TRANSACTIONS

Contents

The Colleges of Medicine of South Africa (CMSA)

50 Years of Excellence
1955-2005

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FEES AND CHARGES

(Applicable 1 June 2005 to 31 May 2006)

PAYABLE BY MEMBERS OF THE CMSA:

Annual Subscriptions

Local:
Associate Founders, Associates, Fellows, Members and Certificants: R510
Diplomates: R300
Overseas (all categories of members): R510
Retired members: R58
Assessment Fee: Fellowship by Peer Review: R750
Registration Fee: Associates: R480
Fellows, Members, Certificants and Diplomates: R330
(The registration fee for Fellows, Members, Certificants and Diplomates form part of the examination fee)

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: R100
Gown only: R70
Hood only: R30
For the purchase of hoods: R175

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

Travelling Allowance: R2,38/km

Invigilating Fee
(not applicable to salaried personnel of the CMSA)
Full day: R300
Half day: R160

Rate of Payment for Secretarial Assistance
(not applicable to CMSA staff)

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 R60 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.

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

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.

EDITORIAL
Prof Gboyega A. Ogunbanjo

Dear Colleagues,

This particular issue of the Transactions (Volume 50, Number 1) is dedicated to the Golden Jubilee celebrations, and in particular to the symposium of the Colleges of Medicine of South Africa (CMSA), which took place on Saturday 22nd October 2005. The theme of the symposium was on "The future of Academic Healthcare in Africa".

The Presidential newsletter highlights some of the important activities that took place in 2005, which included the Golden Jubilee celebrations, Discovery Health Foundation's commitment to funding postgraduate education especially for the marginalized (previously disadvantaged) doctors and the CMSA's increasing relevance and contributions to policy and decisions of the Health Professions Council of South Africa (HPCSA), National Department of Health and the universities through the Committee of Deans.

The Admissions ceremony that took place in Cape Town witnessed the conferment of diplomas in the following categories: 3 Fellows ad eundem, 15 Honorary Fellows, 165 Fellows, 4 Members, 257 Diplomates and 24 Certificants. A total of 19 candidates excelled in their various college examinations and were recommended for medals.

More than half of this issue contains the various presentations by the eminent speakers during the symposium. The editorial by Prof Bongani Mayosi – Chairman of the Golden Jubilee Organising Committee clearly summarizes the events that took place during the Golden Jubilee celebrations, including the symposium. Presentations were made by the following academics:

a. Prof. George Mensah – Centres for Disease Control and Prevention Atlanta, USA
b. Prof. Karen Silwa – University of Witwatersrand Johannesburg, South Africa
c. Prof. Richard Lilford – University of Birmingham, UK
d. Prof. Dan Ncayiyana – Durban Institute of Technology Durban, South Africa
e. Prof. Wole Akande – Institute of Agricultural Research and Training Ibadan, Nigeria
f. Prof. Anthony Mbewu – Medical Research Council of South Africa, Cape Town South Africa
g. Prof. Sarala Naicker - University of Witwatersrand Johannesburg, South Africa
h. Dr. Percy Mahlati – Department of Health Pretoria, South Africa
i. Dr. Mamphela Ramphele – former Vice-Chancellor of University of Cape Town, South Africa

The Golden Jubilee celebrations were also marked by the completion and launch of the book on the "History of the Colleges of Medicine of South Africa" edited by Dr. Ian Huskisson. Copies are available from the CMSA Cape Town and Johannesburg offices for your libraries. Also in stock for sale are Golden Jubilee Insignia, which include ties, ladies scarves, lapel pins, cuff links and key rings.

In this same issue of the Transactions are the minutes of the Annual General Meeting, which took place on the 21st October 2005 in Cape Town, which highlight the important decisions agreed upon by the senate. These included the ratification of the election results for the triennium (2005 to 2008) of the various Presidents, Secretaries and Councillors of the constituent colleges, and the CMSA senate. It is important that you review the list to know the representatives of your college council and CMSA senate.

As I sign off on this special issue of the Transactions, which marks the 50th Anniversary of the Colleges of Medicine of South Africa, I take this opportunity to inform you that the next issue promises to be exciting as the focus will be on the good work taking place in the rest of Africa through initiatives and collaborations of some of the constituent colleges of the CMSA and their African counterparts. In addition, some of the Continuing Professional Development lectures and symposia will be featured.

Enjoy reading this special issue on the 50th anniversary of the CMSA and keep it safe in your study library for posterity.

NB: "Letters to the editor" on previous articles published in the Transactions are welcomed. In addition, if you know the contact details of those listed as "Lost Members", please inform them and the CMSA Cape Town office at administration@colmedsa.co.za

Editor
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E-mail: gao@intekom.co.za

LETTERS TO THE EDITOR

You are cordially invited to submit letters to the Editor.

1. Letters should be addressed to: Prof. Gboyega Ogunbanjo

2. Kindly send letters as follows:
A. To: gao@intekom.co.za and copy bernise@colmedsa.co.za
B. Subject : Transactions – Letters
C. Attach: a virus free MS Word file or an html file

OR

A. Letters by land mail: written/typed or on disk
B. Mrs Bernise Bothma
The Colleges of Medicine
17 Milner Road
Rondebosch
7700

3. All letters must be proofread.

4. No letter should be longer than 250 words.

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.

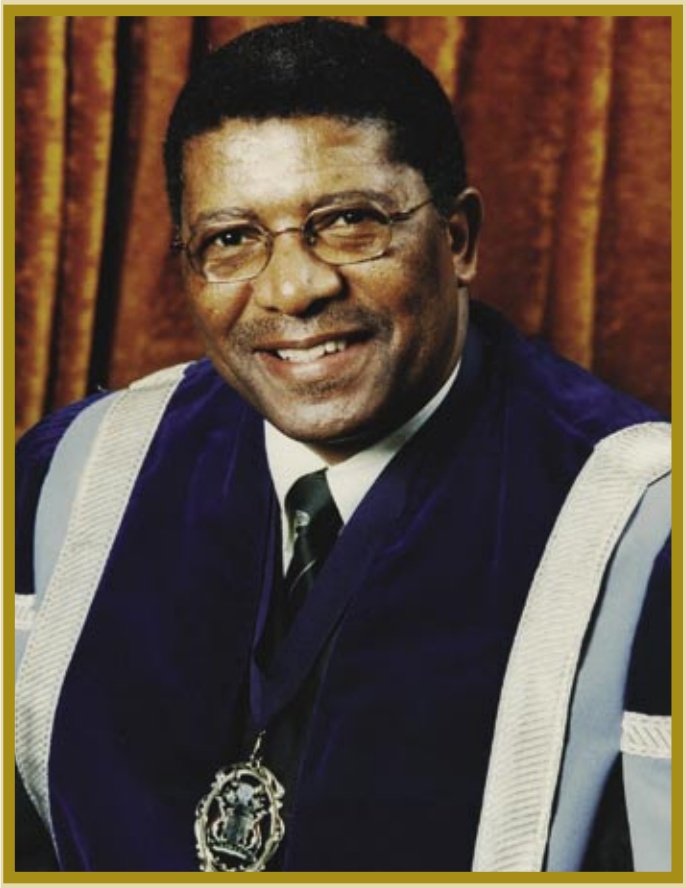
3. References

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.



Lizo Mazwai

President 2004 - 2007

I would like to reflect briefly on the year 2005. Our Golden Jubilee celebrations were a resounding success with participation of Presidents of overseas colleges and academies who formed part of the International Association of College and Academy Presidents (IACAP) membership and international guests from the African continent and beyond. The proceedings commenced with the presidential dinner on Wednesday evening 19 October 2005 and concluded with a golden jubilee dinner at Moyo, on the Spier Estate, on Saturday the 22nd. The business part of the golden jubilee included the IACAP meeting which was held at the CMSA building in Rondebosch on Friday 21 October, followed by the 10th Interdisciplinary Symposium on "The Future of Academic Healthcare in Africa" on Saturday the 22nd at the Protea Hotel Stellenbosch. A full report on the celebrations appears in this issue of Transactions.

Some of the important issues in transformation is not just the way we do our core business, but how we have transformed into a National Body that has a voice to be heard on all matters of national interest.

Apart from the standing relationships with the HPCSA, National Department of Health and University through the Deans, we have also had occasions to comment – particularly on the program of the Human Resource Development nationally. The recent final draft of the Human Resource Development Strategy has been relearned for comment, hopefully by the end of March 2006. The National Department of Health hopes to make an announcement on this on 7 April 2006. The position papers of the CMSA should be a point of focus for further discussion on national issues.

The African Development Initiative led by the President, will also take us into contact with foreign affairs, NEPAD and the African Union.

Finally, the issue of funding of Health Science Education and Training in the country is under discussion and the CMSA should be participating in that important debate.

Some of you will be aware that Discovery Health Foundation is also committed to funding postgraduate education – especially for the marginalised and the President is engaged in research and negotiations on the future of this initiative.

These are just some of the important issues which, in the next three to five years, should characterise the transformation of the CMSA.

ADMISSION CEREMONY
20 OCTOBER 2005

The admission ceremony was held in the Podium Hall, of the City Hall, Darling Street, Cape Town.

At the opening of the ceremony the President, Professor Lizo Mazwai asked the audience to observe a moment's silence for prayer and meditation.

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

The new **diplomates, certificants and members**, were announced and congratulated individually.

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 Anil Madaree individually hooded the new Fellows. The Honorary Registrar – Finance and General Purposes, Professor Bongani Mayosi handed each graduate a scroll containing the Credo of the CMSA.

The Phyllis Knocker/Bradlow Award, the most prestigious award of the CMSA, was awarded to Dr TT Nwe for 2004. Dr Nwe is an Otorhinolaryngologist from Kwazulu-Natal. Five medallists were congratulated by the President for their outstanding performance in CMSA examinations.

Three Fellows ad eundem were admitted. Professor Peter Cleaton-Jones to the College of Dentistry – citation written by Professor John Lemmer and read by Professor John Lownie, Professor John Gear to the College of Public Health Medicine – citation written and read by Professor Brendan Girdler-Brown and Professor Justin van Selm to the College of Ophthalmologists – citation written and read by Professor Andries Stulting.

Fifteen Honorary Fellows were admitted. Dr Mamphela Ramphele to the Colleges of Medicine of South Africa – citation written and read by Professor Bongani Mayosi, Honorary Registrar of the CMSA. Dr Vince Caruso and Professor Lai-Meng Looi to the College of Pathologists – citations written and read by Professor Simon Nayler. Professor Jonathan Azubuike to the College of Paediatricians – citation written and read by Professor John Pettifor. Professor Sheila Hollins to the College of Psychiatrists – citation written by Professor Tuviah Zabow and read by Professor Cliff Allwood. Professor Osato Giwa-Osagie to the College of Obstetricians and Gynaecologists – citation written and read by Professor Zephne van der Spuy. Dr Stewart Hamilton, Professor Niall O'Higgins and Mr John Smith – citations written and read by Professor John Robbs and Professor Lewis Spitz – citation written by Professor Heinz Rode and read by Professor John Robbs admitted to the College of Surgeons. Professors George Mensah, Neil Douglas, Joseph McKenna and Drs Jill Sewell and Bandula Wijesiriwardena to the College of Physicians – citations written by Professor Bongani Mayosi, Professor Ken Huddle, Ralph Kirsch, Bongani Mayosi and Sarala Naicker respectively and read by Professor Ken Huddle.

All in all the President admitted 165 Fellows, 4 Members, 257 Diplomates and 24 Certificants.

Professor Dan Ncayiyana delivered the oration.

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

MEDALLISTS 2005

RECOMMENDATION FOR MEDALS - 2005

FCA(SA) Part I – ABBOTT MEDAL (Best candidate in Pharmacology)
Dr Raveen Behari – October 2005

FCA(SA) Part II – CREST HEALTHCARE TECHNOLOGY MEDAL (Most distinguished candidate)
Dr Deane Brendon Murfin – October 2005

FCA(SA) Part II – JACK ABELSOHN MEDAL & BOOK PRIZE (Best candidate in the clinical section)
Dr Deane Brendon Murfin – October 2005

FC Cardio(SA) Final – LIBERO FATTI MEDAL
Dr Rishendran Naidoo – May 2005

FCMFOS(SA) Final – SA SOCIETY OF MAXILLO-FACIAL & ORAL SURGERY MEDAL
Dr Craig Bradley PEARL – October 2005

FC Neurol(SA) Part II – NOVARTIS MEDAL
Dr Annette Swanepoel – October 2005

FC Orth(SA) Final – JM EDELSTEIN MEDAL
Dr Karl Frielingsdorf – October 2005

FC Paed(SA) Part I – LESLIE RABINOWITZ MEDAL
Dr Angela Dramowski – October 2005

FC Path(SA) – COULTER MEDAL
Dr Nelesh Premapragasan Govender (Micro) – October 2005

FCP(SA) Part II – SUZMAN MEDAL (Best overall candidate)
Dr Yusus Sayed Nanabhay – October 2005

FCP(SA) Part II – ASHER DUBB MEDAL (Best candidate in the Clinical Section)
Dr Suman Maharaj – May 2005
Dr Adnaan Variava – October 2005

FC Psych(SA) Part I – LYNN GILLIS MEDAL
Dr Keshika Singh – October 2005

FC Psych(SA) Part II – NOVARTIS MEDAL & PRIZE
Dr Hendrik Sebastian Temmingh – October 2005

FC Rad Diag(SA) Part I – RHÔNE-POULENC RORER MEDAL
Dr Colin Richard Turner – May 2005

FC Rad Diag(SA) Part II – JOSSE KAYE MEDAL
Dr Shalendra Kumar Misser – May 2005

FCS(SA) Intermediate – BREBNER AWARD
Dr Marc Michael Bernon – October 2005

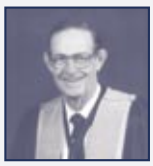
H Dip Int Med(SA) – YK SEEDAT MEDAL
Dr Rudi Renison – October 2005

DA(SA) – SASA JOHN COUPER MEDAL
Dr Kerry Jane Timmerman – October 2005

Dip PEC(SA) – WALTER KLOECK MEDAL
Dr Stephanus Hatting – May 2005

MEDALLISTS 2005

CITATION
FELLOWSHIP AD EUNDEM



PROFESSOR PETER EIDDON CLEATON-JONES

COLLEGE OF DENTISTRY OF SOUTH AFRICA

Peter Eiddon Cleaton-Jones matriculated from the Marist Brothers College in 1957. At the end 1963 he swept the board of all undergra Best regards, duate medals and awards, and received his degree in dentistry with honours at the University of the Witwatersrand, only the fifth person to graduate with honours in the 39 year history of the Faculty of Dentistry to that date. After also qualifying in medicine 4 years later, he went on to gain a PhD at his alma mater in 1975, followed by two postgraduate diplomata, the diploma in anaesthetics of the College of Medicine, and a DSc in 1991, also at Wits. Medunsa awarded him an honorary PhD in 2001.

He is currently Professor and Head of the Division of Experimental Odontology, and Director of the MRC Dental Research Institute at Wits University. He holds a teaching position in the Division of Maxillofacial and Oral Surgery, and until recently he also taught in the department of anaesthesia. For many years he served as a part-time medical officer in emergency medicine at Hillbrow Hospital. He was recently appointed to an Honorary Professorship, Department of Paediatric Dentistry, University of Leeds.

Prof Cleaton-Jones is a full member of the Academy of Science of South Africa, a Distinguished Service Awardee of the International Association for Dental Research, the recipient of the South African Medal (Gold) of the Southern African Association for the Advancement of Science, a Distinguished Researcher Awardee of Wits University, and a Silver Medallist of the South African Medical Research Council.

His vast research experience was gained not only in South Africa but in the UK, in the Netherlands and in Denmark. His special interests lie in the aetiology and epidemiology of dental caries, biocompatibility of dental materials, and tissue response and healing after trauma. His knowledge and expertise in research methodology, and in research ethics have been especially sought after.

He has contributed over extended periods of time to the teaching programmes of no fewer than nine different University Departments at Wits, and several departments at the University of Pretoria. He has served for decades on a variety of committees, boards of control, review panels, and the like, not to speak of numerous selection committees and advisory boards, with a 3-year stint as Assistant Dean (Research) in the Faculty of Health Sciences.

His output of publications has been prodigious, comprising no fewer than 302 full scientific articles, two books, 12 book chapters, 13 editorials, and 394 papers presented at scientific meetings in South Africa and abroad, 130 of these being by invitation, the rest by submission.

Peter is married with a son of 36 years. He is an expert model railway engineer, a philatelist, has an interest in genealogy, and for some years was a member of medical radio broadcasting panels.

Mr President, this man of many talents, and of great scientific accomplishment and integrity is most worthy of being honoured, and we have pleasure in presenting Professor Peter Cleaton-Jones for admission to Fellowship ad eundem of the College of Dentistry of South Africa.

Author: John Lemmer

CITATION
FELLOWSHIP AD EUNDEM

PROFESSOR JOHN SPENCER SUTHERLAND GEAR

COLLEGE OF PUBLIC HEALTH MEDICINE

We honour John Gear for his steadfast and passionate commitment to the ideals and the practice of the speciality of Public Health Medicine in South Africa, and for the teaching and inspiration of an entire generation of Public Health specialists now practising throughout the country as public health leaders, service providers, teachers, and researchers. His influence and leadership are fondly remembered and greatly acknowledged by all who have worked with him.

John Gear was a Fellow of the College of Physicians and a former corporate Fellow, examiner and councilor of the College of Public Health Medicine. It is particularly fitting in the 50th anniversary year of the Colleges that we honour one of the most influential personalities in our discipline, someone who was responsible for helping to get our discipline established in South Africa and building its prestige and reputation.

John Gear received most of his medical and post graduate training at the University of the Witwatersrand, but also at Oxford University where he was awarded the DPhil after 4 years of study on a Nuffield scholarship in 1979. He then returned to Johannesburg as the Head of the Department of Community Health: a position that he filled for the next 11 years before leaving to become the academic director and Professor Assignatus of the Wits rural facility near Bushbuckridge.

During his career John Gear published, either as the leading author or as a co-author, more than 60 articles in the peer reviewed scientific press, with a wide range of subjects covered including complement deficiency, Marburg fever, dietary fibre, hypertension, primary health care, rural health and human resources for health. He also co-authored a set of three text books that were used for several years for the training of medical practitioners in the

discipline using South African examples and a participatory approach that was novel at the time. Although these texts were intended mainly for undergraduate training and are now out of print, they are still sought after by candidates preparing for the specialist exams because they provide such a clear and logical foundation on which to prepare for these exams.

John Gear was one of the pioneers of participatory learning, of community based learning for medical trainees, and of the interdisciplinary approach to public health problem-solving. He supervised 8 successful PhD students and took part in the training and mentorship of a very large number of Public Health Medicine specialists, mainly at Wits although his influence touched many others who trained at other institutions in South Africa. He is well-remembered for fostering a culture within his department of uncompromising opposition to apartheid.

It is noteworthy that, when asked what his proudest achievements are John Gear lists the registrars and doctoral students that he helped to train: the list of names is very long and two thirds are either women or people of colour. Many of the people he names are currently in senior or influential positions, mainly in South Africa but also abroad.

John Gear was the recipient of numerous distinctions, appointments and awards during his career including the CHASA silver medal for service to public health, Kellogg International Fellowship, Nuffield scholarship and membership of the commission of enquiry into health care in Namibia and the Pick committee on human resources for health.

We honour John Gear as an important change agent in university education, Public Health, and opposition to apartheid, and we thank him for his courage, leadership, and sacrifice in the interests of a better, healthier, South Africa for all.

Author: Brendan Girdler-Brown

CITATION
FELLOWSHIP AD EUNDEM

PROFESSOR JUSTIN LEANDER VAN SELM

COLLEGE OF OPHTHALMOLOGISTS

Professor Justin van Selm was born on 6th March 1919 and he was educated at Rondebosch Boys High School and the University of Cape Town. He served in South African, North African, Italian and Far East Commands during the Second World War and wore the rank of Captain. He was in General Family practice from 1945 to 1946. He worked as a registrar in the Department of Ophthalmology at the University of Cape Town from 1946 to 1947 and at the Moorfields hospital in London from 1947 to 1948. He was a part-time Consultant at the University of Cape Town and Groote Schuur hospital from 1949 to 1978. He also was a Consultant at the Red Cross War Memorial Children's Hospital from 1956 to 1978. He became the Professor and Head of the Department of Ophthalmology in 1978 and he served in this position until his retirement in 1984. He then went into private practice in Cape Town and in Plettenberg Bay where he finally retired 2 years ago at the age of 84 years!

He is a Fellow of the American College of Surgeons, a Fellow of the Royal College of Ophthalmologists and a Fellow of the American Academy of Ophthalmology. Prof Van Selm is an Honorary member of the South African Medical Association, the Association of Paediatric Surgeons of South Africa, the American Association of Paediatric Ophthalmology and Strabismus and the International Society of Paediatric Ophthalmology and Strabismus.

He is a Past President of the Ophthalmological Society of South Africa and he was the first recipient of the D J Wood Memorial Lectureship and Medal.

He received Meritorious Awards from the University of Cape Town and the Rotary Club of South Africa. He also received the Paul Harris Medal from the Rotary Club of South Africa.

Prof Justin van Selm was an Examiner in Ophthalmology and Chairman of the Faculty of Ophthalmology for 16 years.

He is married to Cherry Ida Drew and they have three children: Justine, a psychiatrist in the USA, Adrian, a shipping consultant in Cape Town and Janet, a consulting insurance broker in Plettenberg Bay.

He loved to play golf and he is a Past Captain at the Royal Cape Golf Club.

Mr President, I have the honour and great pleasure to ask you to confer the Fellowship ad eundem of the College of Ophthalmologists of South Africa to Professor Justin Leander van Selm.

Author: Andries Stulting

CITATION
HONORARY FELLOWSHIP

DOCTOR MAMPHELA RAMPHELE

COLLEGES OF MEDICINE

Dr Mamphela Aletta Ramphele is a South African academic, businesswoman and medical doctor and was an anti-apartheid activist. She was born near Polokwane in the Limpopo province. She completed her schooling at Setotolwane High School in 1966 and subsequently enrolled for pre-medical courses at the University of the North. In 1968 Dr Ramphele was accepted into the University of Natal's Medical School (then the only university that allowed black

students to enroll without prior permission from the government), where she qualified as a medical doctor in 1972. While at university she became increasingly involved in student politics and anti-apartheid activism and was one of the founders of the Black Consciousness Movement, along with Steve Biko. Due to her political activities, she was internally banished by the apartheid government to the town of Tzaneen from 1977 to 1984.

Continuing her academic studies, Mamphela Ramphele received a PhD in Social Anthropology from the University of Cape Town, a Bachelor of Commerce degree in Administration from the University of South Africa as well as diplomas in Tropical Health & Hygiene and Public Health from the University of the Witwatersrand. She has also authored and edited a number of books.

Dr Ramphele joined the University of Cape Town as a research fellow in 1986 and was appointed as one of its Deputy Vice-Chancellors in 1991. She was appointed to the post of Vice-Chancellor of the university in September 1996, thereby becoming the first black woman to hold such a position at a South African university.

In 2000, Dr Ramphele became one of the four Managing Directors of the World Bank. She was tasked with overseeing the strategic positioning and operations of the World Bank Institute as well as the Vice-Presidency of External Affairs, and was the first South African to hold this position. In June 2004 she was appointed by Kofi Anan, Secretary-General of the United Nations, as the co-chair of a new UN Commission on International Migration. Memphela Ramphele has served as a trustee of the Nelson Mandela Children's Fund, as the director of the Institute for a Democratic Alternative for South Africa (IDASA) and as a board member of the Anglo-American Corporation and Transnet.

She was voted 55th in the Top 100 Great South Africans in 2004.

Dr Ramphele has received eighteen honorary degrees and numerous awards and honorary degrees, including a Doctorate in Humane Letters from Hunter College of the City of New York in 1984; a Doctor of Science degree from Tufts University in May 1991; a Honorary Doctorate in Medicine from the University of Natal; and the Medal of Distinction from Barnard College in the United States.

She is also a former fellow of the Bunting Institute and was elected as an honorary member of the Alpha and Iota chapters of Phi Beta Kappa at Radcliffe and Harvard Colleges.

Some of her publications are:
Uprooting Poverty: The South African Challenge, 1989, Co-author. This book draws together research conducted by the second Carnegie inquiry into poverty and development in South Africa and received the 1990 Noma award, an annual prize given to African writers and scholars whose work is published in Africa.
Bounds of Possibility: The Legacy of Steve Biko, 1991, Co-editor.

Restoring the Land, 1992, Editor This publication deals with the ecological challenges facing post-apartheid South Africa.

A Bed called Home, 1993, Author. This book was based on Ramphele's PhD thesis in Social Anthropology, The Politics of Space, and deals with life in the migrant labour hostels of Cape Town.

Mamphela Ramphele - A Life, 1995, Author.
Dr Mamphela Aletta Ramphele is presented for Honorary Fellowship of The Colleges of Medicine of South Africa to acknowledge her scholarship, her service to the community, and her leading role in raising development issues and spearheading projects aimed at the upliftment of the most disadvantaged sectors of the community in South Africa.

Author: Bongani Mayosi

CITATION
HONORARY FELLOWSHIP
DOCTOR VINCE CARUSO
COLLEGES OF PATHOLOGISTS

Vincent Caruso is a Medical Graduate of the University of Western Australia. He also has an MBA from the University of Western Australia.

He undertook post-graduate training, choosing to work in the discipline of Anatomical Pathology and was admitted to Fellowship of the Royal College of Pathologists of Australia in 1980 and in the same year, was admitted as a member of the Royal College of Pathologists (UK). He spent two years as a lecturer in Pathology at Charing Cross Hospital in London early in his career.

Currently a Partner and Director of Pathology at Western Diagnostic Pathology, Vince Caruso served as the College Councillor for Western Australia from 1990 to 1996 and as Secretary of the WA Branch of the Australian Medical Association from 1997 to 1999. He has been President of the WA Branch of the Australian Society of Cytology, a member of the WA Medical Council and a member of the WA Clinical Oncology Group from 1996 to 2003.

Dr Caruso has been a member of the Pathology Professional Activities Committee of the Royal College of Pathologists of Australasia since 1996, was elected Vice President of the College in September 1999 and re-elected in October 2001. He has represented the Royal College of Pathologists of Australasia on various government committees, including the Pathology Consultative Committee and the Pathology Services Table Committee and has been President of the College since 2003.

Vince Caruso is a member of several international societies including the International Academies of Pathology and Dermatopathology and is a member of the Australian Medical Association and the Australian Society of Cytology.

Born in Mesina, Italy, Vince is the father of three children, all daughters. Outside of Pathology he is a keen golfer, tennis player, skier and enjoys opera.

The College of Pathologists is delighted to confer an Honorary Fellowship on Vince Caruso.

Author: Simon Nayler

CITATION
HONORARY FELLOWSHIP

PROFESSOR LAI MENG LOOI

COLLEGES OF PATHOLOGISTS

Lai Meng Looi was born in 1950 in Bentong, Pahang, Malaysia. After completing her schooling in Kuala Lumpur, she embarked upon medical training as an undergraduate at the University of Singapore, obtaining her MBBS degree IN 1975. She was awarded her M Path from the University of Malaya in 1979, MRC Path (UK) in 1981 and FRCPath (UK) in 1993. She is a member of the International Academy of Cytology, a Fellow of the Royal College of Pathologists of Australasia and has a MD from the University of Malaysia. She is a fellow of the Academy of Medicine of Malaysia and a Foundation Fellow of the Academy of Sciences of Malaysia.

Professor Looi is currently the Professor (Chair), and Senior Consultant Histopathologist, Department of Pathology, University of Malaya, Kuala Lumpur - a post she has held since August 1986. She has also served as Deputy Dean at this institution.

Professor Looi is currently the President of the Malaysian Society of Pathologists, a Council member of the Malaysian Medical Council and serves on several committees and advisory bodies. She is an evaluator for the National Accreditation Board of Malaysia, and is an examiner for the Royal College of Pathologists (UK) and the Royal College of Pathologists of Australia

She is a member of numerous prestigious societies and sits on the editorial boards of several journals including: The Malaysian Journal of Pathology, Histopathology, Human Pathology, Journal of Pathology and Pathology. She has authored over 250 publications, and has presented more than 300 presentations at Scientific Conferences, several as guest speaker.

Professor Looi's contribution to research and teaching has been recognized nationally and internationally; and she has been the recipient of many prestigious prizes for these. Her major research interests include amyloidosis (for which she received her Doctorate in Medicine); renal pathology; oncology, particularly breast, cervical, and childhood solid tumours; computerised image analysis, morphometry; and applied histopathological techniques.

Lai Meng Loo is a multifaceted pathologist, researcher, educator and shining beacon for all pathologists and we are privileged to recognise her massive contribution to the field of pathology with an Honorary Fellowship of the College of Pathologists.

Author: Simon Nayler

CITATION
HONORARY FELLOWSHIP

PROFESSOR JONATHAN AZUBUIKE

COLLEGES OF PAEDIATRICIANS

Professor Azubuike is currently President of the National Postgraduate Medical College of Nigeria, a position he has held for the past two years. The National Postgraduate Medical College is similar to our own Colleges of Medicine, in that it is responsible for organising all postgraduate specialist programmes and examinations in Nigeria. Prior to being appointed President, he was Chairman of the Faculty of Paediatrics in the College for 5 years.

Professor Azubuike completed his schooling in Nigeria and then moved to Bonn, Germany, where he obtained his MD in 1964. Following this, he travelled to the United States of America, where he specialised in Paediatrics, and completed a Fellowship in Ambulatory paediatrics before returning to Germany to complete a neonatal Fellowship in Bonn.

Professor Azubuike is a Fellow of the American Academy of Pediatrics, the Nigerian Medical College, the West African College of Physicians, and the International College of Paediatrics. This year, he was elected a Fellow of the Royal College of Physicians of Edinburgh.

On the Academic front, Professor Azubuike returned to Nigeria and the School of Medicine at Enugu, where he rose rapidly through the academic ranks to become Professor of Paediatrics in 1980, a position he held until the end of last year. During this time he has also served as Deputy Provost of the College of Medicine and a Senate Member of the Governing Council and Deputy Vice-Chancellor of the University of Nigeria.

Professor Azubuike has an enviable list of publications mainly in the field of paediatrics, and is chief editor of the first paediatric textbook published specifically for Nigerian medical students and postgraduate students, the second edition of which should be appearing this year.

In recognition of his services in child health and his standing within the medical community within Nigeria, he was presented with the Paediatrician of the Year Award in 1998, which is the highest honour given by the Paediatric Association of Nigeria. It is clear from his CV, that we are honoured to be able to bestow an Honorary Fellowship of the College of Paediatricians of South Africa on Professor Azubuike during our golden jubilee celebrations.

Author: John Pettifor

CITATION
HONORARY FELLOWSHIP

PROFESSOR SHEILA HOLLINS

COLLEGES OF PSYCHIATRISTS

Sheila Hollins was elected as President of the Royal College of Psychiatrists and was inaugurated at the Annual Meeting in Edinburgh in June 2005. She is Professor of Psychiatry and Head of the Academic Department of Mental Health at St. George's Hospital Medical School, University of London.

She is Consultant Psychiatrist in Learning Disability and Head of the Specialist Learning Disability Psychotherapy Service at South West London & St. George's Mental Health Trust and Vice-President of the Institute of Psychotherapy and Disability.

Sheila Hollins grew up in Sheffield and taught science in Nigeria as a volunteer before studying medicine at St. Thomas's. After three years in General Practice, she turned to psychiatry, working first in child psychiatry, and then in the field of learning disability. Her practice of clinical psychiatry retains a strong interest in physical health. She has had a broad influence across many fields of psychiatry, especially in learning disability, child psychiatry, psychotherapy, bereavement and trauma.

Professor Hollins was Vice-President of the Royal College of Psychiatrists between 2002 and 2004 and during this time was responsible for reviewing gender equality issues in the college. As a member of the College's Board of International Affairs her key contribution has been to develop a Voluntary Service Overseas Fellowship Scheme for Specialist Registrars to work in third world countries in training placements up to a year.

As the recipient of a number of awards, several relating to issues of communication with learning disabled patients, Professor Hollins has also worked at the Department of Health as Senior Policy Adviser on Learning Disability and Autism.

She is author of a wide range of research and professional journal articles, chapters in edited books, books both for professionals and for the public.

In the field of international work she is committed to strengthening the Royal College's global contributions to mental health policy and to support training and service development.

Author: Tuviah Zabow

CITATION
HONORARY FELLOWSHIP

PROFESSOR OSATA GIWA-OSAGIE

COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

Professor Osato Ona Frank Giwa-Osagie is presently Professor of Obstetrics and Gynaecology and Head of the Unit of Reproductive Endocrinology and Fertility Regulation in the Department of Obstetrics and Gynaecology, College of Medicine, University of Lagos and Honorary Consultant and Gynaecologist at the Lagos University College Hospital, Nigeria. He attended Cambridge University where he obtained a BA (Hons) in Pathology in 1969 and graduated MB,B CHIR (Hons) in June 1972. He completed his specialist training at Kings College Hospital Medical School in London. After spending a year in the Division of Steroid Endocrinology at Leeds University as an Adrian Stokes Research Fellow he was awarded the degree MSc . In 1977 he obtained the MRCOG and was admitted to the Fellowship of the Royal College of Obstetricians and Gynaecologists in 1989. He is a Fellow of the West African College of Surgeons and of the International College of Surgeons.

During his training in the United Kingdom he developed expertise in Reproductive Health and fertility regulation, working with some of the major figures in our discipline. After almost two years as a lecturer at the Department of Obstetrics and Gynaecology at Kings College Hospital, he returned to Nigeria to utilise his expertise and develop his research interests within his own country. He was appointed in 1988 as the youngest ever Head of Department of Obstetrics and Gynaecology at the College of Medicine of the University of Lagos, a position he held for an unprecedented three terms.

Professor Giwa-Osagie has been involved in numerous reseach and clinical assignments and has played a seminal role in improving maternal and child health in Nigeria and elsewhere in Africa. He has promoted safe contraceptive practice and abortion care, served on many national and international bodies and committees. He has been involved in WHO projects as well as those for several other international agencies. During his tenure as Head of Department he reorganised and improved the specialist training programme for Obstetrics and Gynaecology and introduced numerous innovations into the care of women. He has been an official in the West African College of Surgeons and has served as Secretary General, Vice-President and President.

His academic endeavour, research and commitment to improving Women's Health have been widely recognized. He has been awarded travel scholarships, recognized by the President of Senegal for his services to surgical education and service, been given a life achievement award for "exceptional dedication to improving Women's Health" by IPAS and in 2000 was presented with the distinguished service award for improving Women's Health by the Society of Gynaecology and Obstetrics in Nigeria. This was the first award of this kind. In 2004 he was honoured with the Nigerian National Honour of Officer of the Order of the Niger for outstanding contributions to health care and medical research and education. Professor Giwa-Osagie truly represents excellence within our discipline. He is an example to all of us. He has chosen to concentrate his professional expertise and efforts within Africa and has contributed enormously to the wellbeing of women and the honours which he has received are well deserved and entirely appropriate and have been earned through great effort and dedication to our discipline.

Author: Zephne M van der Spuy

CITATION
HONORARY FELLOWSHIP
DOCTOR STEWART HAMILTON
COLLEGE OF SURGEONS

Dr Hamilton is a graduate of McGill University; he obtained his Bachelor of Arts in 1972 and his MDCM in 1977. He interned at the Victoria Hospital in London, Ontario and then completed his residency training in general surgery at the University of Alberta, in 1983, also completing an MSc in Experimental Surgery.

He obtained an Alberta Heritage Foundation for Medical Research Fellowship in Critical Care, which was undertaken at the University of Toronto (affiliated with the Trauma Centre at Sunnybrook Medical Centre). Following his return to Edmonton, Dr Hamilton was appointed as an Assistant Professor in the Division of General Surgery. Active in critical care, trauma and general surgery, he was the Director of the Critical Care/Trauma Unit at the University of Alberta Hospital in Edmonton from 1986 to 1993. In 1993, he was appointed as the Walter Stirling Anderson Professor and Chair of the Department of Surgery at the University of Alberta, and Chief of Surgery at the University of Alberta Hospital, completing two five-year terms in June 2003.

Stewart Hamilton was elected to the Council of The Royal College of Physicians and Surgeons of Canada in 1996. He served on the Royal College's Executive Committee from 1998-2002 as Vice-President Corporate Affairs, and in September 2003, became President-elect. He assumed the Presidency of the College in September 2004.

Dr Hamilton was elected to the Council of the Canadian Medical Protective Association in 2002 and served on its Executive Committee for two years. He served as President of the Trauma Association of Canada from 1989 to 1990. Dr Hamilton is currently a governor of the American College of Surgeons and is a member of many professional societies.

He has published papers on multi-organ dysfunction, shock, resuscitation in trauma, the economics of critical care, regionalisation of surgical services and population-based studies of gastric cancer. Dr Hamilton maintains an active practice in gastrointestinal and oncological surgery, in addition to regular emergency surgery on-call duties at the University of Alberta Hospital.

A resident of Edmonton, Alberta, since 1978, Stewart Hamilton is married with four children. His standing in the profession justifies his election to Honorary Fellow of the College of Surgeons of South Africa.

Author: John Robbs

CITATION
HONORARY FELLOWSHIP
PROFESSOR NIALL O'HIGGINS
COLLEGE OF SURGEONS

Niall O'Higgins, born in 1942, is a true son of Ireland. In 1965 he graduated from University College Dublin Medical School with honours and two years later completed a BSc in Anatomy with honours. In 1970 he became a Fellow of the Royal Colleges of Edinburgh, England and Ireland. Four years of research on the hormonal influences in breast cancer resulted in the award of Master of Surgery by thesis.

Clinical training occurred in Ireland and various centres in England. He was appointed to his present post as the Professor of Surgery and Head of Department at University College Dublin and Consultant Surgeon at St Vincent's University Hospital Dublin in 1978.

In 2004 Niall O'Higgins was elected President of the Royal College of Surgeons in Ireland He has a major interest in oncology and serves on various international oncological societies. He is the current Chairman of the Editorial Board of the European Journal of Surgical Oncology.

Numerous awards and distinctions have been made to Niall, including various visiting professorships, throughout the world. He is also an Honorary Fellow of the College of Physicians and Surgeons of Glasgow. He has been extremely productive academically, with more than 250 publications to his credit.

Married to Rosaleen, Prof Nial O'Higgins is a devoted family man and has three daughters and a son. He thoroughly deserves to be admitted to Honorary Fellowship of the College of Surgeons of South Africa.

Author: John Robbs

CITATION
HONORARY FELLOWSHIP
MR JOHN SMITH
COLLEGE OF SURGEONS

John Allan Raymond Smith is currently President of the Royal College of Surgeons of Edinburgh and Consultant General Surgeon to the Northern General Hospital, Sheffield.

Having completed his basic medical degree at the University of Edinburgh he pursued his surgical training in Scotland and under the aegis of the Royal Army Medical Corps. He had the distinction of gaining medals in surgery, pathology, medicine and the course medal for the junior postgraduate medical officer course.

John Smith obtained the Fellowship of the Royal Colleges of Surgeons of Edinburgh and England in 1972. In 1979 he obtained his PhD from the University of Aberdeen.

He has served the Royal College of Surgeons of Edinburgh well and held office since 1990. He has been member and chair of various postgraduate education and examining boards, both for the college and nationally.

John Smith is an active member of hospital and regional committees in the Sheffield area, involved mainly in patient management and medico-legal matters. He has a wide area of interest and expertise.

In amongst this administrative commitment he has still found time to author 6 books, write numerous chapters and peer reviewed articles and to present 80 papers to learned societies.

In short, John Smith is a well rounded surgeon, deserving of being admitted to Honorary Fellowship of the College of Surgeons of South Africa.

Author: John Robbs

CITATION
HONORARY FELLOWSHIP

PROFESSOR LEWIS SPITZ

COLLEGE OF SURGEONS

Professor Lewis Spitz born in Pretoria, schooled at the Christian Brothers' College and graduated from the University of Pretoria, became one of the most distinguished South African born surgeons in the world. During his formative years he worked at the Baragwanath and Transvaal Memorial Hospital for Children. He was intrigued by children and their diseases and made a decision to dedicate his professional life to their plight.

Professor Spitz left the shores of South Africa on a Smith and Nephew Fellowship to the Alder Hey Hospital in Liverpool and returned to South Africa in 1971 as consultant paediatric surgeon. He was appointed in 1979 to the prestigious post of Nuffield Professor of Paediatric Surgery at the University of London and Honorary Consultant Paediatric Surgeon at the Great Ormond Street Hospital for Children in London. He held this position until retiring from clinical practice in 2004.

Lewis Spitz has, through clarity of vision, inquisitiveness and a challenging approach to basic research and clinical application, resolved many of the complex problems of childhood diseases. Innovative surgical approaches were developed which have changed clinical practice. He is world renowned for his work on esophageal atresia, esophageal replacement, nesidioblastosis and the separation of conjoined twins.

He is an excellent teacher with the ability to explain the most complex of problems in an easily understood manner for even the most inexperienced, which has made him sought after as visiting professor and quest lecturer at Universities and international conferences worldwide. Professor Spitz has honorary degrees from the Royal Colleges of England, the American Academy of Paediatricians and the Royal Colleges of Paediatrics and Child Health. He is the recipient of numerous scholarships, prizes and distinctions and is editor and serves on the Editorial Board of all the important Paediatric Surgical Journals and beyond. In addition he has published extensively and is the author of seven standard surgical textbooks. He has also served on numerous committees related to international research, examinations and clinical practice.

An important milestone in his career has been the pivotal role that he has played in our understanding of ethical considerations and surgical separation of conjoined twins

Professor Spitz has always retained strong ties with the country of his birth and has fostered the careers of many South African Paediatric Surgeons. It was a great honour for South Africa when he was appointed as President of the British Association of Paediatric Surgeons.

Mr President it is a great honour to ask you to confer the Honorary Fellowship of the Colllege of Surgeons on a son from Africa, Professor Lewis Spitz

Author: Heinz Rode

CITATION
HONORARY FELLOWSHIP

PROFESSOR GEORGE MENSAH

COLLEGE OF PHYSICIANS

Prof Mensah was born and raised in Ghana in a small, farming village of Kokofu in the Ashanti Region. He immigrated to the United States in 1976 to matriculate at Harvard College where he graduated with honors in Biology. He has a doctorate in medicine from Washington University. His postgraduate training in internal medicine and cardiology fellowship was at the Cornell Medical Center in New York.

Prof Mensah has served on the cardiology faculties at Vanderbilt University, Medical College of Georgia and Emory University. He is board certified in internal medicine and cardiovascular diseases and holds fellowships in the American College of Physicians, American College of Cardiology, European Society of Cardiology and the Council of Clinical Cardiology of the American Heart Association.

Prior to Joining the Centers for Disease Control and Prevention (CDC) in July 2000, he was Professor with tenure at the Medical College of Georgia and Chief of Cardiology at the VA Medical Center in Augusta, Georgia. George Mensah is a past recipient of the Searle Distinguished Research Award of the International Society of Hypertension in Blacks (ISHIB), the Booker Innovation Award and the Hero Award of the Association of Black Cardiologists (ABC). He is a member of the American Heart Association's National Research Program Evaluation Committee and currently serves as the Vice-Chair of the Laennec Postgraduate Education Committee of the American Heart Association.

Prof Mensah has served as chief of the Cardiovascular Health Branch at CDC and had overall responsibility for determining operational policy of the Branch and directing CDC's objectives for a national program for cardiovascular health promotion and the prevention and control of heart disease and stroke. He currently serves as the Acting Director, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Prof Mensah is a frequently invited international speaker. His previous named lectures include the Todd-Brown Memorial Lecture, Dr J B Johnson Lecture of the US National Medical Association, Dr George C Phillips

Memorial Lecture at Duke University School of Medicine, and most recently, the National Heart Foundation of Australia Lecture at the 50th Anniversary Celebration of the Cardiac Societies of Australia and New Zealand at the World Congress of Cardiology in Sydney last year.

Author: Bongani Mayosi

CITATION
HONORARY FELLOWSHIP
PROFESSOR NEIL DOUGLAS
COLLEGE OF PHYSICIANS

Professor Neil James Douglas received his pre-clinical education at St. Andrews University, and his training in Clinical Medicine at the University of Edinburgh, Scotland, graduating MBBCh with distinction in 1973. After completing pre-registration posts in Medicine and Surgery at the Royal Infirmary, Edinburgh, he became a Research Fellow at the same institution in 1974.

This was followed by a stint as Traveling Fellow in the Cardiovascular Pulmonary Research Laboratory of the University of Colorado, Denver, USA. He was awarded an MD from the University of Edinburgh in 1983 for his thesis entitled "Breathing during sleep: studies in normal subjects and in patients with chronic bronchitis and emphysema." Sleep Medicine has been the focus of Neil Douglas' research for more than 2 decades. He is a world renowned expert in this field and his impressive list of original publications, numbering over 160, bear testimony to this. He has also been the author of numerous reviews on the topic of sleep and its related disorders, and has also been invited to lecture on this subject at institutions around the world. In recognition of his many outstanding scientific contributions, Professor Douglas was awarded a DSc by the University of Edinburgh in 2003. He has served on the editorial board of a number of leading publications including the American Journal of Respiratory and Critical Care Medicine; Respiratory Research; Sleep Medicine; and Sleep Medicine Reviews. He has been a member / chairman of the British Thoracic Society, the British Sleep Society, the British Sleep Foundation, and the Scottish Thoracic Society Council.

Professor Douglas' professional qualification include an MRCP(UK) in 1975, an FRCP (Edinburgh) in 1985, and an FRCP (London) in 1998. He has given outstanding service to the Royal College of Physicians of Edinburgh, serving on a number of its committees from 1979 to date. He was co-chairman of the Working Party on Specialist Registrar Assessment for the Federation of Royal Colleges of Physicians in the United Kingdom in 1998, and is presently the chairman of the Education Committee of the UK Academy of Medical Royal Colleges.

Neil Douglas is currently Professor of Respiratory and Sleep Medicine at the University of Edinburgh, Director of the Scottish National Sleep Centre, and President of the Royal College of Physicians of Edinburgh. It is my honour and privilege to present Professor Neil James Douglas for Honorary Fellowship of the College of Physicians of South Africa.

Author: Ken Huddle

CITATION
HONORARY FELLOWSHIP
PROFESSOR JOSEPH MCKENNA
COLLEGE OF PHYSICIANS

Joseph McKenna was educated at University College, Dublin, where he graduated as MB, BCh, BAO in 1966. After completing his Internship at St.Vincent's Hospital, Dublin he spent 2 years as a Medical Research Council of Ireland Research Fellow in Metabolism (1967-1968). He was Tutor in Clinical Medicine at University College Dublin (1968-69) and Resident in Internal Medicine at Georgetown University Hospital, Washington, DC from 1969 to 1971.

In 1972 he was awarded a Fogarty Postgraduate International Fellowship from the National Institutes of Health, USA which allowed him to be a Fellow in Endocrinology, and Instructor in Medicine in the Department of Medicine, Vanderbilt University School of Medicine, Nashville, Tennessee.

In 1975 he was appointed as Assistant Professor of Medicine, in the Division of Endocrinology of the Department of Medicine at Vanderbilt University School of Medicine, Nashville, Tennessee and in 1976 he became Director of the Steroid Laboratory in the same school. He returned to Ireland in 1978 and where he has been Consultant Endocrinologist at St. Vincent's Hospital, and Coombe Lying-In Hospital, Director, Research Section, Education & Research Centre, St. Vincent's Hospital, Dublin, Ireland (1988-92) and Professor of Investigative Endocrinology, University College Dublin since 1994. Professor McKenna became a MRCPI (1971), MRCP (UK) 1972, Diplomate of the American Board of Internal Medicine in the Subspecialty of Endocrinology and Metabolism (1975), FACP (1978) and FRCPI (1982). He was awarded an MD by the University College Dublin in 1980.

Professor McKenna has written extensively in the area of adrenal and reproduction endocrinology. His writings include a textbook and over 150 papers and chapters in national and international publications. He is a member of the editorial boards of 'Clinical Endocrinology' and 'The Endocrinologist'. He has served as secretary to the Irish Committee of Higher Medical Training, Chairman of the Endocrinology and Reproduction Sections of the Health Research Board, and is a member of the Medical Education and Training Committee of the National Task Force on Medical Staffing in Ireland. He has been President of the Irish Endocrine Society and President of the Section of Medicine of the Royal Academy of Medicine.

Professor McKenna has served the Royal College of Physicians of Ireland with great distinction. He was elected

to the College council in 1986, became Registrar in 1996, and President Designate in 2002. He is currently President of the Royal College of Physicians of Ireland which recently celebrated its 350th anniversary. Over the years the Royal College of Physicians of Ireland has trained a large number of South Africans including many who were disadvantaged by apartheid.

Joseph McKenna is married and has 5 children. He shares a keen interest in rugby with many members of our College and has been gracious enough not to mention the most recent match between our two countries.

Mr President, Professor Joseph McKenna has made a significant contribution to medicine, to endocrinology, and to our sister college the Royal College of Physicians of Ireland. It is with great pleasure that I ask you to admit him to Honorary Fellowship of the College of Physicians of South Africa.

Author: Ralph Kirsch

CITATION
HONORARY FELLOWSHIP

DOCTOR JILL SEWELL

COLLEGE OF PHYSICIANS

Dr Jill Sewell is the President of the Royal Australasian College of Physicians, Associate Professor in the Faculty of Medicine of the University of Melbourne, and Principal Specialist Paediatrician at the Royal Children's Hospital, Melbourne, Australia.

She qualified in medicine from the University of Melbourne Medical School in 1971 and trained in basic paediatrics, community paediatrics, and child psychotherapy at the same university before proceeding to the Thomas Coram Research Unit in London to continue her work in developmental paediatrics in 1979-1980. In 1984 she was admitted to the Fellowship of the Royal Australasian College of Physicians, and subsequently went on to make important contributions to fields of childhood development and behaviour, promoting the involvement of women in medicine, and quality assurance in healthcare.

Dr Sewell became the President of the Paediatrics and Child Health Division of the Royal Australasian College of Physicians from 1998 to 2002. In 2002 she was awarded the Ray R Krok Visiting Professorship in Child Health at the National University Hospital in Singapore.

Dr Sewell has received numerous honours in recognition of her contributions to medicine, including the Honorary Fellowship of the Ceylon College of Physicians (2004), Honorary Fellowship of the Royal College of Physicians Ireland (2004), Fellowship of the Academy of Medicine Singapore (2005), Fellowship of the College of Paediatrics and Child Health Singapore (2005), and The Order of Australia (2005).

Author: Bongani Mayosi

CITATION
HONORARY FELLOWSHIP

DOCTOR BANDULA WIJESIRIWARDENA

COLLEGE OF PHYSICIANS

Dr Bandula Wijesiriwardena is a graduate of the Faculty of Medicine, University of Colombo, Sri Lanka. He is a Board-certified specialist in General Medicine and has Board-Certification as a Consultant Physician by the Post Graduate Institute of Medicine, Colombo, Sri Lanka since 1984. He underwent postgraduate training in Medicine at Ormskirk and at the District General Hospital in Liverpool, UK.

He holds the following Memberships and Fellowships: Fellow, Ceylon College of Physicians (FCCP), Fellow, American College of Physicians, Honorary Fellow, Royal Australasian College of Physicians and Member, Royal Colleges of Physicians, UK.

Dr Bandula Wijesiriwardena is Honorary Consultant Physician, Police Hospital, Sri Lanka and Consultant Physician at the Colombo South Teaching Hospital, Kalubowila. He is the President of the Ceylon College of Physicians, Sri Lanka for 2005. As President he is a Consultant to the National Health Sector Development Project of the Ministry of Health and has been a Member, Technical evaluation committees of the Ministry of Health and a Member of the Committee for the Evaluation of 'Guidelines for appropriate use of blood and blood products of the National blood transfusion service in Sri Lanka.

He is the Chairman of the National Lipid Guidelines Committee and co-editor of the book 'Guidelines on management of lipid disorders in Sri Lanka'. He was a member of the National Hypertension Guidelines development committee and member of the writing committee (2000-2001) and Chairman of the Clinical Practice Guidelines committee of the Ceylon College of Physicians (since 2000). He has served as a Member of the National Dengue Fever Task Force and was the Group leader of the Post-Tsunami Basic needs assessment team of the University of Sri Jayewardenepura/Colombo South Teaching Hospital appointed by the National Disaster Management Council

Dr Wijesiriwardena is an undergraduate examiner for the medical schools in Sri Lanka, as well as an examiner for the qualifying examination for MD (Medicine) for the Postgraduate Institute of Medicine (PGIM) and Chief Examiner since 2004, as well as an Examiner for the Diploma in Family Medicine for the PGIM. He has served on Curriculum Development and Curriculum Review Committees for Medical Faculties in Sri Lanka.

Bandula Wijesiriwardena has received the President's research award in 2000 as well as awards for presentations at conferences. He has published widely in medicine, both clinical practice guidelines as well as original research in a variety of medical conditions.

Author: Sarala Naicker

Oration - Admission Ceremony 2005

The Colleges of Medicine of South Africa

Cape Town, 20 October 2005

Professor Dan J Ncayiyana, MD FACOG FCM (SA)

Mr President

I was both flattered and horrified when the President of the College approached me two or three days ago to with the request that I deliver the oration at this auspicious ceremony. I have already had the honoured privilege of addressing this congregation on two previous occasions in the past few years, and the horror emanated from my anxiety that I might have nothing worthwhile to offer, having said all I ever wanted to say in my previous orations.

But before I go on, I would like to direct a few words of congratulations to the candidates presenting themselves for admission to the various Colleges this evening. Today marks the end of a long and arduous journey for you that began when you entered training a few years ago, and culminated in your successful completion of the College's stringent and stressful examinations. Some of you have had to relocate more than once during your tenure in order properly to complete your training. You had to put in long hours working under less than ideal working conditions. You have every right to be proud of your achievement tonight.

This is also an appropriate occasion to commend those who stood by you, supported you and endured the inconveniences that inevitably ensue from being intimately related to a specialist-in-training: your families, your spouses and your significant others.

I have decided to share two stories with you this evening.

The first concerns a young, very blonde lady raised in the sheltered environment of a close-knit Afrikaner family in a small Free State town, who was featured in the Carte Blanche television programme last year. She completed her medical degree in Bloemfontein, and was subsequently posted for her community service stint to a rural hospital in a God-forsaken corner of the Limpopo Province. She soon discovered that she was to be the sole doctor in that hospital. And although she had been promised the support of doctors in private practice in the adjacent town if and when she needed consultation, their availability turned out to be erratic and unreliable.

The camera shows her walking the hospital corridors, desperately trying to cope with any number of simultaneous emergencies: stabs in casualty, a complicated birth in the labour ward, a child in respiratory crisis in the paediatric unit, and a lot of sick people in the medical ward. There is utter bewilderment in her eyes, and her stress level is almost palpable. From her interview, it becomes quite clear that she is a dedicated doctor who cares deeply about her patients, but is frustrated by her professional isolation, the work load, and the lack of supervision in the face of medical challenges well above her level of experience and competence as a relatively recent medical graduate. It also emerges from the interview that the experience has forever immunized her against future service in the public sector.

The next time the camera picks her up some months later, this young doctor is in a radically different world. She is trudging snow, dressed like an Eskimo, in a little northern Canadian town that, the narrator tells us, is snowbound seven months in the year. The young lady has joined a group of South African doctors who serve the town in a group practice. These doctors and their young families have come to constitute a quite cosy, close-knit South African community in which they throw braai parties, import biltong and Mrs Balls chutney, and speak Afrikaans. In her interview, she indicates that she misses South Africa, but enjoys the professional fulfillment that Canada has to offer, with excellent medical facilities and good collegial support.

Doctors migrate overseas for a variety of reasons. For many young doctors nowadays, overseas migration is temporary, for purposes of training, or making quick money to pay off education debts. Some migrate permanently, because they feel let down by the health system in South Africa. The young lady from the Free State was clearly let down by the health system, which is a collective expression to describe the set-up that is necessary in order to deliver optimal health care. The health system can be regarded as consisting of three parts:

- The infrastructure: clinics, hospitals, drugs, medical supplies, ambulances and so forth
- The regulatory framework: that is the rules, regulations, procedures and legislation governing the system, and
- Human resources: doctors, nurses, nurse aids, radiographers, laboratory technicians, ambulance drivers, community health workers and all those other people who are responsible for making the system work

Permanent migration of health professionals largely impacts on the public sector, and is driven by 'push' and 'pull' factors. Push factors include such items as work overload; staff shortages; inadequate medical supplies; and crumbling infrastructure, all leading to burnout, stress, diminished morale and demotivation. Pull factors encompass the 'sponge effect' of the high demand for professionals in wealthier countries (or the private sector in South Africa), which are able to offer socially more attractive environments (schools, neighbourhood safety

and so forth), more congenial working conditions and virtually unlimited support infrastructure and opportunities to practise the very best medicine possible.

But Africans such as our lady from the Free State are culturally and genetically ill-suited for environments such as in the north of Canada and elsewhere in the world. Once an African, always an African. When I travel around the world as I often do, and meet emigrated South African doctors, I am always amazed at the depth of their nostalgia for 'home', and a sense that if they could, they would return. In fact, many emigrants of all occupations do return. The real estate industry reports that a not insignificant proportion of their business consist in finding homes for returning emigrants from such places as Australia, New Zealand, Canada and the like. These are folks who discovered that the grass was not necessarily greener on the other side, and had the courage to admit to themselves that there is no place like home.

The moral of the story is this: Yes, our health system is beset with problems, but we will not resolve them by running away. South Africa is a great country with limitless potential. As you sally forth into your future, make it your resolve to stay in this country, to attend to the health needs of our people, and to dedicate yourselves to helping mend our health system.

The last story is about me. I completed my basic medical education in the Netherlands, and subsequently relocated to New York to specialize in obstetrics and gynaecology, where I was trained in state-of-the-art practice of my specialty. New York University, my alma mater, was (and continues to be) a cutting edge research institution that pioneered hormone replacement therapy, among other breakthroughs.

But here's the catch: little or nothing that I learned at medical school or during my specialist training in those years has any validity or currency today. What I learned in those years is largely of little use to me today. So, here's a warning for you: little or nothing that you have learned from your eminent professors in your many years of training will have currency or validity for the rest of your career. The fact that you have completed your training does not mean that you are through learning. Medicine is an ever-changing art, and you must set yourself up to be a life-long learner.

Your future delight and effectiveness in your professional career will depend on it.

I thank you, Mr President.

Professor Dan J Ncayiyana

LIST OF SUCCESSFUL CANDIDATES

SEPTEMBER / OCTOBER 2006

FELLOWSHIPS

Fellowship by Peer Review

KIES Bryan Michael	College of Neurologists
KRAMER Efraim Benjamin	College of Emergency Medicine
HOWES Dale Geoffrey	College of Dentistry
VAN RENSBURG Barend Wilhelm Jansen	College of Physicians
BEKE Andy Kwaku	College of Public Health Medicine – Occupational Health
EHRLICH Rodney Ivan	College of Public Health Medicine – Occupational Health
KOCKS Daniel Jacobus	College of Public Health Medicine – Occupational Health
LA GRANGE Margritha Aletta Cathrina	College of Public Health Medicine – Occupational Health
LONDON Leslie	College of Public Health Medicine – Occupational Health
MYERS Jonathan Elliot	College of Public Health Medicine – Occupational Health
RAUTENBACH Petrus Gerhardus de Wet	College of Public Health Medicine – Occupational Health
ROBINSON Fiona	College of Public Health Medicine – Occupational Health
ROSS Mary Hazel	College of Public Health Medicine – Occupational Health
VAN ZYL Jacobus Petrus	College of Public Health Medicine – Occupational Health

Fellowship of the College of Anaesthetists of South Africa: **FCA(SA)**

BERMAN Natalie	WITS
BESTER Kotie	UCT
BURCHARD Anne Tamara	WITS
CAMPBELL Elroy Steven	STELL
DE KOCK Rijk Fourie	UCT
DU PLESSIS Pauline	WITS
IBACH Fiona	UCT
LOUW Andries Jacobus	UFS
MURFIN Deane Brendon	WITS
NOWOSAD Ania	UCT
PENFOLD Phillipa Rae	WITS
SINGH Jaswanth Sunil	WITS
SPOELSTRA Magdalena Colette	STELL
TERBLANCHE Morne	WITS
VAN ZYL Hendrik Adriaan	UCT
VAN ZYL Linda	UCT

Fellowship of the College of Cardiothoracic Surgeons of South Africa: **FC Cardio(SA)**

MARTIN Gregory Roy	WITS

Fellowship of the College of Dentistry of South Africa: Orthodontics- **FCD(SA) Orthod**

KSIEZYCKI-OSTOYA Beata Katarzyna	WITS

Fellowship of the College of Dermatologists of South Africa: **FC Derm(SA)**

BRÖNN Lizmaré	STELL
RAMLACHAN Nivana	UL

Fellowship of the College of Forensic Pathologists of South Africa: **FC For Path(SA)**

BLUMENTHAL Ryan	UP
MATTHEÜS Annemarie Louise	WITS
NAIDOO Threnesan	UKZN

Fellowship of the College of Maxillofacial & Oral Surgeons of South Africa: **FCMFOS(SA)**

PEARL Craig Bradley	WITS

Fellowship of the College of Neurologists of South Africa: **FC Neurol(SA)**

MOTALA Ayesha	UKZN
RANCHHOD Jasvina	WITS
SWANEPOEL Annette	UCT

Fellowship of the College of Neurosurgeons of South Africa: **FC Neurosurg(SA)**

BURGER Schalk Willem	UP
SICHIZYA Kachinga Agrippa	UCT

Fellowship of the College of Nuclear Physicians of South Africa: **FCNP(SA)**

HERMAN Shitaleni Chocky	STELL
MPIKASHE Pilisiwe	UL
PERUMAL Nalini Sindy	WITS

Fellowship of the College of Obstetricians & Gynaecologists of South Africa: **FCOG(SA)**

BIKO Nvula Jack	UP

ELEMVA Francis Christian	WITS
ESSILFIE-APPIAH George	UKZN
FABIYI Alfred Afolabi	WITS
FRANK Karlyn Annesa	WITS
ISAACS Salma	UCT
LEKHA Anushka	WITS
MANTHATA Lebogang Allen Anne	STELL
MARK Michelle Lynne	UKZN
MOODLEY Yershini	WITS
MOROENG Moleleki William	WITS
MUZONZINI Gibson	UNITRA
NGAMBU Nontembeko Faith	UKZN
NIMAKO Dan Mintah	UKZN
PANDAY Mala	UKZN
PIENAAR Hannelie Francina	UP
SIBEKO Sengeziwe	UKZN
SIGCU Noluyolo Christina	UCT

Fellowship of the College of Ophthalmologists of South Africa:
FC Ophth(SA)

PARBHOO Dharmesh	UKZN
STEŸN Stéve	STELL
WOLFF Bernard	UL

Fellowship of the College of Orthopaedic Surgeons of South Africa:
FC Orth(SA)

AHMED Haroun	UCT
ATTENBOROUGH Shaun Peter	UCT
BARROW Robert Bruce	WITS
CHEESMAN Michael Ian	UP
DU TOIT Jacques	STELL
FRIELINGSDORF Karl	STELL
HUMAN Mark Colin	WITS
KRIEK Jacobus Johannes	UKZN
MOUTON Nicolas Jacobus	UP
NELL Dirk Joubert	STELL
OO Pe	UKZN
STRYDOM Willem Snyman	UFS
THOMAS Damian Kenneth	UCT

Fellowship of the College of Otorhinolaryngologists of South Africa:
FCORL(SA)

JONAS Nicolaas Everhardus	UCT

Fellowship of the College of Paediatricians of South Africa:
FC Paed(SA)

ABRAHAM Ann	WITS
ADAMS Paul Ernest	WITS
AHRENS Johann Otto	UCT
ALLI Razia	UKZN
ANEES Muhammad	UNITRA
BATT Jacqueline	STELL
DE LACY Ronalda Jacqueline	UCT
DIPPENAAR Anel	STELL
DOORGAPERSAD Prasha	UKZN
DUMANI Gcina	UCT
JOKHAN Rikash	WITS
KHAN Naseema	UKZN
KRIEL Magdalena Marilee	UP
MAMATHUBA Rendani Clarence	WITS
MAPHOSA Thulisile Nelly	WITS
MATABANE Raesetje Olivia	UL
MERVIS Jonathan Glen	UCT
PETERSEN Reneva	UCT
SINGH Sunira	UKZN
THEART Andries Carel	STELL
WIN Tin Tin	UKZN

Fellowship of the College of Pathologists of South Africa: Anatomical-
FC Path(SA) Anat

GILDENHUYS Anita Beth	WITS
LOCKETZ Michael Louis	UCT
SCHUBERT Pawel Tomasz	STELL

Fellowship of the College of Pathologists of South Africa: Microbiology-
FC Path(SA) Micro

BAMFORD Colleen Mary	UCT
GOVENDER Nelesh Premapragasan	WITS
ROSMARIN Caryn	WITS
SWE SWE Khine	UL

Fellowship of the College of Pathologists of South Africa: Virology-
FC Path(SA) Viro

CORCORAN Craig	UCT
HSIAO Nei-Yuan	UCT
KORSMAN Stephen Nicolaas Jacques	STELL

Fellowship of the College of Physicians of South Africa:
FCP(SA)

AHMAD Nazir	
ALEKAR Shabbir	WITS
BARNABAS Connel Alwyn	UKZN
BUDNIK Piotr	STELL
CHIPETA Daniel Chakhumbira	UCT
DE KOCK Frances	STELL
GCELU Ayanda	UCT
HARRICHUND Pretissha	WITS
HENDRICKS Neil	STELL
LEWIS Christopher	UCT
MAFAFO Neonyana Keorapetse Rebecca	WITS
MAGAN Alkesh	WITS
MAHARAJ Rasha	UKZN
MAHLUNGE Raymond	UCT
MVUNGI Robert Sostenes	WITS
NANABHAY Yusuf Sayed	
NANDAGOPALAN Richard	UKZN
NANKISSOR Kevin	UKZN
SCHRÖDER Roland	STELL
SCHRUEDER Neshaad	UCT
VARIAVA Adnaan	WITS

Fellowship of the College of Plastic Surgeons of South Africa:
FC Plast(SA)

BRACZKOWSKI Yvonne	WITS

POTGIETER Anton	WITS

Fellowship of the College of Psychiatrists of South Africa:
FC Psych(SA)

BANDA Mwanza	UCT
DE CLERCQ Helena Glaudina	UCT
FRITTELLI Vega Janine	STELL
GATES Mitchell Leonard	UCT
IBRAHIM Safiyyah	WITS
KOTZE Dirk Adriaan	STELL
MARNEWICK Reinhold Johannes	WITS
MASON Michael Shane	STELL
NAKYAGABA Anne Hilda	UCT
ROFFEY Marc	UCT
SAFFY Samantha Claire	UCT
SUSSMAN Garth	WITS
TEMMINGH Hendrik Sebastian	STELL

Fellowship of the College of Public Health Medicine of South Africa:
FCPHM(SA)

BASU Debashis	WITS

Fellowship of the College of Diagnostic Radiologists of South Africa:
FC Rad Diag(SA)

BOROTO Kahimano	UL
DAYA Dharmesh	WITS
DEVY Kerryn Lynn	WITS
FYNN Edward	UL
GANI Zaheer	UP
GOODWIN Dale	WITS
GOVIND Mayuri	UKZN
KOENIG Jean-Claude Robert	UCT
MBENGO Joan Masetumo	WITS
MEZZABOTTA Marisa Catherine	UCT
MOOSA Sulaiman Essa Ismail	UCT
ROSSOUW Corné	UP
SAYANVALA Husain	WITS

Fellowship of the College of Radiation Oncologists of South Africa:
FC Rad Onc(SA)

CHETTY Dinoshan Namasivayan	WITS
NYONGESA Catherine Naliaka	WITS

Fellowship of the College of Surgeons of South Africa:
FCS(SA)

ALLARD Denis Jean Camille	
CHAMISA Inchien	
LOOTS Emil	UKZN
MAHMOOD Abdul Jalil	WITS
MANZINI Vukani Titus	UKZN
NAIDOO Maseelan	UKZN
POPOV Yuri	WITS
STEER Dion Beecher	UKZN
VERSTER Ryno John	UCT

Fellowship of the College of Urologists of South Africa:
FC Urol(SA)

ADEBISI Oyewole Olanrewaju	WITS
AHMAD Ahsan	WITS
AZIZ Naseem Akhtar	STELL
BATUULE David Rwakibale	UKZN
LIGTHELM Dirk	UP
VENTER Riaan	UKZN

MEMBERSHIP

Membership of the College of Family Practitioners of South Africa:
MCFP(SA)

BAMFORD Elizabeth Fiona	
HEYER Adele Salome	UL
LESLIE Kayode	UP
UMUNNA Olufunmilola Yeside	WITS

CERTIFICATES

Certificate in Cardiology of the College of Physicians of South Africa:
Cert Cardiology(SA) Physicians

BECKER Anthony Charles	WITS
LATIB Mohamed Azeem	UCT
MBIZENI Manene Johannes	UKZN
WEICH Hellmuth Stephan von Heyderhoff	STELL

Certificate in Cardiology of the College of Paediatricians of South Africa:
Cert Cardiology(SA) Paediatricians

MEARES Janine Quiniviere	WITS

Certificate in Endocrinology & Metabolism of the College of Physicians of South Africa:
Cert Endo and Metabolism(SA) Physicians

EKPEBEGH Chukwuma Ogbonna	UCT
MAHOMED Fazleh Ahmed	UFS

Certificate in Geriatrics of the College of Physicians of South Africa:
Cert Geriatrics(SA) Physicians

BADENHORST Henriette Louise	STELL

Certificate in Gastroenterology of the College of Physicians of South Africa:
Cert Gastroenterology(SA) Physicians

BOND Robert Paul	UP
COCK Charles	UFS
MAHOMED Adam Dawood	WITS

Certificate in Medical Genetics of the College of Paediatricians of South Africa:
Cert Medical Genetics(SA) Paediatricians

RAMDHANI Hemendra Baijnath	WITS

Certificate in Medical Genetics of the College of Physicians of South Africa:
Cert Medical Genetics(SA) Physicians

VAN DER WESTHUIZEN André	WITS

Certificate in Neonatology of the College of Paediatricians of South Africa:
Cert Neonatology(SA)

HOLGATE Sandi Lee	UCT
NAIDOO Niree	UKZN

Certificate in Nephrology of the College of Physicians of South Africa:
Cert Nephrology(SA) Physicians

BARDAY Zunaid Ahmed	UCT
NAIDOO Sagren	WITS

Certificate in Paediatric Surgery of the College of Surgery of South Africa:
Cert Paed Surg(SA)

COX Sharon Gail	UCT
SHEIK GAFOOR Mahomed Hoosen	UKZN

Certificate in Pulmonology of the College of Physicians of South Africa:
Cert Pulmonology(SA) Physicians

ROGERS Sean Blaine	UCT
SEWLALL Nivesh Haripersad	WITS

Certificate in Rheumatology of the College of Physicians of South Africa:
Cert Rheumatology(SA) Physicians

DU PLOOY Maria Cornelia	WITS
NAM Jacqueline Leong	UCT
SOLOMON Ahmed	WITS

PART I, PRIMARY AND INTERMEDIATE EXAMS

Part I of the Fellowship of the College of Anaesthetists of South Africa:
FCA(SA) Part I

BAX Nicola Anne	WITS
BEHARI Raveen	
BLACKBURN Michael Richard	WITS
CASSIMJEE Omar Mohammed	
COHEN Steven	
DE WET Janine	
DICKERSON Roger	WITS
DOORGAPERSHAD Rajiv Dharmsi	UKZN
DRUMMOND Leanne Wendy	
EITNER Louis	UCT
FULLER Nicole Gail	UCT
GORDON Mark Patrick	WITS
HARGOVAN Nitesh Pravindas	WITS
HART Margaux	
KATZMAN Gary	WITS
MADURAI Jo-Anne Olivia	UKZN
MAHARAJ Karishma	
MATHIE Karryn Gail	
MWESHIXWA Theresia Tangeni	
NATES Wayne Adam	
NGUBANE Thubelihle	
NIENABER Jan Hendrik	WITS
POONIPERSHAD Ashveer	
ROCHER André Francois Steyn	
ROLFE Deborah Anne	UCT
SHMUKLER Daniel	WITS
VAN DYK Dominique	UCT
WHITE William Andrew	

Part I of the Fellowship of the College of Emergency Medicine of South Africa:
FCEM(SA) Part I

BURGER Adrian	UCT
DE JAGER Jacob Lourens Carolus	UCT
GEDULD Heike Ingemar	UCT
KROPMAN Annemarie	UCT
MÜLLER Monique	UCT
SMIT Yolandé	UCT

Part I of the Fellowship of the College of Dermatologists of South Africa:
FC Derm(SA) Part I

HOFFMAN Tessa-Mari	WITS

Part I of the Fellowship of the College of Forensic Pathologists of South Africa:
FC For Path(SA) Part I

RAHEEM Abdur	UP

Intermediate Examination of the Fellowship of the College of Maxillofacial & Oral Surgeons
FCMFOS(SA) Intermediate

Sunita SINGH	WITS

Part I of the Fellowship of the College of Neurologists of South Africa:
FC Neurol(SA) Part I

BRINK Justinus Anton	
DAUDE Amina Ismael	
MASELA Lungile Silindile	WITS

Part I of the Fellowship of the College of Obstetricians & Gynaecologists of South Africa:
FCOG(SA) Part I

BABAWALE Musiliu Alade	
BABBS Sarah Karen	
BUDHRAM Samantha	UKZN
BUTT Jennifer Leigh	
CLUVER Catherine Anne	
DLAMINI Makhosini Emmanuel	
DU TOIT Maria Magdalena	STELL
GUMATA Nomonde Dorah	
JEKETERA Clara Muchapiwei	WITS
LUBEGA Abdu Muwonge	UP
MADIME Mamphishane Emily	
MASELOANE Jeremiah Akanyang	
MJOLI Faith Thembeka	
MOODLEY Serilla	WITS
MOSTERT Anna Elizabeth	
NGOGA Eugene	
O'CALLAGHAN Kendall Jane	
PILLAY Casandra Letitia	
RAMATSOSO Nkhohola Selina	
SEOPELA Louisa Boledi	WITS
TLALE Karabo Juliet	

Part I of the Fellowship of the College of Ophthalmologists of South Africa:
FC Ophth(SA) Part I

DAHYA Nilesh	
DEWAR Cathrine Valerie	
GOUWS Cornelis Ignatius	
JOUBERT Christa	
KETTLEDAS Hiron	UNITRA
KOETSIE Karen Monica	
MATUBATUBA Justice Thabo	UKZN
MOABELO Tebogo Thato	
MUDELY Magesuaran	
NARAN Jasmita Chhiboo	
PAYNE Barry John	
RAUTENBACH Robyn Marie	
STEENKAMP Margot	
VALLABH Bhavesh Bardavesingh	

Part I of the Fellowship of the College of Paediatricians of South Africa:
FC Paed(SA) Part I

DRAMOWSKI Angela	
GRAY Taryn Catherine	
LINDE Louis Bernard	STELL
MACKAY Cheryl Anne	
MAKAN Bhavna Jasmat	UKZN
MAYER Maria Madelene Martha	
MZIZANA Nomgcobo Laurentia	
ODENDAAL Jeanne Elizabeth	
OMAR Ridwan Ismail	UKZN
REDFERN Andrew	
SCHERMBRUCKER Gillian Mandy	
STRAUSS Stanzi Maria	STELL
TONKIN Selna	
TSHAMALA Mulowa Jean Pascal	
VAN DYK Johannes Botha	STELL
VANKER Aneesa	UKZN

Part I of the Fellowship of the College of Pathologists of South Africa:
Anatomical-
FC Path(SA) Anat Part I

BEKKER Elaine	UP
MABUDE Sisanda Zimkhita	UKZN
MASKE Christopher Philipp	UCT
MOSIANE Nkagisang Pulane	WITS
MTSHALI Nompumelelo Zamokuhle	WITS
SKENJANA Andiswa	UKZN
SUBRAYAN Sumeshini	UKZN

Part I of the Fellowship of the College of Pathologists of South Africa:
Haematology-
FC Path(SA) Haem Part I

BERNSTEIN Penelope Lizetta	WITS
RWEHABURA James Eustace	WITS

Part I of the Fellowship of the College of Physicians of South Africa:
FCP(SA) Part I

ANGEL Gavin David	WITS
ASMAL Zubair Mahomed	WITS
BERA Mumtaz	WITS
GEORGE Deepu Joseph	UCT
GOVENDER Jayandran	UKZN
HARRIS George Spencer	UFS
MAMDOO Farouk	WITS
MEYBERG Anton Brian	WITS
NAHRWAR Shahroch Patrick Emile	STELL
NASH Catherine Ann Bedford	STELL
RAPHALA Modikwe Aleck	UL
THOMAS Vinod	UCT
TOET William Dirk	UCT

Part I of the Fellowship of the College of Psychiatrists of South Africa:
FC Psych(SA) Part I

ASMAL Laila	UCT
LILLA Mogamad Nizaar	UCT
MAYEKO Nombasa Hilary	UNITRA
NIEUWOUDT Deon	UCT
SINGH Keshika	UKZN
TOMCHECK Christine Maria	UCT
VOS Paul Johannes	STELL
ZARDAD Surayah	UCT

Part I of the Fellowship of the College of Diagnostic Radiologists of South Africa:
FC Rad Diag(SA) Part I

GOVENDER Priyadershni	WITS
HLABANGANA Linda Tebogo	WITS
NAKANGOMBE Kanisia Hatshomunimga	UCT
SAID-HARTLEY Mariam Qonita	UCT
SWEIDAN Leora	WITS

Part I of the Fellowship of the College of Radiation Oncologists of South Africa:
FC Rad Onc(SA) Part I

BANDA Lewis	WITS
DALVIE Sameera	UCT
KATHAN Louis	UCT
WOLDEMARIAM Aynalem Abraha	UCT

Primary Examination of the Fellowship of the College of Surgeons of South Africa:
FCS(SA) Primary

ADAM Sumaiya	
BASSON Gerhard	
BEREJENA Edmond	
BHORAT Naseem Yusuph	
BILA Khetani Solly	UL
BREWIS Anton Eben	
BUGWANDIN Satish	
CARAPINHA Charles Philip Do Nascimento Fernades	
CROSBY Neil Wilfred	
DAVID Bradley Andrew	
DEWAR Malcolm James	
DU PLESSIS Leonel Mark	
FABER Alexander	
GEOFFREYS Dale Alex	
GEORGIOU Ellie	
GILDENHUYS Christiaan Gerhardus	
GOVENDER Magenthran	
GRETSCHEL Armin	
KAMALO Patrick Dongosolo	
KASCHULA Andrew Russell	
LAWSON Andrew James	
MABASO Nkosinathi Lucas	
MAGWABA Thangani	
MASONDO Thabani Xolani	

MATHABE Kgomotso Minah
MOROM Adrian Matthew
NAIDOO Sudashan Mathava Krishna
NAIDOO Lalenthra WITS
NATHA Bhavesh
PENNEL Timothy Charles
PHILIP Sunu John
PRETORIUS Philippus
PRETORIUS Carl Joe
PRICE Christopher Edward
PRODEHL Leanne May
REDMAN Laura Anne
REID Cecil
RUGNATH Avin Kissopersad
SAMUELS Peter John
SHAIK Muhammed Zaki
SMIT Shaun Garrick
STARK Alexander Hugo
TALEB Fazleh Hassan
THOMPSON Crispin Maeder
VEERASAMY Calvin Sivan
WALSH Michelle Marie Elise
WARDEN Claire
WESSON Russell Noel
WEYERS Deon William
WINKLER Cordula Louise
YAZBEK Carl Jacobus
ZINN Richard
ZWANEPOEL Pieter

Primary Examination incl Neuroanatomy of the Fellowship of the College of Surgeons of South Africa:
FCS(SA) Primary incl Neuroanatomy

BALAKRISHNAN Theogren
KAMALO Patrick Dongosolo
RUGNATH Avin Kissopersad
SAMUELS Peter John

Intermediate Examination of the Fellowship of the College of Surgeons of South Africa:
FCS(SA) Intermediate

ABRAMS Morton Jacob
APOSTOLERIS Evangelos WITS
BERNON Marc Michael
BHAGA Ravi
BRINK Abraham Justinus
CHEDDIE Nishaan
DE LANGE Susan WITS
ERASMUS Willem Abraham
FERNANDES Tiago Paulo
GARRETT Benjamin Rupert
GELBART Bradley Rael WITS
GOVENDER Prenevin
GREEFF Richard de Villiers WITS
HAYES Philip Michael
JANSON Michael Constantine STELL
KAESTNER Lisa-Ann
KANA Prakash Naran
LECUONA Angus Tertius
MACKERDHUJ Prashim
MAHARAJ Shivesh Harichander
MANDABA Mziwabantu UCT
MAQUNGO Sithombo UCT
MATSHANA Kennedy John WITS
MOHIDEEN Muhamed WITS
NAICKER Kaven
NAIDOO Navendran Dhawapalan
NAIDOO Ruvashni
NORTJE Marc Boydell
OBIDIKE Chinaka Patrick WITS
PADAYACHY Llewellyn UCT
PATON Abigail Cornelia
REID Cecil
SANDLER Simon Jeffrey Ian
SATHYAPAL Sunil
SCHULENBURG Richard Peter UFS
SENAMELA Kgeswalatau Bob
VAN HEERDEN Johan
VEERSAMY Petrosian Dewaker
VERMAAK Jacobus Stephanus
VIVIER Johannes Philip STELL
VLOK Adriaan Johannes
WIGGETT Wilhelm Scholtz UP

Primary examination of the Fellowship of the College of Urologists of South Africa:
FC Urol(SA) Primary

IJANE Kabo Kenneth

HIGHER DIPLOMAS

Higher Diploma in Internal Medicine of the College of Physicians of South Africa:
H Dip Int Med(SA)

BUYS Johannes Hendrik
RENISON Rudi

Higher Diploma in Orthopaedics of the College of Orthopaedic Surgeons of South Africa:
H Dip Orth(SA)

MUKIMBILI Edmond
MUNTHALI James
RAMESH Balasundaram
SEKIMPI Patrick

Higher Diploma in Surgery of the College of Surgeons of South Africa:
H Dip Surg(SA)

TADZIMIRWA Evaristo

DIPLOMAS

Diploma in Anaesthetics of the College of Anaesthetists of South Africa:
DA(SA)

AMOD Natashia
BARRY Elizabeth Malan
BHORAT Ferhana
CILLIERS Amanda
CORBETT Caroline Beth
CRAIB Murray Hofmeyr
CURTIS Elizabeth Louise
DE BEER Karen Elena
DE GOEDE Adéle
DONALD Olivia Elizabeth
DU PLESSIS Jacobus Josephus
DWYER Sean Pierce
EAGAR Mark Alan WITS
ESSOP Zaheer Ismail
FIANDEIRO Carlos Elisebio

FOURIE Ceilia
GORNY Jacek Grzegorz
GREYVENSTEYN Gerhardus Andries
GROENEWALD Elzaan
GROENEWALD Rene
HEYNS Marthinus Daneel
JANSE VAN RENSBURG Pieter
JANSEN Tracy-Lee
JITHOO Suven
JORDAAN Pieter Willem
JOSÉ Ricardo Jorge Paixâo
KENDON Mary-Anne
KHUMALO Ayanda Penelope
KILLOPS Jannelene Gail
KROG Colleen
MABAYA Gamiag
MAEPE Lwazi Mandisi
MARE Frans
MATHEE Rudolf Johannes Botha
MDLULI Sipho Ofentse
MERVITZ Carol
MÖHR Dwayne
MOKAWEM Michael Anthony
MOODLEY Kamani
MOODLEY Alastair Wayne
MOODLEY Thasegan
MTHEMBU Langa Adelaide
MULLER Geoffrey Douglas
NAICKER Shaun
NAIDOO Rubeshan
NAIDOO Yagalen Loganathan
NAIDOO Shaun
NARASIMOOLOO Cindy
NEL Karien
NGOBESE Sibusiso
NTJIE Christine Ntombithini
OBERLEITNER Barry Heinrich
PERKINS Zane Brendan
RAMSON Veena
RICHARDSON Peter Brian
ROBERTS Cecilia Jacomina
ROUX Anne-Marié
SADZIK Jakub
SALKINDER Rael
SAMADI Naisan
SCHÜLEIN Simone
SMIT Rian Wilfred
SMIT Francina Johanna
SMITH Heléne
SOOSIWALA Ismail Usman
STOPFORTH Laura Wendy
SWANEPOEL Elsa
TAYLOR Jenna Leigh
TIMMERMAN Kerry Jane
VAN ANTWERPEN Annelise UP
VAN DER MERWE Braham Swanepoel
VAN HEERDEN Helga
VAN NIEKERK Hugo Johann
VAN WYK Abraham Christoffel
VILJOEN Hendrik Stephanus
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The Colleges of Medicine of South Africa (CMSA)

50 Years of Excellence
1955-2005

Golden Jubilee Celebrations

Editorial

The Colleges of Medicine of South Africa Marks 50 years of Excellence in Postgraduate Medical and Dental Education

Two thousand and five marked the year in which the Colleges of Medicine of South Africa (CMSA) turned 50 years. The Memorandum of Association of the Colleges of Physicians and Surgeons of South Africa, the forerunner of the CMSA, was adopted by the eight founding fathers (i.e., Drs M Cole-Rous, LB Goldschmidt, A Landau, R Lane-Forsyth, DP Marais, H Muller, AWS Sichel, AH Tonkin) in Cape Town on 27 May 1955.[1] The Registrar of Companies granted the certificate of incorporation of the new College on 21 July 1955. The College has grown from the College of Physicians and Surgeons of South Africa to become a confederation of 35 colleges, encompassing all the branches of medicine, surgery and dentistry. As a result, the College underwent a progressive series of name changes to accommodate its expanding membership, culminating in the present name - The Colleges of Medicine of South Africa, on 10 December 1999.

The CMSA was established, in the words of the founding fathers, 'to encourage the study of medicine, surgery and allied arts and sciences; to promote the highest degree of skill and efficiency in their practice; and, in and about all the foregoing, to cultivate and maintain the highest ethical standards and professional conduct'. The CMSA has carried out its mission mainly through the examination of specialists in all branches of medicine and dentistry under one roof, a structure that is unique in the history of medical education in the world. The CMSA has admitted more than 30,000 members over the past 50 years, and has earned international respect for the high 'degree of skill and efficiency' of its graduates.

The CMSA celebrated the Golden Jubilee in 2005 with a series of activities and events that culminated in the 10th Interdisciplinary Symposium that was held in Stellenbosch on 22 October 2005. The 10th Interdisciplinary Symposium, which was opened by the Premier of the Western Cape, Mr Ebrahim Rasool, and addressed by the Minister of Health, Dr Mantombazana Tshabalala-Msimang, was held jointly with the Annual Meeting of the International Association of College and Academy Presidents (IACAP), an organisation with representatives from Africa, Australasia, Europe and North America. The theme of the symposium was 'The Future of Academic Medicine in Africa'. The high-level talks that were presented at the symposium are posted on the CMSA website,[2] and summarised in this special issue of Transactions (pages 27 to 62). By addressing the question of academic healthcare in Africa, the CMSA joins the worldwide campaign to revitalise academic medicine through radical thinking.[3] A number of medical journals and other organisations initiated this project (called 'ICRAM', an acronym for International Campaign for the Revival of Academic Medicine) to bring people together to debate whether the existing structure of academic is still fundamentally sound and, if not, to propose alternatives to it.[4] Academic medicine throughout the world is threatened by lack of funding, poor facilities, and limited career prospects for academic healthcare practitioners. This problem is more pressing in developing countries, such as South Africa, where the need to address historical healthcare inequalities has resulted in greater funding constraints on academic healthcare. The campaign's central working group has stated that 'the time for ivory tower attitude has passed and that modern academic medicine requires transparency, leadership, and a community/patient focus to gain better understanding and support from the public'.

The other highlights of the 2005 celebrations were the presentation of Golden Jubilee Awards to founders and colleagues who have given distinguished service to medicine and society over the past 50 years, [2] and the publication of 'The History of the Colleges of Medicine of South Africa: the First 50 years', a book written by the CMSA historian, Dr Ian Huskisson. Several founders made the effort to attend the Stellenbosch meeting, and it was a great pleasure and honour to interact with them. The book, which is essential reading for all members of the CMSA, provides a summary of the series of papers on the history of the CMSA that have been published by the same author in the Transactions over many years. We trust that you will enjoy reading the excellent Golden Symposium papers contained in this edition of Transactions, and that you will purchase a copy of the splendid book on the history of the CMSA by Dr Ian Huskisson.

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Address By The Western Cape Premier, Mr. Ebrahim Rasool On The Occasion Of The Golden Jubilee Of The Colleges Of Medicine Of South Africa, 21 October 2005

President of the Colleges of Medicine of South Africa, Prof. Lizo Mazwai, Honoured guests and congress participants.

It is a privilege to share with such an august body of health professionals the golden jubilee celebration of the Colleges of Medicine of South African (CMSA), the custodian body of quality medical and dental care in our country. As we celebrate 50 years of excellence at the CMSA, we salute all the outstanding individuals who have over five decades contributed to produce medical and dental specialists, professors and researchers, who are renowned in South Africa, throughout Africa and in the rest of the world. Over many decades the CMSA's unique approach of containing all medical and dental specialties within a single framework, has allowed it to foster aspects of medical education and medical professionalism common to all health disciplines.

Your achievements over the years are underscored by the fact that the standards set by CMSA are accepted by all South African Medical Faculties, as well as by the Health Professions Council of South Africa. On this special occasion we share your pride in this internationally recognized and respected standard of excellence that has helped to place South African health professionals at the forefront of international medical research and practice. Inscribed in the Credo of the College is a commitment to equitable access to health and other social services. Also entrenched is a commitment to serve all the people of South Africa. For many years translating this vision into reality was hampered by apartheid – and the divisions it created amongst our people and in the healthcare provided.

Fortunately, for the people of our country this changed soon after South Africa's first democratic election in 1994, with the dismantling of the country's racially based health system. Over the past decade this has resulted in major improvements to our health system targeting the very people and communities most in need of quality healthcare.
The Western Cape Government is deeply committed to the principle of equal access to quality health care. In support of this principle, it is our belief that removing social and economic factors that contribute to inequities within and between communities is key to improving health.

An examination of one health indicator namely Infant Mortality Rate (IMR), illustrates the inequalities between both the Cape Town Metro District are and the rural areas of the province, and between the different health sub-districts within Cape Town itself. Khayetlitsha has the highest IMR at 44/1000 live births, whilst South Peninsula has the lowest of 13/1000 live births. In helping to ensure greater equity in health care the Western Cape's Healthcare 2010 strategy is geared to reshaping public health to focus on primary-level services, community based care and preventative care. It will also bring health closer to the people by treating patients at the level of care most appropriate to their needs. In all our debates about the future of the country in 1980's & 1990's Health important , we were aware of the importance of Primary Health Care (PHC) organizing principles of reshaping society and public health but PHC needed secondary, tertiary and quarternary health to deal with the entire reshaping of the country.

We have already made some progress on this front with a number of improvements made to the health infrastructure needed to accommodate Healthcare 2010. Our Department of Health is also close to finalizing a new service delivery plan that would define how many hospital beds are required at each level of the service together with the levels of staffing in each case. As mentioned the establishment of a well managed and responsive Primary Health Care Service is the foundation of Healthcare 2010. While services provided at a number of our Community Health Centres have already been improved, the coming years will see further improvements to management and staffing levels together with a greater emphasis on patient needs and satisfaction at our other facilities.

The revitalization and expansion of our regional hospital service is progressing well, with communities on the West Coast, in the Southern Cape and Boland already starting to reap the benefits. It is also our responsibility as government to create the conditions where people are able to make healthier choices. We need to promote health and healthy living and help them choose health by demonstrating the many rewards this holds for individuals, families and our communities.

Funding is often the major stumbling block when it comes to turning ideals into reality. In the current financial year our health budget in the Western Cape stands at R5.7 billion, taking up almost 28% of the provincial budget. This budget provides for:

- Nurse driven primary health care (PHC) service in 242 fixed and 132 mobile clinics.
- Medical doctor support in PHC at 68 community health centers.
- 12.5 million patients contacts at PHC level
- The roll-out of the anti-retroviral programme to extend

to 44 sites with an average of 700 patients per months joining the thousands already on treatment.
- 164,000 patients to be admitted to 22 district level hospitals with 685,000 outpatient visits.
- Trained emergency medical personnel in fully equipped vehicles that will travel approximately 17 million kilometers rendering emergency medical services.
- 218,000 patient admissions and 692,000 outpatient visits at regional psychiatric and tuberculosis hospitals where specialist care is provide
- Dental care for 150,000 patients and training for 90 oral health professionals.
- 119,000 patient admissions and 1,2 million outpatient visits at Groote Schuur, Tygerberg and Red Cross Hospitals where patients receive highly specialized care.

These figures also clearly illustrate that we are committed to maintain a core of essential highly specialized health care services. We recognize the important contribution made by a fast growing private health sector in the Western Cape. While we may serve different sectors of the community, we have a mutual responsibility to ensure quality healthcare for all our people.
It is therefore apt that the theme of your meeting is "The future of academic healthcare in Africa". This theme emphasizes the contract between health professionals and society. It is about protection and standards, and includes expectations from both sides. Partnerships between the public and private sectors are key to meeting some of these expectations. It is a process that has already started, but needs to be accelerated. There are opportunities for collaboration in a number of fields such as the exchange of expertise/skills and the sharing of facilities. I would like to wish you well with your deliberations about the future of academic healthcare in Africa. May you be fortunate in finding a middle road where medical education has more relevance to primary healthcare? And may your stated commitment to medical education reform in Africa, reap rewards only brought about by implementation.

I am confident that the CMSA appreciated the many formidable challenges it faces and that it will continue to rise to these challenges and, in doing so, find suitable solutions in the interest of healthcare in the whole of Africa.

I thank you!
Mr. Ebrahim Rasool

Academic Medicine in the 21st Century: An International Perspective on the Challenges, Opportunities, and Strategies for Success

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Introduction

Academic medicine, embodying the three missions of research, teaching and patient care, has contributed tremendously to the remarkable advances in health made over the last century. However, in this first decade of the 21st century, there is a near universal conviction from within and beyond the walls of academia, that the future of academic medicine, at best, is uncertain and may indeed be in jeopardy.[1, 2] An increasing number of publications characterize all three core components of academic medicine using words and phrases such as "crisis", "disillusionment", "distress", "despair", "crossroads", "failing", and "loss of purpose".[2-4] Most of these reports express serious concern and stress a need for substantive changes in order to prevent academic medicine from becoming irrelevant, if not non-existent.

Fortunately, several academic and professional medical organizations as well as private and public institutions and entities worldwide have recently provided opportunities for global dialogue in an effort to find solution to the "crisis". The International Campaign to Revitalize Academic Medicine (ICRAM) is one such group whose findings and future scenarios have been published[1] and also discussed in this issue of the Transactions. Prior to the ICRAM scenarios, however, numerous publications from South Africa, other countries in Africa, North America, Europe, and Australia had made several clear and consistent diagnoses of the root causes of the academic medicine crisis and suggested approaches for addressing them.

In this presentation, the international perspectives on the challenges and opportunities that have emerged over the years are presented and discussed in three sections, identified as the "Three Towers" of academic medicine. In the "Proud Tower", the unique attributes and contributions of academic medicine are reviewed. In the "Ivory Tower", the findings suggesting that academic medicine is in crisis are presented. In the final segment, "Tomorrow's Tower", a framework for reforming or revitalizing academic medicine is proposed. The perspectives summarized in these three towers are presented as a backdrop for contemplating the five ICRAM scenarios and envisioning the success of academic healthcare in Africa in the 21st century.

The Proud Tower

The defining characteristic of academic medicine is the requirement that its practitioners embrace and become actively engaged in all three core missions: scientific research, medical education, and the delivery of patient care. This unified mission of research, teaching, and service, recognized worldwide as the three-legged stool of academic medicine, has contributed tremendously to the remarkable advances made in field of medical care over the last century.

Through the research leg, important questions in basic, clinical and population science have been rigorously pursued. Key research findings have been disseminated and used to train new generations of undergraduate and graduate medical students and in the continuing education of established practitioners. Most importantly, high quality patient care is delivered in academic centers using the best practices guided by scientific research findings and continuous quality improvement under the leadership of master clinicians who are also accomplished research investigators and outstanding educators.

This phenomenon became most evident in North America, after the Flexner Report on medical education in the US and Canada[5-7] Prior to this period , the scope and quality of medical education, research, and care delivery were highly variable in North America. As Billings poignantly put it, *"We have indeed in America medical practitioners not inferior to the best elsewhere; but there is probably no other country in the world in which there is so great a distance and so fatal a difference between the best, the average, and the worst."*[8] The reforms introduced in medical education after this period were substantial.

The unique milieu of the three-legged stool, typically within an academic health center and, or teaching hospital setting, has often fostered the optimal integration of the best science, best practices, and optimal health care delivery. The on-going success of the major academic health centers today is a testament to the contributions that academic medicine made, especially in the 20th century.

The Ivory Tower

As we pass the midpoint of this first decade of the 21st century, there is growing concern that academic medicine is in crisis and that its future is in jeopardy or, at best, uncertain. Perspectives from medical students, postgraduate trainees, individual academics, deans of schools of medicine, and the leadership of academic societies and colleges of medicine suggest a growing disillusionment with the status, purpose, and direction of academic medicine.[3, 4] Most importantly, there is the additional perspective of many community thought-leaders, individuals in the general public and non-medical professional sector, that academic medicine has failed the public, and that it has lost sight of the "big picture" of protecting and promoting the public health. Thus, the emerging view of academic medicine is that of an Ivory

Tower – isolated, and increasingly becoming irrelevant in the day-to-day societal ills that impact the health of communities.[9]

Even before the ICRAM Report, key factors that account for the bulk of the growing disillusionment within academic medicine had been identified in reviews, letters to journal editors, and other publications. Overall, the major causes identified in these perspectives include forces and drivers internal and external to academic medicine. The most prominent among these causes include known differences in the magnitude and sources of funding, reimbursement, resource allocation and recognition for efforts invested by academics in the three core missions of academic medicine; increasing demands from patient care that take away from time for research and teaching; the recruitment, retention, and training for careers in academic medicine; increasing engagement with industry and concerns over ethical practices; and the impact of market forces and increasing use of business language and practices in the health care setting. Two themes, in addition to the causes highlighted above, that appear to drive the perceived crisis and uncertain future of academic medicine include (1) how academic medicine defines and views health overall; and (2) the relevance of the academic medicine agenda viewed in light of the public health agenda.

First, is "health" a public good that should be available and accessible to all as proposed in the Alma Ata Declaration or is it a commodity that must be allowed to "trade" and fluctuate at the mercy of market forces and thus available to those who can afford it? Of equal importance is the issue of defining health. Does academic medicine define health as the absence of disease or the treatment and control of disease (as espoused in "patient care" - the third leg of the academic medicine stool) or is health much broader, encompassing the promotion of physical, mental, psychological, and social well-being that enables people to live long and satisfying lives as embraced by the World Health Organization and the Centers for Disease Control and Prevention? Second, recognizing that academic medicine, like other vocations and professions, cannot be immune to social, environmental, and economic forces and reforms, how has medical academia evolved or plans to evolve in response to these forces and drivers internal and external to academic medicine?

Judging from the published literature, the public perception is that academic medicine has been mostly concerned with its research, teaching, and patient care and thus, has not been fully engaged in these crucial debates and discussions. Similarly, during its strategic planning endeavors, the focus has mostly been on the three legs of the academic medicine stool with often too little emphasis on issues most important to the public such as access, affordability, costs, quality, and accountability for outcomes for the investments made by the public sector. The perception within academia also includes specific concerns about all three core missions of academic medicine. Tensions between the three legs of the stool, such as those between the responsibilities for teaching, research, and clinical service, remain important causes of the crisis in academic medicine. As Barondess[9] most aptly described it, the continued "hypertrophy" of the research leg of the stool to the "detriment of teaching functions and of immersion in major health care and health promotion issues" fuels the crisis. Within each of the three legs, major issues also persist. For example, the disproportionate allocation of resources[10, 11] to "treatment and cure" vs. "health promotion and disease prevention" in research, teaching, and patient care delivery remains an important source of disillusionment for many medical academics.[1]

Problematic of the research leg is the disproportionate allocation of resources, recognition, and reimbursement within the three types of research (basic, clinical, and population science research). Equally disturbing is the misconception, widely held in many academic medical centers that excellence in scientific research demands "cutting edge bench research" and that prevention research is not real science. Another important cause for the academic medicine crisis in research is the continued prioritization of the biomedical model over the ecological model[12] and that the quest for new knowledge in the molecular and genomic causes of disease is superior, more dignified of academic medicine, and deserves more resources than research into the socioeconomic, cultural, and environmental determinants of health and disease.

Compounding these problems are the changes in extramural funding sources and patterns. Many researchers have to devote increasing amounts of time for patient care service in order to support their salaries thus taking away time from research. Large scientific consortia dedicated solely to research also compete more successfully for the limited research funds, putting the individual academic who is also expected to care for patients and teach students, at a greater disadvantage of receiving research awards. However, most damaging for academic medicine, regarding research, is the widespread realization that most of the scientific findings from the investments made in research remain lost and are not translated into practice to benefit mankind.[13]

The teaching mission of academic medicine has also suffered.[14-16] Changes in extramural funding patterns and expectations have led a prioritization of research activities to the detriment of the teaching mission of the faculty.[14] Strategies that adequately address these issues are likely to return academic medicine to the glory it enjoyed in decades past and assure that it continues to contribute substantively to the creation of safer and healthier people and environments in future.

Tomorrow's Tower

Academic medicine of the 21st century should embrace, support, and equally reward activities in all of its core functions. It should also assure the appropriate translation into practice the best art and science of academic medicine (from the teaching and research missions, respectively) for promoting and protecting the public's health. This assurance calls for redefining the core missions of academic medicine and articulation of a framework within which specific strategies can be undertaken to ensure a vibrant future for the proud tower of academic medicine in the 21st century.

The framework proposed suggests a new icon – a four-legged stool for academic medicine, five strategic imperatives, and ten specific actions that academic medicine can t begin taking today. This framework is proposed as a work in progress, to be refined during this Golden Jubilee Symposium of the Colleges of Medicine of South Africa, and modified from its international perspective to become more suitable for positioning health, healthcare, and academic medicine in Africa. The key domains of the framework are (1) the revised mission and purpose of academic medicine; (2) the strategic imperatives; and (3) actions to be taken now.

The Revised Mission and Purpose of Academic Medicine: The traditional 3-legged stool (research, teaching, and patient care) should be replaced with a more stable, more relevant, and a more viable 4-legged stool. The four legs should represent relevant research, medical education, health service (not patient care), and accountability for equity, access, and quality in all endeavors of academic medicine. The emphasis on health service is to ensure that the focus for academic medicine no longer remains on "patients and their diseases", "disease care", and the search for cures predominantly but that appropriate emphasis is also placed on protecting health, promoting physical, mental, psychological, and social well-being, and preventing disease across the life-span. This new four-legged stool is consistent with, but builds further on the four pillars of global academic medicine proposed by Abbasi[17] and is more likely to be viable, successful, and more relevant to the public's agenda for health.

The Strategic Imperatives: Five strategic imperatives are proposed. They address science, systems, solidarity, stewardship, and scenario-development.

- ***Science***: A strong foundation of science must remain the rock upon which tomorrow's tower is built. Although remarkable advances have been made in scientific research, as pointed out earlier, the translational gap persists as a major challenge. Other challenges include the historical under-funding of prevention research, the disproportionate under-emphasis of the ecological model in research, and lack of significant progress on the key determinants of health inequities and strategies for their elimination. However, as recently pointed out by Gerberding,[18] a true transformation of the current scientific research enterprise and effective translation of the best science to protect the public's health will require a careful and systematic assessment and strategic planning to address the "content, complexity, competencies, and capacity" for science in future scenarios.

- ***Systems***: Development of effective systems to support the core missions of academic medicine is crucial. In particular, appropriate use of information technology for research, teaching and patient care must be fostered. Similarly, effective communication systems between the Colleges of Medicine, professional and academic societies, and the allied health sciences will be important. patients, their families, and the general public will become increasingly savvy about and empowered through access to information technology resources. Academic medicine of the future should be in a position address the public's health.

- ***Solidarity***: Coalitions and partnerships must be broadened, nurtured and supported. Communities and their leadership as well as all stakeholders with an interest in or impacted by health centers should be included. Broad-based partnerships that include all relevant academic departments that speak with a common voice and deliver common messages are more likely to be successful in gaining support for academic medicine.

- ***Stewardship***: As defined by the World Health Organization, stewardship is an essential function of health systems, that reflects overall governance and leadership in assuring that goals, objectives, and outcomes are achieved.[19] Stewardship in academic medicine impacts all core functions, especially accountability for the goals of equity, access, and quality of healthcare delivered.

- ***Scenario-development and visioning***: Academic medicine of the 21st century must be pro-active and must anticipate the inevitable socioeconomic and other changes beyond the walls of academia. Development of alternative scenarios for the future, as done by ICRAM is one approach.

Actions that can be taken today

The dialogue on the future of academic medicine that was rekindled by the ICRAM five scenarios is a healthy one. However, actions are needed now, even as we deliberate and seek out the optimal strategies for revitalizing academic medicine. The ten actions proposed here are offered as starters to be refined and modified to suit the local environment.

1. Adopt a broader definition of health and embrace health as a human right and a public good. Health must be viewed not just as the absence of disease but the presence of physical, mental, psychological, and social well-being that enables people to live longer satisfying lives.
2. Nurture and promote diversity within the academic medicine workforce, trainees, and the communities that academic medicine serves.
3. Support program-relevant research in all domains of scientific endeavor. Encourage and adequately fund research activities whether based on the traditional biomedical model or the more holistic ecological model.
4. Support the translation of research into practice. Require that research proposals seeking new knowledge demonstrate the potential findings of the endeavor and include steps in the research design that will facilitate translation into clinical and public health practice.

5. Eschew commercialization and free-market as primary change agents in academic medicine. The emerging consensus, within international health circles is that health is a public good and access to health promotion, disease prevention, and basic health care must not be dictated primarily by market forces.
6. Take concrete steps to address the "brain drain" phenomenon and put in place viable plans for needed human resource for health care in both developed and developing countries.
7. Use technology to improve healthcare quality and eliminate medical errors. The rapid advances in information technology should be harnessed to improve both continuing medical education and the actual delivery of care at the bedside and in the outpatient settings.
8. Engage governments and policy-makers on stable and appropriate funding streams. Develop a unified front for academic medicine and educate governments and policymakers on the crucial roles played by academic medicine. More importantly, develop and disseminate the evidence on how academic medicine and its activities contribute to improving the public's health and the impact in terms of years and quality of life.
9. Broaden the partnerships for health, and especially promote coordination and collaboration between experts in health promotion, disease prevention, and disease treatment and control.
10. Promote a renaissance of ethics and humanism in all aspects of academic medicine

Summary and Conclusions

Academic medicine has had a glorious past. It has contributed tremendously to the major advances in health of the last century. Increasingly now, however, there are concerns that academic medicine is in crisis and its future is in jeopardy. The causes that have fueled these concerns have been reviewed from an international perspective. A framework comprising revised core functions and a set of strategic imperatives has been proposed. This framework is offered as a work in progress, to be refined and modified to suit the sub-Saharan African context for positioning health, healthcare, and academic medicine in Africa. Taken together, this framework and the lively dialogue prompted by the International Campaign to Revitalize Academic Medicine, provide an important opportunity to address the challenges that academic medicine faces in the 21st century.

Disclaimer

The opinions expressed in this manuscript are those of the author and should not be construed as representing an official position of the Centers for Disease Control and Prevention, the US Department of Health and Human Services, or the United States Government.

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How to increase the impact of academic medicine on health and healthcare?

"The UK Perspective"

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Role of Research in Medicine

Research is and will continue to be one of the most important branches of medicine, as in many other areas of academia. At present there are many issues surrounding research, the most prominent of these being:

1. Where should research be done?
2. What research should be done?

Research is carried out either in higher education institutions, by government departments or by private organisations or individuals, and there are arguments for and against all of these. In 2000, the higher education sector accounted for 19.5% of all research conducted in the UK, while the government sector accounted for 13.4%. This indicates that higher education institutions are the predominant research performing bodies in the public sector, and the share of research and development that they perform is increasing. Business carries out 65.6% of research, twice as much research as the whole of the public sector and can be very effective.

Although universities are probably the most accepted forums for research, the environment that they provide is not always necessary. Some of the greatest scientific discoveries have been made without the assistance of public institutions such as universities. Einstein was working in the Swiss Patent Office in Bern while he produced much of his most influential work including his 1905 publication *Special Theory of Relativity.* During this time he had very little contact with scientific literature or colleagues in the field. More recently, J.Craig Venter led the private Human Genome Project as the President of Celera Genomics, a successful venture that published its results at the same time as the publicly funded Human Genome Project, years ahead of schedule. It remains true however, that most research, both in the medical field and in other areas of science is influenced to a great extent by universities, even if it is carried out by businesses. The majority of influential academic papers are published with the assistance of universities.

Funding for research comes from a variety of sources, both government and non-government. In the UK, the ratio of Gross Domestic Expenditure on Research and Development (GERD) to Gross Domestic Product (GDP) is relatively low, at 1.87%, compared with an average of 2.21% for the member countries of the Organisation for Economic Co-operation and Development (OECD). The input from the government was 27.9% in 1999, compared with 42.0% in 1981, indicating a trend towards the funding of research by other areas such as industry. However, the UK government is aware that university research infrastructure has been under funded and since 1998 has been trying to increase the Science Budget for research by an extra 10% per year. In the UK, the government is the most important source of funding for universities, but this is not he case in other countries. Indeed British universities are chronically under funded in comparison with for example the American Ivy League universities which charge extortionate tuition fees, and there is even evidence that the privately funded Harvard University performs better than the state funded University of Texas at Austin simply because it receives more money. Similarly the private Keio University in Japan is more prominent in terms of research than the public Tokyo University. The message to be taken from this is that Universities should take all of the government money that is available to them, but as this is likely to be inadequate, they should also seek other sources of funding wherever possible.

As the philosopher David Hume suggested, all knowledge is based on unproveable "facts". He said in 1737:

"If I ask you why you believe any particular matter of fact, which you relate, you must tell me some reason; and this reason will be some other fact, connected with it. But as you cannot proceed after this manner, in infinitum, you must at last terminate in some fact, which is present to your memory or senses; or must allow that your belief is entirely without foundation."

This suggests that for any research to be worthwhile, it must be of a good quality in order to minimise the number of "unproveable facts". Indeed,

"The better the quality of intellectual discourse the greater the human welfare that results." (Richard Lilford)

Therefore it is imperative that any organisation providing funding for research makes sure that the research has been properly thought through and is viable. Equally, it is important for anyone running a research programme to ensure that the research is carried out reliably and without bias.

John W. O'Malley characterized in his book "Four Cultures of the West", four cultural configurations that developed together. The first culture is the prophetic culture, which emphasises the transcendence of God and is based on attempting to predict the future as for example in business or politics. The second culture, the academic, philosophic or rational culture is based on definitions and attempts to explore the world without influencing it as for example in science and universities. This is the important culture in the field of science, but unfortunately, it does not always

produce rational explanations for phenomena. Indeed, sometimes the explanations produced seem almost counter intuitive, as will be discussed later in the cases of Rutherford's Gold foil experiment and Copernicus' assertion that the earth moves around the sun. The two remaining cultures are the literary culture, which uses verbal communication to promote ethical living and the Artistic culture, which uses music and art to create expressions of beauty.

Academic research often produces results that are unexpected and do not seem rational at least in relation to the accepted theories of the time. In 1530, Copernicus shocked the scientific world by asserting in his book, De Revolutionibus that the earth rotated on its axis once every day and orbited the sun once a year. Of course, in this day and age his assertion seems almost to be common sense, but at the time was in direct contrast to the accepted Ptolemaic theory of a geocentric universe and so was quite controversial. Similarly revolutionary was Rutherford's Gold Foil Experiment in which he fired alpha particles at a sheet of gold foil, to find that they were deflected, and so disproved the accepted "Plum Pudding Model" of an atom, in favour of a model with a dense nucleus at the centre and electrons orbiting around the outside. Other examples of counter-intuitive ideas from other fields are given for you to consider.

In order for any research or assertion to be considered valid, academic rigour must be observed at all times. This is demonstrated by two stories of our time:

Professor Sir Roy Meadow is the Paediatrician from Leeds who first named "Munchausen Syndrome By Proxy", describing a form of child abuse in which adults invent symptoms in order to make their child undergo unnecessary physical examinations and treatments. He was regarded as an authority on this subject and on many occasions was asked to testify in cases where mothers were being prosecuted for the murder of their children.

In the Sally Clark case, Professor Meadow gave evidence that the probability of two cot deaths occurring in one family is 1 to 73 million, based on squaring the probability of one cot death (1 in 8500). This reasoning however is invalid as pointed out by the Royal Statistical Society, who stated that,

"It would only be valid if SIDS cases arose independently within families, an assumption that would need to be justified empirically. Not only was no such empirical justification provided in the case, but there are very strong priori reasons for supposing that the assumption will be false. There may well be unknown genetic or environmental factors that predispose families to SIDS, so that a second case within the family becomes much more likely."

In fact, if a family has suffered one cot death, then the probability of it occurring again is almost 1 in 100. It was felt that this evidence had been crucial in the conviction of Sally Clark for the murder of her two babies, so when this was proved to be false, and other evidence was given, the conviction was overturned at appeal.

Professor Meadow has since been struck off by the GMC for serious professional misconduct.

Leon Chesley's article in the British Journal of Obstetrics ands Gynaecology in 1986 entitled "Genetics of hypertension in pregnancy: possible single gene control of pre-eclampsia and eclampsia in the descendants of eclamptic women" is another example of a case where more academic rigour was needed. Chesley conducted a case control study to investigate pre-eclampsia. He found that pre-eclampsia fitted the model of an autosomal-recessive condition, but the probability that it is an autosomal recessive could only be calculated by Bayes theorem. As a result of this paper, many researchers started trying to identify the gene that was linked to pre-eclampsia, with no success. Further studies revealed that although in the initial study pre-eclampsia had appeared to be an autosomal-recessive disorder, it in fact was not. If more academic rigour had applied by the scientists who started looking for the gene, and they had interpreted the results of the original study correctly, much time and money would have been saved. They should have sought to replicate Chesley's study.

Inherent in research is the principle that nothing can be proven definitively, but it can be refuted, as stated by Popper and Feyerabend as part of the principle of positivism. This means that "truth claims" cannot be taken at face value, because it is impossible to prove conclusively that they are in fact true. This is in direct opposition to the principle of relativism that states that all opinions are equally valid and does not form a sound doctrine for human affairs to be based on. Relativism as a system has no logic behind it to prove that it is right, and in most cases it is more effective to use rational judgement to consider an issue. This is not to say that people's opinions should not be taken into account and be given weight, but what they are saying should be carefully considered and evaluated. The Alan Sokal case is a famous example of an instance where an assertion by a prominent mathematician was accepted as the truth at face value. Alan Sokal submitted a paper called "Transgressing the boundaries: towards a transformative hermeneutics of quantum gravity" to the journal Social Text in 1996. Unfortunately for the editors, who received a lot of criticism for publishing the article, it was "liberally salted with nonsense". Sokal submitted the paper to see whether an editor would publish anything as long as "(a) it sounded good and (b) it flattered the editors' ideological preconceptions." He proved that this was indeed the case much to the embarrassment of Social Text. Sokal's case emphasised the point that although we should listen to everyone, we should carefully consider what they are saying and evaluate whether or not it is true. Relativism pretends to be emancipatory, but it is clear from this example that it is not, for if all opinions are given equal weight, the people who hold these opinions cannot settle disagreements except through the use of force.

In health care and social policy and other areas where truth statements are important, there must be a move away from the prophetic culture towards the rational culture of research, but the issue remains, where should research and studies be directed?

Different parts of the world are very different in terms culture, landscape, people and wealth as can be seen by

Figure 1: GNI per capita 2004 (PPP)

Source: World Bank 2005

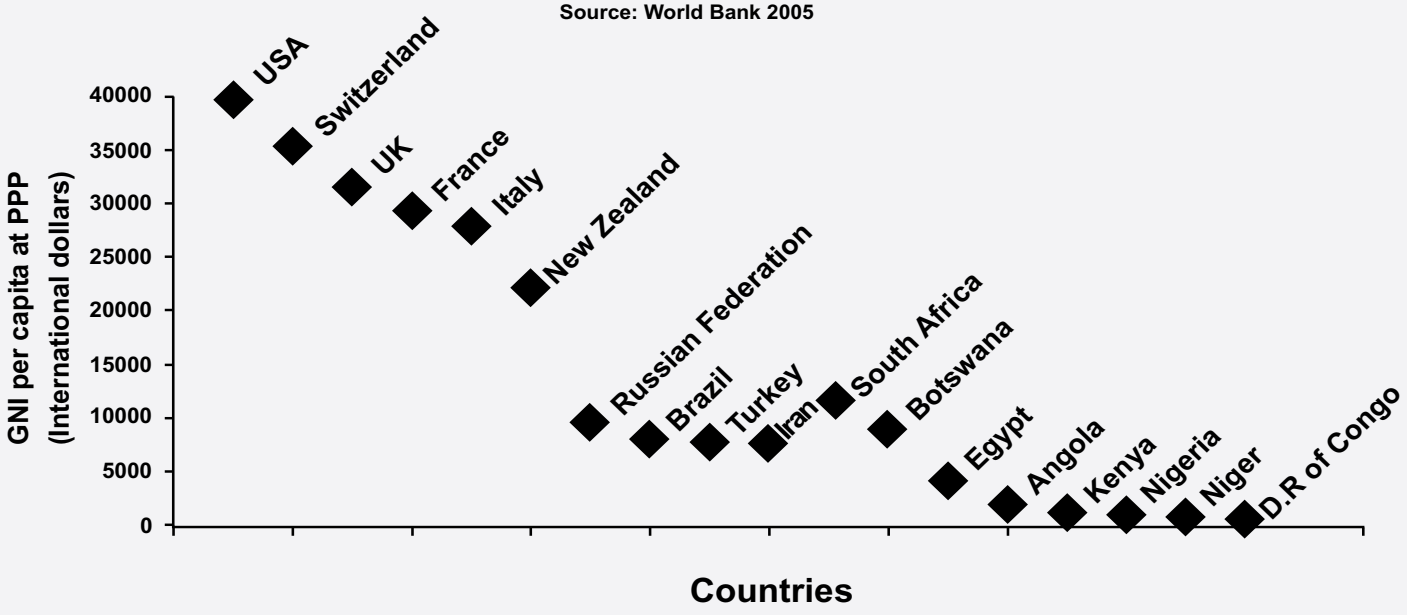
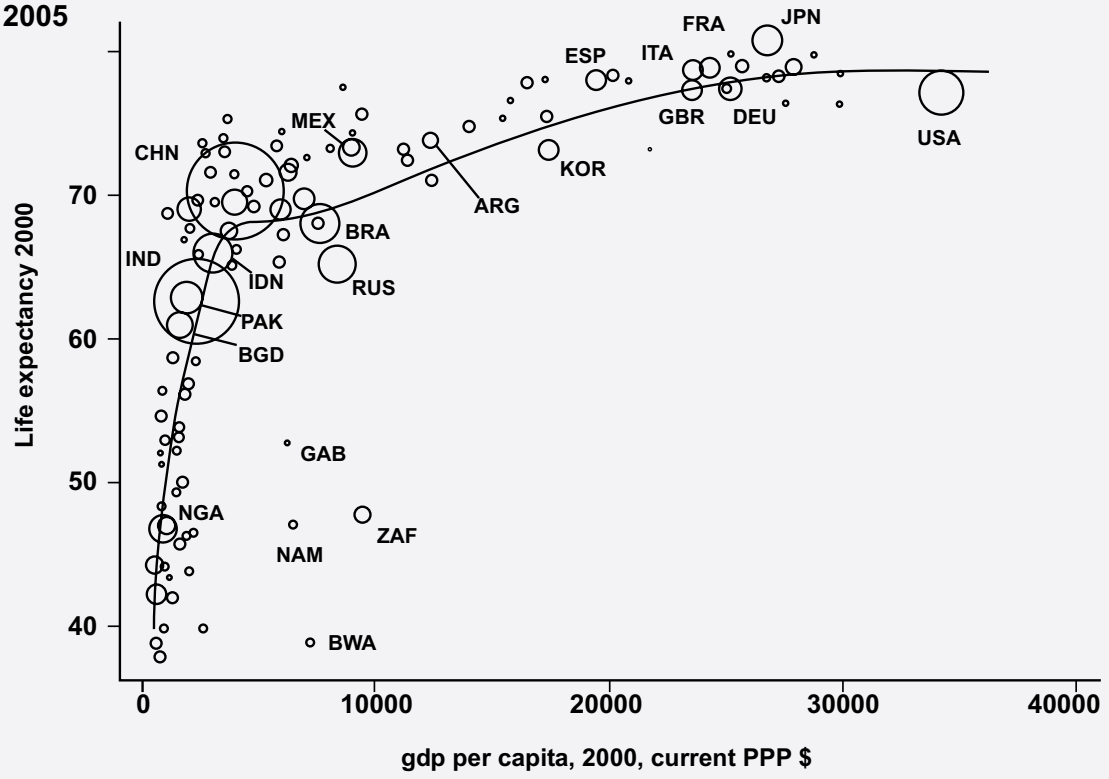


Figure 2:
Source: World Bank: World Development Report 2005

Life expectancy is highly correlated with income, particularly in poor countries



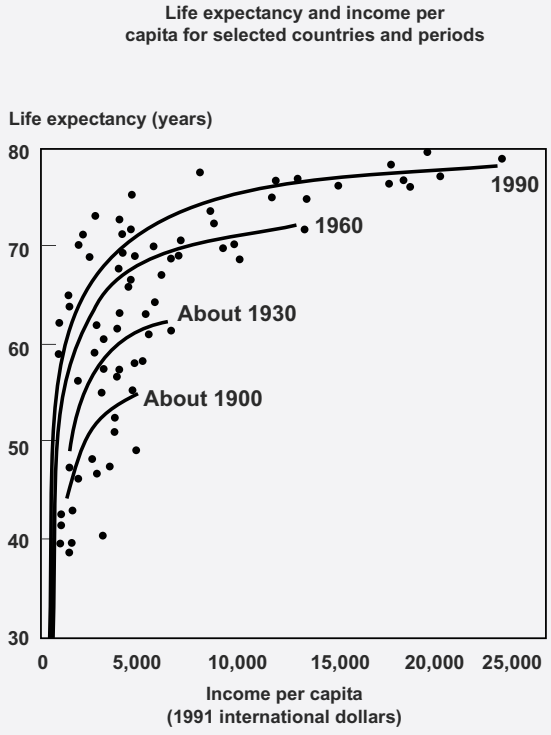
Source: Deaton (2004).
Note: The curve is nonparametrically fitted, weighted by population. The figure plots country life expectancy (using circles whose size is proportional to population) against GDP per capita in purchasing power parity (PPP) dollars at the turn of the twenty-first century

visiting countries around the world, but also by looking at key figures. The best indicator of wealth is Gross National Income (GNI) adjusted for Purchasing Power Parity (PPP) as this gives an indication not only of how much money people have, but also how well off they are in real terms. (See Figure 1)

South Africa has a GNI per capita of $10,960, only a quarter of the GNI per capita of the United States of America, but it is richer than the Russian Federation, Brazil, Turkey and Iran. South Africa is significantly richer than all of the other countries in Africa, in fact when taken as ratios of GNI, the difference between Kenya and South Africa is greater than the difference between South Africa and Switzerland. In health terms, this difference is even greater because of the non-linear value of money (see Figure 2). Figure 2 shows that as wealth increases, health also increases. Up to a GDP per capita of about $5000, this increase is very steep, with just a small increase in income leading to a large improvement in life expectancy. However, the curve levels out and starts to reach a plateau when GDP reaches about $8000 per capita. South Africa's GDP is $10,960, so it is at a stage where although life expectancy may be expected to improve marginally with increasing GDP, no drastic increases can be anticipated. At any given level of income, a person is better off in terms of life expectancy now than they were for example, one hundred years ago, as demonstrated by Figure 3.

This improvement in life expectancy has to a large degree been achieved using very simple methods, such as vaccination, providing rehydration fluids for children suffering from diarrhoea or making antibiotics available for the treatment of tuberculosis.

Figure 3: Source: World Bank: World Development Report 1993



There is a certain utilistic attitude to the role of science in very poor communities, but we should not indulge in this. Success can be achieved even in very poor areas as can be seen from the example of onchocerciasis or river blindness, which has been drastically reduced in recent years, mainly by killing the Simulium flies that spread it. It is therefore important to do research into the social and environmental conditions that affect health, in order to try and prevent disease. Disease prevention measures can be very effective, as has been shown in Cambodia. Here measures such as education and screening programmes were put in place to try to prevent the transmission of HIV/AIDS. Between 1997 and 2003 the HIV prevalence rate in the 15-45 age group fell from 3.0% to 1.9% showing that the campaign was very effective. These measures may need to be applied across the world as the AIDS pandemic is a huge problem, with infection rates increasing every year. The 2004 figures from UNAIDS estimate that in that year, 39.4 million people were living with HIV/AIDS, 4.9 million people were newly infected and 3.1 million people died from AIDS.

In developed countries, research must respond to market forces rather than what is necessarily called for in the rest of the world. Current projects in the UK include a study into abnormal liver function tests in primary care, funded by the Health and Technology Assessment Programme as part of the Department of Health. It will cost £1 million to produce a follow up study which will hopefully produce a better model for the management of liver failure. Whilst this is worthwhile in Britain, it is nowhere near as beneficial as finding methods to prevent the spread of Tuberculosis, AIDS or Malaria.

It is often difficult to get the results research into practise and to get the resources needed to do research in the first place. However, with perseverance it is possible, and as long as scientists adopt a rational approach, steer well

clear of post-modernist ideas and seek alternative funding instead of relying solely on government sources, research should continue to progress and benefit the whole world.

The Monty Hall Problem

"Suppose you're on a game show, and you're given the choice of three doors. Behind one door is a car, behind the others, goats. You pick a door, say number 1, and the host, who knows what's behind the doors, opens another door, say number 3, which has a goat. He says to you, "Do you want to pick door number 2?" Is it to your advantage to switch your choice of doors?" (Parade Magazine, Feb 17, 1991).

This problem was submitted to a magazine called the Sunday Parade. The answer given by Marilyn vos Savant, that it would be to the contestant's advantage to switch, was very controversial as many people believed that she was wrong. An explanation of the reasoning behind the answer is given below.

There are three possible scenarios:

Case	Door 1	Door 2	Door 3
A	Car	Goat	Goat
B	Goat	Car	Goat
C	Goat	Goat	Car

Say you choose Door 1, this means that:

In Case A, the game show host Monty, can open either Door 2 or Door 3
In Case B, Monty must open Door 3
In Case C, Monty must open Door 2

Case	Door 1	Door 2	Door 3
A	Car	Goat	Goat
B	Goat	Car	Goat
C	Goat	Goat	Car

This means that in Cases B and C, by switching you win the car. The only case where switching would cause you to lose is Case A. Therefore by switching, you double your chance of winning from 1/3 to 2/3.

Simpson's Paradox

Say a company tests two treatments for an illness. In trial No. 1, treatment A cures 20% of its cases (40 out of 200) and treatment B cures 15% of its cases (30 out of 200). In trial No. 2, treatment A cures 85% of its cases (85 out of 100) and treatment B cures 75% of its cases (300 out of 400).

	Trial 1	
	% cured	Number cured /number in trial
Treatment A	20%	40/200
Treatment B	15%	30/200

	Trial 2	
	% cured	Number cured / number in trial
Treatment A	85%	85/100
Treatment B	75%	300/400

So, in the two trials, treatment A scored 20% and 85% and treatment B scored only 15% and 75%. One would expect this to mean that Treatment A performed better than Treatment B.

However Treatment B cured more people, 330 (300+30) out of the 600 cases (200+400) in which it was tried, a success rate of 55%. Treatment A on the other hand cured 125 (40+85) out of the 300 cases in which it was tried, a success rate of only about 42%.

This is an example of Simpson's Paradox, a statistical paradox where rank order of averages is reversed when the results of more than one trial are combined. A is the better treatment and this emphasises why, in meta-analysis, a technique is used to allow for differences in event rate and sample sizes between trials.

Scenario paraphrased from the *Ask Marilyn* column of Parade Magazine, 28 April 1996, p6.

Ricardo's Theory of Comparative Advantage

David Ricardo, a British economist in the 19th century realised that although one country may have an **absolute advantage** over another in that it is able to produce all goods at a lower cost in terms of man hours, it may still be beneficial to both to trade, thus gaining a **comparative advantage**.

The example of England and Portugal producing wine and bales of wool may be used, as both of these countries use both of these products, and was contemporary to Ricardo. The value of these two products is taken simplistically in terms of man-days of labour needed to produce the products. These are as follows:

Country	Value in terms of Man-days	
	Barrel of Wine	Bale of Wool
Britain	6	12
Portugal	1	4

It is clear from this that Portugal has an **absolute advantage** over Britain, in that less labour is required in order to produce both the wool and the wine. However, once they start trading the balance shifts.

If Britain exports wool to Portugal, then selling at Portuguese prices each bale of wool will fetch 4 barrels of wine, as opposed to 2 barrels of wine in Britain. Conversely if Portugal exports wine to Britain, then selling at British prices, each barrel of wine will fetch half a bale of wool as opposed to a quarter of a bale of wool back in Portugal. Therefore, even though it is actually cheaper in terms of man-days for the Portuguese to produce their own wool, it becomes beneficial for them to use the man-days to produce wine instead that they can then export to Britain in exchange for bales of wool that are in effect cheaper than the wool they produce themselves. This is **comparative advantage**.

In reality, trade is a lot more complicated than this and there are many other factors involved, but this simple example does at least explain to a certain degree why trade can be beneficial to two countries at once.

Arrow's Impossibility Theorem

As part of any democracy, voting systems are needed. There are certain properties of voting systems that you intuitively expect to be true, these are:

1. Given any set of complete (any two options can be compared), reflexive (***x*** is at least as good as itself), and transitive (if ***x>y***, and ***y>z*** then **x>z**) individual preferences, the social decision mechanism or voting system should result in social preferences that satisfy the same properties.
2. If everybody prefers alternative ***x*** to alternative ***y*** then the social preferences should rank ***x*** ahead of ***y.***
3. The preferences between ***x*** and ***y*** should depend only on how people rank ***x*** versus ***y,*** and not on how they rank other alternatives.

   Take the example of rank-order voting where each person ranks the possible options and assigns numbers to them, with 1 being their preferred option. The numbers are then added up to determine an aggregate score for each of the possible options, with the option that receives the lowest score coming first.

Person A	Person B
x	***y***
y	***z***
z	***x***

   If only alternatives ***x*** and ***y*** were available then in this example ***x*** would be given a score of 1 by Person A and 2 by Person B, ***y*** would be given a score of 2 by Person A and 1 by Person B. So both ***x*** and ***y*** would tie with an aggregate rank of 3.

   If ***z*** is introduced to the ballot ***x*** would receive a score of 4, ***y*** would receive a score of 3 and ***z*** would receive a score of 5. So in this case ***y*** would be preferred to ***x*** by rank-order voting.

All of the three properties seem plausible and desirable features of a social decision mechanism. However, ***Arrow's Impossibility Theorem*** states that if a social decision mechanism satisfies properties 1, 2 and 3 then it must be a dictatorship: all social rankings are the rankings of one individual. Therefore, in order for a voting system to be democratic, one of the properties must be given up.
Paraphrased from: Varian,HR., 1996, Intermediate Microeconomics – A Modern Approach, Fourth Edition, W.W.Norton &Co., London.

The Prisoner's Dilemma

Two partners in crime were arrested, and kept apart from each other with no means of communication. They were questioned separately, and each was given the choice of either confessing to the crime and so implicating the other or denying that they had taken part. If both of the prisoners confessed, they would both be held for 3 months. If both of them denied involvement, they would both be held for 1 month on a technicality. If only one of the prisoners confessed, he would be allowed to go free and the other would be held for 6 months.

What would you do in the position of one of the prisoners?
The most obvious answer if you did not know the conditions might be to deny involvement in the crime, but whether this is the most effective solution depends on the actions of the other prisoner, since if they confess you end up in prison for 6 months. It is actually better to confess to the crime as that way the maximum sentence you will receive is 3 months if the other prisoner confesses, but if he denies involvement, you get away free.

How to increase the impact of academic medicine on health and healthcare?

"The African Perspective"

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Introduction

There are at least 3 possible ways for academic medicine to exert its influence on health and health care, each of which constitutes a huge subject all on its own. These are

1. Education and training: the training of human resources for health
2. Clinical service: the provision of clinical service and in-service training in the public sector
3. Health and medical research: conducting research capable of influencing health provision and health policy

In my address looking into 'how to increase the impact of academic medicine on health and health care', I am not going to attempt to tackle this topic in the context of all three interface areas. At this stage in the evolution of our young democracy, the most critical health dilemmas have to do with health policy in the public sector, which constitutes the foundation for health care provision and service. In this paper, I will therefore confine my remarks to the question of how, in the African context generally and the South African context in particular, health and medical research can be made to influence health policymaking in a manner that promotes health and health care.

Health and medical research has been categorized as follows:

- Organisational research: which involves an analysis of what structures, processes and organisation of health care services result in improvement in the output and quality of care
- Clinical effectiveness research: which examines different types of health care interventions, technologies or treatments to determine their impact on health outcomes
- Public health research: which looks into the determinants of ill-health and what can be done to prevent illness

The discussion that follows largely applies to public health research that is intended to impact on public policy with a view to improving health systems and delivery of care.

Uphill battle for African research

Before delving into the question of how best to enhance the impact of research on health and health policy, it is necessary to acknowledge the parlous state of African medical research in the face of formidable odds: lack of adequate funding from private and public sources; impoverished academic and laboratory facilities; poor technical human resource support; and a lack of institutional commitment to quality research, among others.[1]

International funders have shown little interest in supporting research into the health problems of the developing world that are not seen as a threat to the rest of the world. Very few technological advances have been made in the diagnosis and management of diseases whose prevalence is largely in the Third World, which may be the reason why the techniques for diagnosing TB have remained virtually unchanged since the nineteenth century and the days of Robert Koch. Neither has local public funding been assigned any priority, perhaps because African governments (South Africa not excepted) often place little or no value in scientific questioning, in documentation of local critical health indices, or in evidence-based policy making.

Leading international journals have long had the reputation of largely shunning African research focusing on purely African health problems. On the other hand, Africa has very few home-grown journals with international recognition that are indexed in international databases. All of this has naturally had an inhibiting effect and has served to undermine African research. South Africa, along with a few other countries such as Egypt, has fortunately been an exception in this context. South Africa has a proud record of brilliant, internationally acknowledged research of African health problems going back to the days of the founding of the South African Institute for Medical Research. In those early years of the SAIMR, academic researchers and policy makers planned together and worked hand-in-hand in the battle to eradicate or control indigenous infectious diseases.

In the last two decades, South Africa has witnessed the steady decline of academic hospitals as a result of the State's equity-inspired redistribution of health resources; the continuing loss of leading clinical researchers to migration overseas or to the lucrative private sector; a significant decline in the country's total research output as measured by the number of articles published worldwide, and a decline in the overall citation rate of articles originating in South Africa.[2] The influence of academic medicine on policy makers has diminished considerably over the last decade or two, to the point where one might well speak of low-level hostility between Academia and the Union Buildings particularly as regards the HIV/AIDS pandemic. So, what can we do to restore and enhance the impact of academic medicine on health policy? In the

following paragraphs, I propose some steps that would need to be taken if this goal is to be achieved. Much of what I have to say draws its inspiration from the Health Foundation and Nuffield Trust Report entitled 'Increasing the Impact of Health Services Research on Health Service Improvement', published in September 2003.[3]

The research must be conducted into areas of prime importance for policy makers. In most health research, the research topic and agenda are set by the researchers and the funders, without regard to, or knowledge of the priorities of those who must make policy in the real world. Lomas[4] describes this set-up as resembling 'a retail store in which researchers are busy filling shelves of a shop-front with a comprehensive set of all possible studies that a decision-maker might some day drop by to purchase'. Much of the research from academia thus quickly disappears into the archives without reaching those in a position to apply them, or else is regarded as irrelevant by those who must plan the health system and the procedure policies within health institutions. It is therefore important that researchers are *au fait* with the broad health dilemmas and the big questions confronting the various stakeholders in health and health care, in order to be able to align their research with real people problems. Some have suggested that service providers, policy makers and patients should all in some way or other be able to contribute to the setting of research agendas.

In our own setting, it is imperative that researchers who wish their work to have relevance and application within the health system seek to maintain a good working relationship with provincial and national health departments. This is not always easy as egos and ideological conflicts often get in the way. South African health research has tended to be long on analysis and critique of existing health policy, and short on intervention research. Prior to the roll out of antiretroviral therapy and the prevention of mother-to-child transmission regimen, the literature was awash with articles advocating the introduction of these treatment modalities in the public health service.

After the roll out was initiated, we have seen little or no follow-up research on the effectiveness of the interventions. The research must be rendered accessible to policy makers and other potential users. Medical research is invariably published in inaccessible academic journals, and is presented in ritualistic formats and formalistic jargon that make it difficult to understand and to implement even for qualified medical practitioners.

One interviewee in the Nuffield Trust report put it like this: 'Research needs to be made more understandable, real and relevant to clients.[3] There are analogies with accountancy where accountants "translate" financial laws and accounting principles into real applications for individuals or companies. Academics don't want to and often can't provide that kind of service. The people who need it don't have the skills or the time to access the original research'. The world of medical research tends to be a belly-button-gazing fraternity, in which researchers are rewarded for being cited by other researchers, and impact factors are determined by the number and frequency of citations by fellow researchers, but not by the degree to which their research has influenced policy or practice in the real world. There is therefore little incentive for researchers to seek wider dissemination and incorporation of their findings into policy and practice. If funding and prestige were dependent in part upon dissemination, it would engender a culture of change.

The other side of the coin is the profound lack of capacity within the health system, specifically in both the national and provincial health departments, to process and apply research-based knowledge. Lomas suggests that the health system (including planners, policy makers, practitioners) needs at least 4 capacities in order to absorb and utilize research findings: [5]

- the capacity to access research evidence
- the capacity to appraise research evidence
- the capacity to adapt research evidence
- the capacity to apply research evidence

These capacities are in short supply in our present health system. But of course the challenge of transferring the results of research into policy and practice is a universal one. Researchers all over the world are not well positioned to follow through to the implementation of their own research findings, and Ham and others[6] in the UK have suggested the establishment of an independent foundation or 'academy' with the purpose to collect, interpret and disseminate research findings of a public interest nature to the appropriate users in the health system, and to serve as a forum to bring researchers and knowledge users together. In South Africa, institutions such as the Colleges of Medicine and the Academy of Science of South Africa are probably best positioned to play such a role.

Researchers must be conscious of the complex environment in which decision makers must operate. The relation between research evidence and application cannot be a linear one. Those responsible for formulating health practice policies, health service policies or health governance policies do so in the context of prevailing social, financial, statutory, strategic and political realities. In the final analysis (according to the Richmond and Kotelchuck model [7]) health policy is a product of three influences: the knowledge base, political will and social strategy. For example, according to available research evidence, the prevalence of HIV infection in South Africa is much higher among black people, particularly those living in informal settlements, than among white people and South Africans of Indian origin. But as we have seen, these objective facts cannot simply be applied in a linear fashion in formulating policy for screening potential blood donors by a blood transfusion service. Political, social and other factors must be taken into account in formulating such policy. Similarly, in promoting safe sex practices, the campaign is targeted at the entire population as a matter of public policy, rather than at known high risk groups.

Similarly, drug policies cannot be based solely on evidence-based efficacy, but also on price, conditions for storage and complexity of administration. Drugs requiring

refrigeration, or administration by drip would not do in a rural clinic setting. Sometimes there is no consensus among the researchers themselves on what constitutes research evidence, which can obviously have an impact on policy formulation. What evidence there is might be confounded by the complexity of the subject, inconsistent or contradictory research results, or different interpretations. In the US, opponents of managed care noted that 68 of the 81 published studies showed no tangible benefit for managed care, whereas the protagonists quoted the other 13 studies that demonstrated a benefit. In South Africa, one example of such uncertainty is the questions surrounding the role of so-called exclusive breast feeding in the prevention of mother-to-child transmission of HIV infection. There are those who say it works, and there are those who disagree.

Conclusion

In conclusion, it is fair to say that African academic medicine is under a great deal of pressure. In the recent *BMJ* 'Health in Africa' issue [8], guest editors Jimmy Volmink and Lola Dare, having battled to recruit quality submissions from most of the continent, conclude that 'African (medical) research is moribund', and observe that 'the (paucity) of research done in Africa for Africa is untenable'. One cannot really speak of 'academic medicine' where there is no research. Clearly, therefore, academic medicine barely exists in Africa sufficient to meaningfully impact health and heath care. Only South Africa, Egypt and Mauritius have any ranking at all in the World Bank league tables on productivity in science and technology research. Volmink and Dare warn that inequalities in health research contribute to inequalities in health. Relevant to our discussion today is their exhortation that that research must reflect national priorities, and focus on evaluating interventions that aim to strengthen health systems, and on activities to convert knowledge into action. But as already indicated, academic medicine in South Africa is also under pressure, with a measurably diminishing year-to-year research output. The situation is still rescuable, but will require innovative thinking 'outside the box'.

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How Academic Medicine should be positioned within medicine in Africa?

Lessons from Nigeria

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Introduction

The Chair, Distinguished colleagues, Ladies and Gentlemen. I consider it a great honour to be invited to give a plenary lecture at the Colleges of Medicine of South Africa (CMSA) Golden Jubilee Symposium on 'The Future of Academic Healthcare in Africa'. This session deals with the subject: 'How academic medicine should be positioned within healthcare in Africa'. It should be acknowledged that perspectives of Academic Medicine vary greatly, even in the same country that it is difficult to speak on behalf of the entire African continent, a massive land with hundreds of millions of diverse inhabitants. Therefore, this presentation will concentrate on lessons from Nigeria.

What is Academic Medicine?

The term Academic Medicine has been defined in a variety of ways but the consensus is that the term applies to the tripartite composition of teaching, research, and health care delivery services or patient care.[1,2,3] Academic medicine is, therefore, a combination of education, research, and health care provided by medical faculties, research institutions, and teaching hospitals or academic health centres. The contribution of each element to this tripartite is a matter debate and the concept of academic medicine differs greatly amongst individuals and institutions. In summary, Academic medicine can be said to be scientifically based medical education, research and health care. And Academic health care is scientific approach to health care, which comprises evidence-based medicine and quality management as its essential prerequisites.

Evolution and Current Status of Academic Medicine in Africa

Medical Education in Africa was slow to take off. Only a few medical schools were established in Africa by the colonial administrators prior to the Second World War. However, the period after the war saw a surge in the establishment of medical schools in Africa, especially post-independence. Indeed, there were only six medical schools in Africa during World War II.[4,5] In the immediate post-war era, the British colonial administrators established two medical schools in Sub-Saharan Africa. One was in West Africa at Ibadan (University of Ibadan), and the other was in East Africa at Kampala (Makerere University). After Makerere and Ibadan, the number of medical schools increased rapidly, especially post-independence and today, there are over 90 medical schools in the continent [4,5] of which there are 15 in Nigeria alone!

This increase in the number of medical schools occurred in the community care era of medical education with some emphasis on public and preventive health services. Prior to independence, the schools naturally were generally modelled on institutions in the home countries of the colonial governments and their intellectual traditions, with very little adaptation to African socio-cultural tenets. Unfortunately, this trend continued even after independence.

In Nigeria, a few more medical schools were established post-independence but the number increased gradually at first but rapidly in the last 10 years and today the number stands at 15. This proliferation of medical schools, which also occurred in other African countries, has led to a watering down of quality of medical education due to the fact that Africa does not have enough competent personnel to man these institutions and has had to depend on expatriates who subsequently left following the massive devaluation of the currencies of most African countries. And at about the same time, many African lecturers, especially Nigerians, also left for greener pastures elsewhere.

Health Care Delivery in Africa

One of the greatest tragedies of the developing world, particularly Africa, is that the diseases causing the most morbidity are those that have disappeared elsewhere. Moreover, the most vulnerable populations suffer the most morbidity. Of the 15 million children who die annually, 98% live in the Third World. Two-thirds of these deaths are preventable, and one third is caused by parasitic disease. Because of inequities due to poverty, infectious diseases that have been virtually eradicated in the developed world still cause significant mortality in the developing world. For example, tetanus, malaria, tuberculosis, and measles are 4 of the top 10 leading causes of mortality worldwide.[6] There is also the emergence of the HIV/AIDS pandemic that has hit Africa hardest.

The primary goal of academic health care

The primary goal of academic health care should be to improve the knowledge foundation on which clinical medicine bases its practices, thus improving patient care. To accomplish this, ways to integrate research findings to clinical practice must be identified.

There is a need to review the training programmes of doctors and other healthcare personnel to make them relevant to the healthcare needs of the African environment. Training future clinicians according to the new, broader academic health care will be critical. To accomplish this, traditional academics will need to collaborate with other components of medicine, not work independently.

Involvement of clinicians in the development of research goals will increase their interest in outcomes.

Fortunately, many countries in Africa are engaged in a debate about the appropriateness of the medical curriculum inherited from Britain in the early 20th century, which is still largely in place in most medical schools. In this regard, many are again asking the question posed by Lord Rosenheim in 1972: whether "in this chaotic and changing world, our efforts to train doctors are producing the right men and women for the job".[7] Medical schools are accused of producing elitist doctors best suited to practice in the developed world rather than in the less privileged communities of Africa. In response, medical schools are re-examining their programmes in terms of what is taught, where it is taught and how it is taught. A methodological paradigm shift in teaching is occurring in the form of integrated, non-departmental pre-clinical teaching, student centred learning, and clinical exposure at ambulatory sites.

Some of the changes being advocated include:

- Integration of pre-clinical and clinical learning
- Emphasis on the clinical relevance of the basic sciences
- Early introduction of patient contact and clinical skills
- Problem based learning (PBL) which has proved valuable as a means for incorporating many of the above developments
- A shift in emphasis from the purely biological and scientific model of illness to the one in which the individual is viewed within their biological, emotional and sociological context (the bio-psychosocial model)
- An appreciation of the impact of the illness upon the patient's life and that of his/her family will be regarded as important as a scientific understanding of a patient's disease.
- It will no longer be sufficient for the doctor to diagnose and treat illness, but also to prevent illness, to promote health and to participate in the rehabilitation of people with chronic disease and disability.
- Increase in Community-based learning opportunities aimed at complementing academic hospital-based learning so that students develop competency to practice at primary, as well as secondary and tertiary levels of health care.
- In fact, modern health care should no longer be based mainly in hospitals but should more likely occur closer to peoples' homes in community clinics and in general practitioners' offices.

Role of Research in Academic Health Care in Africa

Research and Evidence Based health Care should be essential components of academic health care in Africa.

Research priorities should focus especially on:

- The major causes of ill-health in the region
- Health systems research
- Appropriate technologies that address major health problems of the region

Challenges and Constraints to Academic Health Care in Nigeria

Nigeria as well as other countries in sub-Saharan Africa, face particular challenges in the field of academic medicine, including:

- Limited research resources;
- Diminishing financing of healthcare institutions; and
- The brain drain of health human resources.

Such constraints contribute to:

- Reduced numbers of faculty members,
- Poor remuneration and
- Diminished capabilities for career advancement.

Limited research resources

Resources for research have dwindled in Nigeria as well as in most developing countries largely due to the low priority that research has in the health-care delivery agenda.

Unfortunately, policy makers in many developing countries, including Nigeria see research, at best as a luxury and at worst as a waste of scarce resources! As a result, little or no financial allocation exists in national health budgets for research. The result is that researchers have to depend almost entirely on research funds from donor agencies leading to a donor driven research agenda that are not necessarily relevant to the health priorities of the country.

Diminishing financing of healthcare institutions

The spectrum of disease and treatment options in publicly funded tertiary academic hospitals has shifted in recent years mainly as a result of an increase in the levels of violent injury, and the HIV/AIDS pandemic.[8]

Moreover, funding constraints also derive from diminishing resources available to most African countries, rapid population growth and increasing poverty. In addition, most African countries are saddled with huge debt burdens that consume a significant proportion of their budgets for debt servicing. There is also the issue of redistribution of available resources to take care of an increasing emphasis on primary and community healthcare. This has left most teaching hospitals in Africa in dire straits.

The "brain drain"

A major concern in Africa is the threat of brain drain: the best and the most talented are leaving the country.[9] This threat faces all low-income academic communities. So far, nobody and nothing can stop people in their quest for better life and proper working environment, where their talent will be appreciated, and adequately rewarded.[9,10]

About 20,000 health professionals are estimated to emigrate from Africa annually.[11] Although most African countries are affected but larger countries like Nigeria are hardest hit. Nigeria is one of the several major health-staff-exporting countries in Africa. For example, 432 nurses legally emigrated to work in Britain between April 2001 and March 2002, compared with 347 between April 2000 and March 2001, out of about 2000 (legally) emigrating African

nurses, a trend that is perceived by Nigeria's government as a threat to sustainable health care delivery in Africa's most populous country. Data on Nigerian doctors legally migrating overseas are scarce and unreliable, largely because most wealthy 'destination' nations like the United Kingdom currently make it virtually impossible for overseas-trained doctors to migrate to their countries primarily on the basis of medical skills.[12] Nevertheless, hundreds of Nigerian-trained doctors continue to migrate annually.

Stilwell *et al*, [13] provided a succinct account of factors influencing migration of health workers from developing countries, and how to manage the complex issues. The three major factors that motivate doctors trained in Nigeria to migrate to work overseas (or de-motivate them from returning) are: [11]

Doctors trained to levels superior to local health realities

- Doctors complain of "brain waste", and seek better opportunities for professional development in countries with better medical infrastructure

Poor remuneration

- In terms of purchasing power parity, Nigeria-based doctors typically earn about 25% of what they would have earned if working in Europe, North America or the Middle East. Emigration is viewed by underpaid doctors as the most effective strategy to address such salary disparities

Limited incentives for overseas-based Nigerian doctors willing to relocate and work in Nigeria

- Scores of Nigerian doctors currently overseas are willing to return to Nigeria provided appropriate employment opportunities are available. Unfortunately, not only are such opportunities very scarce, there is growing unemployment among registered doctors in Nigeria. Furthermore, there is little enthusiasm by locally based senior medical staff to create openings for overseas-based doctors. Also, accreditation processes tend to be based on the principle of reciprocity, thus disadvantaging overseas-based doctors willing to return.[11,14]

Strategies for managing the above encumbrances should be sought in the interest of Nigeria's health system, patients, and doctors.

Conclusion

For Academic Medicine to be relevant to health care delivery in Africa, it must address the major causes of ill health in the region. Academic health care will need to be responsive to the needs and interests of the medical as well as society. In addition to more integration within the medical community, society will be more supportive of diverse areas of academic health care.

It is important to address the issues currently plaguing Academic Medicine in Africa to enable this essential and multi-faceted discipline to flourish in the region.

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How Academic Medicine should be positioned within Medicine in Africa?

"A Global Perspective"

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Introduction

Academic Medicine

Much has been said this morning to define what we mean by academic medicine, and this session deals with how that academic medicine should be positioned within medicine in Africa. I have been asked to provide a global perspective. My understanding of academic medicine as distinguished from medicine per se is a discipline within medicine that is characterized by an emphasis on teaching, research and service. In addition academic medicine encompasses scholarly activity such as the setting of norms and standards in the practice of medicine; and the maintenance of such standards amongst trainee specialists through examination and assessment.

In many ways I am not qualified to speak on this subject having had only a brief sojourn in a South African academic unit upon my return to South Africa 2 weeks before the first democratic elections in 1994; before moving to the MRC as Executive Director for Research in 1996; and then President of the MRC since July. Yet I may be able to offer a few useful insights; and my talk will touch upon the following areas:

1. A global perspective
2. Primary healthcare
3. Research
4. Indigenous knowledge systems
5. Multidisciplinary
6. Indigenous languages
7. Cardiovascular disease in Africa
8. Human resources
9. The African Union
10. Research translation
11. Conclusion

Global Perspective

On the African perspective I have gained some understanding of South African academia and medicine gained on the Board of the South African Medical Association and the Council of the Academy of Science of South Africa. On the global perspective, the 27 years I spent in England, with undergraduate years in Oxford and London; and MRCP (and in 2005 FRCP), cardiology training in Manchester with a University of London research doctorate.

Indeed, when I left the UK in 1994 to return to South Africa 2 weeks before the first democratic elections, I told my colleagues that apartheid was dead but it would take 20 years to reverse the effects apartheid had had on South Africa – 20 years to build a quality National Health Service, accessible to all. Indeed it is clear that in the education sector this will take even longer – 30 years. When my grandfather Dr Donald Mtimkulu, resigned in 1959 as a Professor at Fort Hare University together with most of the Faculty, and went into exile in protest against the University Extension Act; he predicted that amongst all the 330 odd apartheid laws, the Bantu Education would have the most devastating and long lasting effect upon South Africa. His words have proven tragically true in the struggle we have seen the new South Africa engaged in against poverty, poorly skilled and uneducated workforce, high unemployment and underdevelopment, high levels of crime and gender-based violence; and the spread of HIV and AIDS amongst young people. The crises in academic medicine then, are just one facet of our apartheid legacy.

Primary Healthcare

My first observation would be that academic medicine has changed markedly throughout the world in the past 20 years. Academic medicine remains medicine that is firmly grounded in teaching, research and scholarly activity; but the manner in which this teaching conducted has been profoundly affected by curriculum change in terms of problem-oriented medicine, information communication technology and the internet.

In addition, the site in which academic medicine is practiced has moved beyond the boundaries of the teaching hospital as a result of the primary health care movement; particularly since the declaration of Alma Ata in the 1970s. Indeed the severe stresses that academic medicine has faced in this country over the past 10 years of political and socioeconomic transition have been partly as a result of the necessary shift in emphasis to primary care with, unfortunately a decline in tertiary care. We have heard that efforts are underway to reverse this; but global experience teaches us that this tension need never have existed. The UK provides perhaps the finest example of how an excellent primary healthcare system comprising of GPs, practice nurses and allied health professionals is able to seamlessly weave in with the secondary, tertiary and quarternary levels of care. This cohesion exists not only because of well established and characterized referral systems of care; but also through outreach clinics and continuous medical education. Indeed, the very practice of primary care has a solid footing and recognition in academic medicine with the three years vocational training required for aspirant GPs. In Africa we could learn a lot

from this – for us family medicine and primary care still remain the scorned and disadvantaged stepsisters of medicine and academia; and the specialist is still regarded as a demigod.

Furthermore, the increased understanding of the social determinants of health and of health promotion has shown as that much of what determines health status lies outside the health sector within determinants such as education, poverty, housing, water, gender and power relations, and social inequalities. Academic medicine has had to learn some humility in appreciating these facts.

Research

My second observation is on a subject dear to my heart – research. Important as it is in African academic medicine and medicine itself – research is nevertheless given much less regard than in many other continents. This is in part due to the outrageously small health budgets afforded to medical care in Africa; and the enormous clinical loads that physicians labour under. In such circumstances research might be regarded as a dispensable luxury. I would argue however that in such resource constrained settings research is more important than ever, as those with tight budgets and too little time cannot afford to waste time and money on foolish investigations and useless interventions. I would argue that the entire panoply of research, from basic to applied; from laboratory to clinical to public health has extremely great relevance in African medicine.

At the Medical Research Council of South Africa we have a 36 year history of working closely with the academic health sector in order to strengthen the pillar of research in their mission, by funding research units and projects, as well as bursaries and scholarships at masters and doctoral levels for clinicians and scientists. The Objects of the MRC, in its Act of Parliament are 'through research, development and technology transfer, to promote the improvement of the health and quality of life of the population of the Republic, and to perform such functions as may be assigned to the MRC by or under this Act'. Our 500 scientists, half of whom are in the 8 medical schools of South Africa, produce 568 peer reviewed publications per annum, as well as numerous technical reports and 20 patents current and pending. Our 47 research units produce 42 PhD and 45 Masters graduates every year. Such collaborative arrangements between science councils and academic are a productive and globally accepted arrangement for practicing health research and research training.

It is important that academic medicine in Africa should follow the global trend towards the internationalization of research by strengthening South-South linkages in medical research, to augment the traditional North-South linkages that are often based on colonial precedent.

I would urge them to ensure that all the methodologies are developed on the continent; and that tissue are processed in country rather than exported. When recently at the MRC we were unable to use the only MRI spectrometer I at the University of Stellenbosch to derive the molecular structure of an antimalarial extracted from a South African plant, we did not ship the crude extract to London, but rather flew to the University of Botswana and used their MRCI spectrometer.

The erosion of government support for clinical research needs to be halted. The Health Ministers of low and middle income countries committed themselves, both at the Mexico Health Summit in 2004 and later the World Health Assembly in 2005; to spending 2% of their health budgets on health research. Some of this is already channeled through government-funded health research councils; but this needs to be increased and funds could also be channeled through provincial health research committees to the medical schools. In South Africa government funding of the MRC stands at R180 million having recently been doubled. This equates to 9% of the science vote; but additional health research are channeled to other agencies directly and via other government departments such as DOE so that total government funding for health research is probably somewhere between R800 and R1000 million – or 10% of South Africa's total S&T expenditure - both public plus private.

Other measures could be taken to expand the research pillar of academic medicine such as introducing medical students to research through an intercalated BSc year; recruiting overseas faculty to spend time in Africa in research training during sabbatical years or after retirement etc.

Indigenous Knowledge Systems

My third observation is my usual hobbyhorse – indigenous knowledge: strange for a physician brought up and educated in the west. As academic physicians working within African medical systems we have been woefully negligent in tapping the enormous knowledge and resources that have been developed over centuries in African indigenous knowledge systems. And yet these are the systems that we estimate 80% of Africans use; often as their first port of call.

In part this abhorrence has been due to experience of the appalling side effects that traditional medicines can induce when incorrectly used. Yet the knowledge that the third commonest cause of hospital deaths in the USA are of iatrogenic cause does not make us hesitate to use powerful drugs, medical devices and surgery.

In part we have suffered from the vestiges of colonial arrogance that assumed African medicine had nothing to teach western medicine. Yet we knew that medicine had its roots in Africa from the medicinal herbariums of ancient Egypt catalogued in the British Museum, through to Avicenna, culminating in the 3 000 South African plants used in traditional medicine out of a known floral base of 25 000 species.

At the MRC we follow the twin track in research of on the one hand evaluating African traditional medicines in their natural state in clinical trials; to the traditional phytoprospecting route of extracting the active chemical moiety with a view to eventually creating synthetic analogues that can be patented.

I do not argue for a merger of orthodox and traditional medical systems. Far from it – the former would soon subsume the latter; and the methodologies and cultural traditions are far too disparate. No, rather the Chinese and Indian models of having two different systems running side by side; but with each giving due recognition to the other; and with systems of professional self regulation enshrined in law and open to scrutiny for the protection of patients and clients.

In addition, there is much to learn from our indigenous cultures concerning the place of academic medicine in medicine in Africa. For example, a holistic approach to human health, whereby the Descartian split between mind and body receives less emphasis has become increasingly popular; and has to small extent influenced medical curricula.

Multidisciplinarity

Globally there has been a trend towards increasing multidisciplinarity, with medical and allied health professional schools forming faculties of health sciences – and this has certainly happened in South Africa. Internationally it is reflected in medical practice, with teams of health professionals being involved in healthcare for conditions as diverse as asthma to stroke, wherein the varied skills and contributions of the team members are acknowledged and exploited. It is of particular importance in African medicine of course, where the extremely low ratios of doctors to the general population necessitate that other health professionals take on many of the tasks that in more wealthy nations would be performed by a doctor. Such substitution should, however, never become an excuse for substandard care or lack of accountability – and the Colleges of Medicine could assist the Health Professions Council in maintaining standards of care; and the clear distinctions between the roles and competencies of the different health professions. South Africa's unified Health Professions Council with its different professional boards provides a useful model of how the health professions can maintain unity of purpose within a framework of variegated roles.

Indigenous languages

My fourth observation is on the subject of language. Again I am little qualified to speak on this subject being woefully lacking in my own indigenous languages of Zulu, Xhosa and Setsawana. Nevertheless my experience of seeing patients at the Groote Schuur and in the townships is that it is very difficult to fully assess patients without at least a rudimentary knowledge of their indigenous language. In a continent where the media of instruction in academic medicine are the colonial languages English, French and Portuguese this becomes particularly pertinent. Of course in South Africa we do in fact teach medicine and do clinical practice in an indigenous African language – it is called Afrikaans. Interpreters can help, but there is nothing to substitute being at least able to exchange a few words in the patient's home language. At the MRC we increasingly emphasise the importance of using project leaders (not just field workers), to both develop the protocol and do the study, who speak the participants' language and are preferably from a similar community – particularly when it comes to behavioural science research. In this manner health literacy amongst our communities will improve, empowering them to make healthy choices.

Surely then the curricula of African medical schools should include language classes, as well training in sociology, indigenous knowledge systems, health promotion and behavioural science.

Cardiovascular Disease in Africa

The recent publication by the World emphasized that 80% of deaths from chronic diseases occur in low and middle income countries, with nearly 25% of total deaths in Africa being due to chronic disease. Academic medicine in Africa must take cognizance of this in its teaching and research programmes, as well as its service and community health promotion initiatives. I have worked for the past 8 years with the Initiative for Cardiovascular Health Research in Developing Countries that has helped put issue firmly on the global public health agenda; and was part of the drafting team for the 1998 WHO Global Strategy for Non communicable Disease.

Furthermore, the Interheart Study has shown us that 80% of cardiovascular risk is attributable to the 5 major classical risk factors; implying that preventive medicine and health promotion interventions could dramatically reduce the burden of disease from heart attack and stroke.

African Union

My fifth observation is with regard to the African Union. Globalization has had impact not only on trade and communications; but also on the traffic of medical practitioners between countries; and the transnational societies that forge collaboration between associations in different countries. In this country of course, we were acutely aware of this in terms of the global movement against apartheid and the academic boycott; as well as the steady exodus of doctors and other health professionals particularly in the 1980s. More recently however, the formation of the African Union and the peer review processes of NEPAD have increased our awareness of the links between the 53 countries of Africa. In commerce it often said that one of the key elements of prosperity in Europe and the USA was facilitation of trade between member states and states of the Union respectively, accounting for up to 60% of trade flows. By contrast in Africa less than 5% of trade takes place between the 53 states, partially explaining the impoverishment of a continent that, with 50% of the world's mineral wealth and much of its biodiversity, simply exports its raw commodities wholesale with little beneficiation.

A similar situation exists in terms of human capital with a steady exodus of health professionals from the continent; and few collegiate and collaborative links between the different African countries. In defining the place of academic medicine within medicine in Africa, we could learn much from each others experience; and forge the

sort of trilateral linkages that the EU tries to encourage, whereby two African and one European country form collaboration in research, academic or educational activities. Let us collaboratively beneficiate our own human capital for the greater good of all Africans.

Research Translation

Research is an important component of academic medicine, but for medicine research remains simply an esoteric intellectual exercise, useful for building one's CV, unless it is translated. At the MRC our vision statement is *'building a healthy nation through research'* but we are aware that this can only be achieved if the results of our research are translated into:

- health policy
- health practice
- health promotion
- health products

We call this GRIPPPP or 'grip cubed'.

Clearly the greatest impact for academic medicine is in terms of championing evidence-based medicine to influence the practice of doctors and health practitioners for the benefit of patients in terms of curative, preventive, health promotive and rehabilitative care. At the MRC we have attempted to introduce this culture of EBM into academic medicine in South Africa through the establishment of the Cochrane Centre, one of the 13 worldwide. This Centre works throughout Africa and has had a degree of success in its efforts, the latest of which has been the establishment of an African Clinical Trials Register.

Academic medicine however can also influence healthy policy and we at the MRC have had spectacular success in this regard. Our success has been based upon the respect that South African politicians, particularly Cabinet Ministers, have for our academic credentials and experience. I know that colleagues in academic medicine in other African countries also enjoy the kind of privileged access to senior politicians that is almost unheard of in high income countries.

At the MRC we are consulted on virtually every major aspect of health policy in terms of what research evidence exists to inform the policy decision that needs to be made. Other parastatals are also consulted such as the Medicine's Control Council (on which I served for 3 years), the Medical Schemes Council, the Health Professions Council, and the National Institute for Communicable Disease, the National Health Laboratory Service, and the Essential Drug List Committee. We have succeeded in inculcating the understanding amongst senior politicians that health research results are not useful for policy formulation unless they arise from research conducted according to rigorous standards that has been peer reviewed in reliable medical journals.

At the MRC in past 10 years we have had major impact on policies such as tobacco control legislation, excise duties on tobacco, termination of pregnancy policy, policy concerning management of rape victims, prison health, road traffic policy, lead in petrol and paint, environmental pollution, control of illicit drugs, nevirapine for PMTCT, the possibility of moving to dual therapy for PMTCT, the Comprehensive Plan for the Management treatment and Care of HIV and AIDS which includes antiretrovirals, cotrimoxazole, multivitamins and nutritional supplements, as well as the option of traditional medicines; screening blood donors for HIV in a non discriminatory fashion, and latterly health promotion policy for chronic diseases including the National Strategy for Healthy Lifestyles, *vuka! South Africa* and the Youth Fitness Charter. The latter were driven particularly through the dissemination of our Youth Risk Behaviour Survey which identified that youth in South Africa were already beginning to manifest the determinants and risk factors that lead to heart disease, stroke, cancer, and lung disease in the future. It has been an immense privilege to work as a doctor and research scientist in a country were one has such close access to politicians, and can have such profound impact on health policy.

Conclusion

In conclusion then academic medicine does have an important role to play in medicine in Africa in the 21st century. The challenges however are enormous and include the role of academic medicine vis a vis primary healthcare; health promotion and the social determinants of health; research; indigenous knowledge systems and indigenous languages; multidisciplinarity; human resources and the African Union; cardiovascular disease and research translation.

All these varied influences will dictate that academic medicine in the 21st century is likely to be very different to that of the 20th century. The changes are difficult to predict however; and the over riding challenge will be to preserve what is best in the traditions of the past; whilst fully exploiting the challenges that new technology, information and communication tools, globalization and societal change bring about.

Migration of health professionals from sub-Saharan Africa: Practical measures to end the brain drain

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Introduction

The already inadequate health systems of Sub-Saharan Africa have been badly damaged by the migration of their health professionals. The serious consequences resulting from loss of health workers are becoming increasingly recognised. The English-speaking countries (UK, US, Canada, Australia and New Zealand) have a special role in both the genesis of the problem and its solution, as large numbers of the migrating health-workers go to these countries. One obvious issue is the 'vacuum' of the large numbers of job vacancies resulting from the inadequate supply of "home" trained doctors and nurses. Data from 2002 shows that among the 11,234 new registrations with the General Medical Council (GMC) nearly half were from non-EU overseas countries.[1] The pattern is similar for nurses. In 2003, UK work permits were approved for 5,880 health and medical personnel from South Africa; 2,825 from Zimbabwe; 1,510 from Nigeria and 850 from Ghana, despite these countries being included among those proscribed for NHS recruitment.[2,3]

In recent years international migration of health professionals has not only grown considerably, but is often permanent. Walt believes that the greatest challenges to health stem from the global liberalisation of trade with the resulting movement of goods and services (including health workers) within the world economy[4]. A 1998 United Nations Conference on Trade and Development (UNCTAD)/World Health Organisation (WHO) study estimated that 56% of all migrating physicians flow from developing to developed nations, while only 11% migrate in the opposite direction; the imbalance is even greater for nurses[5].

The health services of a continent already facing daunting challenges to the delivery of minimum standards of health care are now also being potentially overwhelmed by HIV/AIDS. Initiatives to tackle HIV/AIDS, such as the WHO '3 by 5' target – for providing life-long antiretroviral treatment for 3 million people living with HIV/AIDS in poor countries by the end of 2005 – require additional health workers; such targets, therefore, are likely to be seriously threatened by the current continuing losses[6]. The authors of a recent study estimated that an additional 1 million extra workers will be required in sub-Saharan Africa to deliver the health services necessary to meet the Millennium Development Goals by 2015[7].

The problem for sub-Saharan Africa

WHO recommends a minimum of 20 physicians/ 100 000 population; 38 of the 47 sub-Saharan countries fall short of this recommended minimum (Figure 1 & Table 1).

Figure 1: Distribution of Doctors/100 000 population

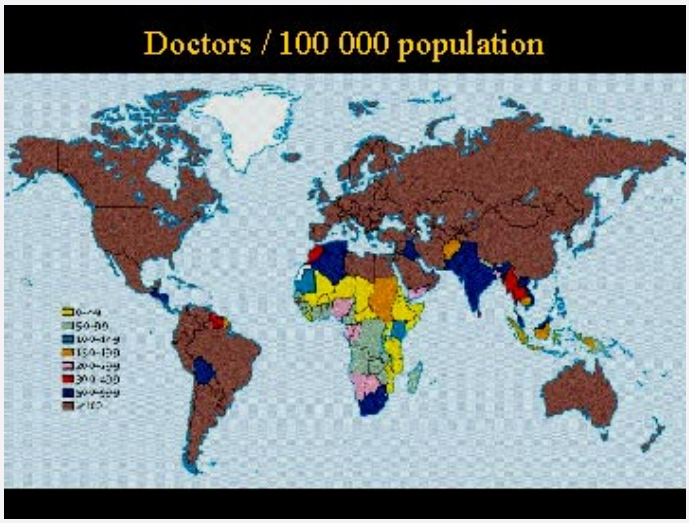

Table I: Numbers of doctors/ 100,000 population: sub Saharan Africa

>WHO MINIMUM		<WHO MINIMUM			
South Africa	69.2	Sudan	15.8	Eritrea	3.0
Namibia	29.5	Kenya	13.2	Liberia	2.8
Botswana	28.8	Ghana	9.0	Tanzania	2.3
Nigeria	26.9	Sierra Leone	7.3	Rwanda	1.8
		Zimbabwe	5.7	Malawi	1.1
		Tanzania	4.1		
		Burkina Faso	3.9		

http://www.who.int/GlobalAtlas/DataQuery/home.asp

In sub-Saharan Africa two-thirds of countries have only one medical school; some have none[8]; Table II.

Table II: Doctors in sub-Saharan Africa

Doctors	82,949
Total population	663.53 million
Doctors/100,000	12.5
38/45 countries	<20 physicians/100,000 population
Medical Schools	87 in 47 countries
None	11
1	24
2+	12

Hagopian A et al. Hum Resources Health 2004; 2: 17[8]

Patterns of migration

A "medical carousel" has been described around which doctors continuously rotate to countries offering a better standard of training, more attractive salaries and working conditions, and a higher standard of living.

Impact on source country

Doctors and nurses are the linchpins of any healthcare system. Medical students and young doctors in training need motivated, well-educated, articulate champions of both the health service and their specialty. Loss of well-trained experienced personnel is perhaps the most serious aspect for the future in many countries, and one that monetary compensation cannot replace, doing little to replace a doctor who has taken five years or more to train and is a teacher and role model to students and junior doctors. Senior officials in Ethiopia, Nigeria and Uganda have cited lack of health personnel as the main constraint to mobilising responses to health challenges.[9]

UNCTAD has estimated that each migrating African professional represents a loss of $184,000 to Africa[10], and the financial cost to South Africa is estimated at $37 million.[11] Africa spends $4 billion a year on the salaries of foreign experts.[12]

Benefits for Destination countries

The migration of health professionals from developing countries provides a very significant financial benefit to the economy of developed countries. In the UK, for example, each qualifying doctor costs £200,000-£250,000 and 5-6 years to train. So every migrating doctor arriving in the UK is in effect importing this sum for the use of the UK's health services. And the effect is immediate rather than in five years' time. In many countries, migrating health professionals constitute a significant proportion of the total workforce.[13] (Table III)

Table III: Percentage of foreign-trained doctors

New Zealand	34.5
UK	31.0
Canada	25.0
USA	23.0
Australia	21.3
Norway	15.4
Germany	5.0
France	4.2

Forcier et al. Hum Resources Health, 2004; 2: 12[13]

Reasons for migration of Health Professionals

Push and Pull Factors

Published literature on the migration of health professionals documents the 'push' and 'pull' factors influencing decisions to migrate.[14] A wide range of factors are clearly at work, affecting both temporary and permanent migration (Table IV). In addition to the factors involved in the decision of the individual to migrate, national policies and international agreements such as GATS Mode 4 can also be an influence, e.g. countries such as India and the Philippines have made country-to-country agreements facilitating the employment of their nationals as health professionals; US visa programmes target highly skilled individuals as well as offering temporary visas which could become permanent without much difficulty .

Table IV: Factors impacting on migration of health professionals

Push Factors	Pull Factors
• Lack of postgraduate training opportunities • Lack of established posts/career opportunities, without any prospects of financial or career advancement • Poor state of health facilities • Unaffordable treatment for many patients • Poor remuneration, conditions of service; perception of lack of recognition and value of contributions of HCW • Lack of retirement provision • Standard of living, civil unrest and personal security • Governance and Health Service management shortcomings	• Opportunities for further training and career advancement • The attraction of centres of medical and educational excellence • Greater financial rewards and improved working conditions • Availability of posts • Higher standard of living • Active/aggressive recruitment by prospective employing countries. • Ease in acquiring work permits and registration

Measures to prevent the brain drain

1. Existing measures / Codes of Practice

African Health Ministers' agreement forbids the brain drain to South Africa from the rest of Africa. The Commonwealth Secretariat's Code of Practice for the International Recruitment of Health Workers represents a wider international effort in tackling the same issue[15], raising the possibility of compensation for source countries. The Revised Code of Practice of the UK in December 2004 proscribes recruitment of healthcare workers from sub Saharan Africa.

2. More radical options

(i) Financial compensation: There is a compelling case for direct financial compensation for those developing countries whose health professionals (usually trained at public expense) have migrated to developed countries. However, financial compensation cannot be a satisfactory answer; there is little immediate prospect of developed countries agreeing to direct compensation.

(ii) Restrictions on freedom of movement: Practically and ethically, it is always difficult to restrict freedom of movement of individuals.

(iii) 'Half-training' of doctors: From time to time it is suggested that the countries of Sub-Saharan Africa should only half-train their doctors - to a standard that would severely limit their employment prospects overseas. Even if half-training were both practicable and acceptable it is clear that half-trained doctors would also be recruitment targets, and the problem of health worker migration would remain. Ghana's loss of health workers in 2003 included almost as many auxiliary nurses as fully trained nurses, and many doctors.

3. Actions by developed countries

(i) Train more doctors and other health professionals to meet the needs of developed countries; norms need to be established for doctors, nurses, and other health professionals[16]
(ii) End active recruitment from developing countries
(iii) Match visa to duration of training
(iv) Compensation to country of origin? These funds would be directed towards specific measures agreed with each country to assist in recruiting and retaining health professionals particularly in rural areas and to improve in-country post-graduate training programmes.

4. Actions by developing countries

(i) Recruitment and training

(a) Selection of candidates for medical training who are unlikely to migrate is not predictable
(b) Appropriate training for needs of country
(c) Bonding schemes- to delay migration
(d) In- country training
(e) Mandatory to return home after foreign training e.g. International Society of Nephrology Fellowship training programmes, THET
(f) Train- increased numbers in developing countries
- doctors from developed countries by countries such as South Africa, with financial and human resource benefits.

(ii) Retention

(a) Incentives
- improved pay
- tax incentives: besides professional fees being rebated, tax breaks should be considered for public service doctors
- career opportunities
  - improvements in standard of living and quality of life
  - research budgets, laboratory facilities

(iii) Re-gain

- return of talent programmes; brain gain network harnessing skills of South Africans abroad
  - return permanently
  - regular/ annual visits for teaching and service provision

In-country post-graduate and specialist training for health professionals

The lack of in-country post-graduate education is clearly a factor in the emigration of health professionals in many countries of sub Saharan Africa.
The Tropical Health and Education Trust (THET)[17], established by Professor Eldryd Parry works in Uganda, Malawi, Zimbabwe and other countries of sub-Saharan Africa; the University of Bristol, in collaboration with THET, runs annual teaching modules for undergraduate and M Med programmes at the University of Mbarara in Uganda. A number of UK hospitals and teaching centres have found real mutual advantage in establishing working links with similar institutions in Africa[18]; these links can make a real contribution to post-graduate health training in countries vulnerable to the loss of health professionals.

Conclusion

There is a need for the concerted political will and funding support that will allow health professionals and administrators in Africa and internationally to do what is necessary. Developed countries and WHO urgently need to agree on criteria for minimum national health training targets for all developed countries so that continuing loss of health workers from developing countries is brought under control.

It may well be asked why special measures should be necessary to influence the migration of health professionals rather than engineers or football players or any other category. The answer must surely be that no other category of worker is so essential to the well-being of the population of every nation.

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John Eastwood, Peter West, Roger Tutt, Jacob Plange-Rhule and Rachel Conroy, co-authors in a previous publication on this subject.

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Retaining Academic Capacity in the Public Health Sector: Investing in the Producer and Nurturer

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Introduction

In this short paper I intend to only raise a few issues that, from a planning perspective I hope will serve to stimulate debate on the topic I have been requested to address. The issue of **retaining academics in the public health sector** is a challenging one that must be seen in the context of social transition over the past 11 years without forgetting how medicine is socialised. Like any other aspect of society, **academia could never be immune to the changes** that the health system had to endure. Unfortunately during the process over the past few years of our young democracy the gap between health authorities and those in academia has not narrowed to the extent that South Africans would have liked.

The concerns we all express could possibly have been prevented or minimised had we all taken a long-term view, ensuring that we pull and pool resources to ensure that we build a sustainable health system. Attracting and retaining high calibre academic staff poses a serious challenge to many tertiary institutions in our country. Complicating this is the fact that there is **national and global competition for good well-groomed academic staff**.

Some universities have since inception struggled to attract the calibre of academic staff in the numbers they need. The past two decades have seen a steady decline in numbers of academic staff, many of them opting for private practice that until recently was seen as very lucrative. Despite several measures put in place to address the exodus of teaching and senior medical staff from public health service, the bleeding has continued. The **mergers of institutions of higher learning** have also added another dimension notably with some institutions suffering serious loss of staff to other better-resourced institutions. Taking the best from each other without investing in producing the best from your own fields does not seem the best way to sustain an institution in the long-term.

Although we face serious fiscal constraints on matters like remuneration for health professionals, there is room for all concerned to pull together in a partnership that will stand a chance of overcoming the challenges faced. There are certainly a number of mechanisms that academic medicine in partnership with the Departments of Education and Health can develop to address these.

It is worth noting that some policy discussion has already commenced within academia to seek solutions. As this challenge has both national and international dimensions, it is necessary for us to also compare and put things into a global context. The work done thus far by the International Campaign to Revitalise Academic Medicine (Awasthi et al, 2005) is interesting and has relevance to this debate. The efforts by the Health Professions Council of South Africa in relation to registrar training and various approaches to the National Department by Specialist Associations on matters of training are welcome developments that certainly need further detailed attention.

A Short History of Pertinent Issues

The academic landscape has changed markedly in the past decade. The signs of impending challenges could be noticed as early as the turbulent eighties. There certainly has never been any specific plan addressing the issue of recruitment and retention of academics in the public health sector. Much of the information available on the university staffing situation is certainly university-specific and discipline-specific. This is a shortcoming that needs urgent attention thus my contention that as a nation and as a national health system we need to invest in the producer and nurturer. I hope that you find the term appropriate because most still believe that the traditional role of academics remains and must remain split into the three areas – education / training, service and research. We are a proud nation that has always grown its own timber to the extent of sharing it with the world. In addressing the need for retaining academics in the public health sector we need to analyse the state of academic medicine (or should I not refer to it as academic health?)

It is critical that academic medicine is not seen as a separate entity on its own, just like we need to start seeing our national health system as being inclusive of the private health sector. This is a mindset issue. The gap between public and private health sectors must be minimised as much as possible. I raise this aspect because the unattended challenges in the public health sector and the lucrative environment of the early-to-mid-eighties in the private health sector have contributed to a decline in academic life within the public sector. During the eighties a lot of pressure was put on health authorities to drastically improve the remuneration of health professionals working within the public health facilities. This coincided with the rapid growth of the private health sector especially proliferation of the Medical Aid industry.

Private practice suddenly became very lucrative putting a lot of pressure on the health professionals and their employers. The advent of Limited Private Practice gave

a glimmer of hope that the system would help retain academics in teaching hospitals. However it was not long before it became clear that this system was not as effective as earlier envisaged. In response to this, a system of Remunerative Works Outside the Public Service was introduced. This also has hit a cul-de-sac, failing to stem the outflows of highly skilled health professionals from the public health service. We have over the past few years tried as the Department of Health sought to improve other areas such as implementing and improving the policy on Commuted Overtime. Probably there should have been a more definitive plan much earlier as the signs on the wall were very clear and unambiguous.

These are certainly some of the issues that I consider to be both internally and externally generated and have compounded the challenges faced by academic medicine. Others are exogenic and find their expression in the changing national education landscape. It may still be early to assess and analyse the impact of the Mergers of Institutions of Higher Learning. However, we can safely express views on the impact of certain developments in the past that were designed to encourage academics and highly skilled health professionals to stay in the public health service. My short input is therefore premised on observations and experiences over the past years. In this short paper I also delve into the need to put whatever plan for academic medicine within the context of a national human resource plan.

Context

I have raised these issues because they have relevance to the topic I wish to address. I remember during my years of undergraduate education and training that senior consultants used to moan about how little they were remunerated and comparing their state of affairs with that of their peers in private practice. One could see even then that a crisis was looming. We need to acknowledge that the way our health education and training system is heavily service oriented. Very few if any health academic gets involved in training students without interacting with patient care. As the phenomenon of health professionals leaving the public health institutions to greener pastures accelerated, senior consultants involved in teaching started following the exodus. There can never be difficult a situation as putting an academic in a position of choosing between solidifying one's academic career versus going for a lucrative private health sector.

Academic life in our country obliges one to fulfil a **trilateral responsibility: teaching, service provision and research**, even though the research arm is in many instances not as intense as it should be. During the development of the process of Modernisation of Tertiary Services many academics supported by the universities expressed a number of concerns. Chief among these were:

- That academic staff do not always have sufficient time for academic functions, in particular to prepare teaching properly and to undertake research due to too onerous service loads.
- Lack of a critical mass of academic staff in each discipline so that expertise is available in the different areas of the discipline.
- That service weaknesses e.g. insufficient nurses, have at times resulted in an environment that is not conducive for student learning.
- The inflexible packages that prevent them paying more to attract or retain scarce staff or those who are the very high earners in the private sector e.g. surgeons.

To balance the scales one must mention the concerns of the provinces too:

- Academics at times lack fiscal discipline in their practice. As the key drivers of expenditure, they need to be more frugal in choices e.g. of drugs and laboratory tests, which can be done without impacting on successful academic practice.
- That service time responsibilities are not always met, undermining patient care.
- Some academics don't take their provincial management responsibility as seriously as their academic one, including in the management of fellow academics' service time responsibilities.
- *That the Universities have historically not opened up their management to Health influence to influence on such matters as curricula and selection towards the health needs of the country.*

Confronting the Challenges

Of major concern have been the declining academic salaries, which prompted a significant number of academic staff to forsake their academic calling. The World Bank notes that some 23,000 qualified academic staff are emigrating from Africa each year in search of better working conditions. The staff retention problems are compounded by weak institutional management capacity and the big gap between health authorities and universities as join employers. Our system of joint appointments seems to be generating a number of challenges prompting some at both province and university to call for a review. My personal view is that this is possibly a result of poor management of contracts especially where financial issues are not the sole measure of control.

Universities have always maintained a substantial autonomy in the sphere of academic programmes, whilst the health service planning has for a long time not been an area of strength. This gap caused by the former lying within universities the latter with the health authorities and these custodians not communicating as partners whose lives depend on each other. If such a gap continues to exist, both academic health sciences and health service planning will remain compromised. I deliberately raise this issue because it is critical to effective management of the

relationship, ensure good professional discipline and guide investment.

To return to the question of retaining academic medical staff in the public health sector, I propose that we start by planning **appropriate long-term strategies** to deal with the challenge.

Firstly, we need to **analyse the problems** that led us to the situation that we are in today, just to make sure we read from the same page. This will help us plan better. *Secondly*, we need to attend to the causes of the problems taking care that our solutions **do not exacerbate the divisions and inequity** especially among health professional categories. *Thirdly*, we need to set up a proper **Health Sciences Academic Development Programme** that seeks to provide good quality academics in health sciences over a long period. This envisaged programme is what I propose should occupy our minds over the next few months. Of course it has to be part of the broader national human resources for health plan.

The objectives of the programme will be to:

(i) Promote the **development and maintenance of educators** in health
(ii) Increase the **pool of academia** in the public health sector
(iii) Ensure the **transformation of health education** from an education and equity perspective
(iv) Develop **specialised programmes** to translate high-end health knowledge into systems and technologies, which can benefit the national health system as well as international health systems.

Our **focus must be on retaining** those that are currently in the system. This process has started through close collaboration with the Department of Education focusing on human resource planning for health care. The major aspect of our collaboration is on planning for human resource production, an issue we raised sharply in the **Strategic Framework** released on 03 August 2005. Subsequent to the release the department interacted with many stakeholders most of those in the health sciences education and training field indicating no lack of students wishing to develop a career in one of the categories of training.
What seems to be a serious challenge is the low number of health science educators in the system. Our planning as the department is strongly geared towards addressing the supply and demand issues relating to health sciences education. This being part of the HRH planning, it is critical that we work closely with partners within government. The most voiced reason why our health professionals are leaving the public health service is low remuneration. The department has taken a step forward by teaming up with the Department of Public Service and Administration and Treasury to focus on improving remuneration and conditions of service. Our focus on the broader health professions is strategic as academic medicine is only a small but very influential part of the health sector. Infact my own view is that our focus on academia must span the whole academic health sciences group. The challenges are the same if not worse if one looks at nursing, pharmacy, dentistry etc. Our health system has in the vast academic sphere tended to neglect the smaller but critical fields like physiotherapy, speech therapy, audiology and so on. We must intentionally create relative interdisciplinary dependence in development but absolute dependence when it comes to measuring health outcomes.

A major challenge we are facing in this area is retaining those that we already have. One should concede that the relationship between academia and health authorities has probably not been managed to the best of all's ability and everyone involved has to take a certain measure of responsibility. However, let me concentrate on what needs to be urgently done. Retention of academics in the public health sector is a dual responsibility of the universities and the Department of Health with the assistance of the Department of Education. There is overwhelming proof that rewarding performance with bonuses works wonders. This therefore means the appropriate use of the performance appraisal system, not as a punitive measure but as a reward and mechanism to encourage development. Many managers especially in the academic sector are not optimally trained in utilising such systems. Performance appraisal geared towards development means that there must exist in our academic institutions solid mentoring system whose intended consequence must be to help improve staff retention. You all know how we worship our teachers, probably because this is entrenched even in the original Oath of Hippocrates.

I am confident that the issues raised above are critical to us retaining many of you in the health system. However we must examine how we replenish our stock. I am certain that those who chose to have a career in academic medicine did not make such a choice long after they had qualified as medical doctors. Academic life must e a calling. If we agree with this supposition, our planning must therefore look at ways of attracting graduate students to increase the pool of academia. Our universities must focus on the recruitment of outstanding students, nurture them and guide them towards the ever-increasing possibilities in the academic field. They must be engaged and nurtured in research and a culture of inquiry long before they qualify as doctors. As academic leaders you need to ensure that universities get truly engaged in what universities are for – centres of intellectual stimulation and innovation.

This cannot be attained unless students are grilled and infected with critical thinking skills essential to survive in a hub of intellectual activity. One is confident that if this became a major aspect of our approach, it would directly enhance the work of the professoriate! South Africa is a vibrant society in transition that lacks no new areas to stimulate and challenge the way we do things. Medicine urgently needs to embrace this and find ways of influence social policy through innovation and entrenchment of itself,

thus making medicine an indispensable part of society. I raise this because the setting and relationship between teachers and undergraduate students forms a good foundation for long-lasting bonds between professors and their students. Unless we utilise such opportunities to engage in intellectually stimulating experiences, we shall keep producing professionals of mediocre quality when they have to deal with issue outside medicine. I therefore would doubt that South Africa could produce a knowledge based medical community able to take its place in guiding the further development of a robust society. The essence of this is that the national health system, specifically the public health sector needs academic leaders who have among others the attributes I allude to below.

The academic leaders' behaviour can guide not only changes within their departments and faculties to enhance quality and foster innovation; they influence the thinking of young aspirant professionals. They influence health systems. They influence people and systems because often they are agents of change, whose own behaviour, thoughts and advice inspire, persuade and affect others. Like all members of the health professions academic leaders set standards for the rest of the profession often high for their peers. This often results in high performance in all who come under their instruction and influence. The academic leadership that we need in the public health sector is therefore leadership that keeps professional value systems at the highest level of integrity thus creating space and authority to hold staff accountable for their performance.

One is fully aware of the challenges of retaining highly skilled academics in the low paying public health sector in the face of a serious economic climate. However, without this fundamental stance, the challenges we face in the public health sector will not help us attract and retain academics and will not produce good ground for academia to thrive. It will not be possible to encourage young professionals with interest in academic life to join if they see their seniors engaged in acts not consistent with their teachings. We all know that some academics in the public health sector spend more time in secondary income generating activities, neglecting teaching and patient care in some instances. They leave juniors to learn through mistakes, thus encouraging a culture of unconcern.

The solution must be a shared one. Firstly we need to develop a system that invests in people. Skills development for academic administration must rank high in our list of priorities. Reward system must be fair, equitable and developmental. We must plan together. We must get out of the blame-each-other mode and concentrate on influencing one another.

For the universities investing in people means creating an environment in which those with interest in following an academic career can develop teaching, research skills whilst playing a major role in providing public health services.

For the Department of Health investing in people means without question that the issue of remuneration, retention incentives and conditions of service must be drastically improved. It also means creating an enabling environment for our health system to attract aspiring young graduates to the academic sector.

It is for these reasons that the HRH Strategy Framework addresses issues of improving the work-life experience of health professionals as a major or key direction for the future. The work-life experience includes conditions, remuneration, feeling valued, supported and appreciated in exchange for the good quality work you provide to your fellow South Africans.

As Horace Williams recently noted 'academic salaries have always been a contentious issue, especially when persuading talented graduates and postgraduates to opt for a higher education career rather than the private sector'. This is in general a serious issue that we are addressing with Treasury. Salary levels for management staff are far higher than for health professionals. This has led, in the case of nursing to very experienced and skilled nurses leaving clinical nursing for administrative jobs. We cannot allow this to continue.

I feel good that I have made you aware that we are aware of the problem and we are working on it! The big question, as I conclude is: What is to be done? The proposal I have in responding to the question I was asked to address is that we urgently need to establish a Health Sciences Academic Development Programme as part of our National Human Resources for Health Plan.

As part of HRH Planning we have started drafting what we call a 'draft strategy discussion document on academic development' along the same lines as the HRH Strategy Framework. This will surely not be an exhaustive document but it will fail to do a detailed analysis from a policy and planning perspective, highlight issues of concern, put the national health policy in context vis-à-vis the academic health sciences across the board and propose an approach to addressing the future. What the document will not fail to do is put all concerned on the spot by asking: 'How should the plan for retaining academics in the public health sector look like?'

My preliminary views are that unless we:

i. Create a conducive environment for a rewarding academic life experience;
ii. Manage our unpredictable but exciting environment well;
iii. Develop trust between health authorities and academics;
iv. Create a strong bond between academic leaders and health policy planners;
v. Maintain a good balance between teaching, service and research;
vi. Locate health sciences academic gaols

within the goals of the national health system;

vii. Ensure that our universities are hubs of intellectual activity;

viii. Ensure that institutions of higher learning are reservoirs of knowledge for our communities;

ix. Invest in our young people, the breeding stock of the profession;

x. Encourage and appropriately fund good research and innovations to help with the achievement of set objectives;

xi. Bridge the gap between the private health sector and the public health sector;

xii. Address issues of transformation of our institutions of higher learning especially at the high-end skills producing levels;

xiii. Address the need for good management and governance of our education and training institutions;

xiv. Recommit to the ethics and values that have characterised this noble profession over centuries;

We will have failed to achieve the goals for which academia should stand for and propagate in a society in need of relevant intelligentsia.

In concluding this short presentation of what government through the Department of Health is striving to correct and achieve, let me re-state that the solution lies in our hands as a collective. The ability to recruit and retain academics specifically in the public health sector is a daunting but not too difficult one. Like many of my colleagues in the department, I am convinced by the commitment that the majority of medical academics in general possess towards serving our society in the public health sector. This is the strength shown through the most trying times. However, we cannot rely on fate, something active must be done and has commenced. I hope that you are all following the process of developing a National Human Resource Plan for Health. I also hope that you have commented on the framework as requested.

Just like we need and have started with elementary work on developing a Strategy on Nursing, we have also started with elementary work on developing a discussion paper on a National Health Academic Development Programme. Academic medicine cannot on its own survive in the long-term without interacting and planning with other professional groupings in the health sciences education and training landscape. Your proactive and intellectually stimulating work towards this will be highly appreciated. Hopefully you will not present us with a 500-page thesis!

I thank you.
Dr Percy Mahlathi

The future of academic health care in Africa

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Introduction

Africa finds herself facing many challenges as she makes her way into the 21st century. The process of globalization powered by rapid changes in the fields of information and communications technology as well as trans-border movements of goods, services and people, has caught Africa off-guard. This is the century of the knowledge ecology that is mercilessly competitive. The future of Africa lies in its ability to rapidly transform itself into a competitive player in this increasingly inter-connected world. It is in this context that we should examine the future of academic health care in Africa.

In this talk I would like to address some of the present challenges academic health care faces, identify some opportunities based on success stories, and suggest some steps that might mitigate some of the risks we face and put us on a better pathway to success.

Challenges

Academics in Africa face many challenges, yet many have succeeded in continuing to do amazing innovative work. Many of the challenges facing us can be traced to the low profile of academics in public policy debates in most of our countries. The choices of trade unionists, business people even NGO's is often much louder than that of academics. This low profile is particularly striking in matters where scientific knowledge could illuminate the issues at stake. Why is this, the case?

The Inter-Academy Council based in the Amsterdam, published two reports in 2004 focusing on how to leverage science to address development challenges worldwide[1]. Both reports point to the sad reality that of all the regions in the world, Africa lags behind on almost all indicators of scientific proficiency. Even South Africa that ranks as a scientifically proficient country lags its peers such as Mexico, Brazil, India, Chile and China.

The origins of Africa's lagging status lie in its legacy of inequity, inadequate investments in human resources and chronic governance problems. Much of these are colonial in origin, but post-colonial Africa needs to take responsibility for its failure to transcend this legacy and build a better future for all. In the review of progress to meeting the Millennium Development Goals by the UN Secretary General at the General Assembly this September, Africa was the only region that was off-track and unlikely to meet these goals by 2015. At best Africa could only hope for 2050! Can Africa afford this?

The inequitable access to opportunities to develop Africa's rich talent in its nearly 900 million people has led to a tendency to discredit science and scientific excellence as elitist and illegitimate. Access to education and training has tended to benefit those privileged by economic or political power. South Africa continues to struggle with this legacy more than a decade post-apartheid. The absence of academics in policy discussions around these issues, including the acknowledgement that much of the excellence o the past was achieved at the expense of those excluded, has allowed tensions to simmer under the surface, exploding at inconvenient moments. Policy makers and implementers reflect these tensions in their ambivalence towards academic health care.

There are persistent differences of view with regard to the link between equity and excellence. Amongst those believing in excellence, who were able to access opportunities to develop, practice and benefit from excellence, are some who feel that any suggestions of promoting equity, threatens excellence. In their view, excellence of institutions and individuals within them, notwithstanding their apartheid legacy, affects the efforts and quality performance of those involved. People holding this view are loathe to entertain suggestions that those previously disadvantaged could perhaps have performed just as well had they been given the opportunity to develop their ability to complete on an equal footing. Suggestions that some "regstellende aksie" or affirmative action could be appropriate to level the playing field are seen as a thin end of a wedge to oust tried and tested players.

Equally strong views are held by those who see any talk of the centrality of excellence to sustainable equity as an excuse to continue the exclusion and marginalization for those unable to perform at the level that is competitive. Those holding this view insist that the focus should be on equity and affirmative action to achieve such equity in all spheres of our social life. Suggestions that equity without a focus on excellence is tantamount to equal access to mediocrity that is not likely to be sustainable are met with either angry stares or silence. Even when one points out that poor people cannot afford mediocrity in social services especially education and health care because they do not have the resources for second chances, strongly held views refuse to yield.

South Africa has witnessed a major hemorrhaging of resources from the academic health complexes in the name of equity. Sadly, some of those resources that were taken away have not produced the desired outcomes in the under-served areas. The redress focus ignored the importance of human and intellectual capital that needs to go with financial resources to build strong health care systems. In addition, little attention was paid to valuing the skills of nurses and other health professionals in order to retain them within the system. What we have as a sad reality is a weaker system than we had prior to 1994, with a growing burden due to greater access, and fewer human and intellectual capital to sustain it. Post-apartheid South Africa is a poster child of the danger of a focus on equity without also emphasizing excellence. A mirror image of apartheid with its focus on excellence without equity! Other African countries have experiences that are variations of the same theme with the same sad outcome.

Donors have over the past decades exacerbated these tensions by labeling any focus on higher education and investments in science and technology in poor countries as unaffordable. Pouring technical assistance at the rate of $4bn US per year was not substitute for home grown and retained talent. India, China and those countries in Latin America that have excelled have done so by defying this short-sighted advice. Today the same donors are scrambling to cash in on knowledge driven economic growth in these counties. The Inter-Academy Council Reports make a strong case that no country can afford not to afford an S&T base to inform and power its national development.

To add insult to injury, the competitive inter-connected world in which we are a part, has mercilessly extracted resources from Africa: natural, human and intellectual, to power their own development leaving us even more vulnerable. The Global Commission of International Migration launched its Report this month2. The Report contains a section on Migration and Development. It notes that the pace of migration is likely to increase as the disparities between countries and regions increase. In particular it identifies disparities in the 3D's - Demography, Development and Democracy, as a powerful dynamic driving the more than 200million people who live outside their countries of origin. The migrants generate remittances of more than USA $200bn with 70'5 of it going to developing countries. This represents more than four times the level of Official Development Assistance. But there are opportunity costs to origin countries in the form of lost intellectual and human capital to drive their economies to greater prosperity.

The migration of skilled professionals especially in the social sectors (health and education) leaves the poorest countries with even more limited intellectual capital and at risk of not even meeting the minimalist Millennium Development Goals. For example, there are more Malawian doctors in Manchester, UK than in Malawi. Nigerian and Ghanaian doctors keep the NHS going in the UK. The Report proposes greater collaboration between labour-rich but resource poor countries and labour poor but resource rich ones to exploit the complementarities that would allow for co-investment in the development of human capital to be shared by both sides of the development divide. India and the UK are already engaged in such a partnership to promote the training of nurses for the benefit of both countries Interestingly, Bill Gates of Microsoft, has proposed a similar approach to developing a global work force to increase the skills with an emphasis on science and mathematics.

Opportunities are now opening for Africa to also harness the power of S&T to get onto a sustainable development pathway. The New partnership for Africa's Development and the growing realization by donors that incoherent development policies have hurt Africa, hold promise. Global political pressure by NGO's that have forced donors to adopt more coherent global policies than link aid, trade and debt relief. Promise to give Africa a chance to put its own house in order. But where is the voice of academics in the shaping of NEPAD? Amongst those engaged with NEPAD one neither sees nor hears from health professionals. Why? The future of academic health care is inextricably linked to the nature of development strategies that Africa adopts. Failure to contribute to shaping these development strategies will put the academic enterprise at further risk.

Opportunities for a brighter future

Academia needs to come down from the ivory tower and be seen to be an indispensable part of the solutions to Africa's challenges. Academic health care's future can only be secured by engaging with, and convincing policy makers and implementers that it can add value to the development effort. This level of engagement entails more than the occasional protest at unfair treatment, but involved a systematic lobbying process. For example, both organised labour and business have forged platforms on which to systematically influence and shape public policy in their interests. Such interests are tired to the importance of sustainable economic growth to which both parties tie themselves as key players alongside government. In contrast, when the academic sector speaks to public policy players it often fails to make a case that links its interests with those of national development. It often comes across as winging. This against the background of this questioned legitimacy as an "elitist enterprise" does not make for success.

I would like to suggest that academic health professionals formally engage the political leadership and offer to lead the charge on tackling Africa's health challenges. Successful examples of such interventions as the elimination of river blindness, guinea worm, polio, as well as reducing malaria and now tackling the HIV/AIDS pandemic illustrate how medical science can contribute to better health and higher economic growth. But do we have the language to engage public policy on these questions? Do we know how to argue the case for investments in high-level medical science in return for the medium to longer-term benefits? Health economics is an underdeveloped

discipline in Africa. Should academic medicine not get closer to economists (who after all have a significant voice in resource allocation decisions) in order to sharpen our arguments and strengthen our case?

Again turning to South Africa as an example. Should academics not be raising their voice not only about the crisis of HIV/AIDS and its impact on South Africa's future development, but also on the tragedy of the failure to halt this unfolding catastrophe in the light of the country's considerable scientific and economic resources to deal with it? Even more shocking is the confusion sown by unscientific claims about causality and treatment of HIV/AIDS. Would the public not be better served by sustained public education campaigns by academics that help to clarify the confusion bout the place of ARVs versus nutrition so lives could be saved? What response do we have to the bewildered estimated one million orphans left to mourn without an understanding of the pandemic that has robbed them of parental love?

The long and short of my proposal is that academic health care needs to build a political constituency if it is to improve its future prospects. USA scientists and health care professionals have learnt "to work the hill" to protect and advance its interests. The US National Academies of Sciences have made themselves indispensable to public policy making and implementation with both political parties trusting their independent advice. How are we building the base for such a possibility in Africa? We need to do the same in our various countries and on continental platforms.

Given Africa's weak democratic systems we also need to actively promote a science culture in our continent by visibly engaging with the problems of our communities throughout the application of science, in order to demonstrate its value to everyday lives of people. What are we doing to contribute to the love for science in our schools? How are we contributing to a better understanding of the role of science in a better life for all? One on one care is critical, but broadening the base to engage with public health impacts of diseases affecting individuals is key to winning the space for a better future.

The media is an ally that academic health care has not used effectively in Africa. We now have radio, TV and newspaper penetration in most countries. How have we taken advantage of this penetration to build public confidence in, and support for academic health care? Show casing the occasional breakthrough is not enough. But being seen to be in the side of those in most need as part of the solution is what is likely to turn public opinion in our favour. In democratic societies politicians after all listen to the public.

Conclusion

The future of academic health care in Africa is in each of our hands. We need to understand the antipathy to the academic enterprise given the legacy of exclusion. We need to acknowledge our complicity in inequitable access that feeds that antipathy. We need to exercise our rights and responsibilities as citizens of this continent to shape its public policies to embrace S& T as a driver of development. We need to actively build a culture of science in our societies in partnership with others in the private sector, the media and NGO's. We need to come down from the ivory tower and strengthen the foundations of our societies so that they may be strong enough to take pride in excellence as the best way of sustaining equity. Each one of us can make a difference. Every action counts. Everyday counts. Let's get down to work. Thank you.

References:

1. Inventing a Better Future: A strategy for building worldwide capacities in science and technology. Realizing the promise and potential of African Agriculture: Science and Technology strategies for improving agricultural productivity and food security in Africa.
2. Migration in an Inter-connected World: New Directions for Action.

GOLDEN JUBILEE INSIGNIA FOR SALE

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The book covers the build-up to the formation of the College, its inauguration and covers most of the important events in the Colleges history right up to 2005, the golden jubilee year.

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This 320 pages hard-cover book contains numerous photographs, many of which are in full colour, was authored by Dr Ian Huskisson and is published by The College of Medicine of South Africa.

At only R125 plus packing and postage of R25, it should be a MUST for all interested in the College!

The book was launched at the Golden Anniversary celebrations in Stellenbosch on the 21st October 2005 and copies are available from the College Office in Cape Town.

For more information contact the College Office in Rondebosch Cape Town on 021 689 9533

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DEREK PETER GORDON-SMITH

Peter Gordon-Smith was born in Johannesburg on the 10th of December 1924. After matriculating at Jeppe High School Peter entered the University of the Witwatersrand where he graduated MB BCh in 1948. Peter served what he described as the "usual housemanships" 6 months in each of Surgery, Medicine, Obstetrics and Gynaecology and Accident Surgery at the Johannesburg General Hospital. This was followed by 3 years of surgical training under Mr John Alexander Douglas, the second President of the CMSA. In 1954 he enrolled in the Basic Science course at the Royal College of Surgeons (London) and spent that year and 1955 as an SHO at the Horton General Hospital in Banbury.

Dr Gordon-Smith returned to Johannesburg in 1956 where he spent the next 3 years in General Practice. In 1959 he was appointed as a medical registrar at the University of the Witwatersrand and in 1962, obtained the Fellowship of the College of Physicians of South Africa.

Peter was attracted to Dermatology and in 1964 he became a registrar in the Department of Dermatology at the University of Pretoria which at that time was headed by Professor George Findlay. He was awarded the MMed (Derm) Pretoria in 1965.

From the time that he entered private practice as a Dermatologist in Johannesburg in 1966, Peter devoted a sizeable portion of his working life to serving the medical profession in South Africa. Thus he taught at his Alma Mater for over 30 years, for which he was awarded the Faculty of Health Sciences 75th Jubilee Medal in 1997. He served the Dermatological Society of South Africa, and was President for 3 consecutive terms (1970 to 1978).

But it was to The Colleges of Medicine of South Africa (CMSA) that Peter chose to devote his considerable skill and boundless energy. He started to examine in 1968, became a member of the Examinations and Credentials Committee in 1972, was elected to the College Council in 1974 and served as Registrar from 1976 to 1983. He served as Secretary of the Faculty of Dermatology of the College from 1968 to 1974, when he became the Chairman and served in that capacity from 1974 to 1995. It was fitting that Peter received admission to Honorary Fellowship in 1993 in recognition of his enormous contributions to the CMSA. He became a life member in 1993.

Peter served as Secretary Treasurer of the College Foundation from 1978 to 1995 and together with his great friend, John Cowley, played a major role in securing the magnificent College Building in Johannesburg. He was Chairman of Fundraising from 1988-1995 and served as the National Chairman from 2001-2005.

Peter Gordon-Smith was elected as President of the CMSA in 1995. His three years as President marked the beginning of a series of constitutional changes which resulted in a considerable devolution of authority to the constituent Colleges. He is widely credited with having resuscitated the IACAP (the International Association of College and Academy Presidents) at a meeting which he hosted in Cape Town in May 1998.

On the occasion of the Golden Jubilee of The Colleges of Medicine of South Africa, the President and Senate presented a special Golden Jubilee Award to Derek Peter Gordon-Smith in recognition of the important role that he played in the history of the CMSA in various offices, but particularly in the office of President. The Award was also presented to him in recognition of his major contribution to the activities of the Colleges of Medicine Foundation and most recently in the capacity of Chairman of Fundraising.

Peter Gordon-Smith's devotion to the CMSA was truly unique. Those who had the privilege of working with him will remember Peter as a warm, loyal and friendly leader who, while always open to new ideas, was fiercely protective of those values and principles that he believed would best serve the CMSA. Peter's enthusiasm for the CMSA was always supported by his wife Denise. We will miss Peter as a warm friend, a wise colleague and an outstanding leader. Our sympathies go to Denise, John and Louise.

Ralph Kirsch, Lizo Mazwai, David Morrell and Bernise Bothma

Minutes of the Annual General Meeting Held on 21 October 2005

Fiftieth Annual General Meeting of The Colleges of Medicine of South Africa (CMSA) held at 08:00 on Friday 21 October 2005 in The Smith & Nephew Foundation Room, 17 Milner Road, Rondebosch

PRESENT:

Prof E L Mazwai	(President) in the Chair
Prof A A Stulting	(Senior Vice President)
Prof Z M van der Spuy	(Vice President)
Prof G J Vlok	(Chairman F & G P Committee)
Prof J F Lownie	(Chairman Examinations and Credentials Committee)
Prof J V Robbs	(Chairman Education Committee)
Prof T Zabow	(Honorary Treasurer)
Prof A Madaree	(Honorary Registrar Education Committee)
Dr J Vellema	(Honorary Registrar Examinations and Credentials Committee)

Prof J Aboobaker
Dr C H Balfour
Prof S Bhagwanjee
Prof C W Allwood
Prof P L A Bill
Prof J J Blitz-Lindeque
Prof J G Brink
Prof B Cassim
Dr S Chetty
Prof U W E Chikte
Prof A J Claassen
Prof B Donde
Prof A Ellmann
Prof B V Girdler-Brown
Prof V U Fritz
Prof L Goedhals
Prof R Glyn Thomas
Prof D Govender
Prof S Govender
Prof C F Heyns
Prof K R L Huddle
Dr A C Hurribunce
Dr I D Huskisson
Dr M H Kabaale
Prof D Kahn
Prof R E Kirsch (IPP)
Dr W G J Kloeck
Prof M A Lownie
Prof A C Lundgren
Dr S S Nadvi
Prof S Naidoo
Prof S J Nayler
Prof G A Ogunbanjo (Editor)
Prof J C Peter
Prof A L Peters
Prof J M Pettifor
Dr L J Ramages
Mr A Reddi
Dr P M Saffy
Prof M M Sathekge
Prof A T Scher
Prof A M Segone
Prof S L Sellars
Dr S Simango
Prof J Terblanche
Prof G Todd
Dr A Walele

APOLOGIES:

The apologies were noted.

SECRETARY:

Mrs Bernise Bothma	(Chief Executive Officer)

IN ATTENDANCE:

Mrs Ann Vorster	(Academic Registrar)
Mrs Jane Savage	(Minute Secretary

The President declared the Fiftieth AGM duly open and welcomed all who had taken time off to attend the meeting.

1. Registration of proxies

Ten proxies were duly registered.

2. Minutes of the Forty-ninth Annual General Meeting held on 15 October 2004

The minutes were ADOPTED and signed.

3. Matters of urgency

None.

4. CMSA election results for the triennium 2005-2008

The President reported that the CEO and staff in the Cape Town office were well organised to handle the elections of all the constituent Colleges and that the whole process went very well.

He presented the following results which were duly RATIFIED:

College of Anaesthetists

Councillors:
BHAGWANJEE, Satish
BOMELA, Mpumelelo Daniel
DANIEL, Clive Herbert
GOPALAN, Pragasan Dean
JOUBERT, Ivan Andrew
LE ROUX, Petrus Jacobus
LUNDGREN, Aina Christina
RANTLOANE, Joseph Letlakane Arthur
SINGH, Usha

President: Prof Arthur Rantloane
Secretary: Dr Clive Daniel

Representatives on Senate:
Prof Arthur Rantloane
Prof Satish Bhagwanjee

College of Cardiothoracic Surgeons

Councillors:
BRINK, Johan Givan
KINSLEY, Robin Howard
MAMORARE, Hendrick Motshongwane
REDDI, Anunathan
STEVENS, Mark Stuart
VANDERDONCK, Katharina-Maria Hendrika
President: Prof Johan Brink

Secretary: Dr Cathy Vanderdonck

Representatives on Senate:
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Mr Anu Reddi

College of Dentistry

Councillors:
CHIKTE, Usuf Mohamed Ebrahim
DREYER, Wynand Pieter
EVANS, William Greig
GUGUSHE, Tshepo Sipho
PARKER, Mohamed Ebrahim
SOLOMONS, Yvette Frances
STEIN, Errol
SYKES, Leanne Mary
THOMADAKIS, Georgios

President: Prof Usuf Chikte
Secretary: Dr Leanne Sykes

Representatives on Senate:
Prof Usuf Chikte
Prof Tshepo Gugushe

College of Dermatologists

Councillors:
ABOOBAKER, Jamilabibi
DU PLESSIS, Pieter Jacobus
JESSOP, Susan Jane
MODI, Deepak
MOTSWALEDI, Mojakgomo Hendrick
NGWANYA, Reginald Mzudumile
RABOOBEE, Noufal
TODD, Gail

President: Prof Jamila Aboobaker
Secretary: Prof Deepak Modi

Representatives on Senate:
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Prof Gail Todd

College of Emergency Medicine

Councillors:
BALFOUR, Clive Hilton
BOYD, Stewart Townley
DIMOPOULOS, George Elie
KLOECK, Walter Gerard Jan
MacFARLANE, Campbell
SAFFY, Patricia Marie

President: Dr Walter Kloeck
Secretary: Dr Patricia Saffy

Representatives on Senate:
Dr Walter Kloeck
Dr Patricia Saffy

College of Family Practitioners

Councillors:
BARDAY, Abdul Wahab
BLITZ-LINDEQUE, Julia Jeanne
CASSIMJEE, Mohammed Hoosen
GOVIND, Uttam
HELLENBERG, Derek Adriaan
KAPLAN, Neville Lewis
MAZAZA, Shadrick Nekhantani Ezeckiel
NAIDOO, Neetheananthan
OGUNBANJO, Gboyega Adebola
PRINSLOO, Engela Adriana Margarietha
SPARKS, Bruce Louis Walsh
VALLABH, Bhadrish Kantilal

President: Prof Gboyega Ogunbanjo
Secretary: Dr Bhadrish Vallabh

Representatives on Senate:
Prof Gboyega Ogunbanjo
Prof Julia Blitz-Lindeque

College of Forensic Pathologists

Councillors:
AIYER, Sageren Manicam
LOURENS, Denise
MARTIN, Lorna Jean
SCHOLTZ, Hendrik Johannes
VELLEMA, Jeanine
WADEE, Shabbir Ahmed

President: Dr Jeanine Vellema
Secretary: Dr Denise Lourens

Representatives on Senate:
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Dr Sageren Aiyer

College of Maxillo-Facial and Oral Surgeons

Councillors:
BÜTOW, Kurt-Wilhelm
KARIEM, Gilmie
LOWNIE, John Forsyth
LOWNIE, Madeline Ann
MORKEL, Jean André
REYNEKE, Johannes Petrus
RUGHUBAR, Vivesh
SINGH, Suvir
VAN DER LINDEN, Wynand Johan

President: Prof Madeline Lownie
Secretary: Dr Suvir Singh

Representatives on Senate:
Prof Madeline Lownie
Prof John Lownie

College of Neurologists

Councillors:
BHAGWAN, Bhupendra
BILL, Pierre Louis Alfred
EASTMAN, Roland William
FRITZ, Vivian Una
KIES, Bryan Michael

President: Prof Pierre Bill

Secretary: Prof Bryan Kies

Representatives on Senate:
Prof Pierre Bill
Prof Vivian Fritz

College of Neurosurgeons

Councillors:
DU TREVOU, Michael Denis
FISHER-JEFFES, Norman Donald
GOPAL, Rasik
GOVENDER, Nadaraj
HARTZENBERG, Henry Benjamin
NADVI, Syed Sameer
PETER, Jonathan Clemence

President: Prof Jonathan Peter
Secretary: Dr Sameer Nadvi

Representatives on Senate:
Prof Jonathan Peter
Dr Sameer Nadvi

College of Nuclear Physicians

Councillors:
ELLMANN, Annare
ESSER, Jan Daniël
MANN, Michael David
RUBIN, David Milton
SATHEKGE, Machaba Michael
WARWICK, James Mathew

President: Prof Annare Ellmann
Secretary: Prof Mike Sathekge

Representatives on Senate:
Prof Annare Ellmann
Prof Mike Sathekge

College of Obstetricians and Gynaecologists

Councillors:
ANTHONY, John
BAGRATEE, Jayanthilall Sarjoo
BUCHMANN, Eckhart Johannes
DHAI, Amaboo
DREYER, Greta
GUIDOZZI, Franco
LINDEQUE, Barend Gerhardus
MHLANGA, Roland Edgar
MONOKOANE, Tshweu Samuel
SHIMANGE, Oscar Christopher
STEWART, Chantal Juanita Michelle
STEYN, Daniël Wilhelm
THERON, Gerhardus Barnard
VAN DER SPUY, Zephne Margaret

President: Prof Zephne van der Spuy
Secretary: Prof Wilhelm Steyn
Representatives on Senate:
Prof Zephne van der Spuy
Prof Gerhard Lindeque

College of Ophthalmologists

Councillors:
AMOD, Rizwana Cassim
CARMICHAEL, Trevor Robin
LECUONA, Karin Alfrida
MEYER, David
MURRAY, Anthony David Neil
PETERS, Anne Louise
ROUX, Paul
STULTING, Andries Andriessen
SURKA, Juzer Abdulhusain

President: Prof Andries Stulting
Secretary: Dr Rizwana Amod

Representatives on Senate:
Prof Andries Stulting
Prof Anne Peters

College of Orthopaedic Surgeons

Councillors:
GOLELE, Robert
GOVENDER, Shunmugam
LUKHELE, Mkhululi
MARASPINI, Christiana Diana
MARITZ, Nicolaas Gysbert Jacobus
SCHEPERS, Anton
VLOK, Gert Jacobus

President: Prof Teddy Govender
Secretary: Prof Anton Schepers

Representatives on Senate:
Prof Teddy Govender
Prof Gert Vlok

College of Otorhinolaryngologists

Councillors:
CLAASSEN, André Jacobus
DAVIDGE-PITTS, Keith James
FAGAN, Johannes Jacobus
LOOCK, James William
MODI, Pradip Chhaganlal
PEER, Dawood Goolam Hoosen
RAMAGES, Leslie Joseph
TSHIFULARO, Mashudu Israel
WAGENFELD, Derrick John Henry

President: Prof André Claassen
Secretary: Dr Les Ramages

Representatives on Senate:
Prof André Claassen
Dr Les Ramages

College of Paediatricians

Councillors:
COOPER, Peter Allan
KLING, Sharon
McCULLOCH, Mignon Irene
MOKHACHANE, Mantoa
PETTIFOR, John Morley

SALOOJEE, Haroon
SHIPALANA, Nancy
VENTER, André
WITTENBERG, Dankwart Friedrich

President: Prof Haroon Saloojee
Secretary: Dr Sharon Kling

Representatives on the Senate:
Dr Haroon Saloojee
Prof John Pettifor

College of Pathologists

Councillors:
ALTINI, Mario
BIRD, Arthur Richard
GOVENDER, Dhirendra
HOOSEN, Anwar Ahmed
JANSE VAN RENSBURG, Esrelita
MAHLANGU, Johnny Ndoni
MIDDLECOTE, Bruce Davie
NAYLER, Simon John
WAINWRIGHT, Helen Cecilia
WRIGHT, Colleen Anne

President: Prof Simon Nayler
Secretary: Dr Johnny Mahlangu

Representatives on Senate:
Prof Simon Nayler
Prof Dhirendra Govender

College of Physicians

Councillors:
BURCH, Vanessa Celeste
CASSIM, Bilkish
HUDDLE, Kenneth Robert Lind
KER, James Alastair
LALLOO, Umesh Gangaram
MacPHAIL, Andrew Patrick
MAYOSI, Bongani Mawethu
MILNE, Frank John
MOLLENTZE, Willem Frederik
NAICKER, Saraladevi
SEGGIE, Janet Lydia
VERIAVA, Yosuf

President: Prof Ken Huddle
Secretary: Prof Sarala Naicker

Representatives on Senate:
Prof Ken Huddle
Prof Bilkish Cassim

College of Plastic Surgeons

Councillors:
COETZEE, Petrus Francois
MADAREE, Anil
MORRISON, Gavin
SIMANGO, Stephen
SNIJMAN, Christopher Nigel
WIDGEROW, Alan David

President: Prof Anil Madaree
Secretary: Dr Stephen Simango

Representatives on the CMSA Senate:
Prof Anil Madaree
Dr Stephen Simango

College of Psychiatrists

Councillors:
EMSLEY, Robin Alexander
MKIZE, Dan Lamla
RATAEMANE, Solomon Tshimong
ROOS, Johannes Lodewikus
SAUNDERS, Jane Noreen
SEEDAT, Soraya
VORSTER, Merryl
WHITE, Denise Anne Campbell
ZABOW, Tuviah

President: Prof Robin Emsley
Secretary: Dr Soraya Seedat

Representatives on Senate:
Prof Robin Emsley
Prof Solly Rataemane

College of Public Health Medicine

Councillors:
BEKE, Andy Kwaku
CAMERON, Neil Andrew
COETZEE, David John
EHRLICH, Rodney Ivan
GIRDLER-BROWN, Brendan Vaughan
KAWONGA, Mary
NAIDOO, Shan
ROBINSON, Fiona
YOUNG, Taryn Natalie

President: Prof Brendan Girdler-Brown
Secretary: Prof Shan Naidoo

Representatives on Senate:
Prof Brendan Girdler-Brown
Prof Shan Naidoo

College of Radiation Oncologists

Councillors:
ABRATT, Raymond Pierre
DONDE, Bernard
GOEDHALS, Louis
JORDAAN, Johann Petrus
LITLHAKANYANE, Victor Letsoejane Joseph
MURRAY, Elizabeth Margaret
STANNARD, Clare Elizabeth
VERNIMMEN, Frederik Jozef Alfons Ivan

President Prof Louis Goedhals
Secretary Prof Bernard Donde

Representatives on Senate:
Prof Louis Goedhals
Prof Bernard Donde

College of Radiologists

Councillors:
BECK, William Proctor
BENINGFIELD, Stephen James
DE VRIES, Coert Stephanus
GLYN THOMAS, Raymond
HURRIBUNCE, Ashwin Chitason
JACKPERSAD, Ramesh
JOSEPH, Elaine
ROYSTON, Duncan David
SCHER, Alan Theodore

President: Prof Alan Scher
Secretary: Dr Duncan Royston

Representatives on Senate:
Prof Alan Scher
Dr Ashwin Hurribunce

College of Surgeons

Councillors:

BIZOS, Damon Basil
KAHN, Delawir
MADIBA, Thandinkosi Enos
NGCOBO, Thula Karen
PILLAY, Subramanion Sathiyanunthan
ROBBS, John Vivian
RODE, Heinz
THOMSON, Sandie Rutherford
VELLER, Martin Georg

President: Prof Del Kahn
Secretary: Prof Sandie Thomson

Representatives on Senate:
Prof Del Kahn
Prof Thandinkosi Madiba

College of Urologists

Councillors:
BARNES, Richard David
BORCHERS, Trevor Michael
COETZEE, Lance Johan Erasmus
HAFFEJEE, Mohamed
HEYNS, Christiaan Frederik
PATEL, Haroun
REIF, Simon
SEGONE, Alpheus Mabose
ZIETSMAN, Cindy Ann

President: Prof Chris Heyns
Secretary: Dr Lance Coetzee

Representatives on Senate:

Prof Chris Heyns
Prof Alf Segone

Diplomate Representatives on Senate:

Dr Sean Chetty
Dr Moses Kabaale

5. Matters arising from the minutes of the last Annual General Meeting

None.

6. Annual report of the Senate of the CMSA for the period June 2004 to May 2005

ADOPTED

The Annual Report of Senate as published on page 17 in the Transactions for July – December 2005.

ACCLAMATION

7. Financial report of the honorary treasurer: Prof Tuviah Zabow

Prof Zabow presented the financial report for 1 June 2004 to 31 May 2005 as follows:

"This institution has an overall turnover of R9,7 million for the financial year with expenditure for the year being R8.4 million. Income increased by 20.29% compared to the previous financial year and expenditure only by 11.76%, but we still kept in line with the budget. My predecessor, Johan Klopper advised me that we should always budget for a surplus and we have always been able to do this as reflected in the surplus this year of R1 336 314 compared to

a surplus of nearly R600 000 last year. The reason for the large surplus is the uncertainty of the number of candidates that will sit the examinations and this year there were additional candidates (more than we had budgeted for).

Annual subscriptions increased by 11.66%. Bad debts increased, but we are trying to think of new ideas to handle this issue. Income from interest generated on investments increased by 13.41% compared to last year.

General overall expenses only increased by 19.16% compared to last year taking into consideration that it was our Golden Jubilee Year and that the elections cost us R65 000. In fact just circulating the annual financial statements cost us R60 754. However, this will be published on the CMSA website in the future.

We have been very active in looking at things like tax rebates and this year the Cape Town office received a grant-in-aid in respect of rates for the current year amounting to R42 042 from the Cape Town City Council.

We can say that the finances are in a healthy state - our Trust funds for lectureships total over R3 000 000 which is reflected on page 7 of the annual financial statements together with our other assets. A suggestion for the surplus money was to ring-fence a percentage to give back to our consumers, i.e. our candidates by not increasing the examination fees. The rest could be utilised for constituent College Council and examiners meetings".

In concluding his report, the Honorary Treasurer thanked Margie Pollock and the staff in the Accounts Department who were doing a superb job.

ACCLAMATION

NOTED:
The request made by Prof Ogunbanjo that the CMSA re-investigate cheaper air tickets for Senators, examiners and staff. He made a plea that the CMSA obtain quotations from a number of travel agents.

AGREED:
That investigations be made into securing cheaper air travel.

Prof Ogunbanjo further requested that the subsistence allowance for Senators and examiners be looked into as the amount often failed to cover their costs.

The Hon Treasurer explained that the amount paid was the maximum allowed by the Receiver of Revenue without being taxed. However, this was also being investigated.

NOTED ALSO:
The request by Prof Lundgren that the CMSA convey to the Registrars either in the Transactions or on the website how the examination surplus would be utilised and who would be benefiting from this.

In response to a suggestion by Prof Sellars that the CMSA properties, especially in the Cape, be valued annually and not triennially, the Hon Treasurer informed Senate that whilst the valuation was not done each year the insurance cover on the building was evaluated annually on the advice of the Auditors.

Dr Hurribunce wished to add his voice of appreciation and congratulations to Prof Zabow for keeping a tight reign on the finances of the CMSA and asked that this be formally recognised. He encouraged past and current Senators to play a role in ensuring that no undue pressure was placed on the finances of the CMSA being an institution not for gain.

ACCLAMATION

NOTED:
The request by Dr Ramages that the auditors be asked to be consistent in their tabulation, for example, they tabulated profits in parenthesis (page 10), losses in parenthesis (page 17) for the same value which was very confusing.

8. Report of the President: Prof E L Mazwai

The President reported as follows:

"In my last report in 2004, I spoke of the first 100 days. Now I speak of the first half of my tenure as President of the CMSA. My report will follow the same format, as many of the issues were identified as being strategic for the next 12 to 36 months. Not unexpectedly, most of the year has been dominated by discussions and organisation of our Golden Jubilee Celebrations, which have now come upon us. This Senate and the Incoming Senate will go down as having been the watershed between the 1st and 2nd half century in the history of our College.
What then have been the highlights over the last months?

8.1. Examinations

The new mode for marking has been given a fair chance. The correlations are good except for both ends of the spectrum: bringing in borderlines and not distinguishing the exceptional students.

The question of the logbooks still needs to be worked on in terms of quality if it has to be used also as part of the summative assessment.

8.2. National Equivalence Examination

At the Strategic Planning Meeting in February 2005, the President decided to put implementation of this on hold as there appeared to be some misunderstanding about intentions and expectations on the matter.

The President is keeping live communication with the Deans on the matter of subsidy. The position of the CMSA will be tabled again at the November 2005 meeting of the Committee of Deans to enlist the support of all Universities at institutional level and also of the Vice Chancellors through SAAHE. Hopefully by February 2006 the position should be clear on the issue of subsidy on the equivalence of examinations.

8.3. Tax Exemption and Fundraising

Through the efforts and assistance of Dr M Qhobela and the Department of Education, the CMSA now enjoys tax exemption status, but not the Colleges of Medicine Foundation. We have therefore been able to raise funds for the Golden Jubilee without tax implications. The donors were Adcock Ingram Healthcare (R200 000), Life Healthcare (formerly Afrox Healthcare) (R200 000), Discovery Health (R100 000) and Aspen Pharmacare (R30 000). I would like to recognise with appreciation the role played by the Chairman of the CMF, Mr Peter Joubert in this fundraising initiative.

ACCLAMATION

8.4 Membership

The rate of defaulters is still high and attempts to reinstate these have yielded little, even with a moratorium. This has now revolved around the discussion of benefits at meetings of the Executive in May, Brainstorming in August and again the Executive in September. We identified one benefit of access to the internet and this should be explored vigorously and implemented as an example of commitment. Financial implications should not be an obstacle.

8.5 Africa Professional Development Initiative

This was submitted in my last report as a Partnership, which is the intention. However, as we still do not have an official partnership it would be prudent to call this an initiative. A new College of South East and Central Africa (COSECA) has been formed, with support from members of the Scottish and English Colleges.

The West African College is well established and we have visiting Presidents currently. I hope this Jubilee will offer the opportunity for people to forge links beyond contacts.

Increasingly the CMSA must be seen as the College of choice for specialist examinations in the Continent, but we need new and progressive policies on immigration and registration if we are to be an effective human resource development partner.

8.6 Links with Colleges and Academies Abroad

These traditional links are active and vibrant. The reports of the President's trips to Canada (Oct 2004), USA (April 2005), Ireland (June 2005) and Edinburgh (July 2005) attest to this. At both the visits to the American College of Physicians and The Royal College of Physicians of Ireland, the President received an Honorary Fellowship.

Our Golden Jubilee Celebrations guest list of College and Academy Presidents is testimony to the relationships we hold. With new additions there will be a meeting of IACAP on Friday to discuss issues such as international collaboration.

8.7 Elections

The overall results and voting rate indicate the interest and participation by members. The percentage poll ranged from 21% to 66%, with an average of 39% (which has been the norm).

As far as transformation is concerned, this came automatically in terms of existing demographic representation. There has been no need to co-opt in order to bring in previously disadvantaged candidates. In any event, further transformation has to take place at the grass root level of constituent Colleges and no longer by co-option.

I want to congratulate those who have been elected, especially the Presidents, Secretaries and representatives on Senate.

8.8 Transformation

The transformation process in terms of demographics has now gone a full circle. What is more important now is transformation in the way we conduct our business. At the strategic planning meeting in February and the brainstorming meeting in August a few areas were identified:

8.8.1 Following up on the examination format.

8.8.2 Implementing the National Equivalence Examination.

8.8.3 Recruiting and retaining membership through a viable benefits programme.

8.8.4 More actively participating in national health and education matters through regular position papers and comments.

8.8.5 Planning of a self-evaluation workshop.

Conclusion

The last 12 months have seen the CMSA continue to do well in its core business with an increase in candidates registering for the examinations. One would like to see more activity and participation of Colleges in shaping transformation at grass root level. This would engender a greater sense of belonging and loyalty to the CMSA.

Our relations with national bodies, including the Industry, should find relevance that promotes the ideals and goals of the CMSA without compromising on its standards and integrity.

Continental relations with Africa should be strengthened to identify and help to serve the needs of the African Continent.

The Golden Jubilee Celebrations with international exposure should bring a renewed sense of pride and inspiration for the future of The Colleges of Medicine of South Africa.

Finally, none of the above things would have been possible or achieved without the able and willing support of all the CMSA Officers and staff. Their dedication to the College even and especially in difficult times is amazing and commendable.

I would further like to thank all the members of the Executive, the two Vice Presidents, Chairmen of Standing Committees, Honorary Treasurer and Honorary Registrars in keeping the structure of the CMSA intact. I would also like to thank all the members of Senate who have given time and talent for the College duties and functions in the last year. The Finance and General Purposes Committee did not report at this meeting, but I would like to single out Prof Gert Vlok for the hard work that he put in as Chairman of that Committee.

May the rest of the academic year be good and may everyone enjoy a well deserved Christmas holiday.

REPORT ADOPTED WITH ACCLAMATION

Prof Stulting thanked the President for an informative report. He also thanked HIM for his personal interaction with all and wished him and his family a Blessed Christmas.

9. Report of the Chairman of the examinations and credentials committee: Prof J Lownie

Prof Lownie reported briefly on the functioning of the Committee as follows:

"We have been very pleased over the last year to see that the overall numbers of candidates entering the

examination have increased as alluded to by the Hon Treasurer. Unfortunately those numbers are accounted for by an increase in the Diplomates - especially those entering for the Diplomas in HIV Management and Anaesthetics, with a slight decrease in the number of entries for the Fellowship examinations.

Unfortunately when we deal with an examination process not everybody is going to be happy and after every examination we have the odd complaints by candidates who feel they have been 'hard done by'. These are in the minority, but what has been a problem is letters from candidates who claim they have been intimidated prior to clinical examinations by examiners in University or other settings. We have also had incidences where examiners have received threatening letters from candidates prior to the examination - a very unhappy situation. To this end, it was necessary for the Examinations and Credentials Committee to draw up a document on intimidation which has been ratified by Senate.

The second issue that we have been dealing with is the period between the written papers and the clinical examination. This is linked to the number of candidates, but unfortunately people are very busy and getting marked scripts returned in that shorter period of time has not been working. This was a request made by Registrars some time ago and we have now gone the full circle and have been approached by SARA and individuals to increase the time. This was passed by Senate at the last meeting in May 2005 and we will revert to the old period between the written and clinical examinations in January 2006.

Regarding the NEE, I am aware from discussions and meetings attended at the HPCSA and other places that people are still supporting this. Certainly, Mr President the Registrars still wants it and I believe that the academic staff at all our Universities are moving towards that examination. It's a matter of the subsidy that is hindering its application and I am sure you will be dealing with that in the New Year.

On the question of defaulters and the particular problem that came from the College of Emergency Medicine via the Examinations and Credentials Committee, the Finance and General Purposes Committee came up with an answer to assist that College to get started with membership.

Just yesterday at Senate we once again addressed the number of attempts candidates should have at the final examination. This is a difficult issue with some Colleges wanting a limit on the number of attempts whilst others don't. However, we have come up with an answer and look forward at the Examinations and Credentials Committee to hearing from the College of Orthopaedic Surgeons how the pilot study that he will be conducting will impact upon our examination process. So in the new triennium, hopefully we will be able to come to finality on that issue.
Also a matter of concern is the name given to our sub-specialities, viz. the word "Certificate". Suggestions were made that we could give another Fellowship, but this is something that will have to be addressed by the Examinations and Credentials Committee as soon as possible.
There have also been a number of other matters that have received attention, the most important being the Phyllis Knocker/Bradlow Award. What has happened over the years is that we have really struggled to find candidates who were willing to apply under the old criteria and in fact for the last two years we probably had only two or three applicants for the award. A small task team constituted by Ann Vorster, Vivian Fritz and myself put forward revised criteria for this award which have been ratified by Senate and we hope that this will increase the number of candidates who apply. We appeal to all constituent College Presidents to ensure that the candidates who qualify in their Colleges are aware of the existence of the Phyllis Knocker/ Bradlow award. It is a significant amount of money for research and I believe this is something we need to pay attention to.

For notification, is that we have made application to HPCSA to get Paediatric Surgery recognised as a full Fellowship examination.

The President alluded to the marking in percentages, but there is still some unhappiness. A suggestion that was brought up at yesterday's meeting, which we will pursue, is that we avoid the 50% mark and only count 45% and 55%. I believe this is a good system and in the long term will be to our benefit. Certainly our overall pass rate for this and the previous examination has been over 60%.

The President also alluded to logbooks. Walter Kloeck has developed an excellent logbook for his the College of Emergency Medicine which he presented at the symposium last year and I believe that the Examinations and Credentials Committee will be looking at this in the future.

The other business of our Committee includes nominating candidates for prizes and accrediting teaching hospitals, replacing examiners and these are done on an ongoing basis.

Mr President, my work is made very easy by first of all the members of the Examinations and Credentials Committee - we have had very active meetings in the last year. However, I would particularly like to thank the office of Ann Vorster and her staff for the tremendous work that they do in running the examinations. I would also like to thank Mrs Bothma and the Cape Town office for the input I receive from them whenever it is needed."

REPORT ADOPTED WITH ACCLAMATION

10. Report of the Chairman of the education committee: Prof J V Robbs

Prof Robbs reported as follows:

"The education Committee is finding its niche. This is essentially the liaison body for registrars and our major

thrust has been to make the CMSA more user-friendly. One of the issues which require CMSA involvement is the contract that will look at their conditions of service and particularly protection of their study time and the like. The HPCSA has already had one working group looking at this where the CMSA was very well represented and fruitful discussion was held.

One of the major commitments of the Committee is the administration of the eponymous lectureships which include the Arthur Landau (Medicine), Francois P Fouché (Orthopaedics), J C Coetzee (Obstetrics and Gynae-cology), Margaret Orford (Obstetrics and Gynaecology) and K M Seedat (Family Practitioners). Many are not financially sustainable and have been taken over by various societies and bodies for which we are grateful.

The Robert MacDonald Fund for Paediatrics has had no applications for at least the last three years. This is aimed at developing rural services.

A further educational outreach is the visits to the Eastern Cape which this year took place in March, May and August. This programme extends over weekends and we are grateful to the participants for giving up their time for this very worthy project.

CPD accreditation is a free service for CMSA members who are paid up. Last year 96 applications were processed, 71 of which were for members. Fees earned were R2 500. New developments are awaited in the administration of the CPD system. Currently there is a system of random checks.

Ethics seminars are held in conjunction with the KwaZulu-Natal Fellows Association. Four are held during the year. These have been extremely successful and well attended. We have established a tradition at the end of the examination week in Durban of holding a morning symposium on ethical matters and these have been highly successful and well received.

There has been an excellent response from the constituent Colleges to the syllabi and these are fully up to date at this time. I think it is incumbent upon us now to establish a template which is compatible with the SAQA requirements. This is extremely important if the concept of a NEE is to be established, and one must bear in mind that any syllabus is a living document.

One of the newer Initiatives is a Newsletter to all members and others to keep them updated on what is happening in the CMSA. There is a schedule of areas that will be covered and this we hope will be on a monthly basis. The first should appear in January or possibly February 2006, but this will be dependent on input of information from members.

There is a desperate need to expand the College premises in Durban as they are already inadequate and we will be investigating ways in which to do this.

Research and Ethics Capacity Building: It is important to introduce this into the various syllabi. There is a possibility that an ethics course should be introduced. This is a distance learning initiative that would be completed prior to registration of qualification.

Finally I wish to thank members of the Committee for the work that they have put into this successful triennium. I would also like to extend special thanks to Mrs Anita Walker and Mrs Antoinette Conning for their hard work in making all this happen and to Mrs Bothma for her input.

REPORT ADOPTED WITH ACCLAMATION

11. Report of the editor of Transactions: Prof G Ogunbanjo

The Editor reported that the last three issues were less glossy, a bit more readable and still contained its academic flavour. A tremendous effort had been made to bring about a reduction in the production costs from about R430 000 to R284 000. He thanked the Hon Treasurer for providing the necessary funds.

The 2005 edition focussed on the Golden Jubilee with a gold trimmed cover. However, for the next twelve months the focus would be on publishing the proceedings of the Golden Jubilee Symposium and also the Africa development initiatives. He asked Senators and members of the constituent Colleges for input under “Letters to the Editor”

ACCLAMATION

The President congratulated Prof Ogunbanjo on the way he transformed the Journal since becoming Editor.

Dr Huskisson as an Editor of 18 years standing of Transactions congratulated the Editor for the changes that had been made as well as the reduction in the production costs.

Dr Hurribunce suggested that consideration be given to utilising the blank space (outer back page) of Transactions for a CMSA message which could be extracted from the History of the College, etc.

12. Annual appointment of auditors

AGREED:

That Deloitte & Touche be reappointed as the CMSA Auditors for the ensuing year.

13. Correspondence

None.

With there being no further matters for discussion, the Chairman called the meeting to a close.

Rondebosch
30 November 2005

CONSTITUENT COLLEGE PRESIDENTS AND SECRETARIES AND REPRESENTATIVES ON THE CMSA SENATE

2005-2008

COLLEGE OF ANAESTHETISTS

President : Prof Arthur Rantloane
Secretary : Dr Clive Daniel

Representatives on the CMSA Senate:
Prof Arthur Rantloane
Prof Satish Bhagwanjee

COLLEGE OF CARDIOTHORACIC SURGEONS

President : Prof Johan Brink
Secretary : Dr Cathy Vanderdonck

Representatives on the CMSA Senate:
Prof Johan Brink
Mr Anu Reddi

COLLEGE OF DENTISTRY

President : Prof Usuf Chikte
Secretary : Dr Leanne Sykes

Representatives on the CMSA Senate:
Prof Usuf Chikte
Prof Tshepo Gugushe

COLLEGE OF DERMATOLOGISTS

President : Prof Jamila Aboobaker
Secretary : Prof Deepak Modi

Representatives on the CMSA Senate:
Prof Jamila Aboobaker
Prof Gail Todd

COLLEGE OF EMERGENCY MEDICINE

President : Dr Walter Kloeck
Secretary : Dr Patricia Saffy

Representatives on the CMSA Senate:
Dr Walter Kloeck
Dr Patricia Saffy

COLLEGE OF FAMILY PRACTITIONERS

President : Prof Gboyega Ogunbanjo
Secretary : Dr Bhadrish Vallabh

Representatives on the CMSA Senate:
Prof Gboyega Ogunbanjo
Prof Julia Blitz-Lindeque

COLLEGE OF FORENSIC PATHOLOGISTS

President : Dr Jeanine Vellema
Secretary : Dr Denise Lourens

Representatives on the CMSA Senate:
Dr Jeanine Vellema
Dr Sageren Aiyer

COLLEGE OF MAXILLO-FACIAL AND ORAL SURGEONS

President : Prof Madeline Lownie
Secretary : Dr Suvir Singh

Representatives on the CMSA Senate:
Prof Madeline Lownie
Prof John Lownie

COLLEGE OF NEUROLOGISTS

President : Prof Pierre Bill
Secretary : Prof Bryan Kies

Representatives on the CMSA Senate:
Prof Pierre Bill
Prof Vivian Fritz

COLLEGE OF NEUROSURGEONS

President : Prof Jonathan Peter
Secretary : Dr Sameer Nadvi

Representatives on the CMSA Senate:
Prof Jonathan Peter
Dr Sameer Nadvi

COLLEGE OF NUCLEAR PHYSICIANS

President : Prof Annare Ellmann
Secretary : Prof Mike Sathekge

Representatives on the CMSA Senate:
Prof Annare Ellmann
Prof Mike Sathekge

COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

President : Prof Zephne van der Spuy
Secretary : Prof Wilhelm Steyn

Representatives on the CMSA Senate:
Prof Zephne van der Spuy
Prof Gerhard Lindeque

COLLEGE OF OPHTHALMOLOGISTS

President : Prof Andries Stulting
Secretary : Dr Rizwana Amod

Representatives on the CMSA Senate:
Prof Andries Stulting
Prof Anne Peters

COLLEGE OF ORTHOPAEDIC SURGEONS

President : Prof Teddy Govender
Secretary : Dr Anton Schepers

Representatives on the CMSA Senate:
Prof Teddy Govender
Prof Gert Vlok

COLLEGE OF OTORHINOLARYNGOLOGISTS

President : Prof André Claassen
Secretary : Dr Les Ramages

Representatives on the CMSA Senate:
Prof André Claassen
Dr Les Ramages

COLLEGE OF PAEDIATRICIANS

President : Prof Haroon Saloojee
Secretary : Dr Sharon Kling

Representatives on the CMSA Senate:
Dr Haroon Saloojee
Prof John Pettifor

COLLEGE OF PATHOLOGISTS

President : Prof Simon Nayler
Secretary : Dr Johnny Mahlangu

Representatives on the CMSA Senate:
Prof Simon Nayler
Prof Dhiren Govender

COLLEGE OF PHYSICIANS

President : Prof Ken Huddle
Secretary : Prof Sarala Naicker

Representatives on the CMSA Senate:
Prof Ken Huddle
Prof Bilkish Cassim

COLLEGE OF PLASTIC SURGEONS

President : Prof Anil Madaree
Secretary : Dr Stephen Simango

Representatives on the CMSA Senate:
Prof Anil Madaree
Dr Stephen Simango

COLLEGE OF PSYCHIATRISTS

President : Prof Robin Emsley
Secretary : Prof Soraya Seedat

Representatives on the CMSA Senate:
Prof Robin Emsley
Prof Solly Rataemane

COLLEGE OF PUBLIC HEALTH MEDICINE

President : Prof Brendan Girdler-Brown
Secretary : Prof Shan Naidoo

Representatives on the CMSA Senate:
Prof Brendan Girdler-Brown
Prof Shan Naidoo

COLLEGE OF RADIATION ONCOLOGISTS

President : Prof Louis Goedhals
Secretary : Prof Bernard Donde

Representatives on the CMSA Senate:
Prof Louis Goedhals
Prof Bernard Donde

COLLEGE OF RADIOLOGISTS

President : Prof Alan Scher
Secretary : Dr Duncan Royston

Representatives on the CMSA Senate:
Prof Alan Scher
Dr Ashwin Hurribunce

COLLEGE OF SURGEONS

President : Prof Del Kahn
Secretary : Prof Sandie Thomson

Representatives on the CMSA Senate:
Prof Del Kahn
Prof Thandinkosi Madiba

COLLEGE OF UROLOGISTS

President : Prof Chris Heyns
Secretary : Dr Lance Coetzee

Representatives on the CMSA Senate:
Prof Chris Heyns
Prof Alf Segone

DIPLOMATE REPRESENTATIVES ON SENATE

2005 - 2008
Dr Sean Chetty
Dr Moses Kabaale

CMSA PRESIDENT
PROF LIZO MAZWAI

SENIOR VICE PRESIDENT
PROF ANDRIES STULTING — **College of Ophthalmologists**

VICE PRESIDENT
PROF ZEPHNE VAN DER SPUY — **College of Obstetricians and Gynaecologists**

CHAIRMAN FINANCE AND GENERAL PURPOSES COMMITTEE
PROF GERT VLOK — **College of Orthopaedic Surgeons**

CHAIRMAN EXAMINATIONS AND CREDENTIALS COMMITTEE
PROF JOHN LOWNIE — **College of Maxillo-Facial and Oral Surgeons**

CHAIRMAN EDUCATION COMMITTEE
PROF JOHN ROBBS — **College of Surgeons**

HONORARY TREASURER
PROF TUVIAH ZABOW — **College of Psychiatrists**

HONORARY REGISTRAR EDUCATION COMMITTEE
PROF ANIL MADAREE — **College of Plastic Surgeons**

HONORARY REGISTRAR FINANCE AND GENERAL PURPOSES COMMITTEE
PROF BONGANI MAYOSI — **College of Physicians**

HONORARY REGISTRAR EXAMINATIONS AND CREDENTIALS COMMITTEE
DR JEANINE VELLEMA — **College of Forensic Pathologists**

MEMBERS OF THE SENATE

PROF JAMILA ABOOBAKER
DR SAGEREN AIYER
PROF SATS BHAGWANJEE
PROF PIERRE BILL
PROF JULIA BLITZ-LINDEQUE
PROF JOHAN BRINK
PROF BILKISH CASSIM
DR SEAN CHETTY
PROF USUF CHIKTE
PROF ANDRÉ CLAASSEN
PROF BERNARD DONDE
PROF ANNARE ELLMANN
PROF ROBIN EMSLEY
PROF VIVIAN FRITZ
PROF BRENDAN GIRDLER-BROWN
PROF LOUIS GOEDHALS
PROF DHIREN GOVENDER
PROF TEDDY GOVENDER
PROF TSHEPO GUGUSHE
PROF CHRIS HEYNS
PROF KEN HUDDLE
DR ASHWIN HURRIBUNCE
DR MOSES KABAALE
PROF DEL KAHN
PROF RALPH KIRSCH (IPP)
DR WALTER KLOECK
PROF GERHARD LINDEQUE
PROF MADELINE LOWNIE
PROF THANDINKOSI MADIBA
DR SAMEER NADVI
PROF SHAN NAIDOO
PROF SIMON NAYLER
PROF GBOYEGA OGUNBANJO (EDITOR)
PROF JONATHAN PETER
PROF ANNE PETERS
PROF JOHN PETTIFOR
DR LES RAMAGES
PROF ARTHUR RANTLOANE
PROF SOLLY RATAEMANE
MR ANU REDDI
DR PAT SAFFY
PROF HAROON SALOOJEE
PROF MIKE SATHEKGE
PROF ALAN SCHER
PROF ALF SEGONE
DR STEVE SIMANGO
PROF GAIL TODD

MRS BERNISE BOTHMA — **Chief Executive Officer**
MRS ANN VORSTER — **Academic Registrar**

*** Note:**
The election of the President and Vice Presidents will take place in October 2006 and the new incumbents will take office in May 2007.

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: administration@colmedsa.co.za
Internet: http://www.collegemedsa.ac.za

Block, Joseph (College of Neurosurgeons)
Block, Sidney (College of Family Practitioners)
Bresler, Pieter Benjamin (College of Public Health Medicine)
Clark, Donald Charles (College of Ophthalmologists)
Costa, Dario Adolfo (College of Anaesthetists)
Dewhurst, Christopher John (College of Obstetricians and Gynaecologists)
Drew, James du Preez (College of Anaesthetists)
Egbeyemi, Olanrewaju Yaqub (College of Obstetricians and Gynaecologists)
Friedmann, Allan Isadore (College of Ophthalmologists)
Gibson, John Hartley (College of Obstetricians and Gynaecologists)
Hill, John William (College of Physicians)
Hugo, Daniël (College of Obstetricians and Gynaecologists)
Iqbal, Zahid (College of Surgeons)
Kenyon, Michael Robert (College of Physicians)
Khalpey, Mehboub (College of Anaesthetists)
Kornell, Simon (College of Physicians)
Leigh, Werner Eberhard Julius (College of Family Practitioners)
Lunt, David William Raymond (College of Family Practitioners)
Lwin, Zarnie (College of Physicians)
Macovei, Liliana Simina (College of Psychiatrists)
Macovei, Liviu Christian (College of Orthopaedic Surgeons)
Malik, Muhammad Atif (College of Psychiatrists)
Matus, Szlejma (College of Radiologists)
Mayet, Zubeida (College of Paediatricians)
Medaiyese, Ayorinde Adebayo (College of Family Practitioners)
Muir, Susan Maura (College of Psychiatrists)
Musoke, Elijah Paul (College of Physicians)
Ndimande, Benjamin Gregory Paschalis (College of Anaesthetists)
Oduwole, Olusesan Odusami (College of Anaesthetists)
Pasha, Asma (College of Paediatricians)
Phillips, Kenneth David (College of Family Practitioners)
Raubenheimer, Arthur Arnold (College of Obstetricians and Gynaecologists)
Richmond, George (College of Physicians)
Rozwadowski, Marek Antoni (College of Anaesthetists)
Sartorius, Kurt (College of Public Health Medicine)
Seaward, Lizette Ann (College of Urologists)
Sesel, John Ruby (College of Radiologists)
Shaw, Keith Meares (College of Surgeons)
Siwinska, Dorota Sylvia (College of Psychiatrists)
Skinstad, Alvin Vaughn (College of Family Practitioners)
Smith, Robin Errol (College of Paediatricians)
Swart, Henry Charles (College of Obstetricians and Gynaecologists)
Van den Aardweg, Machteld Sonja (College of Surgeons)
Vaithilingam, Karthikesan Asoka (College of Family Practitioners)
Van Wyk, Hester Catharina (College of Surgeons)
Viswanathan, Sornalatha (College of Obstetricians and Gynaecologists)

Information as at 13 February 2006

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**

We are pleased to announce that we now have a monthly news bulletin posted to our web site. View at www.collegemedsa.ac.za: click on crest then on News. The News Bulletin can then be accessed as a word document.

Contributions and comments would be welcomed.

EPONYMOUS LECTURES

Francois P Fouché Lecturer for 2006

Professor Anton Schepers will deliver his lecture "In Search of the Truth" at the SA Orthopaedic Surgeons Congress to be held in September 2006.

The JN and WLS Jacobson Annual Radiology Lecture

Professor A Andronikou and Dr AC Hurribunce have both been appointed lecturers for 2006. Professor Andronikou's lecture is entitled "Imaging of Tuberculosis in Children" and Dr Hurribunce's is "A Systemic Approach to Clinical Imaging". These lectures will be delivered at various major centers throughout the country.

EDUCATIONAL DEVELOPMENT PROGRAMMES

Robert McDonald Rural Paediatric Fund

Applications for funding from the above should be sent to the CMSA Durban offices:
PO Box 17004, Congella 4013.

Eastern Cape Visits

From 9 – 12 March 2006, academics from Cape Town will visit Umthatha to deliver lectures on Emergency Medicine.

MEDICO-LEGAL ETHICS SEMINARS FOR 2006

Held in the Steve Biko Lecture Theatre, Nelson R Mandela School of Medicine, Umbilo Road, Durban from 18:00 – 19:00 on the following dates:

8 February	"Zealots in ethics have crucified the advancement of modern medicine"
12 April	"Do not resuscitate – definition, ethics and the law where is the line to be drawn?"
14 June	"Ethics CME points – why bother?"
13 September	"Whistleblowing – impaired or unethical behaviour of colleagues"
8 November	"Supercession (patient pinching)"

CMSA

The Colleges of Medicine of SA
12 Glastonbury Place
Umbilo, Durban 4001

THE COLLEGES OF MEDICINE OF SOUTH AFRICA

PROUDLY PRESENT

ARTHUR LANDAU LECTURER FOR 2006

PROFESSOR STEPHEN HOUGH

Professor and Head, Endocrine Unit and Chair, Department of Medicine,
University of Stellenbosch and Tygerberg Academic Hospital

PROFESSOR HOUGH'S LECTURE IS ENTITLED:

"A Rational Approach to the Treatment of Osteoporosis: is it Possible?"

Cape Town: Thursday 15 June 2006: 16:00 – 17:00
Venue: Lecture Theatre No 2, E Floor, New Groote Schuur Hospital

This lecture will also be delivered at the following centres:

Durban: date to be advised
Venue: Nelson R Mandela School of Medicine, UKZN

Johannesburg: date to be advised
Venue: Auditorium, Johannesburg Hospital

Bloemfontein: date to be advised
Venue: Lecture Theatre, 1st Floor, Universitas Hospital

ALL WELCOME