Paper-knives**, silver plated, with gold-plated CMSA Crest ………	R 350	
14.	**Wall plaque**, rectangular or oval, with hand-cut CMSA Crest in colour, mounted on imbuia or oak ……………………………………	R 200	

HOW TO ORDER

Complete your details, then FAX it to us on (021) 685-3766 or POST it to the address below.

I wish to obtain the above indicated CMSA Insignia

Title: Initials: Surname:

Delivery address:

Tel: Date: / /

PAYMENT DETAILS: (NB: R10 per item to be included with order to cover postage)

Enclosed please find my cheque/postal order for R **.00** (including p&p) **OR**

Debit my Visa/Mastercard: V M

Name of Cardholder:

Card Number:

Expiry Date: / CPD Number:

Amount: R **.00** (including p&p)

Signature: ______________________

Post/ Fax to:
Ms Carol Price
The Colleges of Medicine of SA
17 Milner Road
RONDEBOSCH
7700
Tel : (021) 689-9533
Fax : (021) 685-3766
(Or contact your closest branch)

To avoid disappointment, please make sure payment is enclosed.

MPG2220040901DM

Report on the International ATOM (Assessment Tool for Occupational Medicine) Workshop held in Barcelona, November 9-10 2006

Mohamed F Jeebhay
Associate Professor, Occupational Medicine Division of the Colleges of Public Health Medicine,
The Colleges of Medicine of South Africa

The full report is available on the College website

Background

Assoc. Prof Mohamed Jeebhay was invited by the organising committee of this international workshop aimed at the development of a common assessment tool of skills and competencies for specialists in Occupational Medicine (ATOM).

Occupational Medicine is the medical speciality dealing with the assessment of workers' health, linking working conditions and processes to workers' health, assisting in managing the health, skills and working capacity of the entire working population, and managing individual cases in the context of work ability.

The length and content of the training curriculum for the training of Occupational Medicine Physicians differs in each country. The lack of any common standard for the assessment of competence of doctors completing training programmes in each country, inhibits the mutual recognition of Specialist Qualifications, and the acceptance of other countries specialist qualifications. There is a growing shortage of specialists in Occupational Medicine which has been highlighted at the ICOH conference on 'OH education & Training for everyone everywhere' (Strasbourg, Sep 05). The need to train more doctors and ensure transferability of skills in this field is a major challenge.

The **objective of this ATOM** project is to develop common assessment methodologies, which countries could choose to use, as part of the assessment of doctors completing the training programme in order to become recognised specialists in Occupational Medicine. The development of a common element will facilitate the development of quality assurance of assessment of specialists in occupational medicine and will improve the consistency of occupational medical advice available to workers, employers and trade unions. This project is being conducted in collaboration with EASOM (European Association of Schools of Occupational Medicine) and the Occupational Medicine section of the UEMS (Union of European Medical Specialists). Currently there are 14 countries across Europe participating
in the project, and it has been broadened to include other countries including South Africa. The project director is Dr. Ewan Macdonald, University of Glasgow, Scotland, (also past president of the OM section of the UEMS and member of EASOM) and the Assistant Director is Dr Consol Serra, University of Pompeu Fabra, Spain (also President of the OM Section of the UEMS).

Aims of the workshop

One of the major objectives of the ATOM project was to identify the different types of assessment methodologies already in place in individual countries, and this was conducted through a survey of standard setting/examining bodies (in which the Colleges of Public Health Medicine of South Africa also participated). The results of this survey were presented at this workshop, which concluded the first phase of this project. At this workshop, participants were invited to discuss these results and identify the most appropriate assessment methodologies that could be used as part of the assessment of trainee specialists in Occupational Medicine.

Another objective of this workshop was to establish a network of experts involved in the training and assessment of specialists in Occupational Medicine who could advise on the development of a common assessment tool. This network will ensure that the tool produced will be appropriate for use in all participating countries. Workshop participants were given the opportunity to nominate individuals from their country who can contribute to this network. The ultimate objective of the ATOM project is to create the foundation of a self-sustaining cooperation between the professional organisations responsible for the standard setting of assessment in their countries. This self-sustaining network, which will also include members of the ATOM project, will be ultimately responsible for the management of the tool beyond its creation.

Collaborating Organisations

- Austrian Society for Occupational Medicine
- Catholic University of Leuven, Belgium
- Czech Society of Occupational Medicine
- Finnish Institute of Occupational Health
- Louis Pasteur University, France
- Medical Association, Portugal
- Mediforce, Netherlands
- Monash University, Australia
- National Institute for Occupational Health, South Africa
- Norwegian Association of Occupational Medicine
- Royal College of Physicians of Ireland
- Society of Occupational Medicine, Ireland
- Statens arbeidsmiljøinstitutt, Norway
- The Netherlands School of Public and Occupational Health
- The Nofer Institute of Occupational Medicine, Poland
- University of Bari, Italy
- University of Koln, Germany
- University of Naples, Italy

Summary of workshop proceedings

1. Introduction to the ATOM project: Dr Ewan Macdonald, University of Glasgow, UK

The idea of this project was developed by the UEMS (Union of European Medical Specialists) section of Occupational Medicine and it has since been supported by the European Association of Schools of Occupational Medicine and ICOH. Within the European Directive on the introduction of measures to encourage improvements in the safety and health of workers at work (89/391/EEC) refers to the need for 'competent persons' to be involved in health and safety. Furthermore, theoretically the European Directives 93/16/EEC and 2005/36/EC facilitates the free movement of doctors and mutual recognition of diplomas and certificates and formal qualifications. So, across Europe there is this potential for free migration which then raises the question whether the training is developing the appropriate competencies.

He indicated that one cannot talk about Occupational Medicine without mentioning Ramazzini who defined the importance of the occupational history and the competence of determining the

occupational history and the importance of risk assessment of workplaces. Ramazinni said 'the physician should visit the lowliest of workshops and study the mysteries of the mechanic arts' and that probably is the competence that most defines occupational medicine professionals differently from other health professionals. Donald Hunter (1955) was a London based clinician who wrote the Hunter's Diseases of Occupations where he talked about the competencies of occupational physicians:

- "(s)he must be prepared to make himself technically minded to a degree that used to be thought quite foreign to the sphere of practical medicine"
- "be in a position to make the industrialist understand the risks to which his men are exposed" i.e. communication skills; speaking to interested companies dealing with trade unions – there is therefore a very unusual range of competencies that are required.

The World Health Organisation (WHO) definition in 1950 talked of the physical, mental and social wellbeing and prevention of disease and protection of the worker. The global strategy of Occupational Health for All in 1996 talked about the overall promotion of health and workability of all employees – indicating the need to focus on health promotion and improving work ability. The latest paradigm shift comes probably from Scotland, which focuses on working lives - it focuses on maximizing the functional capacity of the working age population. The emphasis in Occupational Health is now on the working age population - not just individuals employed in workplaces but people of working age. And working age individuals can range from 16-85 years, which includes individuals doing voluntary work, home caring, home building and so on. Occupational Health is therefore a spectrum of activities, requiring targeting of different competences as the scope evolves in different countries too.

The historical journey for the ATOM project began in 1995 as a proposal, which was endorsed by EASOM (European Association of Schools of Occupation Medicine), to do a Delphi study in competences of Occupational physicians and identify what were the competences across Europe. Members of EASOM, UEMS (which was just being formed) and ENSOP (European Network of Societies of Occupational Physicians) which has since merged with UMES, were targeted. A modified Delphi study was conducted using two rounds of surveys. The UK Faculty of Occupational Medicine training syllabus was used as a reference for the list of competencies – mainly because it had been recently derived from well established Australian competences, the USA competences and the existing British ones. The results of this study were presented and discussed at a conference on 'The Requirements of Occupational Medicine training in Europe' which was organized in Glasgow in 1997. This conference attracted significant interest from around the world. Various agencies including UK Society of Occupational Medicine, the UK Faculty of Occupation Medicine, ICOH, EASOM, the UEMS and WHO were involved. The objectives there were to identify the training needs and differences in the training methods (because they are different and they *always will be different*). At that meeting the different assessment methodologies, the different ways in which people are assessed and the length of training in different countries were also discussed. In some countries the length of training was 6 months and in others it was 4 years. In some countries these were purely academic taught courses, whilst others were workplace based – this is not too different today.

The aim of the ATOM project was to define and assess the competences required of physicians across Europe. A number of publications resulted from these discussions one of which was the WHO document entitled "Occupational Medicine in Europe - Scope and competences, 2000' which is being used in Europe.[1,2,3] This document was stimulated by the WHO and Professor Bogdan Baranski who took the initiative, to produce a consensus statement, which is based on similar other workshops and networks of individuals (not just Occupational Health physicians), to produce this text. It proved to be quite useful as it was endorsed by UEMS and EASOM and it has been used as a guideline for helping develop curricula across Europe and many of the accession countries to harmonise their training - so there has been some progress in terms of harmonisation.

Another research based survey conducted by Andy Slovak from the UK and Clodagh Cashman from Ireland, both members of the Occupational Medicine section of the UEMS[1] looked at this WHO document to evaluate whether it reflected what Occupational physicians *actually* do? Generally there was quite good consensus across Europe as to the *most important* activities which included "Assessment of fitness for work" as well as "Advice and prevention of occupational disease" and the *least important* activity being "Primary care and treatment" which exists in some areas of Occupational Medicine practice in some parts of the world but with relatively less importance. There was greater ambivalence as to their role in other areas of practice such as first aid and exposure assessment and sickness absence surveillance.

Another study that was done by Macdonald's colleagues more recently in the UK that looked at what the occupational medicine doctor's *customers* think. It is usually a professional group that determines its own competences - but what does the factory owner or factory worker think of these competences? Employees, employers and trade union representatives were surveyed to establish their priorities then these opinions were compared with those of Occupational physicians. Interestingly, there is amazing consensus that if you look at the broad headings of the curriculum areas such as "Law", "Hazards to health" and "Fitness" - were common to *all* groups, whether it was employers, workers or trade union representatives, regarding these as particularly important. But the fact that "Law and ethics" was regarded as of *greatest importance* to customers, was not anticipated and a very interesting, unexpected result. They also compared for example what were the priorities of customers and Occupational physicians from the previous study and found that customers have slightly different priorities to Occupational physicians, with academics not particularly interested in "Fitness assessment". This work led to the background of the work planned for the ATOM project which is to try to encourage transferability of skills and mutual recognition of competencies of Occupational Physicians. Initially the project was designed as a European project, but given the nature of their work, *Occupational physicians tend to work globally, the project was extended worldwide with the objective to expand this idea on an international scale.*

2. Report back on the survey of training and assessment bodies: Dr Nundita Reetoo, University of Glasgow, UK

Dr Reetoo provided feedback on the first phase of this study, a worldwide electronic survey of training and assessment organisations, which was conducted to identify the current training format in each country and the assessment methodologies currently being used. Participants were approached through contact lists submitted to the project by contributing country representatives and the study was also advertised through an international forum. The questionnaire aimed at exploring the similarities and differences between countries on the training prerequisites, methods of training, length of training, competencies required and assessment methodologies used. In total 45 responses were obtained for the survey and these were from 26 countries (European countries, Japan, India, South Africa, Australia, New Zealand, USA and Canada). Almost 90% of the respondents originated from organisations involved in the training or assessment of specialists in occupational medicine in their country. The majority of these (82%)

were public organisations. A large proportion of the respondents represented standalone training bodies (40%) or training and assessment bodies (40%).

When questioned about prerequisites for entry to the training programme 100% of the respondents indicated that undergraduate training was a pre-requisite but only 30% indicated that postgraduate qualifications were pre-requisites. Almost half (47%) of the respondents indicated that postgraduate experience however was a prerequisite for the training programme. Postgraduate experience was in the field of internal or general clinical medicine for the majority of organisations, although some organisations indicated that experience in general practice or experience in working in industry was preferred. The length of the training programme was on average 4 years (range 4-6 years) in the countries participating in the survey. Overall, 58% of countries indicated that the competencies required of trainee specialists in occupational medicine were based on the published WHO list of competencies for occupational medicine. While all countries required an academic and occupational health clinical posting, only 61% of the respondents indicated that their trainees were expected to complete a general clinical posting as part of their training. All respondents indicated that a posting for at least 3 months in an Occupational Health Clinical set-up was included as part of the training.

Respondents were given a list of assessment methodologies commonly used in the assessment of trainee specialists in occupational medicine and asked to identify the methods used in their country and to weigh the importance attached to each assessment method in the final assessment of the trainees. The majority of respondents (45%) indicated that workplace assessments were included as part of the assessment methodologies used (Table I). This refers to the assessment of work experience in different workplace settings e.g. companies, factories, environment etc.

Table I: Current and anticipated preferences for assessment tools in occupational medicine

Assessment type	Preference Rank	Percentage of respondents using methodology	Present rank usage
Workplace assessments	1	45%	1
Logbook/portfolios	2	43%	2
Objective Structured Clinical Examination	3	24%	12
Research Based Dissertation/Thesis	4	38%	3
Traditional Long Cases	5	29%	10
Literature Review	6	29%	11
Project Assessment	7	36%	5
Multiple Choice Questions	8	31%	8
Modified Essay Papers	9	21%	13
Oral Examinations	10	31%	9
Short Questions Paper	11	17%	14
Photographic Slide Show Questions	12	14%	16
Epidemiological Assessments	13	33%	7
Essay Questions	14	33%	6
Attendance	15	38%	4

Other commonly used methods included log books (43%) and research based dissertation/thesis assessments (38%). Attendance was also recorded by most respondent organisations (38%). The least used assessment methods were short answer questions papers (17%) and photographic slide show questions (14%). Respondents found it difficult to rate the weighting given to each assessment methodology as part of the final assessment since some of the assessments were necessary for award of degree completion but carried no weighting in final exam or some assessments were incorporated into others.

Respondents were also asked to rank the assessment methodologies listed from most preferred to least preferred (Table 1). The majority of the respondents ranked the following in order of decreasing preference:

- Workplace assessments
- Log books/Portfolios
- Objective Structured Clinical Examinations (OSCE)
- Research-based dissertation/ thesis
- Clinical traditional long-cases (LC)

OSCEs and Clinical traditional long cases were in practice only used by 24% and 29% of the respondents' organisations respectively. Multiple Choice Questions were used by 31% of the respondents and ranked 8th in the preference list.

The majority of the respondents chose a web-based tool as the format of the preferred common assessment tool that could be designed for use with the trainee specialists in Occupational Medicine.

In conclusion, it would appear that workplace assessments and the maintenance of log books and portfolios appear to be the assessments of choice by the majority of the countries taking part in this study. However, these assessments are mostly formative assessments and therefore will be very complex and require significant resources, to use as part of an international assessment of trainees in Occupational Medicine.

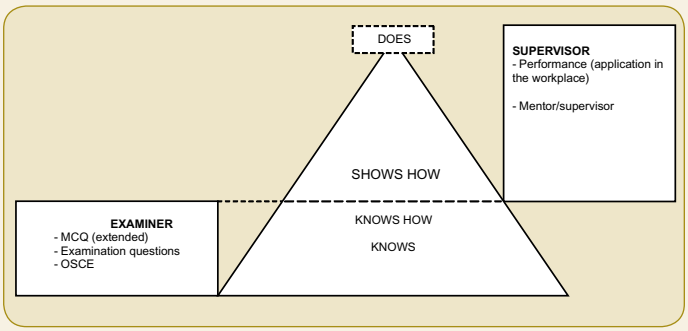
3. Conclusions of the workshop

- The WHO document (2000), although slightly dated, should be used as a basis for defining the broad framework for competencies and purpose
- Multiple assessment techniques testing all knowledge domains and performance throughout the training period of an occupational medicine specialist is the preferred approach - see Miller's Pyramid (see Figure 1)[1]
- The test for quality assurance in a multinational network such as this one is "Professionalism"
- A working group was established based on participants from the workshop from EASOM, UEMS, ICOH, UK, Ireland, Spain, Finland, Netherlands, Romania and South Africa to develop the blueprint competency document and assessment toolkit (library of assessment tools currently being used supported by reference documentation)

4. Actions for the Occupational Medicine Division (CPHM, CMSA) arising out of the meeting

- Continued involvement in the working group activities of the ATOM project on an ongoing basis to establish and maintain benchmarks
- Ongoing review of current Occupational Medicine Regulations (2004) in the light of the UK document /international consensus documents on training and competencies
- Finalisation of the Scope of Practise document based on the WHO (2000) document – submission to medical aid administrators
- Ongoing review of Exam Regulations in occupational medicine as consensus develops on appropriate assessment tools

Figure 1. Miller's Pyramid of clinical competence



through the ATOM project

- Develop a databank on assessment tools (e.g. MCQ bank, log-books) through international networking and collaboration in the ATOm project

Acknowledgements

The funding support provided by the CMSA and the University of Cape Town for Prof. Jeebhay to attend the meeting in Barcelona is hereby acknowledged. Special thanks to Dr Ewan Mc Donald and Dr Nundita Reetoo from the University of Glasgow for their invitation to participate in the workshop and for providing the information that formed the basis for this report.

References

1. Macdonald EB, Ritchie KA, Murray KJ, Gilmour WH. Requirements for occupational medicine training in Europe: a Delphi study. Occup.Environ.Med. 2000;57:98-105.
2. Macdonald EB, Baranski B, Wilford J – Occupational medicine in Europe: scope and competencies – World Health Organisation, Copenhagen, 2000
3. Reetoo KN, Harrington JM, Macdonald EB. Required competencies of occupational physicians: a Delphi survey of UK customers. Occup.Environ.Med. 2005;62:406-13.
4. Cashman C,.Slovak A. The Occupational Medicine agenda: routes and standards of specialization in Occupational Medicine in Europe. Occup.Med.(Lond) 2005;55:308-11
5. Wass V, Van der Vleuten C, ShatzerJ, Jones R. Assessment of clinical competence. Lancet 2001; 357: 945–49.

R W S CHEETHAM AWARD IN PSYCHIATRY : 2007

The award is offered annually (in respect of a calendar year) by the Senate of The Colleges of Medicine of South Africa for a published essay of sufficient merit on trans- or cross-cultural psychiatry, which may include a research or review article. **All medical practitioners registered and practising in South Africa qualify for the award.**

The award consists of a Certificate and a Medal.

The closing date is **15 January 2008**. The Guidelines pertaining to the award can be requested from the Chief Executive Officer, Mrs Bernise Bothma at 17 Milner Road, Rondebosch, 7700. Tel: (021) 689-9533, Fax: (021) 685-3766 and E-mail: bernise.ceo@colmedsa.co.za

MAURICE WEINBREN AWARD IN RADIOLOGY : 2007

The award is offered annually (in respect of a calendar year) by the Senate of The Colleges of Medicine of South Africa for a paper of sufficient merit dealing either with radiodiagnosis, radiotherapy, nuclear medicine or diagnostic ultrasound.

The award consists of a Certificate and a Medal.

The closing date is **15 January 2008**. The Guidelines pertaining to the award can be requested from the Chief Executive Officer, Mrs Bernise Bothma at 17 Milner Road, Rondebosch, 7700. Tel: (021) 689-9533, Fax: (021) 685-3766 and E-mail: bernise.ceo@colmedsa.co.za

Thoughts on the future of the family practitioner in South Africa

KM Seedat lecture -13th National Family Practitioners Conference Mthatha, South Africa (Aug 2005)

Derek Hellenberg, MBChB, FCFP(SA), M FamMed(Stell)
HOD: Family Medicine, University of Cape Town
Correspondence to: Prof Derek Hellenberg, e-mail: derek.hellenberg@uct.ac.za

SUMMARY
This article addresses some global challenges facing healthcare, problems the family practitioner working in the South African Health System faces and concludes with some suggestions as to what could be done to solve these problems, drawing on international experience, and how we should adapt to meet such challenges in the future.

INTRODUCTION
We are all aware of tensions within the healthcare system that touch every health practitioner. These range from financial concerns to issues concerning patients' rights, but the changing environment has or will affect every practitioner to a greater or lesser degree. The situation reached a level which compelled the Society for General and Family Practitioners of South Africa to compile a document on the "GP state of affairs"[1] which examines the pressures affecting general practice in South Africa. The South African Medical Association held two conferences over the past three years on the strategies for survival of the medical profession in South Africa. Therefore, there are major concerns about the challenges facing family practitioners today. There are also global imperatives driving changes in undergraduate medical education, the way health services are delivered, the economic models used for health care financing, rapid technological advancements and the increasingly burdensome regulatory framework within which family practitioners are expected to operate.

GLOBAL CHALLENGES FACING HEALTH CARE DELIVERY
Change is inevitable and is happening at such a rate that it seems we have very little control over our futures. However, we have to see change in the context of what has gone before and the effect these changes have had on our lives and society. In an effort to prepare family practitioners for the future, a policy document outlines four challenges to the way health professionals practice, are educated and trained:[2]

1. To redesign the ways in which health professionals' work is organized in hospitals, clinics, private offices, community practices and public health activity.
2. To re-regulate the ways in which health professionals are permitted to practice, allowing more flexibility and experimentation, but ensuring that the publics' health is protected
3. To "right-size" the health professional workforce and the institutions that produce health professionals; for the most part this will mean reducing the size of the professions and programmes
4. Education itself must be restructured to make efficient use of the resources that are allocated to it.

THE COMMISSION MAKES THE FOLLOWING RECOMMENDATIONS FOR MEDICINE:

- Reduce the number of medical training positions
- Change immigration law to tighten the visa process for international medical graduates ensuring that they return to their native countries for service upon completion of training
- Redirect graduate medical training programmes so that a minimum of 50 % of them are in the primary care areas of family medicine, general internal medicine and general pediatrics
- Move training of physicians at the undergraduate and graduate levels into community, ambulatory and managed care based settings for a minimum of 25 % of clinical experience
- Create a public – private payment pool for funding health professions education that is tied to all insurance premiums and is designed to achieve policy goals serving the publics' health
- Create an enlarged National Health Services corps to attract graduate physicians into service roles currently being met by the large number of training positions

You would be forgiven for thinking that this came from a South African Government Policy document. However, it was taken from a document titled: *Critical Challenges*: *Revitalizing the Health Professions for the Twenty First Century* (The Pew Health Professions Commission, San Francisco, California, USA).[2] There is significant overlap with our needs at present but the concern remains as to what came first – our needs or the imperatives of external role-players?

The medical profession feels largely frustrated by the changes that it is experiencing now. We need to strategise around how these changes could be harnessed in a positive way, using the window of opportunity it provides, to effect other change which is necessary in the way we conduct our business or the level of knowledge required, the financing of health care, our relationships with our professional and regulating bodies and with the organs of state. There are some local issues that have been raised by colleagues over a number of years, but which have become more acute over the past few.

PROBLEMS FACING THE FAMILY PRACTITIONER IN SOUTH AFRICA
The South African Health System has been undergoing structural transformation towards a District Health System based on the PHC approach since 1994. Until 1994, 14 separate national departments were responsible for rendering healthcare to the South African population along racial lines. The historical picture of health human resources in South Africa has the following features[3]

1. The distribution of health professionals is inequitable in terms of access and availability
2. Access to educational opportunity to train as health professionals is equally inequitable
3. Education and training are often inadequate and inappropriate

To fully understand the problems we face, we have to understand the context in which we operate at present. We will discuss this context under various headings:

Population statistics

- South Africa had a population of 44,8 million based on the 2001 census
- According to the United States based Population Reference Bureau, South Africa's population is expected to take a dip of 26 % by 2050 due to HIV / AIDS which reflects a drop from 44 m in 2003 to 32,5 m in 2050.

- It gives an estimated percentage of South Africans between the ages of 15 and 49 with HIV / AIDS at the end of 2001 as 20,1 % and,
- Life expectancy at present mortality rates at 53 for men and 54 for women.

Health care worker statistics
- The public health sector is battling to function, as it is facing a critical shortage of family practitioners and nurses, with rural areas being the hardest hit.
- There has been a substantial shift of key healthcare professionals out of the public sector.
- Statistics also show that provinces that have had the most difficulty spending their health budgets have a high rate of vacancies.
- Our well-trained professionals have become a sought after resource in high paying industrialized countries.
- The problem is compounded by the ongoing poor distribution of health workers between the public and private sectors and urban and rural areas.

Disease profiles
- HIV and Tuberculosis epidemics
- Malnutrition
- Trauma
- Chronic diseases

Against the fast changing social, political and economic landscape of health care in this country, family practitioners and other health professionals face a daily range of stresses and strains and I thought it would make sense to briefly list the strengths and elaborate on the weaknesses before dealing in more detail with the threats and opportunities.

STRENGTHS
- Family practitioners are generally caring people and the general public still has a lot of respect for the work which family practitioners do although this also, is declining as newspaper reports continue to portray family practitioners in a negative light
- We usually live in, or close to the communities in which we work and are involved in many other aspects of community life
- We have the advantage of seeing more than one generation of the same family
- We know our patients well, both professionally and sometimes personally as we see them in our rooms, at hospital and at their homes on occasion
- Most family practitioners keep abreast of the latest developments in medicine and so are able to give their patients the very best advice
- We have good national and international support networks

WEAKNESSES
- Fragmentation of the profession – this is our biggest problem at present with multiple organisations all claiming to represent family practitioners
- We are vulnerable to the dictates of medical aid schemes who set the levels of remuneration for the profession
- We have to spend long hours in our practices which impacts negatively on our family lives

IN THE PUBLIC HEALTH SYSTEM
- Policy decisions concerning health care at a national level are not backed by resource flows, as the provincial governments are responsible for budget setting for health services. As a consequence, a fundamental public health principle, that of equity, is potentially undermined and most national policy implemented at a provincial level only relates to relatively minor issues that can be informally agreed to by all provinces at a national level. [4]
- Budget allocations for health departments are declining in real terms in all provinces despite substantial emerging needs.
- The conditional grants allocated for teaching and research and supra-regional services are not linked to any specific services, and are being reduced in real terms without any clearly defined policy framework.
- As yet no specific norms and standards that can be used for budget motivation and resource allocation have been satisfactorily developed so the basis for resource allocation decisions cannot be defined.[4]
- The allocation to the health service is declining in real terms on a per capita basis. This results in staff reductions and capacity problems. The reduced quality of service available in the public sector creates a privatisation by default, with only the private health system as an alternative. The absence of any real choice of sector for higher income groups results in the monopoly pricing of both medical services and medical scheme contributions. Public sector budget cuts appear to be one of the most significant contributors to increases in overall health spending.[4]

HUMAN RESOURCES

The rigidity of the centralised system of human resource regulation has resulted in a significant deterioration in morale and capacity within all elements of the public sector. This has had a more severe impact on the health system that is already complex and multi-disciplinary. Staff retention in critical areas of the health service is now difficult both as a consequence of inadequate budget, remuneration and career opportunities. Options that allow staff to work in both environments simultaneously are currently very difficult to operationalise and control.[4]

PRIVATE SECTOR

Cost increases

The private sector is characterised by chronic cost increases linked to the fee-for-service reimbursement of providers. Recent trends also show that people are in a weak bargaining position relative to open medical schemes. As a consequence consumers face an inelastic demand for medical scheme cover, which is abused. This takes the form of over-charging administration fees, the extraction of underwriting surpluses from schemes using quota share reinsurance agreements, and the paying of excessive commissions to brokers in competition for market share.[4]

Low-cost contributory environment

The following hinder the development of a low-cost market for medical scheme cover:

(a) The inability of medical schemes to formulate contracts for improved amenities at public hospitals, or for other relevant public health services, due to public sector inflexibility; and

(b) The existing tax subsidy which only serves to reduce the cost of cover for higher income groups. The value of the tax subsidy toward the private health system is substantial and is estimated at R7, 8 billion. It currently lacks clear public policy objectives with associated identifiable positive outcomes. The subsidy therefore needs to be reconsidered within a broader subsidy reform framework.[4]

Risk-Selection

There is evidence that a significant degree of residual risk-selection continues to exist in the medical schemes market. In the absence of any system of risk-equalisation, this will result in instability between medical schemes.[4]

Intermediaries

Intermediaries do not always act in the best interests of scheme members and the public at large. This includes instances where administrators abuse their influence over schemes under their management; where brokers exert pressure on administrators into

paying kickbacks to retain members; and where managed care arrangements are merely structured to extract additional fees from schemes. The shift of members between schemes is largely induced by broker activity, rather than active decisions of members. Thus schemes are incurring substantial increased costs, for no added value to the environment. Overall non-medical expense related expenditure, which includes administrative expenditure and broker fees, is the fastest growing cost-driver in the private health market.[4]

Unfair Discrimination

There is evidence of significant discrimination against people with chronic conditions in open medical schemes. Currently the prescribed minimum benefits do not protect members from this form of abuse. As most people who suffer from chronic conditions are in older age cohorts this amounts to unfair discrimination on the basis of age.[4]

THREATS

Medical Aid Companies

A visit to GP's across the country will confirm that private practices have never been quieter. Reserves and prescribed minimum benefits have been funded by a significant increase in cost of membership and a cutting of overall benefits provided. Increasing numbers of GP's and specialists are working overseas as they cannot survive financially in South Africa. However, there are 7million South Africans currently on medical aid, paying out an annual R40 billion for access to quality private health care.[4] So why are so many health professionals so unhappy and feel that they have to leave to earn a decent living?

An article written in an industry magazine states it is because of the following:[5]

1. *The intervention of a third party into the payment process*

- Family practitioners are concerned because their payments are delayed without good reason.
- Every year patients pay more and their benefits decrease and
- Family practitioners cannot treat patients as they would like to because of onerous protocols and various algorithms.
- High costs involved with telephone delays when confirming benefits
- Restrictive Drug formularies
- Co-payments
- Walk in service at family practitioners – Family practitioners may only serve patients if belonging to certain schemes if they have an agreement with their medical aid. This will effectively put an end to families going to the same doctor for generations

2. *Expectations from medical aids that all practices should operate with the same level of IT capacity and efficiency.*

- An affluent practice may have many staff while a poorer practice may be run by a single practitioner whose spouse still does all the administrative work.
- Even when patients can pay upfront, family practitioners often battle with the administrative burden of keeping tabs on dozens of different schemes, each with their own pricing and claiming procedures.
- Schemes also appear to delay large payments deliberately.
- There are constant stories of bankruptcies and family practitioners leaving to work overseas.

3. *The old autonomy for family practitioners is changing to a new model in which non-medical organisations want to specify what is, essentially medical performance requirements.*

4. *Managed health Care needs much more paperwork, as one needs pre-authorisation.*

- You have to fill in a form every time you change a drug or the dosage and you are limited in what medicines you can prescribe.
- The public expects family practitioners to prescribe the best treatment and to keep abreast of the latest technology and means of treatment. The problem is, if they do, they get attacked by medical aids.[5]

Administrators say…

- That there are various factors affecting costs, which include: differing levels of health care in urban and rural settings, low doctor-patient ratios and the effect of exchange rates on the costs of drugs and equipment. So, although they leave treatment decisions to doctor and patient, they use clinical and risk- actuarial expertise to make funding decisions that take all factors into account and ensure sustainable and clinically effective results.
- Medical Savings accounts let patients decide what they want to spend their money on.
- According to BHF estimates, as much as R12 billion pa is spent on inappropriate and fraudulent activities, including over-servicing, cash for goods, collusion between providers and staff of administrators, rebates and discounts. As a result, they say, many medical schemes are falling apart.

The implication is, that this is perpetrated by family practitioners.[5]

Economic difficulties

Banks are no longer willing to give overdraft facilities to GPs working in certain areas.

Psycho- social issues

In a 2001 survey of the profession by the Ethics Institute of South Africa,[6] 92% of medical practitioners agreed with the following statement: "Inadequate remuneration is an important source of stress"

- Increased financial pressures on family practitioners leads to increased working hours. This is particularly relevant in those employed full time in the public sector who earn poor salaries and often have to hold down a second job to make ends meet. The result is less time spent with the family with inevitable discord and further stress leading to negative attitudes in the workplace.
- Increased tension at work leads to frustration, depression and spillover of stress into the family
- In rural communities the obligations to the local community are very time consuming and again impacts on the time spent with the family

Public Hospital System

1. Deterioration of public sector facilities
   State Hospitals

- Major state hospitals are not only battling equipment shortages and budget constraints but are also having to put up with thieves who are stripping the hospitals bare, forcing patients to bring their own bedding and cutlery.
- Staff shortages
- Medicines not available
- Formularies
- GP sessions abolished at state health care facilities

2. Staffing

- Despite the aggressive recruitment drive to address the shortage of nurses, South Africa's will reach critical levels by 2011, with a shortage of 60 000 nurses. The shortages are attributed to poor pay and working conditions, emigration and not enough supply to meet the demand.[7]
- Western Cape and Gauteng provinces have the best health systems and about 80 % of all interns choose hospitals in these provinces Rural family practitioners have special problems such as both physical and intellectual resources, safety issues, long working hours, poor salaries and poor facilities for recreation.[7]

3. Abolition of district surgeons

Effect of new legislation

Government has legislated extensively in an attempt to regulate the framework in which health professionals operate, often leading to further uncertainty and stress in the profession. The following legislation has been enacted over the past two years or is under consideration at the moment

1. Traditional Health Practitioners Bill
2. Health Professions Amendment Bill 2003
3. Pharmacy Amendment Bill 2003
4. Medicines and Related Substances Control Amendment Bill 2003
   - SECTION 22 (F) OF THE MEDICINES AND RELATED SUBSTANCES CONTROL ACT
     The act makes provision for dispensing family practitioners to be licensed to dispense medicines and aims to promote the dispensing of interchangeable multi-source medicines (Generic Medicines).
5. National Health Bill 2003
   To provide for a legislative and regulatory framework for a structured National Health System in S A
   Chapter 6
   Deals with the classification of health establishments and the certificate of need
   CHAPTER 7
   The new version merely refers to the powers of the Minister who may establish Academic Health Complexes
   The establishment of a National Council for Academic Health Service Complexes has been deleted
6. *South African Medical Research Council Amendment Bill 2003*
   The aim of the amendments is to bring the activities and role of the MRC into line with Departmental public health initiatives and enable it to assist in meeting departmental needs in this regard

Encroachment on GP functions

1. ***Nurse Practitioners***
   Four nurses opened a PHC practice in Manhattan in 1997 as part of a research project by the Columbus University School of Nursing, doing what family practitioners with a general or family practice ordinarily do. They diagnose all kinds of complaints and refer patients with complicated problems to specialists or admit them to the hospital. They are accredited as primary care providers by several big HMO's, which pay them the same managed care rates per visit, as they pay primary care physicians[8]
   In recent years twenty-six states have passed laws allowing nurse practitioners to work without a link to a physician
   Many others collaborate with a physician who can be called at a moment's notice. Nurses with advanced training are also allowed to prescribe medicines, with varying restrictions, in every state except Illinois.
2. ***Pharmacists***
   Are already able to consult with patients after undergoing a short period of training
3. ***Specialists***
   According to Government Gazette No 12958 of 11th Jan 1991, a specialist may treat any person who comes to him/her direct for consultation. This legislation has encouraged both specialists on the one hand and patients on the other for patient self-referral to specialists. The result of this is inappropriate management of primary care patients by specialists at a relatively high cost.
   Some do not refer patients back to their GP. The offenders are mainly pediatricians, gynecologists and general physicians
4. ***Big Business***
   Moving mainly into the low cost scheme market and forcing practices to accept lower fees for seeing patients

COMPETITIONS COMMISSION

Hospitals, SAMA and medical schemes have been prosecuted for alleged collusion and price fixing.

OPPORTUNITIES

- Consolidate the profession under one umbrella to strengthen the voice of family practitioners
- The shift of services down to primary care and district level gives us an opportunity to increase the range and quality of the services we offer
- The 2-year internship training programme with compulsory rotation in Family Medicine, gives us an opportunity to inculcate family medicine values into young graduates and will give the intern the opportunity to manage common medical conditions and to integrate experience, knowledge and skills gained in other domains. It also provides the experience of working in a health care team, collaborating with other primary health care workers such as nurses, allied health professionals, and colleagues working in specialities at secondary and tertiary levels of care to provide support and build capacity. Specialist status for family practitioners will increase the status of the profession

New state medical scheme

1. Due to start in Jan 2006
2. It would offer cover to 650 000 employees and their dependants – about 2 million would move from existing schemes to government schemes
3. The new scheme would add between 350 – 480 000 new civil servants to the system which would boost the number of people covered by medical aid from 7 to 8 million

TECHNOLOGICAL DEVELOPMENTS

These offer us the opportunity to spread services over a wider area and to communicate with colleagues more effectively. It will also provide some support for colleagues practicing in remote areas through linkages with major centers.

Telemedicine

1. *Co-operative working with hypermedia documents* has applications in many areas where it is necessary for geographically dispersed people to jointly and interactively converse over a common information pool. Scenarios within the medical sphere include: remote consultation, remote diagnosis and wide area conferencing.
2. *Continuing Medical Education:*
3. *Telepathology*

Practice of pathology at a distance – visualizing an image through a monitor rather than viewing a specimen through microscope

4. *The next major breakthrough will be computer voice recognition* to a level that can be used more or less routinely in health care. Beginning with laboratory reports and extending to routine medical practice, this technology will revolutionise the way health care is delivered.
5. *Improved picture archiving and communication systems (PACS)* and the use of a "smart card" will provide caregivers with instantaneous information on which decisions can be taken.
6. *Knowledge based systems* are being developed which will allow individuals to monitor their health and diseases and to participate more fully in their management. This will facilitate care in the home, nursing home or small hospital.
7. *Trans-dermal blood tests and micro-laboratory techniques* will further bring services to the periphery. These developments will be spurred by the continuing military and peaceful use of outer space.

These technological changes will result in a revolution in patterns of medical practice as it now exists. With the availability of electronic learning centers in the home and the reduction in the num-

ber of textbooks and journals, medical education will be radically changed and electronic communications will eventually replace the written word.
Despite these and other unimaginable developments, the human side of medicine should prevail as it has since its inception. To ensure this, it will be the responsibility of those who develop and use technology to bear in mind human needs and to fashion all innovations to benefit the human race.

What other countries have done
Most commentators agree that the most important problem facing the health care sector, relates to the *lack of an integrated human resource development strategy* and that, if proper attention and planning were devoted to this, we would be on the road to building a health system that is sustainable. New Zealand [9]faced this same problem not too long ago:

- For a decade health workforce planning was badly neglected. The Minister of Health took responsibility for developing a strategic approach to creating a unique New Zealand health workforce.
- In 1997, Sir Frank Holmes, Chair of the Committee advising on Professional Education (CAPE) presented it's long term strategy on educating and developing the health and disability workforce. Nothing was done with that report. The Health Workforce Advisory Committee was established subsequently with a remarkably similar brief to Committee Advising on Professional Education's.
- Some of the issues which emerged from CAPE's extensive consultation within the health sector are:
  - *Inadequate government attention to workforce planning*
  - *Short term quick fixes* instead of investment in people
  - *A lack of continuity* between pre-entry and post – entry and continuing education
  - *The compartmentalization of professions*
  - A health workforce need to be made up of *professionals who work in teams, across disciplines*. An overemphasis on one sector at the expense of another leads to silo planning and consequently workforce gaps
  - *Continuing stress and morale problems* – long term planning was needed to combat these problems but it had to be combined with short and medium term actions
  - The launch of the tertiary education strategy and the establishment of the Tertiary Education Commission provided a structure in which the education sector will be much more responsive to the present and future needs of the health sector
  - HWAC's first job was to compile a stock-take of existing workforce issues and capacity
- Provision of PHC to rural NZ - a package, designed in consultation with rural GP's, drawing on their expertise and experience
- Provided funding to support innovative primary health care initiatives
- Setting up an $11,8m bridging programme to help overseas-trained family practitioners pass the NZ General Registration Exam
- The number of NZ funded medical students was increased from 285 to 325. The government recommended an emphasis with the extra students on General Practice and mental health
- Government also made a *commitment to work with Universities, College of GP's* and others to promote this emphasis
- Government also recognized that the *level of student debt* acts as a barrier to recruitment and retention. The ministry of education is completing a comprehensive review of student loans and allowances. It looks to develop a sustainable set of policies for student support rather than individual band- aid solutions
- District health boards are also *collaborating on a number of workforce projects*, particularly around recruitment. Establishment of a tripartite approach (DHB's, unions and government) to workforce issues affecting the health sector has the potential to address long-standing retention issues
- The current *workforce mix may not be appropriate to deliver health care* in the future. For example, we may need more generalists than specialists and different health professionals may take on roles traditionally taken on by another group e g nurse practitioner
- Change: Global trend to *increase the use of information technology*, which can provide services from one part of the country from a completely different part. We have to ensure that our workforce is aligned with our overall strategic health approach and it is also important for health practitioners themselves to be able to adapt to the rapidly changing health environment. The speed of this change is unlikely to slow down.
- We must also recognize that health workforce development is an investment rather than a cost and needs to be balanced against the huge costs of recruitment [9]

COALITION HEALTH POLICY (QUEENSLAND, AUSTRALIA)
The coalition health policy[10] is directed towards providing Queenslanders with a caring, professional and cost-effective health system. The "back to basics" health care approach has included improvements to emergency, intensive care, oncology / palliative care, rehabilitation and end-stage renal failure services. These have been accompanied by funding increases in public hospitals, community health and aged care. Among the aims are:

- To enhance the well being of all citizens with a concerted programme of health promotion and preventive measures
- To place emphasis on family care with a range of innovative programmes
- To provide support and care for those who are treated in their own homes
- To ensure that patient care with a personalized service is a priority
- To enable staff to feel pride in serving and caring for the patient
- The coalition believes that at the heart of a healthy society is a cohesive and healthy family. The family in a rapidly changing society, requires support and services for young children, adolescents, parents and the extended family.
- Support and education of family practitioners as primary health care providers to women

Management of services

- Has improved the management of health services with the introduction of service agreements between all Queensland health Districts and Queensland Health's corporate office
- These agreements ensure that DHS are provided with realistic budget and appropriate reporting requirements
- Understands that *the lynch-pin to a first class health system is a professional, talented and loyal staff coupled with best practice in our hospitals*
- Acknowledges the roles of all staff groups as being of critical importance in the delivery of a high standard of health care
- Places emphasis on ensuring professional development job opportunities and security
- Will build on existing services with initiatives that meet the needs of children and youth with mental disorders by supporting the GP in their role as family carer
- Assistance has been given towards indemnity insurance for rural procedural GP's as an incentive
- Isolated GP's and health professionals will be given greater support through further development of telemedicine facilities and locum database facilities
- Palliative care services – maintaining continuity of care with strong community / hospital linkage. There is a recognition of specialized needs within palliative care.
- Drug prevention and rehabilitation [10]

LESSONS FOR SOUTH AFRICA

New Zealand and Australia are developed countries that have been through the same restructuring processes that we are undergoing at the moment. They have realized that they have neglected the most important part of their service: the people who work in the system and are now desperately trying to correct matters. We have already reached that critical phase, where we now have to import family practitioners. It is time for government to come up with a comprehensive Human Resource strategy for health care in South Africa.

RECOMMENDATIONS FOR SOUTH AFRICA

The strategies for the family practitioner must be:

1. To improve patient care
2. To form a unified body for family practitioners to look after their interests: At present we are divided and being ruled by both medical aid schemes and government. I only hope lies in unity of the profession. I would like to appeal to all present here today to put aside your differences and to work hard at presenting a unified voice for the profession.
3. To develop a comprehensive, integrated human resource policy for delivering health care in both urban and rural areas
4. To improve the working conditions and salaries of family practitioners both in the public and private sectors

Tentative steps taken in an effort to solve the problem:

- The first South African Cuban medical graduates arrived in the country on the 15th August 2003.
- The Health Dept was allocated R500 million for the first time in 2003 to recruit and train scarce professionals and attract new recruits into rural areas
- Proposed WMA statement on ethical guidelines for the international recruitment of physicians, May 2003 may help to stem the tide of family practitioners leaving the country:
  Every country should do its utmost to educate an adequate number of physicians, taking into account its needs and resources. A country should not rely on immigration from other countries to meet its need for physicians.
  Every country should do its utmost to retain its physicians by providing them with the support they need to meet their personal and professional goals, taking into account the country's needs and resources.

5. To expand the role of Family practitioners as teachers in university undergraduate as well as postgraduate programmes: This will keep them in touch with what is happening in medical education, as well as giving them access to support and resources.
6. To review the basis for specialist consultations:

- Except in emergencies and other special circumstances, specialists should only see patients on a clear referral from a GP who is the custodian of the patient's health care
- Specialists should act as consultants, dealing with special management problems and advises the referring GP regarding ongoing management. Hanging on to only complicated cases requiring management at that level
- Medical aid schemes should be requested to pay specialists for management of only those cases referred by GP's

7. To review structure and functions of medical schemes:

- The long wait for payment for professional services rendered is the leading cause of stress and strain in the relationship between medical practitioners and medical schemes. Every day's delay puts an extra squeeze on cash flow and adds to the administrative burden of running a practice.
- Solution: Paper based claims lead to administrative inefficiency. An electronic, real-time environment is needed. About 32 % of claims are still paper based at present.
- More money on both sides of the equation would certainly help to heal the rift. But the real answer lies in the power of relationships. Health professionals, health care funders, politicians and bureaucrats need to find a better, smarter way of working together, for the greater good of the patient.
- The despondency shown by many health professionals at the current state of affairs is hard to ignore. The problem lies in the third party system of payment we have that is run by people with a profit motive. Any savings are siphoned off for brokers and shareholders. Society needs to create a mutual fund that operates on a not-for profit basis and pays decent professional fees, because at present family practitioners are getting a clear message: professionalism is not rewarded and their skills are not valued.
- To strike a joint venture between the providers and the funders. This has to be directed by the medical schemes council and government, something in the way of a central bargaining chamber so that a win-win situation emerges as the final outcome.

CONCLUSION:

The plan should include the following:

Basic essential service and benefits

In order for equity to have practical meaning it must be expressed in terms of actual services or conditions that must be provided on an equitable basis. Policy instruments may differ between public non-contributory and private sector settings. Nevertheless, the principles remain the same.

Public sector

The public sector will have to define minimum services primarily through the establishment of a minimum basic package of services. This can be expressed practically in terms of policy through the establishment of service norms and standards.

Private sector

The Medical Schemes Act No.131 of 1998 introduced prescribed minimum benefits as a policy instrument for defining minimum allowable levels of medical scheme cover. This involves a positive list of conditions and treatments.

Requirements for the future

There is no coherent approach as yet to defining the basic essential minimum services between the public and private sectors. Ultimately both systems will need to provide a minimum core set of services that are consistent with one another. Once rationally defined, Government will have to establish clear mechanisms for ensuring that the desired entitlements can be met in an equitable manner in both settings.

I end with the following words by Dr. Khosi Letlape, the Chairman of SAMA, when he speaks on -
"SURVIVAL OF THE MEDICAL PROFESSION IN SA" and the impasse between the medical profession and funders on the remuneration for medical services:
"The survival of the medical profession in S A depends solely on the ability of family practitioners to take control of their destiny and their commitment to practice ethically and professionally. We cannot allow medical schemes, government or any other entities to determine our scope of practice based purely on financial reasons, and to interfere with our autonomy to treat our patients appropriately and effectively. ".

REFERENCES

References are available on request

"Do not resuscitate" - definition, ethics and the law. where is the line to be drawn?

Scenarios from Medico-Legal Ethics Meeting Durban, 12 April 2006.

These scenarios were drawn up against a background of severe shortfalls in resources and thus before discussion of the individual cases the extent of the shortfall will be outlined. The number of adult intensive care beds that should be available to the population as a whole is of the order 5 or 6 beds per 100,000 population[1]. In Kwazulu-Natal in 1998 it was reported that the number of adult beds was 1.25/100,000. This has been a persistent and worsening problem over the years until in 2004 the number of beds was less than 1/100,000.

Figures from Addington and IALCH hospitals give some idea of the effect of this shortfall on ICU admissions. At Addington hospital in 2000, there were 935 requests to admit. Of these 410 (43%) were refused admission to ICU. Reasons to refuse admission included 95 patients (23%) who were refused on the basis that admission would not accomplish any useful outcome i.e. was futile. Seventeen (3%) of the patients could be managed in the general ward and did not require ICU admission (futility at the other end of the scale). The remaining patients, (298 or 59%) were refused admission because the unit was full. Similar figures from the new, partially commissioned, unit in Inkosi Albert Luthuli hospital for 2005 show a similar but worsening picture as 61% of patients were refused admission with 66% of these due to lack of ICU beds. In both instances there is the need to make decisions as to who should be or should not be treated as not every patient can be admitted.

The futility of treatment in the individual patient is often far from clear thus admission to ICU proceeds until the futile nature of the case has become apparent when treatment is stopped.

Death occurs in everyone, meaning that at some point the probability of survival precludes resuscitation which must then be regarded as futile.[2] But there is a "stubborn quest" for diagnostic certainty in order to determine the moment wherein the process of death becomes irreversible.

This moment defies precise definition leading to confusion whereby on the one hand there will be a propensity to forestall death through a "technological imperative" while on the other hand there will be attempts to distribute the resource in a fair and just manner. Perceptions of legal responsibilities as well as medical oaths weigh heavily in favour of the individual patient and this together with the severe shortfall of the resource means that patients who would reasonably be expected to survive intensive care may now be denied intensive care while clinicians persist with resuscitation in patients with little chance of survival.

Scenario 1

Male aged 35 years

MVA – noticed to have widened mediastinum. Angiography – traumatic aneurysm of the aorta. Operation means the phrenic nerve on the left has had to be sacrificed.

On the right side he appears to develop a fibrosing alveolitis that is progressive.

He has thus far proved to be impossible to wean from the ventilator. Ultrasound shows the left hemidiaphragm to be totally paralysed. The right lung does not ventilate because of the fibrosing alveolitis.

Plan is to firstly confirm the permanent nature of the fibrosing alveolitis on the left by open lung biopsy

R Pneumonectomy is contra-indicated as L lung cannot expand
Diaphragmatic pacing?
Remove from ventilator

He is fully conscious

Answer

Fibrosing alveolitis occurring in a ventilated patient is progressive and ultimately leads to hypoxic death. The problem in this patient is the diagnosis of unilateral fibrosis together with phrenic nerve palsy precluding spontaneous ventilation.
The diagnosis of fibrosis was pivotal as diagnosis to this point was inferred by xray and CT Scan. An open lung biopsy was planned in order to establish the diagnosis. Assuming histology gives an answer, two outcomes were possible. Firstly the diagnosis of fibrosis would not be confirmed and the clinicians would persist in attempts to wean. Secondly the diagnosis would be confirmed.

If the diagnosis were confirmed then it would be clear that the condition would ultimately be fatal. Under this circumstance continued treatment would be of little benefit and is causing harm to others turned away from the unit. The clinicians were spared the decision as over a weekend, while waiting for the biopsy, his condition unexpectedly improved and he was weaned from the ventilator.

Legally had the diagnosis been that further treatment would have been futile there would have been no obligation on the clinicians to prolong hopeless treatment. The test is would a reasonably competent clinician have regarded the prognosis as futile? If so, the clinicians would have had to consult with the patient and explain the position to him. Fortunately for the patient and the clinicians there was a miraculous recovery by him.

Scenario 2

Male patient aged about 40 years admitted from a private institution on the South Coast.

Problem. He is a migrant worker from Pakistan who has traveled to Kokstad from a malaria endemic area. He was admitted to a private institution with a diagnosis of cerebral malaria with multisystem organ failure. At 3 days in ICU he is in severe respiratory failure – there is coma of questionable degree – he is in renal failure. He has 3-organ failure (brain, lungs and kidneys)

Although clinicians are in agreement that the prognosis is extremely poor they are at odds as regards stopping treatment so decision to continue treatment, including dialysis, is made. Later on in the day following dialysis he collapses. Attempts to resuscitate him fail and he dies.

His family is handed an account of R33,000-00 by the public hospital.

Answer

The mortality of cardiac failure, respiratory failure, renal failure together in ICU from any cause approaches 100% by three days. The prognosis of cerebral malaria with renal failure requiring admission to ICU is also extraordinarily high. In my opinion this patient should probably not have been admitted to ICU in the first place. It is to be emphasized that not admitting to ICU does not constitute a failure to care for the patient. Care is an abstract term that is too often confused with treatment and thus a refusal to treat is taken as a refusal to care for the patient. This is not the case. There is much that can still be done for the patient to help and ease his dying but that is not within the scope of this discourse.

Having admitted him there is the question as to how far to persist and this also highlights the differing opinions that clinicians can hold. Being of the opinion that he should not have been admitted in the first place it was my opinion that continued treatment was of no benefit to him i.e. was futile and should cease. At the same time it was also argued that his continued treatment was denying others treatment.

The fact that his family was handed an account for R33,000-00 is not normally something that the public service clinician has to consider. For the clinician the major problem where financial issues are concerned is not to fall between the twin stools of protecting the hospital budget and the interests of the patient.

Legally, if a reasonable clinician would have regarded the proposed treatment as futile there would have been no point in the patient being admitted to ICU and no legal liability for failing to do so. Admitting such a patient to ICU would be unethical and a waste of the hospital's and family's resources and justification for refusing to pay the R33 000 bill. However, it appears that once he was admitted there was no agreement amongst the clinicians regarding the stopping of treatment which indicates that some of them thought that the treatment was not futile. Therefore it could be argued that a reasonable clinician in their position did not regard the treatment as futile.

Scenario 3

Male patient aged 55 years – delayed laparotomy for intra-abdominal sepsis. Admitted to ICU following laparotomy and is in multiple organ failure (requires inotropes - high inspired O_2 on ventilator – Urine output poor – urea 12 mmol/L)

Treatment and support continued with antibiotics as required

Day 4 - no response. Still in multiple organ failure – inotropes - ventilated – FIO_2 70% - urine output poor – urea 15 mmol/L)

Answer

Shaw 100 years ago in 1906 wrote - "*There is a point at which the most energetic policeman or doctor, when called upon to deal with an apparently drowned person, gives up artificial respiration, although it is never possible to declare with certainty, at any point short of decomposition, that another five minutes of the exercise would not effect resuscitation".* This case highlights the problem of statistics applied to the individual case and the manner in which individuals approach resuscitation. As stated previously the mortality of this situation approaches 100%. This patient survived against all the odds. With the benefit of hindsight a decision to stop resuscitation would have been wrong. However decision-making is an exercise, a choice, that can only be made against a background of uncertainty. The real question is what to do when the next case appears where there is no benefit of hindsight and there is the knowledge that others are being denied treatment. Decision-making carries with it the implicit fact that, statistically, a decision can be wrong. If this is unacceptable then the only decision that can be made will be to continue against all the odds in the vanishing hope of a survivor contrary to the principle of justice.

For the legal position see answers in Scenarios 1 and 2 regarding futility of treatment – the test is what would a reasonable clinician have done?

Scenario 4

Patient TE, African male, a 30 year old shop assistant: shot in the back during a robbery.

On admission to hospital, he was found to be paraplegic at T10 level and with peritonitis. Laparotomy performed. Found to have perforated ascending colon with gross faecal soiling, right hemicolectomy performed. Fourteen days later, multiple abdominal abscesses drained. Seven days later he developed fecal fistula, this became unmanageable. Ten days later, relaparotomy performed, multiple abdominal abscesses drained and defunctioning ileostomy performed. Patient was ventilated post-operatively. Abdominal pus swab grew streptococcusfaecalis and enterobacter agglomerans, developed pneumonia on chest x-ray and was ventilator dependent. HIV status then determined. Found to be HIV positive, viral load 124882 cp/ml, CD4 count 221 per µl.
What now?

Answer

The only question that should be asked concerning any admission to ICU is the question of medical chances of survivability. Setting

aside the HIV status intra-abdominal sepsis with recurring infections carries a bleak prognosis. The progress of this patient is a picture of deterioration with recurring infections (pneumonia – abscesses) and must therefore be regarded as unlikely to survive.

The HIV complicates the matter. Intuitively the HIV makes the situation more bleak but as the Health Act precludes research into the incompetent patient in ICU it is difficult to say quite how much the situation is made worse – if it is! In any event the patient should be treated according to the same ethical principles as other patients i.e. beneficence, non malfeasance, autonomy and justice.

Legally the position is the same as required in terms of medical ethics. The patient cannot be discriminated against on the basis of his HIV status – his overall prognosis must be taken into account in determining the treatment regimen.

Scenario 5

A newborn baby weighing 950 gms is delivered normally to 15 year old mother. She presented fully dilated to the hospital and the baby was delivered within a few minutes. The baby has extensive bruising, has respiratory distress that would require support. The cranial scan reveals a major intraventricular haemorrhage. The pregnancy was unplanned and the mother did not seek prenatal care. Her family are annoyed about the situation and are not very supportive. It is expected that the clinical condition of the baby will deteriorate.

How much care and at what level should care be provided for this baby?

Answer
Palliative care. Send mother and family for counseling. Ensure mother has family planning advice.

Legally, if the prognosis for the baby's survival is hopeless – given the resources available at state hospitals – the baby must be made comfortable and provided with the necessary palliative care.

Scenario 6

A newborn baby weighing 950 grams is delivered by Caesarean section to a 16 year old mother who received appropriate prenatal care. She developed pre-eclampsia and a decision was taken to deliver her. The blood pressure was controlled and steroids given. The grandmother (mother's mother) is supportive. At the time of delivery the baby has mild respiratory distress but it is anticipated that baby may deteriorate over the next few hours or even later. The cranial scan is normal

What care should be offered in this case?

Answer
Offer all care required for the condition of the baby. If ventilation is necessary at a later point this should be offered. The clinical picture may change and if baby develops a major IVH consideration of withdrawal of care or not escalating care can be considered at that point. Counseling for mother and family – young mother, very ill, small baby – very stressful. On recovery – mother should have counseling for family planning. Regular counseling and explanation throughout hospital stay. When baby is discharged, follow-up arrangements must be made and counseling for follow-up given.

Legally, if the baby's prognosis is not hopeless and it can be saved – given the resources at state hospitals – then it should be ventilated. If its condition deteriorates to the extent that the prognosis becomes hopeless treatment should be withdrawn and palliative care provided.

NB: Legal input given by ***McQuoid-Mason DJ*** PhD. Howard College School of Law, University of KwaZulu-Natal, Durban

References:

1. Lyons RA, Wareham K, Hutchings HA, Major E, Ferguson B Population requirement for adult critical care beds: a prospective quantitative and qualitative study *The Lancet* vol 355 Feb 19 2000 pp595-598
2. SchneidermanLJ, Jecker NJ & Jonsen AR. Medical Futility: its meaning and ethical implications 1990 *Annals of Internal Medicine* 112: 949-954.

The impaired practitioner – scope of the problem and ethical challenges

Ames Dhai, MBChB, FCOG (SA), LLM, PG Dip Int Res Ethics
Director - Steve Biko Centre for Bioethics, Adjunct Professor and Head - Bioethics
University of the Witwatersrand Medical School
Christopher P Szabo, MB BCh, MMed (Psych), FCPsych, PhD
Division of Psychiatry, University of the Witwatersrand
David J McQuoid-Mason, BComm**,** LLB, LLM, PhD
Howard College School of Law, University of KwaZulu-Natal, Durban

Correspondence to: Prof Ames Dhai, e-mail: Amaboo.Dhai@wits.ac.za

This article has been reprinted from SA Medical Journal 2006; 96(10): 1069-1072 with kind permission

Abstract
Practitioner impairment occurs when a physical, mental or substance-related disorder interferes with his or her ability to engage in professional activities competently and safely. The Health Professions Council of South Africa makes reporting of impaired colleagues and students mandatory. The ethical dilemma faced by many colleagues on the issue of reporting an impaired practitioner is that of having to choose between protecting the privacy of the practitioner and the safety of patients. However, medicine as a profession with an acknowledged fiduciary relationship has a clear responsibility to assure the public, and all patients, that its practitioners and institutions are trustworthy. An awareness of and sensitivity to physician vulnerability and early detection and prevention of impairment is important.

Introduction
While recognition of the impaired physician as a distinct problem in medicine emerged in the 1970s,[1] and has been the subject of attention for over 35 years, insufficient attention has so far been given to ensuring that these practitioners obtain the services that they themselves provide for others. Practitioner impairment occurs when a physical, mental or substance-related disorder interferes with his or her ability to engage in professional activities competently and safely[2] (and unpublished HPCSA document, 2005, obtained directly from Itumeleng Maloa, Committee Co-ordinator – Health Committee). Professional activities refer to those situations where there is direct involvement in patient care, i.e. the practitioner-patient relationship. Conditions causing impairment can affect anyone in the general population and health practitioners, who have a fiduciary relationship with patients, are not immune. The purpose of this paper is to highlight dilemmas concerning mental and substance-related disorders causing practitioner impairment.

Scope of the problem
The prevalence of illnesses causing impairment in physicians is not known, but it has been estimated that as many as 1 in 6 may be affected.[2] Anxiety, depression and mental illness occur commonly among health practitioners, especially doctors.
Depression is seen in 10 - 20% of doctors and about 21% who report work-related stress have contemplated suicide. The suicide rate among doctors is reportedly 50% higher than that of the general population.[3] Chemical dependency is an important cause of physician impairment, with a lifetime prevalence approaching 10 - 15%, and alcohol dependence varies from 8% to 15%. The most common drug of abuse is alcohol, followed by opiates.[4] Abuse of benzodiazepines and opiates has been shown to be facilitated by self-prescribing.[5,6]

Of concern is that physicians as a group deviate from the norm when seeking treatment when they fall ill. They may not seek help for mental problems because they do not recognize the problems; they may be in denial; they may recognise the problems but believe they do not require professional care; or they may recognise the problems and realise that treatment is needed but nevertheless do not seek help. In addition, physicians have a tendency to diagnose and treat themselves, and if they do seek care they often do not use the usual programmes of the health service, choosing instead to seek the advice of colleagues.[7] This is possibly due to the complexity of establishing a therapeutic relationship between the impaired practitioner and the treating one, as well as the reversal of roles from practitioner to patient.

The Health Professions Council of South Africa approach
In October 1998, the Interim National Medical and Dental Council of South Africa added two new rules to the existing set of Ethical Rules. The following would be regarded as acts of omissions in respect of which Council may take disciplinary steps:

'Failing on the part of a student or practitioner to –
(a) Report impairment in another student or practitioner to the Council if he or she were convinced that such other student or practitioner was impaired as defined in the Act;
(b) Self-report his or her impairment or alleged impairment to the Council if he or she was aware of his or her impairment or had been publicly informed of being impaired or had been seriously advised by a colleague to act appropriately to obtain help in view of an alleged or established impairment.'[8]

Because impaired practitioners are not usually able to recognise their own impairments and therefore do not voluntarily seek help, these rules place a positive duty on students and practitioners in terms of the Health Professions Act[9] to report colleagues to the Health Professions Council of South Africa (HPCSA) whom they are 'convinced' are impaired in terms of the Act. It also requires them to report their own impairments if they are 'publicly informed' or 'seriously advised by a colleague to act appropriately or obtain help'. 'Publicly informed' would seem to mean that the student or practitioner must have been informed by somebody in public, as opposed to in confidence (e.g. being seriously advised by a colleague) – in other words more than one person was present at the time the information was given.[10]

In 2002 there were 30 cases of impaired physicians reported to the HPCSA, and in 2003 there were 33. Over 50% were because of substance abuse (Itumeng Maloa, Committee Co-ordinator, Health Committee, HPCSA – personal communication). Because of the increase in substance abuse, in 2004 the Health Committee of the HPCSA embarked on establishing mechanisms and procedures to oversee the implementation of treatment programmes for such individuals. The approach of this Committee is non-punitive, with a focus on rehabilitation. The essential components of these

programmes include comprehensive medical and psychiatric assessment as well as treatment and active long-term followup. The Committee has assumed the role of promoting support to such practitioners in effectively managing their impairment rather than penalising them for it. Where necessary, practitioners are restricted to supervised practice while undergoing suitable treatment, or in more severe cases management is by means of temporary suspension linked to specific measurable achievements in treatment. Urgent and speedy action by the Committee is provided where there is an immediate risk to the patient and/or he or she is not compliant with the management proposed.[11] In this manner assistance and rehabilitation rather than discipline is employed so as to aid the impaired practitioner in retaining or regaining optimal professional functioning consistent with the safeguarding of patients.

Practitioner vulnerabilities

The non-punitive approach adopted by the Health Committee probably reflects awareness of and sensitivity to physician vulnerability. Health practitioners experience high levels of stress in their professional roles and responsibilities, where expectations are high and room for error small. Their responsibilities not only take a great deal of professional time but also impact on family and personal time. Hence personal relationships can be strained, with the physician often being caught in a conflict between commitment to the patient and all his or her other responsibilities. In addition fears of being perceived as 'weak' are pervasive, with practitioners tending to maintain the belief that their patients and not themselves are the ones with the problems, hence perpetuating resistance and denial.[12] When confronted with the stresses of clinical practice and the expectations of unblemished behaviour, every practitioner is at risk of substance-induced or mental impairment. Such personal risk cannot be underestimated. Moreover, controlled substances are more readily accessible to health practitioners than to the lay public. In addition, it is difficult to identify practitioners with substance abuse, especially as physicians are adept at disguising their addictions and often manifest exceptionally rationalised denial and sophisticated resistance. Professional colleagues and family members are also very trusting and rarely recognise even very obvious signs of addiction.[13]

Reporting – ethical issues

The ethical dilemma faced by many colleagues on the issue of reporting an impaired practitioner is that of having to choose between protecting the privacy of the practitioner on the one hand and the safety of patients on the other. Failure to report the impaired colleague may be because of the potential for adverse social, financial and legal consequences. Although physicians may acknowledge a duty to report impaired colleagues, they can be reluctant to do so because of the potential social stigmatisation of both the impaired practitioner and the accusing physician.[5] Hence there are two sets of outcomes that are typically considered by reluctant witnesses to physician impairment: concerns about the personal consequences for the informant, and concerns about the consequences for the impaired.[13] While there is a need for patient protection, physicians need to feel safe in reporting an impaired colleague and to be assured that the impaired practitioner will be helped rather than harmed. The situation is complex and fraught with conflicts of interest.

Nevertheless, medicine as a profession with an acknowledged fiduciary relationship has a clear responsibility to assure both the public, and all patients, that its practitioners and institutions are trustworthy. Justice and fairness demand that the vulnerability of patients is addressed. This is achieved when practitioners can be trusted to promote their patients' best interests. The privilege of one's calling requires a dedicated and competent fulfillment of responsibilities, and the fiduciary aspect of the relationship is eroded when patients lose confidence and trust in their practitioners. Moreover, the perception that medicine is failing to live up to the terms of its social covenant is further reinforced.

Impairment generally leads to decreased or altered clinical judgement, or diminished technical skills with consequent implications for patient safety. The risks to patients as a result of practitioner impairment far outweigh the risks to the person reporting such impairment. When clinical responsibilities are not being appropriately addressed, patient protection becomes paramount.[13] Moreover, altered judgement could have farreaching implications for one's family, institution and wider community. Impairment can also result in significant problems with others in the medical community.[14] Professionals who are silent with regard to a colleague's impairment are guilty of perpetuating the problem and resultant dangers to patients, institutions and society at large. Hence, they become part of the problem itself.

Some recommendations

If medicine's fiduciary relationship with society is to be truly honoured, and if society is to be assured that patient safety is to be preserved, early detection and management of practitioner impairment is critical and of paramount importance. When the stresses of training and clinical practice become too great, every physician should seek professional assistance to minimise the risk of personal substance abuse and other potential consequences. Formal workplace programmes need to be instituted, or when already established, to be strengthened in order to assure impaired practitioners that they will receive empathic and supportive care. Furthermore, their anxieties and fears over punitive consequences will be allayed.

In addition, institutional support should include educational programmes on impairment. While there are many accounts in the literature of the scope of physician impairrment problems, there is a paucity of information regarding effective ways to educate practitioners about impairment.[15] A shift in practitioner attitude, i.e. a move away from the 'all powerful' to recognition of their own human frailty and hence vulnerability, is necessary as well. Perhaps the current reactive approach to physician performance problems should be replaced with a routine, formal, proactive system of monitoring that uses validated measures to focus strictly on clinical and behavioural performance with the goal of identifying problem practitioners early, before patient safety is jeopardised. Such a system would need to be objective, fair and promptly responsive.[12]

It has recently been shown that disciplinary action against practising physicians by a medical board is often associated with unprofessional behaviour by those practitioners when they were in medical school, pointing to the need for professionalism to play a central role in medical education and throughout one's medical career. The earliest signs of problems often emerge during the training years when it may be possible to take remedial preventive action.[16-18] Robust preventive programmes at an undergraduate level, focusing on the recognition of early warning signs of impairment in oneself and one's fellow students and stressing management that enhances coping skills and problem-solving abilities, are imperative. These could include confidential peer assistance programmes run by students, support services established by psychiatrists, and regular formal and informal seminars on mental health and substance abuse.[19]

Despite the increase in substance abuse among impaired practitioners, and the resultant harmful impact on patient care, the impaired practitioner and in particular the impaired student are under-researched. This problem should be recognised as a research priority. Finally, while impairment that interferes with practitioner ability to engage in professional activities competently and safely applies to those situations where there is direct involvement in patient care, the possibility of broadening the scope of the definition

to incorporate practitioners who, although not directly involved in managing patients, engage in activities that impact on patients, should be investigated. The profession's rules on the impaired practitioner should pertain equally to all practitioners, including those servicing the profession at the level of professional bodies and institutions. It is imperative that the image of medicine as a profession is upheld and that public confidence in the profession is preserved.

Conclusion

A health practitioner's primary duty is towards his or her patient, and patients are required to be treated with reasonable skill and care. Any practitioner who is unable to provide appropriate medical services because of physical or mental impairments should only be allowed to treat patients to the extent that their ability is not restricted by their impairment. Any practitioner servicing the profession at a macro level of decision making should only be allowed to do so to the extent that his or her ability is not restricted by any form of impairment. Treatment of patients by impaired practitioners beyond their competence as a result of such impairment could result in medical malpractice and professional negligence claims against them. There is also a duty on members of the medical profession to uphold the standards of the profession in order to protect the public. Accordingly, they have an obligation to inform the HPCSA when they become aware of colleagues who are a danger to their patients. Not doing so could be perceived as an act of omission that could result in a disciplinary process.

References

1. Gastfriend DR. Physician substance abuse and recovery: What does it mean for physicians – and everyone else? *JAMA* 2005; 293: 1513-1515.
2. Roberts LW, Warner TD, Rogers M, *et al.* Medical student illness and impairment: a vignettebased survey study involving 955 students at 9 medical schools. *Compr Psychiatry* 2005; 46(3):229-237.
3. Zabow T. The management of the impaired doctor and student: the Health Committee (HPCSA) experience. *Transactions* 2004; 48(2): 40-42.
4. Broquet KE, Rockey PH. Teaching residents and program directors about physician impairment. *Academic Psychiatry* 2004; 28(3): 221-225.
5. Farber NJ, Gilbert SG, Aboff BM, Collier VU, Weiner J, Boyer EG. Physicians' willingness to report impaired colleagues. *Soc Sci Med* 2005; 61: 1772-1775.
6. Hicks PJ, Cox SM, Espey EL, Goepfert AR, Bienstock JL, Erickson SS, Hammoud MM, Katz NT, Kreuger PM, Neutens JJ, Peskin E, Puscheck EE. To the point: Medical education reviews – Dealing with student difficulties in the clinical setting. *Am J Obstet Gynecol* 2005; 193: 1915-1922.
7. Tyssen R, Rovik JO, Vaglum P, Gronvold NT, Ekeberg O. Help-seeking for mental health problems among young physicians: is it the most ill that seeks help? *Soc Psychiatry PsychiatrEpidemiol* 2004; 39: 989-993.
8. Health Professions Council of South Africa. *Ethical Rules.* 2001.
9. Health Professions Act No 56 of 1974.
10. McQuoid-Mason DJ. The impaired doctor: legal aspects. *Transactions* 2004; 48(2): 37-39.
11. HPCSA Document: Fitness to Practice. http://www.hpcsa.co.za/hpcsa/default.aspx?id=308 (accessed 3 July 2006).
12. Veldenz HC, Scott KK, Dennis JW, Tepas III JJ, Schinco MS. Impaired residents: Identification and intervention. *Current Surgery* 2003; 60(2): 214-217.
13. Kushner TK, Thomasma DC. *Ward Ethics. Dilemmas for Medical Students and Doctors in Training.* Cambridge, UK: Cambridge University Press, 2001.
14. Florida Medical Association. Impaired Healthcare Practitioners: Identification, Intervention and Management. http://www.firstlab.com/JCAHOPressKit.pdf (accessed 2 August 2006).
15. Leape LL, Fromson JA. Problem doctors: Is there a system-level solution? *Ann Intern Med* 2006; 144(2): 107-115.
16. Papadakis MA, Teherani A, Banach MA, *et al.* Disciplinary action by medical boards and prior behaviour in medical school. *JAMA* 2005; 353: 2673-2682.
17. Paice E, Orton V. Early signs of the trainee in difficulty. *Hosp Med* 2004; 65(4): 238-240.
18. Fletcher CE, Ronis DL. Satisfaction of impaired health care professionals with mandatory treatment and monitoring. *J Addict Dis* 2005; 24(3): 61-75.
19. Galambos G. Doctors Mental Health. RANZCP Dissertation. 1999. http://www.ep.org.au/gg/int/diss.htm (accessed 10 July 2006).

Accepted 11 August 2006.

JOHANNES FREDERICK VAN REENEN

Johannes Frederick van Reenen (20:04:1926 to 08:09:2007)

Johannes Frederick van Reenen was born in 1926. His father was a dentist and his memories of early childhood were seared with the hardship of the Great Depression of 1930-1934.

He was a great pianist, graduated in dentistry from the University of the Witwatersrand in 1949 and pursued his postgraduate studies there and at the University of London. He served his alma mater for more than three decades as Professor of Dental Science, Professor of Prosthetic Dentistry and Dean of the Faculty of Dentistry.

Professor van Reenen published some 65 scientific papers. His research interest covered areas of clinical prosthetic dentistry, bacteriology and anthropology. He was a great authority on the dentitions and jaws of the San, Damara, Vassekela, !Kung, Himba, Barakwana and other Southern African and Southwest African indigenous populations.

His distinguished service record included leadership positions the Dental Association of South Africa, the Odontological Society of South Africa, the International Association of Dental Research, the Prosthodontic Society of South Africa, the South African Association for the Advancement of Science, the Academy of Prosthodontics of South Africa, the South African Medical Research Council, the South African Medical and Dental Council and several other prestigious bodies. He served as scientific editor of the Journal of the Dental Association of South Africa for almost a quarter of a century. Professor van Reenen was an Associate Founder of the College of Medicine of South Africa in 1973 and was conferred the Fellowship ad eundum of the College of Dentistry of South Africa in 2003.

Honours bestowed on him included Fellowship of the Odontological Society, Brookdale Foundation Essayist, R V Bird Award, Honorary Life Membership of the Dental Association, the Bronze Medal of the City of Paris, Honorary membership of the South African Division of the International Association of he Dental Research, Honorary membership of the Prosthodontic Society of South Africa and the Exceptional Service Medal of the Faculty of Health Sciences of the University of Witwatersrand, Johannesburg .

CMSA DATABASE INFORMATION

It would be appreciated if members of The Colleges of Medicine of South Africa could complete this form and send it to the administrative office in Rondebosch (address below).

Title: _____ Initials: _____

(State whether Prof or Dr)

Surname: _____

E-mail Address: _____

Telephone (Work): _____

Facsimile Number: _____

Telephone (Home): _____

Cell phone Number: _____

Identity Number _____

Change of Address

Please also advise the office if your postal address has changed:

Title: _____ Initials: _____

(State whether Prof or Dr)

Surname: _____

New Address _____

_____

_____

_____ Postal Code: _____

Post/Fax to:

The Colleges of Medicine of South Africa

17 Milner Road, Rondebosch 7700, South Africa or **Fax: (021) 685-3766**