



TRANSACTIONS

Journal of The Colleges of Medicine of SA (CMSA)

Volume 53 (1) JAN-JUN 2009

ISSN 0010-1095

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Journal of The Colleges of Medicine of SA (CMSA)

Admission Ceremony October 2008



Photograph: William Raais, © 2008 David Arment and Mariska Fick-Jordan

Volume 53 (1) JAN-JUN 2009



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Medpharm Publications (Pty) Ltd

Publisher: Medpharm Publications (Pty) Ltd

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Designer: Jenny Waterson (X-Axiscc)

Printed by: Intrepid Printers (Pty) Ltd

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In support of contemporary Zulu telephone wire baskets

Artist: Zama Khanyile, KwaMashu

Photographer: William Raats

Zama's story is one of perseverance, and is the stuff of fairy tales – a politically correct Cinderella-meets-Pygmalion story. Zama had a low-wage job at a restaurant at Durban Station. She wishes for better things and always kept an eye open for something better. And one day it came to her. She read a news story about Ntombifuthi Magwasa, a settlement dweller who had won the big FNB Vita Craft Now Award for her telephone-wire baskets. Her artwork is available at from the BAT Shop, Durban, Tel: (031) 332 9951, E-mail: batcraft@mweb.co.za

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Fees and Charges

(Applicable 1 June 2009 to 31 May 2010)

PAYABLE BY MEMBERS OF THE CMSA:

Annual Subscriptions

Local:

Associate Founders, Associates, Fellows, Members and Certificants	R 570.00
Diplomates (local)	R 335.00
Overseas (all categories of members)	R 570.00
Retired members	R 65.00
Assessment Fee : Fellowship by Peer Review	R 950.00
Registration Fee : Associates	R 620.00
Fellows, Members, Certificants and Diplomates	R 400.00

(The registration fee for F, M C and D forms part of the examination fee)

Voluntary Constituent College Levy	R 70.00
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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)

Occasional hire: Gown and hood	R 150.00
Gown only	R 100.00
Hood only	R 60.00

Purchase of hoods	R 250.00
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Cost of Past Examination Papers (per set of 6 papers)	R 50.00
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PAYABLE BY THE CMSA:

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

Senators, examiners and staff <i>(local)</i>	R 260/day
CMSA delegates <i>(overseas)</i>	\$ 215/day
Honorarium <i>(local subsistence)</i>	
Local examiners : R260 per day less PAYE of R65	R 195.00

Remuneration for Setting FCS(SA) Part I Papers	R 330.00
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Remuneration for Invigilating

(not applicable to salaried personnel of the CMSA)

Full day	R 385.00
Half day	R 210.00

Remuneration for Secretarial Assistance *(not applicable to CMSA staff)*

The following sliding scale applies:

Hours worked	Remuneration	Hours worked	Remuneration
Up to 8 hours	R 40 per hour	26 – 30 hours	R 945
08 – 10 hours	R 385	31 – 35 hours	R1 060
11 – 15 hours	R 555	36 – 40 hours	R1 175
16 – 20 hours	R 725	41 – 45 hours	R1 265
21 – 25 hours	R 835	46 – 50 hours	R1 320

There is a ceiling of R1 320 as persons providing secretarial assistance to the CMSA at examination time already receive a full-time salary. Claims in respect of secretarial assistance rendered have to be supported by a special recommendation for payment signed by the examination Convener.

Remuneration to Laboratory Technologists/Technicians and Nurses

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. R 85 p/h

Travel Reimbursement <i>(prescribed by the Minister of Finance)</i>	R 2,92/km
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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 have electronic access to the Journal Transactions and other important Collegiate matter.

Waiving of Annual Subscriptions

Payment of annual subscriptions are 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.



By the time you receive this edition of the Transactions, South Africa would have had its fourth democratic elections with the President and cabinet in place. The Colleges of Medicine of South Africa (CMSA) will also conduct elections for its new President and Vice Presidents half-way through the tenure of office of the new Senate. The CMSA senate reflects the diversity of our rainbow nation and as an organization; it is well positioned as the national examining body for medical and dental specialists.

This edition has interesting articles which should generate discussions among members and stakeholders in health. Ralph Kirsch's article on "A model for the governance of academic health centres" is a personal opinion based on his experience on the topic which spans more than 3 decades. He advocates that academic complexes should not operate in isolation, and that the number and composition of the health care personnel trained must be tailored to meet the needs of the nation. He enumerates the issues with the current status which include inequalities and disparities of the joint agreements between various provincial departments of health and university health science faculties; variation in training outputs; no national agreement on the cost mapping of quaternary service provision for the country and budget cuts which have resulted in bed closures and unmet service needs to mention a few. He proposes a model that will place all existing academic health centres under the control of the National Minister of Health and managed as Public Entities with a Central Academic Health Centres Board. The details of how this new structure will function are explained in the article. It is a discussion document by the author in which he hopes will generate responses from all stake holders.

The second article on: "Respect for autonomy as a Prima Facie Right: Overriding patients' autonomy in medical practice" by Sylvester Chima discusses exhaustively that prima facie, every competent adult has the right to decide whether to consent or refuse any medical treatment, even if such refusal could lead to death. However, this right of respect for autonomy can be overridden where there is temporary or permanent mental incapacity. He further explains the concept of autonomy, autonomy vs. utilitarianism, consent to treatment, doctrine of necessity and decision-making capacity vs. autonomy with many interesting case studies. He concludes that patient autonomy is a desirable moral obligation that needs to be enhanced in medical practice but may be overridden, in the best interest of the patient, due to necessity, or as a matter of public policy, either for the good of the individual concerned or for the benefit of the society in general.

The third article titled: "Assessor recruitment, training and validation – experience from the UK" by Elizabeth Owen is based on a presentation made at the CMSA workshop on assessments in 2007. The article explains in detail the changes that have taken place in the training program and assessment of Obstetrics and Gynaecology registrars in the UK. What caught my attention is the examiner selection process, who are recruited on the basis of their skills, attributes and are then trained to the best of their ability, with their performance evaluated and constantly improved. She explains that the aim of examiner training should be to ensure consistent and reproducible results; examiners are seen to be fair and objective; examiners understand the scoring system and its standard setting process; and that discrimination awareness on the grounds of sex, race, disability are discussed.

The article highlights the various modalities of examiner training which include principles of assessment and examination design, use of videos or actors to demonstrate good interviewing and communication skills, punctuality and commitment to the smooth running of the exam process, understanding the scoring system, and discrimination and diversity training. During such training, inconsistent examiners are identified and may be potentially eliminated from examining. The latter is challenging in our setting as we are diversifying our examiner base in most colleges. However, the CMSA is already investing resources for examiner training to ensure quality assurance and improvement of our exam processes.

The 2008 Margaret Orford Memorial Lecture by Franco Guidozzi covers the "Surgical options for obstetric complications arising during delivery". Some interesting data are presented which include the following: Africa has the highest maternal mortality rate of 830 per 100 000 deliveries; in Sub-Saharan Africa less than 40% of women deliver with the assistance of a skilled attendant; and that obstetric haemorrhage is the single most common cause of maternal mortality, accounting for 25-33% of all maternal deaths globally. He then discusses in detail the various surgical options for most common complications arising during delivery. It is interesting to read about the various complications, management and surgical options including his preferences.

I hope that this edition will encourage submission of more articles from members as we contribute to the body of knowledge in our various disciplines. I await your positive responses.

Prof. Gboyega A Ogunbanjo
Editor: Transactions.

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

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.

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:

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Han, Thin Maung (College of Physicians)

Hill, John William (College of Physicians)

John, Jolene (College of Psychiatrists)

Keaikitse, Nonofu Lawrence (College of Anaesthetists)

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Macharia, Benson Ndegua (College of Forensic Pathologists)

Malago, Kahubangwa Tulinabitu (College of Obstetricians and Gynaecologists)

Ndimande, Benjamin Gregory Paschalis (College of Anaesthetists)

Phillips, Kenneth David (College of Family Physicians)

Raubenheimer, Arthur Arnold (College of Obstetricians and Gynaecologists)

Richmond, George (College of Physicians)

Schutte, Roxanne (College of Anaesthetists)

Smith, Robin Errol (College of Paediatricians)

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Van den Aardweg, Machteld Sonja (College of Surgeons)

Van Straaten, Barend Johannes (College of Forensic Pathologists)

Walker, Nigel Patrick (College of Paediatricians)

Wessels, Dirk Hermanus (College of Family Physicians)

Presidential Newsletter



In May 2007 I took office as President of The Colleges of Medicine of South Africa together with Professor Anil Madaree as Senior Vice President and Professor Gboyega Ogunbanjo as Vice President. We have now been in office for just short of two years and this is an opportunity to report on our progress and the initiatives which have been developed to date.

Prior to commencing our term of office, we discussed what we hoped to achieve over the coming three years. We identified African partnerships, upgrading and updating our examination assessment processes and the College Project as priorities. These represent some of the core business of The Colleges of Medicine of South Africa and we also recognise that we need to develop links and continue to interact with Colleges and colleagues in Europe, America and the Pacific Rim. We are particularly concerned about productive interaction with our colleagues in Africa and we hope that the initiatives of the past few years will continue and expand in the future.

The Colleges of Medicine Project: To Strengthen Academic Medicine and Specialist Training in South Africa.

This project has provided the CMSA with considerable challenges. We initially developed the project in 2007 and brought together stakeholders in medicine and dentistry in South Africa to a Policy Forum which was held at the Colleges of Medicine. We were funded by DFID and the consensus which developed within this meeting was that we need to move this project forward and, in particular, have a

clear indication of what the specialist needs are in South Africa, both in the private and public sector, and review governance of academic centres.

The past year has seen intensive fundraising efforts and the appointment of an extremely experienced consultant, Dr Brigid Strachan to run our project. We established two sub-committees within the CMSA, one chaired by Professor Ralph Kirsch to review specialist needs and numbers and the other chaired by Professor Lizo Mazwai to review governance models for academic centres and the conditions of service within the public sector. Both committees were asked to develop reports to be presented at a Forum in late 2008.

At the beginning of December 2008 the second College Forum was held with the theme: "Specialist training: Meeting South Africa Needs". This was again attended by representatives of all the constituent Colleges, the Deans, invited representatives from the Departments of Health and Education, representatives from the Treasury and experts in health planning from around South Africa. The two day symposium provided a unique and dynamic opportunity for interaction and, at the conclusion of this meeting, several resolutions were developed which will be published elsewhere in Transactions.

Essentially there was consensus that we need good data on specialist numbers and about the location of specialist services in South Africa. The various databases accessed by this College subcommittee have demonstrated enormous discrepancies. The project commissioned by Dr Percy Mahlathi from the DoH and undertaken by Dr Nicholas Crisp has concentrated on public health care. Given that many of our specialists are working in private health care, we need to have this additional information when we review the distribution of specialists and how to develop specialist services. The data which are available often only address a specific sub-set of specialist services and need to be expanded and improved.

It is possible that the HPCSA, through the annual registration process of all medical and dental practitioners, can obtain more information which would result in accurate information on the distribution of specialists within South Africa and details of where they work.

The second major project was to review governance models for academic centres. At the Forum several different models were proposed and there was general consensus that academic centres were national assets and need to be developed, maintained and expanded. Various models for governance were discussed and these are currently being reviewed and documentation on the various options is being prepared.

The 2009 programme for the College Project has been developed and we are again involved in fundraising to make this a reality. We hope to continue with the two subcommittees already established but may add an additional subcommittee to review health policy and funding. In addition we need to develop additional educational processes about HIV/AIDS which will impact on every constituent College and ensure that every curriculum addresses this particular clinical need. This will involve both the Education Committee and the Examinations and Credentials Committee.

Interaction with the Departments of Health & Education and the HPCSA

The past year has seen very valuable interactions with the Departments of Health and Education and the HPCSA. We were delighted to be informed that representation from the CMSA will in future be included in the Medical and Dental Professions Board of the HPCSA. We also hope to retain the positions we currently hold on various other subcommittees but await confirmation from the newly constituted HPCSA and particularly the MDPB after its inaugural meeting in March 2009. The Department of Education has agreed to interact with us and to send representatives to our various meetings including the Executive Committee meetings and some of the subcommittees. Dr Percy Mahlathi from the Department of Health has already attended several of our meetings.

Recently we have been privileged to have an opportunity to meet with Minister Barbara Hogan. She is well aware of the problems facing academic medicine in South Africa and we hope that we will be able to interact with her and the Department of Health in the future. We have assured her that the resources, experience and knowledge available through the CMSA can be accessed in developing solutions to the problems facing academic medicine. We are very appreciative of her willingness to engage with us and her commitment to improving health care and academic medicine in South Africa.

Examinations

We continue to review our examination and assessment processes and the workshop arranged in 2007 by the Examinations and Credentials Committee after the Cape Town examinations was particularly worthwhile. There was an agreement that this type of workshop should be repeated and recent discussion has indicated that workshops should ideally rotate through all the centres, independent of examination and Senate business. The ECC is presently organising a further meeting in mid 2009 to review assessment processes.

We hope that the CMSA will be chosen to arrange a unitary examination for specialist and subspecialist training and we are well aware that our assessment process has to be valid, reproducible and affordable. We have asked the HPCSA for an outline of the requirements and await their response. It is likely that a research component to specialist examinations will become compulsory and many of the constituent Colleges have already included this in their examination requirements. We have also taken the decision within the CMSA that every postgraduate student presenting for an examination has to produce a portfolio of experience and each College has been tasked with developing this. In some Colleges this process is fairly well advanced while others are only now starting to

develop their portfolios. The Senate decided that the presentation of a portfolio will be compulsory for all constituent Colleges from January 2010.

African Partnerships

One of our priorities is to develop interactions with our colleagues elsewhere in Africa. We were delighted when the College of Physicians and Surgeons in Ghana invited examiners from the Colleges of Physicians, Paediatricians, Obstetricians and Gynaecologists and Surgeons to participate in their College examinations and we do hope this is the beginning of an interactive process. In addition the College of Obstetricians and Gynaecologists funded and invited two colleagues from the Faculty of Obstetrics and Gynaecology in Ghana to attend the meeting of the South African Society of Obstetricians and Gynaecologists in October 2008.

Obviously we hope to extend our African contacts and at present Professor Dhiren Govender, the Registrar of the Finance and General Purposes Committee, has been tasked with taking over the role of developing a database of African Colleges and Societies. It is important that the CMSA is informed of any contacts which are developed and we would ask that you write to Professor Govender giving him this information.

Links with Colleges and academics abroad

Invitations are regularly received by the CMSA for the President or his/her representative to attend meetings abroad. Unfortunately the invitations exceed the capacity of our College to send representatives. In the past year I have been very privileged to attend the 42nd Singapore-Malaysian Congress of Medicine held in Kuala Lumpur. I was honoured to be awarded an Honorary Fellowship from the Malaysian Academy of Medicine on this occasion. This meeting offered an opportunity to attend academic meetings and to interact with Presidents from Colleges from around the world.

The highlight of 2008 was the opportunity to attend an educational symposium in Ottawa, Canada, arranged by the College of Physicians and Surgeons of Canada. This reviewed resident training and colleagues from Colleges around the world, interested in training, attended this meeting. It was followed by a unique conference which is, at present, the only international meeting concentrating on registrar training. This was a very valuable few days and I think I gained a great deal from the interaction with my colleagues and also with the educationalists in Canada. I have already written a report about this visit and I do hope that the CMSA will be able to benefit from the extensive Canadian educational experience.

In November I attended the 15th Anniversary celebrations of the Hong Kong Academy of Medicine. Once again there was interaction and discussion between Presidents from many Colleges who, at the same time, attended a meeting of the International Association of College and Academy Presidents (IACAP). All were concerned about the standards of registrar training, the ability to provide specialist experience and finally the way we deal with the underperforming candidate. This offered numerous insights and information.

Many of the invitations which we receive within the CMSA, clash with College activities. Sometimes Presidents of constituent Colleges represent the CMSA at meetings. Most recently Professor Del Kahn,

President of the College of Surgeons represented us at the meeting of the American College of Surgeons in New Orleans and Prof Simon Naylor, President of the College of Pathologists, at a meeting of the International Liaison Committee of Presidents of Colleges of Pathology (ILCP) in Sydney.

Developments within the CMSA

We continue with fundraising to develop an office in Durban. Professor YK Seedat has been central to our acquisition of property in Durban and we now have acquired the three properties adjacent to the CMSA building. There are ongoing attempts at fundraising in a very difficult financial environment. I hope that by May we will be able to give positive feedback on this initiative. Central to our attempts to develop the Durban office is Dr Warren Clewlow, Chairman of the Colleges of Medicine Foundation. We are most appreciative of Dr Clewlow's input and expert contributions.

CMSA Infrastructure

With the recent elections there have been changes in all three standing committees of the CMSA. The chairpersons of these committees and the honorary registrars are central to CMSA activities. The Finance and General Purposes Committee is chaired by Professor Del Kahn with Professor Dhiren Govender as the Registrar. The Examinations and Credentials Committee is chaired by Professor Jeanine Vellema with Professor Arthur Rantloane as Registrar and the Education Committee is chaired by Professor Anu Reddi, with Professor Jamila Aboobaker as Registrar. These committees oversee functions central to the running of the CMSA and we are most appreciative of the input of both the officials and the committee members. As the College Project develops, we anticipate that either a further standing committee may be established or the activities in this project will be attached to one of the standing committees. Professor Gboyega Ogunbanjo has transformed the Transactions and continues to edit our journal. The presentation of Transactions is attractive and innovative and has received very positive feedback.

The South African Registrars Association (SARA) continues to send a representative from the national registrar body to our meetings. SARA has been invited to send representatives to the Senate, EXCO and also to the three standing committee meetings of the CMSA. Registrar representatives do not have voting rights but can contribute to all the debates within the Colleges.

Central to the work of the CMSA is the role of the Treasurer. We were delighted when Professor Tuviah Zabow agreed to accept the nomination for this post for a third term. We realise the enormous amount of work this represents and we appreciate his meticulous attention to detail, his enthusiastic and diligent attention to College finances and his regular feedback to various committees. We are most appreciative of his very important input.

I should like to take this opportunity to thank all the officers for their input, innovation and loyalty to the CMSA. I am very aware of the extra work this involves in very busy academic and clinical schedules. I also wish to express appreciation of the support we receive from all the staff at the three College offices. In addition the Administrative Secretary at the Durban office, Anita Walker, our Academic Registrar, Ann Vorster and our CEO, Bernise Bothma, all contribute enormously to College business. Without their input and support, their institutional

knowledge and their willingness to engage with all of us, I am not certain how successful our organisation would be. I personally have gained enormously from their support, knowledge and input. We value their considerable contributions a great deal.

Finally I wish to take this opportunity to thank the two Vice Presidents, Professor Anil Madaree and Professor Gboyega Ogunbanjo for their enthusiasm, involvement and support. Working with them is a privilege and they bring important insights and experience to the College business. The contributions of Professor Lizo Mazwai and Professor Ralph Kirsch, who are involved in our College Project and their willingness to contribute to this, adds to the richness of our Colleges. We are indeed fortunate to have their support and expertise.

I trust the coming year will see further developments and innovations within The Colleges of Medicine of South Africa. We hope to take the College Project forward and to develop additional programmes and committees. This is, undoubtedly, one of the most innovative developments within the CMSA in recent years and we hope it will establish our relevance within medicine and dentistry and medical and dental education in South Africa.

Zephne M van der Spuy
President

Admission Ceremony

23 October 2008

The admission ceremony was held in the Joosub Hall, on the Westville campus of the University of KwaZulu Natal, Durban.

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

Professor YK Seedat, Honorary Fellow of the Colleges of Medicine of South Africa delivered the oration.

Two Honorary Fellows were admitted. Professor Victor Ngu to the College of Surgeons – citation written and read by Professor Del Kahn. Professor Vivian Fritz to the College of Neurologists – citation written and read by Professor Pierre Bill.

Five medallists were congratulated by the President on their outstanding performance in the CMSA examinations.

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

The new Certificants were announced and congratulated.

The Honorary Registrar - Examinations and Credentials, Prof Jeanine Vellema announced the candidates, in order to be congratulated by the President. The Honorary Registrar – Education, Professor Bilkish Cassim individually hooded the new Fellows. The Honorary Registrar – Finance and

General Purposes, Professor Usuf Chikte handed each graduate a scroll containing the Credo of the CMSA.

The new Members and Diplomates were announced and congratulated.

All in all the President admitted 30 Certificants, 220 Fellows, 6 Members and 311 Diplomates.

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.

The Changing Scene In Medicine

Prof YK Seedat

Nelson Mandela School of Medicine, Faculty of Health Sciences, University of Health Sciences, Durban.



Professor Zephne van der Spuy, President, respected Senate members, fellows and diplomates of the Colleges of Medicine of South Africa (CMSA), ladies and gentlemen, I feel deeply honoured to be asked to be guest speaker for the admission ceremony of CMSA. I obtained my fellowship of the previously named College of Physicians, Surgeons and Gynaecologists – which was renamed the Colleges of Medicine of South Africa – in April 1962. The exhilaration and joy of obtaining the fellowship which I had is something that I am sure the newly qualified fellows and diplomates are experiencing today.

We have a wonderful heritage. The history of medicine is fascinating. We all know of Hippocrates who was a Greek physician born in 460 BC on the Island of Cos, Greece. He became known as the founder of medicine and was regarded as the greatest physician of his time. He based his medical practice on observations and on the study of the human body. He rejected the view of his time that considered

illness to be caused by superstitions and the possession of evil spirits and disfavour of the gods. Hippocrates held the belief that the body must be treated as a whole and not just a series of parts. He was also the first physician who held the belief that thoughts, ideas and feelings come from the brain and not the heart as others of his time believed. He traveled throughout Greece practicing his medicine. He founded a medical school on the island of Cos, Greece and began his ideas. He soon developed an Oath of Medical Ethics for physicians to follow. The Oath is taken by physicians today as they begin their medical practice. He died in 277BC.

Today Hippocrates is known as the “Father of Medicine”.¹ At about this time (about 500 BC), Susruta in India made great strides in the field of surgery. He is recognized as the father of Indian surgery. His contribution to plastic surgery, classification of burns, types of blunt and sharp instruments, techniques of incisions, operations for lithotomy, cataract removal, caesarean sections, repair of ear lobes and hare lips have been noted.² Whilst Europe was in the “dark ages” two reputable Persian medical scholars in the Middle Ages were Razi (865 – 925AD) and Avicenna of Baghdad (980 – 1037 AD). The Canon of Medicine was the greatest work of Avicenna. It remained as a standard medical text book in Europe for nearly 700 years. Sir William Osler described the Canon of Medicine as “the most famous medical text book ever written.”³ The chief medical work of Rhazes was the Comprehensive Book of Medicine known in Europe as Liber Continens. Rhazes was a chemist, physicist and discoverer of alcohol and its use in medicine.⁴ During the Middle Ages, Moses Maimonides (1135 – 1204 AD) was a rabbi, physician and philosopher in Cordoba, Spain, Morocco and Egypt. He was a pre-eminent medieval Jewish philosopher, and his ideas influenced the non-Jewish world. He was a physician of Sultan Saladin of Egypt and was considered the greatest physician of his time being influenced by renowned Islamic thinkers.⁵

Let us reflect on medicine today.

The practice of medicine combines both science and art. The role of science is clear. Science-based technology and deductive reasoning form the foundation of many of our problems; the spectacular advances in genetics, biochemistry and imaging technology, allow access to the innermost parts of the cell and the most remote recesses of the body. We have the advent of major surgical procedures like renal dialysis and transplantation of organs like renal, liver and pancreas, and coronary artery bypass. Yet one finds

that the respect of the modern doctor is not the same as before the age of antibiotics which occurred with the discovery of penicillin. Before 1947, the general practitioner used to make home visits with a paucity of drugs like aspirin, morphine, phenobarbitone, yet the general practitioner in many a town was respected by the community and, in the social strata, came close to the mayor of the town. The general practitioner provided tact, sympathy and care to the patient and his family. When the patient died the doctor provided care to the bereaved family. One of the essential qualities of the doctor is interest in humanity, for the secret of the care of the patient is in caring for the patient. Many trends in contemporary society tend to make medical care impersonal.

The include (1) vigorous efforts to reduce the escalating costs of health care; (2) the growing number of managed care programs which are intended to reduce costs but in which the patient may have little choice in selecting a physician; (3) increasing reliance on technologic advances and computerization for many aspects of diagnosis and treatment; (4) increasing geographic mobility of both patients and physicians; (5) the need for numerous physicians to be involved in the care of patients who are seriously ill; (6) an increasing tendency on the part of patients to express their frustration with the health care system by legal means (i.e. by malpractice litigation). Studies in the US have shown that an important cause of litigation is due to the failure of communication by the doctor to the patient. The causes are a major challenge for physicians to maintain the humane aspects of medical care. We should encourage patients to participate in ethical and approved clinical investigations and treatment and, as stated by Sir William Osler, "to wrest from nature the secrets which have perplexed philosophers in all ages, to track to their sources the causes of disease, to connote the vast stores of knowledge, that they may be quickly available for the prevention and cure of disease – these are our ambitions."

Today the relationship between the doctors and society is changing. Doctors are born into a society that is more materially minded, where corruption is rife and this is a phenomenon not only in South Africa but throughout the Western world as seen recently in the business corporates of the US. Allan Greenspan, the previous federal finance chairman in the US, recently stated that there is an "infectious greed" among some business executives in the US. A small segment of our profession has resorted to this "infectious greed" by taking part in fraud, over-servicing and/or false medical certificates. This has tarnished the image of the medical profession to the public.

Several reports throughout the world have described the declining morale among doctors but little is known about the reasons. A paper by N Edwards, *et al* on "Unhappy doctors: what are the causes and what can be done" analyses the potential causes of unhappiness. Pay and workload are obvious causes of unhappiness among doctors. However, workload and pay, though important, do not fully explain the problem. The medical profession has seen significant reduction in medical autonomy and increases in accountability and a long-running attempt to bring medicine under management and cost control by government, medical schemes, payers and employers.

This has resulted in the growing use of guidelines, protocols, audits, regulations and inspections that many doctors perceive as eroding their control over their professional lives. Though there are benefits from the changes, heavy control over work is important for the job satisfaction of clinicians and can have implications for the overall health of patients. We have witnessed this tragic saga in the treatment of HIV (mother to child transmission) and in the treatment of AIDS.

There is a change in our relationship with patients and society. There is a decline in deference for all professions and a perceived loss of trust, coinciding with a feeling that the media has become much more hostile. In fact, doctors are a highly trusted profession. At the same time, patients are increasingly active consumers and they demand and they have been encouraged to expect enhanced services, including extended hours and rapid access. The easy access of information, coupled with a sense of entitlement, is shifting the power in the doctor-patient relationship and causing unease. This is exacerbated by sometimes unrealistic expectations to solve the ills of modern life. The job is more difficult and emotionally demanding and often produces work-related stress. Thus one will find new imperatives in medicine which includes greater accountability, patient centred care, be more accessible to patients and to provide personalized service, work collectively with other doctors and staff to improve quality, evaluation by non-technical criteria and patients' perceptions and a growing blame culture.

I would like to end with the first aphorism of Hippocrates, the father of medicine when he stated that, "Life is short and the art (of medicine) long, opportunity is fleeting, judgment difficult and experiment dangerous. The physician must do the right thing at the right time."¹

With these wise words I wish the new qualified fellows and diplomates all the best in their careers.

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Citation: Prof Vivian Una Fritz

Honorary Fellow

College of Neurologists



Professor Vivian Una Fritz obtained her MB BCh degree at the University of the Witwatersrand in 1967. Her internship was followed by a registrarship in internal medicine at the Johannesburg General Hospital. She was awarded the Fellowship of the College of Physicians of South Africa in 1972 and worked as a consultant physician until 1979, with a major interest in cardiology. In 1979 she undertook a second registrarship, completing 3 years of neurology training. She then changed her specialist registration to neurology and started a second career as a specialist neurologist in 1981. She was employed as a Senior and then Principal Neurologist until 1987. In 1988 she was appointed to the chair of Neurology at the University of the Witwatersrand and Chief Neurologist at the Johannesburg and Helen Joseph Hospitals. She retired from Hospital service in 2001, having completed 19 years as a full time academic neurologist and was appointed Emeritus Professor of Neurology at the University of the Witwatersrand.

Professor Fritz has had an illustrious career in academic neurology. With her background as a physician with an interest in cardiology, she then became actively involved in the clinical and research aspects of stroke. During her time as a consultant in neurology she undertook research on the role of the extracranial arteries in acute cerebral ischaemia and was awarded a PhD for her work in 1986. In 1996 she was awarded an Honorary Fellowship of the College of Physicians of London (FRCP (Lond.)) and in 2000 she received the Fellowship of the College of Neurologists by peer review. She has been active in developing and organising stroke services in South Africa, organising the first Stroke Unit at Milpark Hospital in 1998. In the same year she conceived the idea of a Stroke Foundation for Southern Africa, which was established with the backing of pharmaceutical and insurance companies. She became the chairman of the management committee and in 1999, the chairman of the Board of Directors of the Stroke Foundation of Southern Africa, a position she has held to the present time. She was also a founder member of Stroke Aid and of the Stroke Rehabilitation Centre in Johannesburg. She has organised 3 symposia in South Africa - in 1999, 2001 and 2003 and has

authored many articles in Continuing Medical Journals on stroke care and a book entitled "Stroke, Caring and Coping". She was appointed to the World Stroke Education Action Group in 2004 under the auspices of the World Federation of Neurology and the WHO and appointed to the Board of Directors of the World Stroke Federation and the International Stroke Society from 2003-2007. In 2006 she was the South African Convener of the World Stroke Congress held in Cape Town, putting South Africa firmly on the map of cerebrovascular diseases.

During her career, Professor Fritz has also served the neurological fraternity by her active involvement and leadership roles in the Neurological Association of South Africa and in The Colleges of Medicine (CMSA). She served as President of the Neurological Association in 1981-1982 and as president of the College of Neurologists (CMSA) from 1991 to 2002. She has continued to serve as a member of the Council of the College of Neurologists and as a member of Senate of the CMSA from 2002 to May 2008.

Professor Fritz has published extensively over the course of her career, being the author or co-author of 110 articles and 2 books, mainly in the field of cerebrovascular diseases and stroke. She has presented numerous papers and has been an invited lecturer at international and national congresses. She has served as an editor and associate editor of several national and international journals and has supervised many Masters and PhD theses. She has also served as a South African representative on a number of international committees, including the World Federation of Neurology, the International Federation of Multiple Sclerosis Societies, various International Stroke Councils and organisations. She has been an active teacher and examiner throughout her career, being involved in both undergraduate and postgraduate neurology teaching and as an examiner in neurology for the College. She was the recipient of 2 awards for excellence in clinical teaching, receiving the Convocation award for best clinical teacher (Tobias medal) in 1992 and in 1993 the Vice Chancellor's award for best clinical teacher at the Faculty of Medicine of the University of the Witwatersrand.

Professor Fritz's role and leadership in neurology has been enormous and she has influenced and guided the careers of many young and developing neurologists. She is highly respected by her colleagues for her academic achievements and standing, is recognised for her knowledge and expertise in cerebrovascular diseases and for promoting and developing awareness, research and active intervention in the management of cerebrovascular diseases. Interwoven in this exacting schedule, she has also managed to fulfill her role as a wife, mother and grandmother of 2 children and 2 grandchildren. The College of Neurologists is proud to present her for the award of an Honorary Fellowship as an appropriate honour for her many contributions.

Author : Prof Pierre Bill

Citation: Prof Victor Anomah Ngu Honorary Fellow College of Surgeons



Victor Anomah Ngu was born in February 1926 and he trained at the St. Mary's Hospital Medical College, London, where he was awarded the University of London's prestigious Max Bonn Prize and medal in Pathology in 1954. He was admitted into the Fellowships of the Royal College of Surgeons in Edinburgh and England in 1959 and was awarded the Masters degree in Surgery of the University of London in 1962. He was an Exchange Professor of Surgery at Johns Hopkins Medical School in Baltimore USA in 1964 and started his academic career in 1962 as Lecturer in Surgery and then Professor of Surgery at the University of Ibadan, Nigeria from 1965 to 1971.

During this period he became African President of the International Union against Cancer (UICC), Founder President of the Nigerian Cancer Society and Founder of the Association of Surgeons of West Africa, which he almost single-handedly transformed into the present-day West African College of Surgeons (WACS).

During his stay in Ibadan, he built a reputation as a clinical oncologist and his interests in Lymphoma crystallised in the chemotherapy of Burkitt's lymphoma (BL) and its immunology. He published widely on the subject of immunoglobulin synthesis in BL and his efforts were rewarded with the Rockefeller Foundation Research Fellowship in Cancer at the Children's Cancer Research Foundation and Harvard Medical School, Boston, USA from 1962-63. His work received early international recognition through the Albert Lasker Medical Research Award in Clinical Cancer Chemotherapy in 1972.

He relocated to his native Cameroon in 1971 to head the Department of Surgery at the University Centre for Health Sciences, University of Yaoundé, Cameroon. The rewards for his early leadership and scholarly roles in surgery snowballed into new responsibilities: Vice-Chancellor, University of Yaounde, Director-General of Scientific and

Technical Research, Minister of Public Health in the Government of Cameroon (1984-1988), Director of the Cancer Research Laboratory, President of the Cameroon Academy of Sciences (2001-2005) and Pro-Chancellor of the University of Buea (1993-2004). He is a proud recipient of the Grand Officier de l'Ordre National de la Valeur, Francaise (1986) and more recently Grand Officier de l'Orde Nationale Valeur Camerounais (2001).

Professor Ngu's leadership, foresight and altruistic qualities have resulted in the development of academic institutions in 15 of the 26 participating countries that constitute the membership of the WACS. His work unified Anglophone and Francophone West Africa by the establishment of common surgical standards notwithstanding the political plurality that often threatens international governmental organizations. Today, the predominant postgraduate surgical diploma in West Africa is the Fellowship of the West African College of Surgeons, which has received international recognition.

The role Professor Ngu played in the promotion of postgraduate surgical education, examination, accreditation and certification in West Africa has been truly magnanimous and his contribution to the continued development of the African surgeon has been unparalleled and without equal. This confirms him as the ideal role model and a true doyen of African surgery.

Author : Prof Del Kahn

List of Medallists - 2008

FCA(SA) Part I – Janssen Research Foundation Medal:

Dr Richard Barry LAWSON – October 2008

FCA(SA) Part I – Abbott Medal:

Dr Richard Barry LAWSON – October 2008

FCA(SA) Part I – Hymie Samson Medal:

Dr Kim DE VASCONCELLOS – May 2008

FCA(SA) Part I – Glaxosmithkline Medal:

Dr Kim DE VASCONCELLOS – October 2008

FCA(SA) Part II – Jack Abelsohn Medal & Book Prize:

Dr Mark Alan EAGAR – October 2008

FC Derm(SA) Part I – Janssen Research Foundation Medal:

Dr Mahendran Perianathan MOODLEY – May 2008

Dr Nokubonga Fredericka KHOZA – October 2008

FCMFOS(SA) Final – SA Society of Maxillo-Facial Oral Surgery Medal:

Dr Christiaan Frederik HOOGENDIJK – October 2008

FC Neurol(SA) Part II – Novartis Medal:

Dr Kathleen Jane BATEMAN – May 2008

Dr Kaminie MOODLEY – October 2008

FC Neurosurg(SA) Final – Rowland A Krynauw Medal:

Dr Llewellyn Cavill PADAYACHY – May 2008

FCOG(SA) Part I – GP Charlewood Medal:

Dr Dominic Giles Dudley RICHARDS – May 2008

FCOG(SA) Part II – Daubenton Medal:

Dr Mziwethu Siyabulela BODLANI – October 2008

FC Ophth(SA) Part I – Neville Welsh Medal:

Dr Yavische REDDY – October 2008

FC Paed(SA) Part I – Leslie Rabinowitz:

Dr Yavini REDDY – October 2008

FCP(SA) Part I – AM Meyers Medal:

Dr William Wayne LUBBE – May 2008

FCP(SA) Part II – Asher Dubb Medal:

Dr Muhammad Yusuf CHOHAN – October 2008

FCP(SA) Part I & Part II – Suzman Medal:

Dr Brian William ALLWOOD – May 2008

FC Psych(SA) Part I – Lynn Gillis Medal:

Dr Katherine Verne GILFILLAN – October 2008

FC Psych(SA) Part II – Novartis Medal:

Dr Marietta VAN DEN BERG – May 2008

FC Rad Diag(SA) Part I – Rhône-Poulenc Rorer Medal:

Dr Hofmeyr VILJOEN – May 2008

FC Rad Diag(SA) Part II – Jose Kaye Medal:

Dr André Tertius DU PLESSIS – October 2008

FCS(SA) Primary – Frederich Luvuno Medal:

Dr Eloise Juliet MILLER – October 2008

FCS(SA) Primary – Trubshaw Medal:

Dr Yomesh DASSAYE – October 2008

FCS(SA) Intermediate – Brebner Award:

Dr Stefan HOFMEYR – May 2008

Dr Chetan BHULA – October 2008

FCS(SA) Final – Douglas Award:

Dr Lydia Leone CAIRNCROSS – October 2008

Dr Nicolaas Francois VAN NIEKERK – October 2008

DA(SA) – SASA John Couper Medal:

Dr Richard Barry LAWSON – May 2008

Dr Leah Dunn REID – October 2008

Dip HIV Man(SA) – The HIV Clinicians Society:

Dr Rispah Nyambura IRUNGU-CHOMBA – May 2008

Dip PEC(SA) – Walter G Kloeck Medal:

Dr Muhommed Ridwaan SYED – October 2008

Dip PEC(SA) – CAMPBELL MACFARLANE MEDAL:

Dr Tracy Lyn NIELSON – May 2008

2008 Medalists



Sathiaseelan Parmersivan Nair
Robert McDonald Medal, FC Paed(SA) Part II



Pralene Maharaj
Novartis Medal, FC Psych(SA) Part II



Anupa Ramnarain
Douglas Medal, FCS(SA) Final



Surendra Sirkar
Claude Harris Leon Medal, MCFP(SA)



Mohamed Raiman
SASA John Couper Medal, DA(SA)

List of Successful Candidates

October 2008

Fellowship

Fellowship of the College of Anaesthetists of South Africa – FCA(SA)

AGJEE Dawood	UKZN
COHEN Steven	UCT
DULIN Natasha	
EAGAR Mark Alan	WITS
HARRIPERSADH Manita	UKZN
HAYLETT Revyl Ann	UCT
KIRSCH David Mendel	UCT
LEE Clover-Ann Patricia	WITS
LEE Carmen Ann	UP
LEKHA Leraj Ashook Kumar	UKZN
MADIMA Nthatheni Rosemary	WITS
MAHARAJ Ameela Devi	UKZN
MUKADDAM Hizir	WITS
NAIDOO Thavendree	WITS
NEJTARDT Marcin Bartosz	UCT
PARBHOO Vinaykumar Bhagwandas Kika	WITS
RODSETH Reitze Nils	UKZN
SCHMIDT Dirk Ernest	
SCHMIDT Joan Annette	UKZN
SLABBER Daniel Joubert	US
THANGAVELU Dheshnie	UKZN
VALLABH Chetna	WITS
VAN NUGTEREN Janieke Aleid	UCT
YOUNG Ian	UKZN

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

NAICKER Kaven	UKZN
REDDY Darshan	UKZN
SCHERMAN Jacques	UCT

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

EISMAN Samantha	UCT
MAGIGABA Basil Phakamile	UKZN
MAZIBUKO Zandile Sizakele	UKZN

Fellowship of the College of Emergency Medicine of South Africa – FCEM(SA)

GOLDSTEIN Lara Nicole	WITS
LAMPRECHT Heinrich Hilgardt	US

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

ANTHONY Daphne	US
DU TOIT-PRINSLOO Lorraine	UP
HATTINGH Christa	UKZN
JESSOP Nicola Lee	WITS
MOENG Shirley Faith Angela Portia	

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

HOOGENDIJK Christiaan Frederik	
MUNZHELELE Thifhelimbilu Irene	UP
MUTHRAY Enesh	WITS
SULEMAN Yusuf Farouk	WITS

Fellowship of the College of Neurologists of South Africa – FC Neuro(SA)

BHANJAN Ashleigh	UKZN
MOODLEY Kaminie	UKZN
SHIPANGA Hilma	WITS

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

SANDLER Simon Jeffrey Ian	UCT
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Fellowship of the College of Nuclear Physicians of South Africa – FCNP(SA)

GUTTA Aadil Abdulaziz	UL
JAWA Zabah Muhammad	US
MAHARAJ Masha	US

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

BODLANI Mziwethu Siyabulela	UKZN
BUDHRAM Samantha	UKZN
DU PLESSIS Jacomina Hendrina	UP
DU TOIT Maria Magdalena	US
GRIEVE Clayton Lance	US
GUMATA Nomonde Dorah	UKZN
JUUL Leonard	US
KENNETH Lynelle Anne	US
MOODLEY Serilla	WITS
O'CALLAGHAN Kendall Jane	UCT
PILLAY Casandra Letitia	UP
SELANTO-CHAIRMAN Nonkosi Pinky	UCT
SEPELA Louisa Boledi	WITS
SINGH Nikhil	UKZN
TLALE Karabo Juliet	WITS
VAN GREUNEN Johannes Petrus	UCT

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

ALBRECHT Eric	UCT
BVUMBI Azwihangwisi	UCT
EKSTEEN Petrus Johannes	UFS
KETTLEDAS Hiron	WITS
MATUBATUBA Justice Thabo	UKZN
SLAZUS Catharina Elizabeth	UKZN
SMIT Derrick Peter	US
STEENBERG Celeste	UKZN
VAN DYK Marius	US

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

COERTZE Pieter Johannes	UP
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CRANE Jason Lance	US
DE LANGE Susan	WITS
FERRAO Paulo Norberto Faria	WITS
FIRTH Gregory Bodley	WITS
GELBART Bradley Rael	WITS
GREEFF Richard De Villiers	WITS
HUMAN Andre Wynand	UKZN
JONKER Cornelius Johannes	UFS
MEARS Stewart Guy Scott	UCT
MULDER Michael John	UCT
MUNGERHERA Andrew Robert Were	UKZN
NDZERU Thidziambi Eric	WITS
SNYCKERS Christian Hugo	UP

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

BASANTH Sujith	UKZN
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Fellowship of the College of Paediatricians of South Africa – FC Paed(SA)

DEMOPOULOS Despina	WITS
HANNI Tabea Mathilde	WITS
JOOLAY Yaseen	US
JOSHI Jayneel Aswin	UP
LINDE Louis Bernard	US
MAMDOD Fahmida	UKZN
MITCHELL Jennifer Gwen	WITS
MODIPANE Vezamafa Rivonia	UCT
MOONSAMY Glenda	WITS
NAIDOO Visva	UKZN
NAIDOO Lerusha	UKZN
NETU Thandeka Judith	UKZN
RAMMEGO Kealeboga Maboshakoane	UP
RAMOUTHAR Lovelene	UKZN
RHODE Delano	US
SEEDAT Yazeed Aboobaker	WITS
SIGWADI Patience	UP
SINGATA Vuyelwa	UKZN
SINGH Nevan Bijai	UKZN
STEENEKAMP Marelie	UP
TONKIN Selna	US
WALABH Priya	UCT

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

MOSIANE Nkagisang Pulane	
NOKOANE Lerato Mmakentse	WITS
WALKER Christopher Louis	UCT

Fellowship of the College of Pathologists of South Africa - Clinical Pathology – FC Path(SA) Clin

MOELETSI Tshogofatso Mathabane Mamolefe	WITS
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Fellowship of the College of Pathologists of South Africa – Haematology – FC Path(SA) Haem

LOUW Susan WITS
RAMPARSAD Narisha UKZN

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

LOWMAN Warren WITS
MOODLEY Krishnee UKZN
MOORE Chanelle Verona UP
SITHOLE Sindisiwe Myrtle UKZN

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

MAKATINI Zinhle Nomusa UL

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

ABDOOL-GAFOOR Bilal UKZN
BUDHOO Amritha UKZN
CASSIM Farhana UKZN
CHOHAN Muhammad Yusuf WITS
CHOTHIA Mogamat-Yazied
DISSANAYAKE Arjuna WITS
GOVENDER Sedeshan Soobramoney UKZN
GURUVADU Leann Soobramoney UKZN
HERBST Philippus George US
HOFMEYR Johannes Wynand Louw US
JAIKARUN Roull Justin UKZN
KALK Thomas WITS
LALLA Usha
LOUW Ruan WITS
MAHARAJ Vishal Rameshchand UKZN
MODY Priyesh Grish UKZN
MOHAMED Nazeer Ahmed WITS
MOODLEY Jayendran UKZN
MORLEY Julia Claire US
NAIDOO Balram UKZN
NOMVETE Mfanufikile UKZN
PATEL Anupa WITS
PINHEIRO Paulo Alexandre Rodrigues WITS
RAMJIWAN Beena Devi UKZN
RICHTER Ern e US
SARDIWALLA Zahir WITS
SPOOLDER Lee-Ann WITS

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

DE WET Jacob Daniel UL
VAN DER WALT Johannes Christiaan US

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

ABRIE Anina WITS
ALISON Heather Clare UP
BENSON-MARTIN Janine Juanita UCT
BRUMMERHOFF Ralf Arnold UP
BRUWER Belinda Rogena US
CLOSE Mirriam WITS
KASSEN Pravesh Chaganlal WITS
KHAMKER Nadira UP
LEGG Elizabeth Anne UCT
LIPPI Gian UP
MAGUBANE Nokukhanya Debra UKZN
MALEROTHO Molekwane Evelyn UL
MASINGA Nkululeko Michael UKZN
MOOLA Nai'm Moosa UP
MOTALA Zaahir Ahmad Ebrahim WITS

MTSHEMLA Sisanda UKZN
MUDALY Niresha UKZN
NAICKER Pevashnee WITS
NKOWANE Nomnandi Imelda UCT
RAMDEYAL Mahendra Kumar UKZN
SMIT Ean Johannes UP
TEMA Nkokone Shimane Zacharia WITS
VOS Paul Johannes US
WICOMB Robert Albert US
WILLIAMS Mohamed Faadiel UCT
ZARDAD Surayah UCT

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

CORRIGALL Joanne UCT
MAHLATI Unati UCT
PIENAAR David Charles UCT

Fellowship of the College of Public Health Medicine of South Africa - Occupational Medicine – FCPHM(SA) Occ Med

MAIPHETLHO Lerato Patience UCT
MEINTJES Willem Albertus Jacobus US

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

CANTRELL John Anthony WITS
DU PLESSIS Andr e Tertius UP
GRIFFITH-RICHARDS Stephanie Barbara US
JAJBHAY Nadia WITS
JASAT Naheed UKZN
NDLOVU Neo Brenda WITS
RANCHOD Amaresh Indravadan WITS
RUDAKEMWA Emmanuel WITS
SULEMAN Farhana Ebrahim
SWEIDAN Leora UKZN

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

BANDA Lewis
ERASMUS Thomas Frederik UFS
GOVENDER Poovandren Soobiah UKZN
NARINESINGH Dylan US
RAMIAH Duvern WITS

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

BEKKER Wanda UCT
BERNON Marc Michael UCT
BOUTALL Adam Brunette Taunton UCT
CAIRNCROSS Lydia Leone UCT
CHEDDIE Nishaan UKZN
CHINNERY Galya Eileen UKZN
CHIRKUT Subash UKZN
EAGLES Per-Erik US
ELOFF Edmund Phillipus UCT
FERNANDES Tiago Paulo WITS
GANGAT Dawood Sulaiman
HOOSEN Ismail Goolam Mahomed UKZN
JAGIELLO Robert Dariusz UCT
MUSOKE Deogratias
NAIDOO Kessendhra UKZN
NAIDOO Ruvashni UKZN
NAIDOO Noel UKZN
RAMKELAWON Vikesh Vickrampersad UKZN
REDDY Jenendhiran UKZN
SENAMELA Kyeswalatau Bob UKZN
SIKHOSANA Mbokeleng Happiness UKZN
VAN NIEKERK Nicolaas Francois UFS
WIGGETT Wilhelm Scholtz UP

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

RAMKISSOON Shiven UKZN

Memberships
Membership of the College of Family Physicians of South Africa – MCFP(SA)

ASHFORD Gail Lindsay WITS
GIBBS Audrey WITS
IGE Olabode Adeboyejo UP
KARANI Hafeeza UKZN
MOTARA Feroza WITS
SIDDIQUE Muhammad Irfan UKZN

Certificates
Certificate in Cardiology of the College of Physicians of South Africa – Cert Cardiology(SA) Phys

MUGABI Aine
SHEIN Kyi UKZN

Certificate in Clinical Haematology of the College of Pathologists of South Africa – Cert Clin Haematology(SA) Path

SEWPERSAD Natasha UKZN

Certificate in Critical Care of the College of Anaesthetists of South Africa - Cert Critical Care(SA) Anaes

MILLER Malcolm Gregory Andrew UCT
PIERCY Jenna Louise UCT

Certificate in Critical Care of the College of Paediatricians of South Africa - Cert Critical Care(SA) Paed

AHRENS Johann Otto UCT
DUMANI Gcina UCT

Certificate in Critical Care of the College of Surgeons of South Africa - Cert Critical Care(SA) Surg

CASSIMJEE Hussein Mohammed UKZN

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

KLISIEWICZ Anna Maria WITS
MOFOKENG Thabiso Rafaki Petrus UFS

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

GEORGE Deepu Joseph
GOVENDER Kugan UKZN
SEABI Manoko Elizabeth WITS

Certificate in Gastroenterology of the College of Surgeons of South Africa – Cert Gastroenterology(SA) Surg

FERNDALE Lucien UKZN
HEWAT Mark John Victor UCT
NAIDOO Maseelan UKZN
TROSKE Casparus Gerhardus UCT

Certificate in Gynaecological Oncology of the College of Obstetricians and Gynaecologists of South Africa – Cert Gynaecological Oncology(SA)

MAKWELA Mathebele Ray

Certificate in Maternal and Fetal Medicine of the College of Obstetricians and Gynaecologists – Cert Maternal and Fetal Medicine(SA)

CHAUKE Hlengani Lawrence

Certificate in Medical Oncology of the College of Paediatricians of South Africa – Cert Medical Oncology(SA) Paed

GEEL Jennifer Ann WITS

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

SINGH Sunira UKZN

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

ADENIYI Aderemi Babatunde
ARENDSE Craig Grant UCT
ASMAL Zubair Mahomed WITS
NTARINDWA Joseph

Certificate in Paediatric Surgery of the College of Surgeons of South Africa – Cert Paediatric Surgery(SA)

JEENA Vinesh UKZN
MAHARAJ Ashwini Girjasunker UKZN

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

GOVENDER Paramanathan UCT
PLEKKER Dante US

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

MAHOMED Yusuf UKZN

Part I, Primary & Intermediate exams

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

BHETTAY Anisa Zeenat WITS
BRENNAN Brigid Emma UKZN
CAIRNS Carel Jacobus Johannes UKZN
CHETTY Thamindran UKZN
CLOETE Willem Francois WITS
DE BEER Karen Elena US
DE VASCONCELLOS Kim UKZN
DERKSEN Conrad Cornelis UCT
DIYELELA Pumza Kunjulwa
ERNST Adalbert Henry UCT
EVANS Charlotte Ann Mary UKZN
GOBIND Rishant UKZN
GOVENDER Sashen UKZN
KEENAN Michelle UFS
KRANSINGH Samantha UKZN
LAWSON Richard Barry WITS
MBEKI Motselisi WSU
MOODLEY Kamanthree UKZN
MOODLEY Thasegan UKZN
NETHATHE Gladness Dakalo WITS
ODENDAAL Willem Johannes WITS
PEROLD Izak Abraham Francois
PILLAY Lutchmi UKZN
POORUN Rohith WITS

RAJAH Chantal UKZN
RAUBENHEIMER Jean Louis US
SAFFIN Andrew Peter WSU
SAMUEL Raphael Anthony UKZN
SEMENYA Elizabeth Mmamorabane WITS
SHAIKH Mohmed Iqbal WITS
TAYLOR Jenna Leigh UKZN
THERON Annette UKZN
WAGNER Janine Louise WITS
WAGNER Warren James UKZN

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

KGABALE Olehile Quinn
KHOZA Nokubonga Fredericka UKZN

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

CARIM Sameer WITS
CREDE Andreas US
LAHRI Sa'ad US
PIEK Hanneli
POTGIETER Deidré Ann WITS
SHUMBA, Edias
VALLABH Kamil Ishwarlal UCT

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

NEL Hestelle WITS

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

ABUSADIRA Fuad Muftah UKZN
GORA Shaheed WITS
MAFANYA Busisiwe WITS
NAIDOO Ansuya Kasavelu UKZN

Part I of the Fellowship of the College of Nuclear Physicians of South Africa – FCNP(SA) Part I

JOGI Hema Himatlal

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

APPIAH Francis
ASSAN Edwin Buabeng UL
AUGUSTINE Lynette Michelle UKZN
BRITZ Anna Maria UFS
BUGA Chandia Edward WITS
DHAVAR Navashree UKZN
GOVENDER Kamendran UKZN
HASSIM Taheera WITS
JACK Noxolo WITS
KALENGA Mwewa Martinho
KUNENE Sifiso Justice UKZN
MAJEKE Busiwe Deaconess UCT
MASHILOANE Sinah Magalane UL
MCCAUSLAND Katrin UCT
MONGWE Popikana Alta UP
MOODLEY Avril WITS
MOSEHLE Setheme Daniel WITS
NAIDOO Dheshni WITS
NGENE Nnabuike Chibuoke UKZN
PHOFA Seema Lawrence WITS
SEFOLO-SHUPING Masego Veronica UL
STEEL Stefanie UCT

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

DINDAR Ismail Ahmed WITS
DOLLAND Riana Sarita WITS
DU TOIT Schalk Hugo
FLETCHER Taryn WITS
OBHOLZER Sven Andreas US
PARTAB Parvis UKZN
RAMAN Petronella Yureshinee WITS
REDDY Yavische UKZN
SHABALALA Jabulani Welcome UKZN
VAN DEN HEEVER Henning Johannes Viljoen
ZINI-MALEKA Nomathamsanqa Louisa UKZN

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

ABRAHAM Vinita UKZN
ADEWUYI Olusegun Adeniyi UL
ANNAMALAI Medeshni UKZN
BADAL Voshika UKZN
BATCHELOR Sarah Jane
BEDDY Chévaun UKZN
BISETTY Suveena UN
BRUCE Deborah Lee WITS
BUCKLEY Jonathan UCT
BUNDUKI Kenga Dominique UKZN
DANGOR Ziyaad WITS
FOURIE Barend WITS
GEORGIU HAJI NICHOLA Salome UP
GOVENDER Prashini UKZN
GOVERE Eugene UKZN
HLATSHWAYO Bongwiwe Princess Sibongile UL
KAJEE Zaheera US
KAMANGA Noela Holo Bertha WITS
KGWADI Dikeledi Maureen WITS
KHAN Ayesha Bibi WITS
LEDGER Michael Ryan
LELAKA Salome Mpho WITS
LUBISI Khensane Victoria WITS
MAHARAJ Subashni UCT
MBADI Carol Noxolo UKZN
MOODLEY Praven Morgan UKZN
MOONSAMY Nicolene UKZN
MORKEL Gerhardus US
MOSHESH Nthabeleng Marcia WITS
NAIDOO Romola Suriakumarie UKZN
NAIDOO Doshendran UKZN
NAIDOO Kuban Dhasaradha WITS
NANA Shetil UKZN
ODYSSEUS Dimitri
RAMDIN Tanusha Devi WITS
REDDY Yavini UKZN
SIBIYA Nandi Sihle WITS
SIHLANGU Kanyane Judy
SINGH Shire Karan WITS
THOMAS Angeline UCT
TIVA Tears Gabaza UL

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

MOHAMED Nooroudien UKZN
MQADI Buhle UKZN
VAUBELL Jonathan Iain UKZN

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

NTAGANDA Fabien UKZN

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

ABRAHAM Shinu	UKZN
BHOOLA Rajesh	
BLACK John Maule	UCT
BOBAT Bilal	WITS
CHINNAH Keith Jordan	UKZN
DE WET Hayley Beryl	WITS
DIANA Nina Elisabeth	WITS
GANI Raazik Suliman	WITS
GRAHAM Anita Kathryn	WITS
HENDRICKSE Muhammad Chevaan	UCT
LAMBIOTTE Marc Elmy Jacques	US
MAHARAJ Nirvarthi	WITS
MOOSA Muhammad Zaid	WITS
MOTALA Naseem Ebrahim	WITS
NAIDOO Leon	UKZN
NARAINSAMY Jayalakshmi	UKZN
NYIRENDA Mulinda	WITS
OLOYEDE Oyekola Oluyimika	UL
PECORARO Alfonso Jan Kemp	US
PILLAY Somasundram	
RAMJEE Rohan Amratlal	WITS
SCHÄR Bronwyn Elise	WITS
SCOP Myron	WITS
SEWGOOLAM Narisha	UKZN
SKELTON Joanna Jane	UCT
TECKIE Gloria	WITS
VARKEL Leon	UCT
WINCHOW Lai-Ling	WITS

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

GILFILLAN Katherine Verne	UCT
JONNALAGADDA Chanakya	UCT
LAKSHMANAN Priya Darshni Hama	WSU
LEHLOENYA Keneilwe Lindiwe	UCT
LOUW Kerry-Ann	UCT
MANIKKAM Liane Camilla	UKZN
VAN DEN HEUVEL Leigh Luella	UL
WILLIAMS Ronell Marelize	UCT

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

DAIRE Arthur	UCT
DE GRAAF Karien	UL
DU PLESSIS Vicci Clark	UKZN
HO-YEE Ruschka Farrah	UCT
JOSEPH Febin	UL
KAMAAR Nadia	UCT
KOBO Kolisa Peliwe	WITS
MACINGWANE Nwabisa Bisiswa Hilary	UCT
MADIBA Thembisa	UCT
MAYDELL Arthur Thomas	US
MBATHA Wonder-Boy Eumane	UKZN
SCHOLTZ Paul Victor John	UCT
VAN STRAATEN Werner	UKZN
VAN WYK Matthys Johannes	WITS

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

ATIYA Yahya	WITS
BENNEH Albert Yeboah	WITS
CAPON Timothy Paul	
CHETTY Natasha	UKZN
CHOWDHURY A.H.M. Sharfuddin Mahmud	UCT
CONRADIE Wilhelmina	UCT
DALWAI Ebrahim Khan	
DANNATT Russell de Martini	US

DASSAYE Yomesh	UKZN
DIFELA Kagelelo	UCT
DOMAN Nicolaas Jacobus	WITS
DUBE Bhekifa	WSU
EMMANUEL Andrew Richard Henry	
ESHRAHGI Hooman	WITS
FALAIYE Michael Oluwatobiloba	UCT
FRANK Ruvyn	UKZN
FRIEDMAN Robin Barry	WITS
GOVENDER Nishantha	UKZN
GOVENDER Russell Dennis	UKZN
GREYVENSTEYN Gerhardus Andries	
HARRISON Kenneth Reuben	UCT
HELD Michael	UCT
HOUSEN Ebrahim	WITS
JABAR Ardil	UKZN
KALENGA Nkomba Christophe	UKZN
KAUTA Ntambue	WSU
MAMO Dereje Gebrehiwot	WITS
MATSEBULA Lindewe Fortunate	
MERVEN Marc	UKZN
MILLER Eloise Juliet	
MSITHINI Thobile Nozizwe	UKZN
NAIDOO Deon	UKZN
NDJOZE Ike Kairanderua	
NEL Corné Pieter Gustav	UFS
NORTJÉ Johan Gerhardus	
NUNES Daniel Dominques	WITS
ONAH Everestus Collins	
PANDEY Sarita	UKZN
PARBHOO Menesh Naresh Bacher	UP
PILLAY Jehron	UKZN
RAMDIAL Shaal	
RATTAN Bishum	UKZN
RAYAMAJHI Shreya	US
REDDY Kriban	UKZN
RUDOLPH Mattheus Johannes	WITS
SERFONTEIN Charles Jacobus	
SHANGASE Thobekile Nomcemo	UKZN
SINGH Shalin	
SOFIADELLIS Foti	
STEPHENSON Katherine Anna	UCT
THOBEJANE Mabatane Eddie	WITS
TOBIKO David Oidamae	WITS
TSAI Ming-Chih	WITS
URRY Ronald James	UKZN
VAN DEN BOSCH Chloe Mary	WITS
VAN DEN HEEVER Anories Petrus	UCT

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

DOUGLAS Arnold	US
GOVENDER Gonasagren	UKZN
HARRISON Kenneth Reuben	UCT
MJOLI Ntethelelo Spiritus Amadeus	UKZN
THOBEJANE Mabatane Eddie	WITS

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

SEHUME Mosidi Gillian	WITS
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Intermediate Examination of the Fellowship of the College of Orthopaedic Surgeons of South Africa – FC Orth(SA) Intermediate

DACHS Rubert Paul	
FLEMING Mark Alexander	UCT
HARIPARSAD Rikesh Dhuneshwar	UKZN
KARIEL Firoz	UKZN

KHETSI Seipati Puseletso Beverley	UKZN
KISTNASAMI Prenolin	UKZN
MARITZ Mark Frans	UKZN
MAYET Ziyaad	WITS
MAZIBUKO Allen Dumsani	WITS
MOODLEY Leon Paul	UKZN
MOOLMAN Johan Adriaan	WITS
PATERSON Richard Wingate	WITS
PIKOR Timothy Daniel	WITS
RAMUSHU Leah Dimakatjo	WITS
REDDY Luren	UKZN
RIEMER Bryan Lawrence	UCT
SATHEKGA Mokgopo Cynthia	WITS
STANDER Harrich Johan	UCT

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

ADEWUNMI Abdus-Sami Adegoke	
AKHOURY Mukesh Kumar	UL
AKHUNDOV Kamil	UKZN
ARNOLD Marion	US
BANDERKER Mohammed Asif	UCT
BASSON Gerhard	UP
BHULA Chetan	UKZN
BLIGNAUT Stephanus Johannes	UKZN
BOPALAMO Kennedy Molefi	WITS
BUGWANDIN Santosh	UKZN
COETZEE Emile Du Toit	UCT
CROSBY Neil Wilfred	UKZN
DARKO Nii Amu	UKZN
DONGO James Lehlohonolo	UL
ENICKER Basil Claude	UKZN
GOGA Riaz	UKZN
GOMES VARELA Carlos	UCT
GOVENDER Lubendran	UP
GOVENDER Saveshree	UKZN
JACOBS Christopher Richard	UKZN
JENNINGS Vicky Adele	WITS
JORDAAN Louis Jacobus	UP
KAIRUKI Muganyizi Clemence	WITS
KALPEE Amit Roxy	UKZN
KAMEDIEN Mogammad Sauliegh	UCT
KHUZWAYO Zamokuhle Brian	UKZN
KUHN Warren Paul	UKZN
LAING Grant	UKZN
LAMPRECHT Jan-Hendrik Andriaan	UFS
LUTCHMINARAIN Nithin Nundkissoor	UKZN
MAHARAJ Reshma	UP
MAHARAJH Suhani	UKZN
MAKATA Philip Kalipa	WSU
MARINGA Rhulani Knowledge	WITS
MATHIR Ahmed	UKZN
MBATHA Sikhumbuzo Zuke	UKZN
MELARIRI Herbert Ikechukwu	UCT
MEWA KINOO Suman	UKZN
MONZON-TORRES Banbaro Ignacia	WITS
MOOLLA Zaheer	UKZN
MOORE Rachel Louise	WITS
MURUGAN Nivashini	UCT
NAIDOO Shanisa	UKZN
NAIR Vimal Manmohan	UKZN
NCAPAI Phumzile	UN
PEDRO Maria Laurentina	UKZN
QUAYSON Francis William	UCT
SINGH Urishka	UKZN
SINGH Simmi	UKZN
SKINNER David Lee	UKZN
STRUWIG Daniel	WITS
TAYLOR Liezel Phyllis	US
THIEBAUT Wilna	UKZN
THOMSON David Alexander	UCT

VAN DER MERWE Renier	US	OBERHOLSTER Melissa		SUBRAMONY Cassandra	WITS
VAN RENSBURG Carla		OBIENU Emeka Churchill		VAN DER WALT Jessica Gwendoline	UCT
WICHT Jonathan Henri	US	ODUNTAN Opeoluwa Olumuyiwa	UP	WICOMB Varnia Chantal Saretha	US
Higher Diploma in Internal Medicine of the College of Physicians of South Africa – H Dip Int Med(SA)		PASSMOOR Duncan William	WITS	Diploma in Forensic Medicine of the College of Forensic Pathologists of South Africa – Clin – Dip For Med(SA) Clin	
PRETORIUS Lielzel	US	PELSER Anél	UKZN	BADUL Lalitha	
Higher Diploma in Orthopaedics of the College of Orthopaedic Surgeons of South Africa – H Dip Orth(SA)		PIENAAR Rudolf Philip	UP	LUKHOZI Siphon Michael	WITS
HATFIELD Paul Adrian	UKZN	PIENAAR Gert Johannes	WITS	MARAIS Johanna Maria	
MABUSHA Sepelong Johannes	UKZN	PLAATJES Natasha	UKZN	Diploma in Forensic Medicine of the College of Forensic Pathologists of South Africa – Path – Dip For Med(SA) Path	
ROCHER Antoine Gideon Louw	UKZN	RAMKILLAWAN Arisha	UKZN	MAHULUHULU Thandi	
SIBIYA Duduzile Gloria	WITS	RAMNARAIN Mitha	UKZN	MAISTRY Sairita	UCT
Higher Diploma in Surgery of the College of Surgeons of South Africa – H Dip Surg(SA)		RAMSAMY Trisha	UKZN	NYAWOSE Lindani Wilson	
MOTALE Dibaba Peter	UCT	REID Leah Dunn	UKZN	SHINGANGE Sydney Mdelwa	UL
Diploma in Allergology of the College of Family Physicians of South Africa – Dip Allerg(SA)		RENCKEN Andrea	UKZN	STAWICKI Marek Jan	
COETZER Theresa		ROUX Neill Sidney	UP	VERSTER Janette	US
DU PLESSIS Nicolette Marie	UP	RYAN Lisa	UKZN	Diploma in HIV Management of the College of Family Physicians of South Africa – Dip HIV Man(SA)	
Diploma in Anaesthetics of the College of Anaesthetists of South Africa – DA(SA)		SHELDON Jonathan	WITS	ADEWOLE Olusoji Olalekan	
AKERELE Tolatlewa Marian	WITS	SINGH Varsha	UKZN	AIGBE Ehisuan Aziengbe	
AMWAAMA Martha Jakula	US	SMIT Cecile	UP	AKWEYO Nancy	UFS
ATIYA Ashiqah	WITS	SMIT Anneme	UP	APELEHIN Adeolu Olarinde	UKZN
BELLEW Boyne	UKZN	SONI Shanya	UKZN	ASSARAM Shirelle	
BEN-ZEEV Shachar	WITS	STARKOWITZ Jed Paul	WITS	BANA Tasnim Mohammed	
BRITZ Mia	WSU	STUBBS Melissa Kim	WITS	BHANA Suresh Chotoo	
CARROLL Bronwyn Nicola	UKZN	THERON Thomas	UKZN	BURTON Rosemary Carol	UCT
CAVEDON Giancarlo Enrico		THORNE Dale Wesley	UKZN	CASSIMJEE Zaheera	
CHETTY Jenine Candice		TROSKIE Adri		CHINGONZOH Tatenda Lea Angela	
CHETTY Aneshree	UKZN	VAN DER MERWE Francia	UKZN	CUNNINGHAM Jayne Elizabeth	WITS
CHOONOO Janine Olivia		VAN DER MERWE Dawid Johannes	WITS	DLAMINI Xolile Prudence	
CHOSHANE Thabishi William		VAN DER VYVER Susanna Maria		DOMBO Muthelwana Yvonne	UL
CHUNG Wai Yee Maggie	UKZN	VAN DER WALT Izette	UFS	DUBE Fikile Cynthia	WITS
COETZEE Paulus Philippus	UP	VAN EEDEN Christine Corné	UKZN	DUNGA Babalwa Ndyebokazi	UCT
CROCKER Fay Megan	UKZN	VAN HEERDEN Mariska Elizabeth	UKZN	DUVEL Heidi Carmen	UCT
DASS Deshandra	UKZN	VAN JAARSVELD Leanda	UL	EVERTON Taryn Cindy	
DE BEURS Jaco	UKZN	VAWDA Nafeesa		GANESH Shayhana Ganesh	
DE JAGER Christelle	UKZN	VILJOEN Ebeth	UFS	GANGULOO Amanda Leigh	UKZN
DE KOCK Cornelia Petronella		WATSON Tanja	UKZN	GIBANGO Nsungu Ntemo	UL
DE KOKER Annemarie		WEILBACH Carina	WITS	GILBERT Louise Joy	WITS
DIAS DOS SANTOS Monica Sheila		ZINN Christa	UP	GOEIAMAN Bridgette Joan	
DU PREEZ Irene Ada	WITS	Diploma in Child Health of the College of Paediatricians of South Africa – DCH(SA)		HANSRAJ Shevani	UKZN
DUNPATH Ashveer	UKZN	BARRY Gillian Carol	WITS	HANSRAJH Verushka	
EDE Chikwendu Jeffrey	UFS	BOSMAN Mareelize	UKZN	HIRAWAN Natasha	
GAYAPARSAD Menoka	UKZN	BROOKER Janine Anne	UKZN	HUNIDZARIRA Lloyd	
GIBBS Matthew Winton		BROWNE Natalie Ann	UCT	IFEBUZOR Adaku Grace	UL
HANDTRACK Claudia	WSU	CHAUKE Tintswalo Mercy	UL	IKAFIA Attai Gregory	
HAUMAN Daniël Francois Taillifer	UFS	CHETTY Strinivasen Kamalan	UKZN	IMARALU Frederick	UL
HAWMAN Lynzie	US	FERREIRA-VAN DER WATT Talita Aletta		ISLAM Ferdousi Ashrafi	UKZN
HAYES Morgan Philip	UKZN	GANI Soomaiya	WITS	ISMAIL Majedah	UCT
HENDRICKS Charlene Cheryl		HASSIM Zeenat	UKZN	JUBASE Khokela	
KAMBARAMI Timothy Chamunorwa	WSU	KOEKEMOER Marsha	UFS	KALK Emma	
KOCK Alexander	UP	KRZESINSKI Emma Iva	US	KASONGO Henriette Mbu	
KRÜGER Herman	UFS	LEITCH Ailsa Marjorie	UKZN	KENDON Mary-Ann	UKZN
LAMBRECHTS Lelanie	UKZN	MAHARAJ Sharika	UKZN	KENNY Vincent Sakhi	
MALATSI Mmatubudi	WITS	MAKWELA Marothi Lehumo	UL	KERBELKER Tamara Charmian	UCT
MAZWAI Odwa Monde	WITS	MALAN Eloise	UCT	KGANAKGA Matome	WITS
MEYERSFELD Nicholas David	WITS	MANKHAMBO Limangeni Alex	UKZN	KGOPA Manape Mahlatse	
MORGAN Gwen		MBATHA Sibongile		KHAHLA Noxolo	
MUFENDA Josef Kamunoko	US	MOHLAHLANA Machaba Rufus	UL	KHOSA Madala Gilbert	
NAIDOO Devarani		OYEMWIMINA Osarenren Andrew	UKZN	KUHLASE Mfundo Vikelizizwe	
NGOBENI Tsakani Ntombizanele	WITS	PAMACHECHE Togara Manomano		KUSEL Belinda Senta	
NOCK Maria Elisabet	UKZN	PEENS David Herculaas	UFS	LAZARUS Erica Maxine	WITS
NOLTE Dean Christopher		PETERS Waseema	UCT	LINDA Christopher	
		PHIRI, Ajib Ismail		LYESHCHUK Yana Vdimovna	
		PIETERSE Deirdre Ilse	US	MABALE Primrose	WITS
		RADEBE Lindokuhle Thobile	UKZN	MABUDE Sisanda Zimkhita	
		RAMSDEN Deborah Louise			
		REDDY Deveshni	UCT		
		SEOPA Matshelane Rose	UL		
		SLABBERT Maria Magdalena	UFS		
		SMIT Marése			
		STANDER Ruaan Johann	UCT		
		SUBRAMONY Tamarra	UKZN		

CMSA Examinations/KGSA-Eksamens

August/September/October 2008

Augustus/September/Oktober 2008

List of Examiners/Lys van Eksaminatore

FCA(SA) Part I/GKN(SA) Deel I
– Overall Convenor: Dr IA Joubert

Pharmacology/Farmakologie

Prof A Milner (Convenor)
Dr G Wilson
Dr S Etoe
Dr A Rowse

Physics & the Principles of Clinical Measurement / Fisika en die Beginsels van Kliniese Meting

Dr EH Welch (Convenor)
Prof MFM James
Dr RE Hodgson
Dr JD van der Vyfer

Physiology & Chemical Pathology/Fisiologie & Chemiese Patologie

Dr HM Radford (Convenor)
Dr B Biccard
Dr J de Bruin
Dr E Campbell

FCA(SA) Part II/GKN(SA) Deel II

Dr PF Gopalan (Convenor) **Observer:**
Prof BJS Diedericks Dr NA Kalafatis
Dr Z Farina
Prof J Matsipa
Dr P le Roux
Prof SATS Bhagwanjee (CC)
Prof JLA Rantloane
Prof DJ Pudifin (Physician)
Dr A Reed

FC Cardio(SA) Final/GK Kardio(SA) Finaal

Mr A Reddy (Convenor) **Observer:**
Prof GJ Rossouw Mr M Munasur
Prof JG Brink

FCD(SA) Part I/GKT(SA) Deel I (same as FCMFOS(SA) Primary)

NO CANDIDATES ENTERED

FCD(SA) Orthod Part II/GKT(SA) Ortod Deel II

Prof E Stein (Convenor)
Dr G Thomadakis

FC Derm(SA) Part I/GK Derm(SA) Deel I

– Overall Convenor: Dr A Mosam

Anatomy & Histochemistry/Anatomie en Histochemie

Dr A Mosam (Convenor) **Observer:**
Mrs S Bux (Histologist) Dr A Mankahla (UKZN)

Physiology & Biochemistry/Fisiologie en Biochemie

Dr N Grillo (Convenor) **Observer:**
Prof A Chaturgoon Prof C Musabayane (UKZN)

Principles of Pathology/Beginsels van Patologie

Dr D Ngwanya (Convenor)
Dr M Forder

FC Derm(SA) Part II/GK Derm(SA) Deel II

Prof JA Aboobaker (Convenor)
Dr CN Dlova
Dr MH Motswaledi
Prof W Sinclair
Prof G Todd (External)
Dr NP Magula (Physicians)

FCEM(SA) Part I/GKNM(SA) Deel I

NO ORAL/CLINICAL/PRACTICAL

Dr WGJ Kloeck (Convenor)
Dr A Engelbrecht
Dr C van Loggerenberg
Prof LA Wallis

FCEM(SA) Part II/GKNM(SA) Deel II

Dr WGJ Kloeck (Convenor)
Dr A Engelbrecht
Prof LA Wallis
Dr GE Dalbock
Dr GE Dimopoulos

FC For Path(SA) Part I/GK Gereg Pat(SA) Deel I

Dr SM Aiyer (Convenor) **Observer:**
Dr T Naidoo Dr B Kryzstofiak
Dr GM Kirk
Dr R Blumenthal
Dr JJ Dempers
Dr KJ Fourie
Dr BD Bhana

FC For Path(SA) Part II/GK Gereg Pat(SA) Deel II

Dr SM Aiyer (Convenor) **Observer:**
Prof LJ Martin Dr B Kryzstofiak
Prof G Saayman
Prof SR Naidoo
Prof J Vellema
Dr IG Brouwer

FCMFOS(SA) Primary/GKKG(SA) Primêr (same as FCD(SA) Part I) Overall Convenor: Prof M Altini

NO ORAL/CLINICAL/PRACTICAL

Anatomy, Histology, Embryology & Oral Biology/Anatomie, Histologie, Embriologie en Mondbiologie

Prof MA Lownie (Convenor)
Prof B Kramer

Physiology/Fisiologie

Prof CP Jooste (Convenor)
Prof D Gray

Principles of Pathology including Microbiology/Beginsels van Patologie insluitend Mikrobiologie

Prof M Altini (Convenor)
Dr S Meer

FCMFOS(SA) Intermediate/GKKG(SA) Intermediêr

Overall Convenor: Prof M Altini

General Principles of Surgery/Algemene Beginsels van Chirurgie

Prof KD Boffard (Convenor)
Prof PJ Struthers

Oral Pathology/Mondelinge Patologie

Prof M Altini (Convenor)
Dr S Meer

FCMFOS(SA) Final/GKKG(SA) Finaal

Prof KW Butow (Convenor)
Prof MA Lownie
Dr V Rughubar
Dr PB Uys
Prof FJ Jacobs

FC Neurol(SA) Part I/GK Neurol(SA) Deel I NO ORAL/CLINICAL/PRACTICAL

Prof AI Bhigjee (Convenor)
Dr A Mochan
Dr VB Patel

FC Neurol(SA) Part II/GK Neurol(SA) Deel II

Prof AI Bhigjee (Convenor)
Prof G Modi
Prof JA Carr

FC Neurosurg(SA) Final/GK Neurochir(SA) Finaal

Dr MD du Trevou (Convenor)
Prof HB Hartzenberg
Prof MSM Mokgokong
Dr ND Fisher-Jeffes

FCNP(SA) Part I/GKKG(SA) Deel I:

Overall Convenor: Prof MM Sathekge

Radiation Physics, Instrumentation & Statistics/Stralingsfisika, Instrumentasie & Statistiek

Dr DM Rubin (Convenor)
Dr H Du Raan (Oral only)

Physiology & Applied Anatomy/Fisiologie & Toegepaste Anatomie

Prof AC Otto (Convenor) **Observer:**
Prof MDTH Vangu Dr S Perumal

FCNP(SA) Part II/GKKG(SA) Deel II

Prof MM Sathekge (Convenor) **Observer:**
 Prof AC Otto Dr P Mpikasho
 Prof MDTH Vangu
 Dr JS Moller
 Dr CD Libhaber

**FCOG(SA) Part I/GKOG(SA) Deel I
NO ORAL/CLINICAL/PRACTICAL**

Dr TH Smith (Convenor)
 Dr NE Pirani
 Dr LK Schoeman
 Dr A Muse
 Dr N Matabese
 Dr PJ Swart
 Dr R Gangaram
 Dr H van der Merwe
 Dr JM du Plessis

FCOG(SA) Part II/GKOG(SA) Deel II

Prof RE Mhlanga (Convenor) **Observer:**
 Dr M Moodley Prof GAB Buga
 Prof GB Theron
 Prof DW Steyn
 Prof L Denny
 Prof AP MacDonald
 Prof F Guidozi
 Prof BD Goolab

FC Opth(SA) Part I/GK Oft(SA) Deel I

Dr L Visser (Convenor)

Additional examiners:

Prof AA Stulting Dr K Naidu
 Prof P Roux Dr M Harrison
 Prof TR Carmichael Dr JS Naidu
 Prof GHM Vawda Dr VB Patel

Observers:

Dr AG Zaborowski
 Dr C Kruse

FC Opth(SA) Part II/GK Oft(SA) Deel II

Dr L Visser (Convenor)

Additional examiners:

Prof AA Stulting Dr K Naidu
 Prof P Roux Dr M Young
 Prof TR Carmichael Dr VB Patel
 Prof G McLaren

Observer:

Dr AG Zaborowski
 Dr C Kruse

FC Orth(SA) Intermediate/GK Ort(SA)**Intermediër**

Prof S Govender (Convenor)
 Prof GJ Vlok

Set questions/Stel vrae op:

Prof M Lukhele
 Prof JA Shipley
 Dr S Dix-Peek

FC Orth(SA) Final/GK Ort(SA) Finaal

Prof S Govender (Convenor)

Additional examiners:

Prof E Goga Mr ME Senoge
 Dr MN Rasool Prof J Walters
 Prof GJ Vlok Prof JA Shipley
 Prof RP Grabe

Prof M Lukhele

Observers:

Dr M Siddique
 Mr V Hlope
 Dr E Naddumba

FCORL(SA) Final/GKORL(SA) Finaal

Dr SK Naidoo (Convenor)

Observer:

Dr DJH Wagenfeld Dr CL Myataza
 Prof JJ Fagan

Prof JW Looek

Prof PC Modi

FC Paed(SA) Part I/GK Ped(SA) Deel I**NO ORAL/CLINICAL/PRACTICAL**

Dr LL Linley (Convenor)
 Dr S Kachauli
 Dr C Sutton
 Dr I Smuts
 Dr S Kling
 Dr G Reubenson

FC Paed(SA) Part II/GK Ped(SA) Deel II

Dr R Thejpal (Convenor) **Observer:**

Prof M Adhikari Dr S Thula

Dr MPB Mawela

Prof RJ Green

Dr R van Toorn

Dr VA Davies

Prof J Kriel

Prof C Motala

FC Path(SA) Anat Part I/GK Pat(SA) Anat Deel I**NO ORAL/CLINICAL/PRACTICAL**

Prof PK Ramdial (Convenor)
 Dr HC Wainwright
 Prof SJ Nayler

FC Path(SA) Anat Part II/GK Pat(SA) Anat Deel II

Prof PK Ramdial (Convenor)

Dr HC Wainwright

Prof SJ Nayler

FC Path(SA) Chem/GK Pat(SA) Chem**NO CANDIDATES ENTERED****FC Path(SA) Clin/GK Pat(SA) Klin**

Prof AG Duse (Convenor)

Prof PN Badenhorst

Prof WJH Vermaak

FC Path(SA) Haem Part I/GK Pat(SA) Hem**Deel I****NO ORAL/CLINICAL/PRACTICAL**

Dr VL Naicker (Convenor)

Prof W Stevens

Prof R Pool

FC Path(SA) Haem Part II/GK Pat(SA) Hem**Deel II**

Dr VL Naicker (Convenor) **Additional examiner:**

Prof W Stevens

Dr N Rapiti

Prof R Pool

FC Path(SA) Micro/GK Pat(SA) Mikro

Prof YM Coovadia (Convenor)

Prof AA Hoosen

Dr O Perovic

Dr P Moodley

FC Path(SA) Oral Path - Part I /GK Pat(SA)**Mondpatologie – Deel I****NO CANDIDATES ENTERED****FC Path(SA) Viro/GK Pat(SA) Viro**

Dr DR Hardie (Convenor)

Dr P Moodley

Dr W Preiser

Observer:

Dr R Parboosing

FCP(SA) Part I Basic Sciences/ GKI(SA) Deel I**Basiese Wetenskappe****NO ORAL/CLINICAL/PRACTICAL**

Dr FJ Pirie (Convenor)

Prof BL Rayner

Dr P Raubenheimer

Prof MJ Mpe

Prof FJ Raal

Prof PA Brink

Dr EM Makotoko

Dr S Ellemdin

Prof KA Newton

Prof AG Assounga

Prof MYS Moosa

FCP(SA) Part II/GKI(SA) Deel II

Prof RJ Hift (Convenor)

Prof BM Mayosi

Prof MO Mzileni

Prof EM Irusen

Prof MR Moosa

Rensburg

Prof Y Veriava

Prof KRL Huddle

Prof BW Jansen van Rensburg

Prof CD Potgieter

Prof B Cassim

Prof G Maartens

Observers:

Dr KT Naidoo

Dr F Paruk

Dr NP Magula

Dr BJ van

Prof P Oluboyo

Dr N Tonjeni

Dr F Mahomed

FCPHM(SA)/GKPG(SA)**Core examiners (set and mark questions, mark any long reports, do oral exams)**

Dr SE Knight (Convenor)

Prof S Whittaker

Dr GMC Louwagie

Dr M Kawonga

Additional examiners**(set & mark questions, mark short reports)**

Dr B Kistnasamy

Dr AJ Hawkrigde

Dr C Reddy

Prof BV Girdler-Brown

Observers:

Dr B Kistnasamy

Dr C Reddy

FCPHM(SA) OCC MED

Core examiners

Prof D Rees (Convenor)

Prof RJ Ehrlich

Prof MF Jeebhay

Dr S Naidoo

Dr S Carstens

Additional examiners:

Dr FH Fox

Prof R Naidoo

Dr PGD Rautenbach

Prof G Todd

FC Plast Surg(SA) Final/GK Plast Chir(SA)**Finaal**

Dr M Daya (Convenor)

Prof FR Graewe

Prof PF Coetzee

Prof A Madaree

Observer:

Dr D Hoffmann

FC Psych(SA) Part I/GK Psig(SA) Deel I

- Overall Convenor: Prof R Thom

NO ORAL/CLINICAL/PRACTICAL**Neuroanatomy & Neurophysiology/
Neuroanatomie en Neurofisiologie**

Prof RGM Thom (Convenor)

Dr PD Carey (Neurophysiology)

Prof ML Channa (Neurophysiology)

Prof GHM Vawda (Neuroanatomy)

Dr I Lewis (Neuroanatomy)

Dr H Uys (Neuroanatomy)

Prof W Daniels

**Psychology & related subjects/
Sielkunde en verwante vakke**

Prof AJ Fisher (Convenor)
Prof C Smith
Prof FJW Calitz
Dr NBM Vawda

**FC Psych(SA) Part II/GK Psig(SA) Deel II
– Overall Convenor: Prof DL Mkize**

Psychiatry/Psigiatrie Observers:
Prof S Saloojee (Convenor) Dr S Paruk
Prof DL Mkize Dr J Naidoo
- Neuropsychiatry
Dr T Madigoe Dr V Hitzeroth
Prof PJ Pretorius Dr Z Kader - Psychiatry
Prof JL Roos Dr S Mashaphu - Psychiatry
Prof ST Rataamane (Written only)
Dr S Paruk - Neuropsychiatry

Dr GP Jordaan
Prof O Alonso-Betancourt

Additional examiner:
Dr J Ranchhod

Prof WP Pienaar
Dr S Baumann

Neuropsychiatry/Neuropsigiatrie

Dr S Ramlall (Convenor)

Independent observer:

Dr J Burns Prof T Zabow
Prof PLA Bill
Dr MYS Moosa
Prof PP Oosthuizen
Dr S Ramlall
Dr JA Joska
Dr AHD Mochan
Prof PM Joubert

**FC Rad Diag(SA) Part I/GK Rad Diag(SA) Deel I
- Overall Convenor: Prof A Ndlovu****Radiological anatomy & radiological
techniques/Radiologiese anatomie en
radiologiese tegnieke**

Dr J Maharajh (Convenor)
Prof V Mngomezulu

**Radiation physics & imaging/Straalfisika &
beelding**

Dr AC Hurribunce (Convenor)
Dr WID Rae

FC Rad Diag(SA) Part II/GK Rad Diag(SA) Deel II

Prof A Ndlovu (Convenor) **Observers:**
Prof E Joseph Dr AF Stoker
Prof V Mngomezulu Dr M Govind
Dr J Maharajh
Dr AC Hurribunce

**FC Rad Onc(SA) Part I/GK Rad Onk(SA) Deel I -
Overall Convenor: NO CANDIDATES ENTERED****FC Rad Onc(SA) Part II/GK Rad Onk(SA) Deel II
- Overall Convenor: Prof JP Jordaan****Paper I - Medicine, Surgery & Gynaecology/
Geneeskunde, Chirurgie en Ginekologie**

Prof J Wilson (Convenor)
Prof FJAI Vernimmen

**Paper II-Radiotherapy & Cancer
Chemotherapy/Vraestel II Radioterapie en
Kankerchemoterapie**

Prof B Donde (Convenor)
Prof RP Abratt

**Paper III-Radiotherapy & Cancer
Chemotherapy/Vraestel III-Radioterapie en
kankerchemoterapie**

Prof JP Jordaan (Convenor)
Prof L Goedhals

**FCS(SA) Primary/GKC(SA) Primêr
Prof DB Bizos (Convenor)****FCS(SA) Primary/GKC(SA) Primêr including
Neuroanatomy/GKC(SA) Primêr insluitend
Neuroanatomie****NO ORAL/CLINICAL/PRACTICAL**

Dr ND Fisher-Jeffes (Convenor)
Prof HP Shapiro
Prof R Gopal

**FCS(SA) Intermediate – Principles of Surgery
in General/GKC(SA) Intermediêr - Beginsels
van Chirurgie in die Algemeen****Overall Convenor: Prof B Singh**

Prof DJJ Muckart (Convenor)

Additional examiners:
Prof JP Pretorius Mr TV Mulaudzi
Prof KD Boffard Mr S Maseme
Prof D Kahn Mr DL Clarke
Mr MS Moodley
Mr L Allopi

**FCS(SA) Intermediate – Principles of
Surgical Speciality Disciplines/GKC(SA)
Intermediêr - Beginsels van Chirurgiese
Spesialiteitsdissiplines****Overall Convenor: Prof B Singh**

Prof B Singh (Convenor)
Prof TE Madiba
Mr SS Pillay
Dr SJA Smit

**FCS(SA) Final/GKC(SA) Finaal
Prof JV Robbs (Convenor)**

Additional examiners:
Prof M Veller Prof D Kahn
Prof JHR Becker (Written only) Prof RS du Toit
Prof BL Warren Prof TE Madiba
Prof MCM Modiba Prof B Singh
Prof E Panieri Prof SR Thomson
Prof AA Haffejee **Observer:**
Prof R Barry Dr I Buccimaza

FC Urol(SA) Primary/GK Urol(SA) Primêr

Dr T Fourie (Convenor)
Dr SG Naidu
Prof GHM Vawda
Prof PK Ramdial

FC Urol(SA) Final/GK Urol(SA) Finaal

Dr T Fourie (Convenor) **Additional examiners:**
Prof AM Segone Dr P Chetty
Prof SW Wentzel **Observer:**
Dr H Patel Dr MC Conradie

MODERATOR

Prof CF Heyns

MCFP(SA)/LKH(SA)

Prof SS Naidoo (Convenor) **Observers:**
Prof MH Cassimjee Dr M Naidoo
Prof GA Ogunbanjo Prof J Chandia

Dr U Govind
Dr K Naidoo

Additional examiner:
Dr AJ Mbokazi

H Dip Int Med(SA)/H Dip Int Gen(SA)

Dr SK George (Convenor)
Dr FJ Muller
Dr AA Aboob

H Dip Orth(SA)/H Dip Ort(SA)

Prof S Govender (Convenor)

Additional examiners:

Prof E Goga Mr ME Senoge
Dr MN Rasool Prof J Walters
Prof GJ Vlok Prof JA Shipley
Prof RP Grabe Prof M Lukhele

Observers:
Dr M Siddique
Mr V Hlope
Dr E Naddumba

**H Dip Sexual Health(SA)/H Dip Seksuele
Gesondheid(SA)**

Dr S Delany (Convenor)

Prof H Rees
Dr F Venter
Dr V Black

Dr C von Mollendorf

H Dip Surg(SA)/H Dip Chir(SA)

Dr TE Madiba (Convenor)

Additional examiners:
Prof JHR Becker (Written only) Mr RR Chetty (UKZN)
Prof D Kahn
Dr SJA Smit

Dip Allerg(SA)/Dip Allerg(SA)

Dr AI Manjra (Convenor)
Prof PC Potter
Dr R Masekela
Dr M Levin

**DA(SA) NB: ALL SCRIPTS TO BE DELIVERED TO
CMSA, JOHANNESBURG**

Dr L Cronje (Convenor) **Observers:**
Dr KS Poole Dr R Hurley
Dr T Mabusela Dr JJF Handley
Dr R Mulder
Dr JM Dippenaar
Dr PJ Erskine
Dr T Louw
Dr WA Nates
Dr DH Barrett
Dr S Blakemore
Dr BM Gardner

DCH(SA)/DKG(SA) LETTER TO EXAMINERS

Dr NH McKerrow (Convenor)
Prof DK Stones
Dr TJ Avenant
Dr H Buys
Dr V Karaire-Mushabe
Dr M Mokhachane
Prof H Saloojee

**Dip Dent(SA)/Dip Tand(SA)
NO CANDIDATES ENTERED****Dip For Med(SA) Clin/Dip Gereg Gen(SA) Klin**

Dr SM Aiyer (Convenor) **Observer:**
Dr T Naidoo Dr B Krysztofiak
Dr RG Ngude
Dr GM Kirk
Dr JJ Dempers
Dr AL Mattheus
Prof BL Bhootra
Dr KK Hlaise

Dip For Med(SA) Clin/Path/Dip Gereg Gen(SA) Klin/Pat

Dr SM Aiyer (Convenor) **Observer:**
 Dr T Naidoo Dr B Krysztofiak
 Dr RG Ngude
 Dr GM Kirk
 Dr JJ Dempers
 Dr AI Mattheus
 Prof BL Bhootra
 Dr KK Hlaise

Dip For Med(SA) Path/Dip Gereg Gen(SA) Pat

Dr SM Aiyer (Convenor) **Observer:**
 Dr T Naidoo Dr B Krysztofiak
 Dr RG Ngude
 Dr GM Kirk
 Dr JJ Dempers
 Dr AI Mattheus
 Prof BL Bhootra
 Dr KK Hlaise

Dip HIV Man(SA)/Dip MIV Hant(SA)**NO ORAL/CLINICAL/PRACTICAL**

Prof G Maartens (Convenor)
 Dr F Venter
 Dr SM Andrews
 Dr D Wilson
 Dr K Cohen
 Dr M Mendelson
 Dr J Nuttall

DMH(SA)/DGG(SA)

Dr HV King (Convenor) **Observers:**
 Dr MJ Ndlovu Dr N Ngam
 Dr CM Maud Dr K Jhazbay
 Dr V Hitzeroth **Additional examiner:**
 Dr A Pillay (Written only) Dr J Naidoo
 Dr TE Katunzi
 Dr LA Panieri-Peter
 Dr F Potocnik

Dip Obst(SA)/Dip Obst(SA)

Dr HC Maise (Convenor)
 Dr MH Sebitloane
 Prof E Buchmann
 Dr T Matinde
 Dr PS Steyn
 Dr H Lombaard

Dip Opth(SA)/Dip Oft(SA)

Dr RB Spooner (Convenor)
 Dr V Thunstrom
 Dr P Bean

Dip PEC(SA)/Dip PNS(SA)

Dr GE Dimopolous (Convenor) **Observers:**
 Dr WGJ Kloeck Dr P Hargovan
 Dr AW Geard Dr M Wells
 Dr TC Hardcastle
 Dr W Lubinga

Cert Cardiology(SA) Paediatricians/Sert Kardiologie(SA) Pediaters**NO CANDIDATES ENTERED****Cert Cardiology(SA) Physicians/Sert Kardiologie(SA) Interniste**

Prof DP Naidoo (Convenor)
 Dr EM Makotoko
 Prof AS Mitha
 Dr S Khan
 Dr J Patel

Cert Child Psychiatry(SA)/Sert Kinderpsigiatrie(SA)**NO CANDIDATES ENTERED****Cert Clinical Haematology(SA)/Sert Kliniese Hematologie(SA)**

Prof VB Jogessar (Convenor) **Observer:**
 Dr J Mahlangu Dr VP Pooralingham
 Dr FC Bassa

Cert Critical Care(SA) Anaes/Sert Kritiese Sorg(SA) Anes

Dr PD Gopalan (Convenor) **Observer:**
 Dr S Pershad (Surg) Dr RE Hodgson
 Prof LR Mathivha (Paed)
 Prof M Mer (Phys)
 Prof SATS Bhagwanjee (Anaes)

Cert Critical Care(SA) Paed/Sert Kritiese Sorg(SA) Ped

Dr PD Gopalan (Convenor)
 Dr S Pershad (Surg)
 Prof LR Mathivha (Paed)
 Prof M Mer (Phys)
 Prof SATS Bhagwanjee (Anaes)

Cert Critical Care(SA) Surg/Sert Kritiese Sorg(SA) Chir

Dr PD Gopalan (Convenor)
 Dr S Pershad (Surg)
 Prof LR Mathivha (Paed)
 Prof M Mer (Phys)
 Prof SATS Bhagwanjee (Anaes)

Cert Endocrinology & Metabolism(SA) Phys/Sert Endokrinologie & Metabolisme(SA) Int

Prof AA Motala (Convenor)
 Prof NS Levitt
 Prof WF Mollentze

Cert Gastroenterology(SA) Physicians/Sert Gastroënterologie(SA) Interniste

Prof KA Newton (Convenor)
 Prof R Ally (Written only)
 Prof HdeK Grundling
 Dr G Watermeyer
 Prof AE Simgee (Oral only)

Cert Gastroenterology(SA) Surgeons/Sert Gastroënterologie(SA) Chirurge

Prof SR Thomson (Convenor) **Additional examiners:**
 Prof PC Bornman Prof GJ Oettle
 Prof MD Smith Dr F Makumbi
 Prof DB Bizos Dr SAH Moola
Observer:
 Prof TE Madiba

Cert Gynaecological Oncology(SA)/Sert Ginekolgiiese Onkologie

Dr MH Botha (Convenor)
 Dr R Soeters

Cert ID(SA)/Sert ID(SA)**NO CANDIDATES ENTERED****Cert Maternal and Fetal Medicine(SA)**

Dr L Govender (Convenor) **Observer:**
 Prof DR Hall Dr H Lombaard (Kalafong)

Cert Medical Oncology(SA) Paediatrics/Sert Mediese Onkologie(SA) Pediaters

Dr A Davidson (Convenor)
 Dr RD Wainwright
 Prof M Kruger
 Dr F Desai

Cert Medical Oncology(SA) Physicians/Sert Mediese Onkologie(SA) Interniste**NO CANDIDATES ENTERED****Cert Neonatology(SA)/Sert Neonaatologie(SA)**

Prof M Adkhikari (Convenor)
 Dr MBP Mawela
 Dr HR Mackanjee
 Prof VA Davies

Cert Nephrology(SA) Paediatricians/Cert Nefrologie(SA) Pediaters

Prof R Bhimma (Convenor)
 Prof UK Kalla
 Dr G van Bijlon

Cert Nephrology Physicians/Sert Nefrologie Interniste

Prof AG Assounga (Convenor)
 Prof S Naicker
 Prof BW Jansen van Rensburg
 Prof MR Davids

Cert Paediatric Neurology(SA)/Sert Pediatriese Neurologie(SA)

Dr L Mubaiwa (Convenor)
 Dr JM Wilmshurst
 Dr I Smuts
 Prof JL Rodda

Cert Paediatric Surgery(SA)/Sert Pediatriese Chirurgie(SA)

Prof AJW Millar (Convenor)
 Prof PG Beale
 Prof JHR Becker (Written only)
 Prof SW Moore

Cert Pulmonology(SA) Physicians/Sert Pulmonologie(SA) Interniste

Prof UG Laloo (Convenor)
 Prof GM Ainslie
 Dr JA O'Brien
 Prof GA Richards

Cert Rheumatology(SA)/Sert Rumatologie(SA)

Prof GM Mody (Convenor)
 Prof AA Kalla
 Prof M Tikly
 Dr N Patel

Cert Vascular Surgery(SA)/Sert Vaskulêre Chirurgie(SA)

Prof JV Robbs (Convenor)
 Prof MG Veller
 Prof DF du Toit
 Prof J van Marle

Annual General Meeting Minutes

Fifty Third Annual General Meeting of The Colleges of Medicine of South Africa held At 11:30 on Thursday 23 October 2008 in the Steve Biko Lecture Theatre, Nelson R Mandela School of Medicine, University of Kwa-Zulu Natal, 719 Umbilo Road, Durban

PRESENT:

Prof Z M van der Spuy	<i>(President) in the Chair</i>
Prof A Madaree	<i>(Vice President)</i>
Prof J V Robbs	<i>(Chairman EC)</i>
Prof T Zabow	<i>(Honorary Treasurer)</i>
Prof U M E Chikte	<i>(Honorary Registrar FGPC)</i>
Prof J Vellema	<i>(Acting Chairman and Hon Registrar ECC)</i>
Prof B Cassim	<i>(Honorary Registrar Education Committee)</i>

Prof J Aboobaker	Prof D Kahn
Dr S M Aiyer	Prof B M Kies
Dr S Andronikou	Dr W G J Kloeck
Prof J S Bagratee	Dr T K S Letlape
Prof J J Blitz	Prof M A Lownie
Prof J G Brink	Dr W Lubinga
Dr I G Brouwer	Prof E L Mazwai (IPP)
Dr B T Buthelezi	Prof DL Mkize
Dr S Chetty	Prof P S Mntla
Prof P F Coetzee	Dr S B A Mutambirwa
Dr G A Davids	Prof S Naidoo
Prof B Donde	Prof S J Nayler
Prof R W Eastman	Prof J M Pettifor
Prof A Ellmann	Prof A Reddi
Prof L Goedhals	Prof J P Reyneke
Prof D Govender	Prof H Saloojee
Prof K R L Huddle	Prof M M Sathekge
Dr A C Hurribunce	Prof P L Semple
Prof M F M James	Prof G Todd
Dr M H Kabaale	Dr I D Huskisson <i>(Secretary/Treasurer CMF)</i>
Dr A Lawrence	
Prof S R Thomson	

By Invitation:

Dr B Mashiloane

APOLOGIES:

The apologies were noted.

SECRETARY:

Mrs Bernise Bothma *(Chief Executive Officer)*

IN ATTENDANCE:

Mrs Ann Vorster	<i>(Academic Registrar)</i>
Mrs Jane Savage	<i>(Minute Secretary)</i>
Ms Patricia Bredenkamp	<i>(Administrative Secretary)</i>
Mrs Naomi Adams	<i>(Administrative Secretary)</i>

Welcome

The Chairman welcomed all the members who were attending the Annual General Meeting and particularly those who came for the first time.

1. REGISTRATION OF PROXIES

The Secretary duly registered 87 proxies.

2. MINUTES OF THE FIFTY SECOND ANNUAL GENERAL MEETING HELD ON 17 OCTOBER 2007

The minutes were ADOPTED and signed.

3. MATTERS OF URGENCY

None.

4. CMSA ELECTION RESULTS FOR THE TRIENNIUM 2008 TO 2011

4.1 Constituent College Councils and Officers

RATIFIED: The election outcome for constituent College Councils and officers.

4.2 Constituent College representation on Senate

RATIFIED:

The results of constituent College representatives on Senate.

5. MATTERS ARISING FROM THE MINUTES OF THE LAST ANNUAL GENERAL MEETING

None.

6. ANNUAL REPORT OF CEO ON BEHALF OF SENATE FOR THE PERIOD JUNE 2007 TO MAY 2008 ADOPTED:

The Annual Report of Senate presented by the CEO, which appears on page 30 in the Transactions for July – December 2008. ACCLAMATION

7. FINANCIAL REPORT OF THE HONORARY TREASURER

Prof Zabow reported as follows:

“I am happy to report that our financial statements reflect a very positive balance. These have been circulated electronically and published on the website and as we will review them very briefly, I hope all in attendance have had an opportunity to view them.

The finances of the CMSA are rather complicated and sometimes difficult to understand, but I will highlight a few factors to indicate our ‘state of health’.

The total assets of the CMSA amount to R49 000 000 of which R30 000 000 is property the details of which appears on Page 15 of the financial statements. Investments total R5 500 000 which hopefully we will not have to utilise at any stage and you can see a breakdown of that on Page 18. Cash at bank and on deposit of just over R7 000 000 which is partly invested short term (32 days or 90 days) and the balance is needed to run the institution. There is trust money invested of R5 000 000 and this is money that pays for our lectureships, etc.

Our income for the year was R14 000 000. There was an increase from last year of 14%. Our expenses were R11 000 000 and the happy news is that we now have a surplus of over R3 000 000. As emphasised at all the meetings and at previous AGM meetings, the reason for the surplus is the fact that the number of candidates who enter the examinations is extremely difficult to calculate and it is likely that we will report a similar situation next year because of the fluctuation in numbers. Overall for both examinations we had 189 more applicants than expected. We made a decision not to increase examination fees and the decision has been taken that the fees will not be increased for 2008/09. We will decide whether fees will be increased for the next financial year in February 2009.

The other reason for the surplus was the particularly good interest rates received on investments and much higher than anticipated resulting in more funds to invest at good interest rates in the short term. I am no economist, but I am sure you will agree that we will not get these higher interest rates in the next year.

We purchased two additional houses in advance of our plans to redevelop the Durban facilities for which we have been receiving rent.

This should give you an idea of what the financial statements are all about, keeping in mind that the CMSA's accounting practises are very carefully audited.

The most important aspect of the finances is to adhere to a budget

In conclusion I would customarily like to thank the staff in the Cape Town office and in particular, Margie Pollock and her team for their hard work and assistance whenever needed. In fact I extend appreciation to all three offices as one is unable to stick to the budget unless everyone cooperates."

AGREED:

That in future the entry "Bad Debts" be changed to read "Membership fees unpaid".

As one of the Hon Treasurer's predecessors. Dr Huskisson congratulated Prof Zabow for keeping a tight rein on the College's finances which was appreciated by all.

Report ADOPTED with Acclamation

8. REPORT OF THE PRESIDENT : PROF Z M VAN DER SPUY

The President reported as follows:

Introduction

This Annual General Meeting is taking place at the transition from the "old" Senate which has served for the previous triennium and the "new" Senate which takes office after this AGM. About 50% of the senators are newly elected but adequate institutional knowledge and continuity of previous business of the senate will be guaranteed by those who have been re-elected. I look forward to working with the new and re-elected presidents and the officers of the various constituent Colleges.

When I reviewed the proceedings and minutes of previous annual general meetings, it is interesting to note how the areas of concern and emphasis change and shift over the years. There have, however, been some central themes which continue today. The CMSA has made a concerted effort to effect meaningful transformation, there continues to be concern about a fair examination system with reproducible assessment processes, numerous attempts have been made to retain membership and engage members in CMSA activities and there is an ongoing imperative to engage, not only with our colleagues in developed countries, but also with those in Africa.

The Executive of the College has identified several challenges. In particular we hope to upgrade and standardise our examination processes, ultimately be accepted as the national examination body in South Africa and also to engage with our colleagues in Africa. We recognise the challenges which academic medicine is currently facing and the College has developed a fairly ambitious project in an attempt to address these difficulties.

Examinations

There has been a great deal of discussion, debate and varied enthusiasm about the possibility of a national equivalence examination. This concept is now being developed by the HPCSA and we are informed that within the next year institutions which may potentially organize and manage this examination will be invited to present their credentials to the HPCSA. The CMSA already provides the only national examinations for the various diplomas in multiple disciplines within our constituent Colleges and also the certificate examinations for the sub-specialities. These are all recognised by the HPCSA. At present specialist qualifications may be obtained either through a university degree (MMed) or a CMSA fellowship.

We are informed that the final decisions about a single exit examination will be made by the HPCSA and that the Department of Education will give input. It seems certain that a research element will be mandatory and this obviously will be supervised and overseen by the University departments.

We are presently reviewing our examination system and attempting to ensure we standardise the methods by which we select examiners, run examinations, assess candidates and validate our processes.

Last year an excellent seminar on portfolios and logbooks was arranged in Durban by Professor John Robbs and this year there will be discussion and debate about the research requirements. The

Senate has determined that a portfolio should be provided by every candidate writing their final specialist examination and this should give an outline of experience, academic interaction and be assessed prior to the final examination.

Links With The Department of Health, The Department of Education and the HPCSA

We are delighted that Dr Percy Mahlathi of the National Department of Health has attended several of our strategic planning meetings, has met with us in Pretoria and has ongoing input into our College Project. Undoubtedly this interaction is important and beneficial to us. We hope this will continue into the future.

Communication with the DG of the Department of Education, Mr Duncan Hindle, has met with cooperation. He has assigned Dr M Qhobela and Professor Ian Bunting as our liaison people within the DoE. Professor Bunting has already attended several of our meetings and given very valuable input and we certainly hope both he and Dr Qhobela will be attending the College Forum in December.

Professor T Mariba attends our Senate meetings representing the HPCSA. We are most appreciative of his informed and interested input and we do hope this connection will continue into the future.

CMSA membership

A decision has been taken that registrars may become affiliates of The Colleges of Medicine of South Africa. They will pay a very small membership fee and, will be sent College communications and the Transactions. They will be able to utilise the College website for their communications within their society.

We have also tried to identify other areas in which we can provide benefits to CMSA members and this is an ongoing project.

African partnerships

Professor Usuf Chitke, registrar of the Finance and General Purposes Committee, was tasked with developing a list of all African contacts within our Colleges.

One recent link, which has been established, is with the College of Physicians and Surgeons of Ghana. Six members of our Colleges – the Presidents of the Colleges of Physicians, Paediatricians, Surgeons and Obstetricians and Gynaecologists, Professor Lizo Mazwai and myself were invited to attend a meeting of the Ghana College in November 2007. During this visit, we interacted with colleagues from our own discipline. We agreed that we need to develop links, that we will accept trainees from Ghana, and that we will share examiners.

The follow-up came in October 2008 when examiners from the four Colleges were invited to participate in the Ghana Fellowship examination. In addition the College of Obstetricians and Gynaecologists financed two members of their sister Faculty in the Ghana College to attend the 33rd National Congress of Obstetricians and Gynaecologists which was held in Somerset West in October 2008.

There are numerous other African links and we do hope these will expand and develop in the future. Everyone who has particular contacts is asked to inform the registrar of the F and GP Committee in Cape Town so that we can build up a list of African contacts and colleges.

Links with Colleagues abroad

Numerous invitations were received by the CMSA for the President to attend meetings abroad. I attended the 42nd Singapore – Malaysian Congress of Medicine in July/August 2008 in Kuala Lumpur and the International Meeting on Residency Training organized by the College of Physicians and Surgeons of Canada in Ottawa in September 2008. Later this year I will attend the IACAP meeting which will be hosted by the Academy of Medicine of Hong Kong which is celebrating their 15th anniversary.

I have enjoyed this contact enormously. I was very privileged to be awarded an honorary fellowship both by the College of Physicians and Surgeons of Ghana and by the Colleges of Medicine in Malaysia and Singapore.

The meeting in Canada was particularly valuable. This is one of the few conferences which concentrates on registrar training and experts in education contributed a great deal to this meeting. The congress was organized on the basis of a few plenary sessions and multiple workshops and Professor Mazwai and I both attended this meeting and took part in different workshops. Both of us enjoyed this interaction and have come back with new concepts and ideas which we hope will be utilised within the College.

Professor Del Kahn is presently representing the CMSA at the meeting of the American College of Surgeons in New Orleans.

Examinations and assessments

The Examinations and Credentials Committee is expending considerable energy on reviewing our assessment and examination process. Undoubtedly this is going to involve all the Colleges in some reassessment so that all our examination are validated and reproducible.

College project: “Strengthening Academic Medicine and Specialist training in South Africa”

This CMSA Project started with the Policy Forum in October last year. This was arranged because of the concern throughout South Africa about the cuts in funding for academic medicine and the deterioration in tertiary services. We recognise that academic medicine takes place at all levels of care and we stress that future meetings should address academic input at primary and secondary levels of care as well as tertiary care.

There was considerable consensus among the stakeholders who attended this meeting and the decision was taken that this momentum should not be lost and the College should move forward with this clearly defined project. As a consequence, two workgroups have been established – the one to review specialist needs in South

Africa and the other conditions of service and governance models for training institutions.

Fundraising has been fairly successful with us generating sufficient funding to pay for a salary for a part-time project coordinator, Dr Brigid Strachan, and for the Forum later this year as well as the expenses of a number of consultants who have provided input.

Durban office

The attempts by the CMSA to generate sufficient funding to build a new office in Durban opposite the Medical School is regarded as a funding priority. This funding process is ongoing and is being spearheaded by Dr Warren Clewlow who is Chairman of the College of Medicine Foundation.

Conclusion

I should like to take this opportunity to thank the many members of the CMSA who contribute to our activities and our wellbeing. The chairpersons of the three standing committees and the honorary registrars are obviously central to College activities. The Finance and General Purposes Committee was chaired by Professor Gert Vlok and the honorary registrar is presently Professor Usuf Chikte. This committee is responsible for the day to day running and finances of the CMSA. The Examinations and Credentials Committee is based in Johannesburg and was chaired by Professor John Lownie, until his recent death, and Professor Jeanine Vellema, the honorary registrar, has acted as chairperson since then. This committee deals with the many problems which arise during examinations and with assessment procedures. The Education Committee is based in Durban and chaired by Professor John Robbs with Professor Bilkish Cassim as honorary registrar. This committee deals with the many educational aspects of CMSA business.

The Transactions are currently edited by Professor Gboyega Ogunbanjo who is now vice-president. I think all of you will agree that the journals he produces are attractive and relevant and he needs to be congratulated on his editorial input.

Professor Tuviah Zabow has been the honorary treasurer of the CMSA since 2003. This position is central to the management of College business and I think few of us appreciate what an enormous load it places on the incumbent of this honorary position. Professor Zabow has performed this task diligently, enthusiastically and meticulously and we owe him a considerable debt of gratitude. In addition, in the past year the treasurer's role has also involved being part of the core committee for the College project and he is responsible for this budget. We really do appreciate his input.

I should like to thank all these officers for their support and input and I appreciate the considerable sacrifice and extra commitment which is demanded in an already very busy schedule.

I wish to also express our appreciation of the support we receive in the three College offices. Thanks are due to the administrative secretary of our Durban office, Anita Walker, our Academic Registrar Ann Vorster, and our CEO Bernise Bothma. Their support is central

to anyone in the presidential role. Theirs is a pivotal role in running the CMSA and the enormous input they give is perhaps sometimes under-appreciated. Without their support we would certainly not be very effective as an institution.

Finally I wish to thank the two vice-presidents, Professor Anil Madaree and Professor Gboyega Ogunbanjo for their input, for their innovation and for their ongoing support. I really enjoy working with them and I think we are very privileged to have their input. The immediate past president, Professor Lizo Mazwai continues to be an important contributor to College business and has been a very important mentor to me. As a team I trust that over the next year you will see us achieving ongoing developments and making more progress with regard to the College Project."

ACCLAMATION

9. REPORT OF THE ACTING CHAIRMAN OF THE EXAMINATIONS AND CREDENTIALS COMMITTEE : PROF J VELLEMA

Prof Vellema reported as follows"

"Apart from the usual "Housekeeping Duties" of the ECC with respect to examinations, this Committee has been putting a lot of effort into preparing for the eventuality of the CMSA becoming the HPCSA's "National Equivalence Examination" Body of choice.

As background to this, I refer to a discussion held with Prof Bongani Mayosi (who was representing the Postgraduate Education and Training Subcommittee of the Medical and Dental Professions Board of the HPCSA) during an Exco meeting in March this year. He pointed out that this HPCSA Subcommittee had been given the task of considering and finalising matters related to the education, training and registration of specialists and subspecialists in the medical disciplines of South Africa.

Prof Mayosi confirmed that four components had been identified, which future specialists would need to satisfy, in order to register with the HPCSA:

- 9.1 There must be proof of training time for the required period in a HPCSA numbered post (e.g. minimum of 4 years in an accredited institution);
- 9.2. The completion of a continuous assessment report ("Formative Assessments") by the training institutions, i.e. evidence of in-course assessment and continuous assessment;
- 9.3 There must be completion of a research component as set out by the academic institution;
- 9.4 There must be successful completion of the national professional examination/national equivalence examination ("Summative Assessments").

Prof Mayosi also pointed out that the HPCSA would be appointing an "agency" (such as the CMSA) to run the National Equivalence Examinations, but there was nothing stopping the HPCSA from putting out a tender asking other "agencies" to do this, and potentially assigning this tender to another "agency", provided it met the requirements.

Based on all of this, it became clear that the CMSA would have to get its house in order regarding examination policies, assessment processes, language and translation policies, not only to align with the expectations of the HPCSA, but also to better serve our candidates with fair, reliable and valid assessments and examination processes. A number of these issues fall within the mandate of the ECC, with other issues, such as “Training Portfolios” and the “Research Component” being dealt with by the Education Committee.

We have already had a “Logbook/Portfolio Symposium” at the Steve Biko Lecture Theatre, Nelson R Mandela School of Medicine on Friday 11 May 2007, organised by the Education Committee and we will be having a “Research Component Seminar” tomorrow (Friday 24 October 2008) at the Susser and Stein Lecture Theatre, Nelson R Mandela School of Medicine, UKZN, also organised by the Education Committee.

With the HPCSA requirements as well as the continued improvement of our own examination processes in mind, the ECC has actively been working towards fulfilling our mandate regarding policies and procedures relating to examinations and assessment processes:

Earlier this year, the ECC organised a one-day “Assessment Process Workshop”, towards fair, reliable and valid assessments, with a focus on the assessor role. The Workshop was held at the offices of the Colleges of Medicine of South Africa in Rondebosch on the 15th May 2008, lasted a full day and was attended by 116 people. At the end of the workshop report-back session Prof Ken Huddle summed up the day’s proceedings and recommended that:

- The workshop report should be circulated to all Colleges;
- Each College should be asked to develop an “assessment blueprint”;
- Each College should identify the most appropriate methods of assessment for each objective while bearing in mind the need for validity and repeatability and the need to “sample widely”;
- Each College be asked to produce a written policy for the selection and training of assessors;
- Each College be asked to produce a guideline for marking and a policy regarding model answers;
- That each examination should be followed by a debriefing session in each College.

The report including the outcomes of this workshop was recently posted on the CMSA website.

In order to achieve the goal of “fair, reliable and valid assessments” the ECC has already started planning further training workshops in this regard. At our last Senate meeting (a short while ago), we requested a follow-up Workshop in Assessment Processes in 2009, where Prof Det Prozesky (from the College of Public Health

Medicine) and Dr Elizabeth Owen (from the RCOG) will be invited to guide and train the constituent Colleges in the setting of good multiple choice questions and the drafting of “assessment blueprints”.

One of the other tasks that the ECC undertook was to evaluate our examination processes and establish an “Examination Policy”. With this in mind, we appointed a task team (including including Professor Arthur Rantloane, Prof Ken Huddle, Prof Haroon Saloojee and Mrs Ann Vorster) to draft a document which was tabled at Senate this morning. Numerous topics were covered, including moderation of the examinations, appeal mechanisms for students who fail, a process for the written examinations and feedback processes for candidates. When finalised, this document will be available to all and will highlight the CMSA’s transparency relating to its examinations.

The issues of translation of papers and the CMSA “Language Policy” remain very contentious and a meeting was held on 6 October this year (2008) between the CMSA’s Academic Registrar, Mrs Ann Vorster, and representatives from some of the “Afrikaans” Universities. This meeting was proposed in order to find mutually acceptable solutions to deal with translations of the CMSA’s examination papers. A report on the outcome and recommendations of this meeting was tabled at Senate this morning.

I would finally like to extend my very sincere appreciation to Mrs Ann Vorster who runs the very busy Examinations Office extremely efficiently, together with her staff. I also wish to thank all the ECC members who regularly attend our meetings late on Friday afternoons which, with Gauteng traffic and many members commuting from Pretoria, is no mean feat. Thank you very much for your input and assistance in keeping this Committee running this past year. It was a very difficult year in which we sadly lost our Chairman, Prof John Lownie, due to an illness. Thank you very much for all your support.”

REPORT ADOPTED WITH ACCLAMATION

10. REPORT OF THE CHAIRMAN OF THE EDUCATION COMMITTEE : PROF J V ROBBS

Prof Robbs reported as follows:

“As lunch time approaches, this will be a very brief report. I believe that, in general terms, the Education Committee is operating well. The outreach and educational programmes that were established are functioning smoothly. The eponymous lectures attached to the various societies are also working extremely well.

At this stage, at the end of the triennium, it may be fitting to look at what we have achieved as a Committee. The first thing that has been put to rest is the handbook with information for university graduates which they receive at their graduation. This is a very useful feature as it explains what the CMSA has to offer.

The formulation of syllabi has been proceeding very well and is virtually complete in all the constituent Colleges. I want to thank the members of the constituent Colleges who cooperated so well in finalising this matter. As this is an essential part of our examination process, the syllabi should be treated as living documents which underlines what needs to be taught and what ground is covered.

The next major commitment of the EC relates to issues concerning the Registrars. It has taken a long time, but the Conditions of Service/Contract for Registrars has now reached the HPCSA's Executive and we will have to start implementing these in the near future.

We had a very successful symposium on the logbook/portfolio concept which has been adopted and our challenge now is implementation of this as a tool for formative assessment of which in training should be an integral part and it may, at some stage, be necessary to have another symposium to look at ways of implementing the conclusions that we came to. Some Colleges were not using logbooks and a deadline has now been set for implementation of portfolios which could be modified somewhat to suit the individual Colleges, the most important aspect of the portfolio/logbook being formative assessment.

The other challenge that is looming now is implementation of the research component for the Masters degrees and the debate on whether the College will be involved, will be debated tomorrow and we will hopefully come up with some guidelines as to what is acceptable as a research project and how we can integrate this into our training programmes.

I think for the future a really major challenge is to get more trainee participation in the College, more Registrar input. We have not had one Registrar attend one meeting of the Education Committee this year despite reminders and phone calls.

As alluded to by the President, the Durban staff cannot continue to function out of three rooms – we need bigger premises to accommodate the increasing number of candidate and increased scope of our activities.

Finally I would like to say a big “thank you” to our Committee – it has really been a pleasure working with all of you. Some do more work than others and I thank you for your extra effort. Special thanks also to Anita Walker who has a deep understanding of educational matters as she has been working in education for many years. She is an important and integral part of our offices and is ably assisted by Antoinette Conning in an administrative capacity. Finally, on a personal note I would like to say that it has been a very great privilege to serve this College as Chairperson of this Committee.

REPORT ACCEPTED WITH ACCLAIM

11. REPORT OF THE EDITOR OF TRANSACTIONS: PROF G OGUNBANJO

The President stated that the Editor of Transactions, Prof Gboyega Ogunbanjo was abroad attending a three-week session as a “FAIMER fellow” in Philadelphia, USA. Transactions was tabled and she felt certain that all would agree on this being an attractive and worthwhile production. The Editor worked very hard on getting information and articles for publication in Transactions. She extended her appreciation to him for his ongoing enthusiasm.

ACCLAMATION

12. ANNUAL APPOINTMENT OF AUDITORS

AGREED:

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

13. CORRESPONDENCE

None

The meeting concluded at 13:12.

Annual Report Colleges

College of Plastic Surgeons

The AGM of the College of Plastic Surgeons was held on 21 October 2007 at Spier Estate, Stellenbosch.

The new format of the written paper was implemented in the 2007 examinations. This was with Paper I consisting of 4 long questions and Paper II with 12 short questions. It was felt that this worked well with a significant broadening on the spectrum being examined. There has also been an attempt to standardise the cases and questions in the clinical and oral components of the examination.

Dr Ken Salyer, a craniofacial and cleft surgeon from Dallas, USA was admitted as an Honorary Fellow of the College of Plastic Surgeons at the October 2008 graduation ceremony in Johannesburg.

A meeting was convened by the Health Professional Council of South Africa in January 2008 regarding the issue of cosmetic surgery being performed by non-specialists. The College was represented at the meeting. After discussion it was recommended that any elective cosmetic surgery or permanent fillers would be performed only by specialists.

Prof Anil Madaree
President

College of Psychiatrists

The FC Psych(SA) Part II, FC Psych(SA) Part I, and DMH(SA) examinations continue to attract a growing number of candidates. In the last round of examinations (March/May 2008), the pass rate was 65% in the Part II, 50% in the Part I, and 91% in the DMH. The College of Psychiatrists is highly appreciative of the contributions and efforts of the various departments of psychiatry and neurology in the training/teaching and organisation/hosting of the examinations.

A recent development in our College has been the introduction of a research dissertation requirement in the training of registrars. The research dissertation for the Part II has become a compulsory requirement for entry to the examinations. It is applicable to all registrars who commenced training after 31 December 2006 and who will, at the earliest, sit the Part II examinations in September 2009. Another new development is the formalisation of the psychotherapy logbook. The logbook for psychotherapy constitutes a record of experience and training in the field of psychotherapy and is a mandatory requirement for candidates sitting the Part II examination. In addition, the College of Psychiatrists has revised and compiled more detailed marking guidelines for examiners for the DMH(SA), FC Psych(SA) Part I and FC Psych(SA) Part II.

The Council of the College of Psychiatrists held 6 teleconferences over the past year. These meetings have been held on a 2-monthly basis and provide a valuable opportunity for Council members to discuss and debate issues of competency and training in a time-effective manner. Prof Yasmien Jeenah (Department of Psychiatry, University of Witwatersrand) was co-opted onto the Council in April 2008. The Council has been working hard at establishing subspecialties in key areas, including forensic psychiatry, old age psychiatry, neuropsychiatry and addiction psychiatry, and several proposals have been submitted to CMSA for consideration.

In respect of achievements within the College, Dr Pralene Maharaj received the Novartis Medal (September 2007) for the FC Psych(SA) Part II examinations and Dr MYH Moosa received the RWS Cheetham Award for the best cross-cultural paper in psychiatry. The RWS Cheetham award, which consists of a certificate and medal, was presented to him at the Philosophy in Psychiatry Congress at Sun City in August 2007. It is gratifying to know that four colleagues (Profs Christa Kruger, Dana Niehaus, Orlando Alonso-Betancourt and Dr Gerhard Jordaan) were awarded Fellowships by Peer Review for their professional standing and service to the discipline of Psychiatry. Moreover, Dr Tom Sutcliffe was awarded a Fellowship *ad eundem* for his outstanding contribution to the development and promotion of mental health services in the Western Cape.

As a College we are hopeful that the new Council in the next triennium will continue to improve standards and strive for world-class excellence as an examining body.

Prof Robin Emsley
President

College of Radiation Oncologists

The present syllabus, which has been reviewed for the past few years, will hopefully be replaced by a new, more appropriate syllabus in the next few months when consensus is reached by the various University faculties.

This new syllabus will include input from various other areas such as Australia, New Zealand and a few European syllabi.

The examination process and assessment of candidates will also change when the new syllabus has been approved by all the relevant parties. The new syllabus will include a research component as well as a personal portfolio.

The FC Rad Onc(SA) examinations held in October 2007 and May 2008 were well run and organised but it is worrying that so many of the primary candidates are failing at the first and sometimes second attempts.

Over the past 2-3 years some of the training departments have received government funding necessary for upgrading of radiation equipment, thereby enabling training of postgraduates in state of art radiation therapy techniques.

There are presently 6 academic institutions accredited for radiation oncology training and, depending on accreditation from the HPCSA, we might include other centres such as those from the Eastern Cape and North West province for part of the training program.

A decision to include heads of departments to attend the examinations as observers when they have a candidate for the final examinations, if they are not part of the examination panel, has also improved the fairness and impartiality of the examinations. This "observer status" also allows HOD's insight into the possible gaps in their candidates' knowledge.

Prof Louis Goedhals
President

College of Radiologists

The new executive team and Council set its agenda for the year focussing mainly on regularising the conduct of the examinations. A significant amount of stability and consistency has been achieved in both the FC Rad(SA) Part I and Part II. The written examinations now can boast fair variety both in scope and depth of knowledge that is tested. For both oral examinations, stability around the weighting that each section enjoys has been achieved. The use of sub-minima for any one or a combination of parts of the oral examination is yet to be confirmed. Reasonable regularity in applying the new evaluation framework has been achieved.

The executive committee has committed to formulate a strategy for the College. This event has been deferred to the new executive to be elected for the next triennium. The examinations committee has successfully formulated and submitted the new Rules and Regulations of this College. The arduous 3 years work culminated with the Examinations and Credentials Committee approving it in March 2008. In the pipeline for ratification are The Performance Portfolio and Internal Guidelines for Examiners. A common examiners roll is now also in operation. The education committee was seized with preparations for the Radiology Refresher Course which takes place on the 2nd to 3rd August 2008 in Cape Town.

One of the highlights of the year was engaging a process to evaluate application for equivalence that was submitted to this College by the Universities of Pretoria and Stellenbosch. After due deliberation by the Council, driven by both the examination and education committees, the University of Stellenbosch was granted equivalence for the Part I MMed Radiology (Diag). A few shortcomings in the Part I of the University of Pretoria's Part I MMed Radiology precluded the granting of equivalence. However, to ensure further progress, a meeting was held between the President and Professor Lockhat to assist

with the appropriate modification that needed to be made. Many significant lessons and insights were gleaned from the debates that ensued during the deliberations, which will bode well for applying a consistent approach to such applications in the future.

The education committee has planned a Paediatric Imaging workshop in conjunction with the Paediatric Imaging Society of South Africa (PISSA) and the Radiological Society of South Africa (RSSA). This is to be held in Johannesburg and Cape Town in September 2008 and features 3 international speakers and an advanced program. In addition, paediatric imaging training will be enhanced by a locally produced book which is almost complete and features contributions from all over South Africa. The book is sanctioned by the education committee of the College of radiologists and PISSA. As mentioned above, the annual refresher course (pre-exam course) for registrars in radiology is planned for early August in 2008 and has become an anticipated educational activity of the College of Radiologists. Furthermore, the education committee has played an active role in producing educational and research material and reviewing for the South African Journal of Radiology which hosts numerous committee members on its editorial board. Future goals for the education committee include creation of a recommended reading list and review of the curriculum to be more explicit and representative of current practice. Enforcing the use of the new logbook is also a goal in progress and is already active in at least 3 universities based on the new College of Radiologists template. Associations with the Radiological Society of North America are in progress through Introduction to Research for International Young Academics (IRIYA) and via the RSSA's successful application. Prof S Andronikou who chairs the education committee is also the official contact person for the visiting lecturers who will attend 3 of our universities to infuse and support teaching and training.

The JN and WLS Jacobson lecturer in Radiology was Dr AC Hurribunce. In the period 16th July to 24th July 2007 he presented his lecture titled "A Systemic Approach to Clinical Imaging Services." The lecture was hosted in six venues around the country. This was the first time that this eponymous lecture was hosted in Polokwane and Port Elizabeth in addition to the usual venues of Cape Town, Bloemfontein, Durban and Johannesburg. The lecture was open to the attendance of radiologists, radiographers and clinicians. It was quite pleasing to host a healthy turnout of Clinician at most of the centres. Given the rising cost of travel and accommodation, consideration will be given to making this lecture a biennial event.

The College also notes with appreciation, the acceptance by the editorial board of the CMSA's journal Transactions of the two papers on quality assurance authored by Dr AC Hurribunce, which was published in its last two issues.

This triennium ends with this College achieving a healthy internal routine and collaboration with the relevant administration and support sections of the CMSA. We wish to extend our specific appreciation to Mrs Ann Vorster who supported this College tirelessly, particularly through finalising the Rules and Regulations.

Prof Savvas Andronikou
Secretary

College of Surgeons

Several important changes in the functions of the College of Surgeons have taken place in recent years, especially with regard to the examination process.

Profs John Robbs and Sandi Thomson have been responsible for major curricula revision for the FCS(SA) Final and Intermediate examinations. These changes have been finalised and are available on the CMSA website. The curriculum for the FCS(SA) Primary examination has also been revised and Dr Damian Bizos, with representation from each of the Departments of Surgery, is establishing a bank of new questions which are more clinically relevant.

The submission of a logbook has now become mandatory for the FCS(SA) Final examination. However the assessment of the logbook remains a problem and the establishment of minimum requirements, especially with regard to the numbers of procedures, remains unresolved. The College would like to move towards more importance being placed on a formative assessment of registrars.

The College has agreed to include a research component as part of the assessment for the FCS(SA) Final. In the first instance, candidates will be required to provide evidence that the dissertation for the MMed degree has been submitted by the time they write the College examination. This will be implemented for the March 2009 examination.

The number of subspecialist examinations offered by the College has also increased. The College now offers Certificate examinations in Surgical Gastroenterology, Vascular Surgery, Paediatric Surgery and Trauma.

The relationship between the College of Surgeons and the Association of Surgeons of South Africa (ASSA) has also been under review. In view of the common representation on the Executive of both, it was decided to formally co-opt the Chairman of ASSA onto College Council. The President of the College is a member of the ASSA Exco.

The College of Surgeons has had preliminary discussions with members of the College of Physicians and Surgeons of Ghana. The areas of interest have included exchange of examiners and assistance with Subspecialist training.

A new Council is in the process of being elected. I would like to thank the outgoing Council for their service to the College during the past triennium.

Prof Del Kahn
President

Apology from the Publisher

The five Annual Reports published in this issue should have been published in the October 2008 issue of Transactions. They were submitted in time, but were accidentally omitted. We apologise to these Colleges for the mistake and for any inconvenience incurred.

CMSA – History Book

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.

It documents the development of having all the different Colleges under one roof.

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 Colleges of Medicine of South Africa.

At only R130 plus packing and postage of R40, 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.



A Model for the Governance of Academic Health Centres

Ralph Kirsch

Presented at the CMSA Forum, December 1, 2008

This paper describes a proposal for a new Governance model, which can reverse the decay in academic health centres and restore their excellence in service provision, teaching, training and research.

Background

Academic health centres have faced significant budget cuts over the last three decades. Bed closures and staff losses, coupled with increased service needs, have had a major negative impact on teaching and research¹. Indeed, there is a real danger that academic medicine in South Africa, although apparently still coping, will find itself unable to produce and sustain the health care professionals required to meet the needs of our country.²

Definitions

Academic medicine encompasses looking for better ways of promoting health, preventing disease, understanding health and disease processes, making a diagnosis, and improving patient care by basic and applied research and by using evidence based medicine and rational policies. It also includes conducting research into psychosocial and societal aspects of health and disease, looking for a better understanding of patient and community needs; studying bioethics and ensuring that the fruits of all of these studies are translated into policy and practice. Academic medicine demands that the efficacy of all new processes are carefully assessed and that all knowledge gained through the preceding processes is widely disseminated via teaching, refresher courses, publication and presenting work at congresses.

Academic Centres or Academic Complexes are facilities in which all categories of healthcare workers can acquire the knowledge, attitudes and skills necessary for professional practice. The institution must have the necessary concentration of staff required to facilitate the learning process and must provide students with access to various resources, including laboratories, source material, and the clinical settings in which they can achieve the necessary level of competence.³

Staff must be qualified to teach at tertiary level, to facilitate learning and to act as role models for both undergraduate and postgraduate students. Equipment, reagents, library material, pharmaceutical agents, etc. must be of the standard necessary to allow both staff and students to acquire first-hand knowledge of their use. It follows that the physical structures of the academic complex must include buildings housing the preclinical and clinical departments, a library, lecture theatres, seminar rooms, etc. and a series of clinical facilities in which students can be exposed to the processes involved in promotion of health, prevention of disease, and the diagnosis, treatment and rehabilitation of patients at primary, secondary and tertiary levels of care.

Since many of these activities take place outside the traditional teaching hospital it is clearly incorrect to use the terms

'academic complex', 'academic hospital' and 'teaching hospital' interchangeably.

Similarly, if they are to fulfil their functions as university teachers, facilitators and role models, the staff of academic complexes must be leaders in their field, must have the critical mass necessary to be self-sustaining and must have access to regular opportunities for continuous professional development. Like all university teachers, they must have a deep knowledge of their field coupled with that ability to critically analyse new information, which is only found in those who are themselves actively engaged in research. This research should increase the understanding of all aspects of health and disease, should audit current practice, including educational practice and health care systems, and should include the identification and the study of problems peculiar to each region, ultimately attempting to provide solutions to these problems.

In addition, staff of those departments involved in patient care, in its broadest sense, must maintain a level of competence worthy of emulation by their students. This will require access to patients or, in the case of pathologists, to material appropriate for practising their discipline. Academic physicians should also have mastered the processes required for the allocation of scarce resources. In the case of pharmaceutical agents this requires access to all drugs licensed for use in this country.

Academic complexes should not operate in isolation. The number and the composition of the health care personnel trained must be tailored to meet the needs of the nation.

Similarly, they should act as resource centres so that knowledge and skills are transmitted to all other parts of the health care system. Finally, they should design and test models for better health care and advise government in all aspects of health care. Thus academic complexes aim to train health professionals at under- and postgraduate level in health promotion, disease prevention, and curative and rehabilitative medicine at primary, secondary and tertiary levels; i.e. they must (i) increase knowledge and understanding of health and disease; (ii) improve patient care by means of research; (iii) study disease patterns and solve local problems by means of research; (iv) promote knowledge and skills in other sectors of the health care system;

- (v) design and test model systems for improved health care; and
- (vi) advise government on health care.³

The outcomes of such research should be used not only to define the physical structure of the academic complex but must determine its staffing, the type and number of patients for which it is responsible and the relative time spent on teaching, research and patient care.

Current Status

Currently academic health centres are run by the provincial departments of health. There is little uniformity between the various provinces' academic health centres. There are differences in the way these institutions are governed and managed and there is little co-ordination between them. Importantly, joint agreements between various provincial departments of health and the university health science faculties differ, creating inequalities and disparities. There is little consistency in the level of funding. Training and service outputs vary significantly. There is duplication of services in some areas and absence of services in others and no national agreement on the cost effective mapping of quaternary service provision for the country as a whole. Budget cuts over the last three decades have resulted in bed closures and unmet service needs. The increased pressure has led to staff losses. Unfilled posts have been frozen or abolished leading to further increases in pressure and further staff loss. The loss of skilled specialist and sub-specialist staff from the academic health centres is particularly concerning, as many have emigrated and are lost to the country and the sub-continent.

Poor plant and building maintenance, failure to introduce modern equipment and technologies, relatively poor scales of remuneration on any comparative basis and a general absence of affirmation of public sector tertiary services from the provincial health departments have all added to the general demoralization of the remaining dedicated members of members of staff.

The complexity of managing academic health centres as they are currently conformed has aggravated the situation. This complexity stems from inadequacies in managerial capability and capacity; the physical size of most of the academic complexes; the multiplicity of role players and stakeholders, often with conflicting demands and expectations of management, and the lack of uniform guidelines and policies for the provision of tertiary and quaternary health services, teaching, training and research.

The multiplicity of stakeholders has led to confusion, conflict and resentment. For example, while the universities' health science faculties are significant stakeholders in academic health centres, the CEOs of these institutions, provincial appointees whose only responsibility is towards the provision of service. This has related in the primary employer making decisions which are detrimental to the academic functions of the institution. For example, human resource planning is exclusively based on service requirements while academic needs excluded from work force planning on a full time equivalent (FTE) basis. This unilateral decision making on the creation, filling, freezing and abolishment of posts leads to critical positions not being filled and results in the universities being forced to buy in academic services, a process which is often impossible to anticipate and budget for. Equally important, there is no proper protection of academic and research responsibilities and these activities are often excluded from performance management assessments. All of this has impacted negatively on the universities meeting national needs and national mandates. Unilateral increases in remuneration

packages and financial privileges lead to discrepancies between salary packages offered by different employers for the same levels of staff and subsequent detrimental competition for the services of scarce expertise.

Further aggravating the situation is the fact that academic health centres' CEOs do not have fully delegated authorities and are not personally accountable to parliament for the effective and efficient management of these centres and their outcomes. This responsibility rests with the Chief Accounting Officer, i.e. the Head of the Provincial Department of Health.

The management of academic health centres, therefore, currently requires the extremely difficult integration of the vested interests of many different stakeholders, including Treasury and the National Departments of Health and Education for certain grants, the HPCSA for professional and regulatory standards, the Provincial Departments of Health for service outputs, provincial policies and the equitable share of the budget and the Universities and their associated Health Sciences Faculties for teaching, training and research and community interaction.

Aim

The proposed structure aims to restore excellence in service, teaching, and research and community interaction at the Academic Centres. In doing so it will strengthen undergraduate, specialist and sub-specialist medical training; secure the appropriate provision of tertiary and quaternary health care services; ensure equity in all aspects of tertiary health care throughout South Africa; provide adequate opportunity for research; establish the future needs of specialist professionals in South Africa; establish strategies that will facilitate training programmes to meet South Africa's needs; recruit and retain persons with appropriate skills within the public sector and ensure that South African academic health centres play a strategic leadership role in providing sub-specialist services and the development of health care skills nationally and internationally, particularly in the field of research and health care solutions as they apply to developing countries.

Urgency

A new solution is urgently needed. Decay of the academic health centres is eroding the capacity to provide tertiary and quaternary health services and impeding training and research all of which are central to the integrity of both public and private health sectors. As a result tertiary and quaternary service needs, as well as the national needs for teaching, training and research, are currently not being met and the gap between service need and the capacity to deliver is rapidly increasing. Many health science faculties are closing academic departments and services because they have fallen below the critical mass required to justify their continued existence. The exodus of highly trained professional staff from the academic health centres is escalating and is a major threat to health care generally. It is worth recalling that in many instances, academic health centres in South Africa are providing the only tertiary and quaternary services of their kind on the entire continent of Africa.

Key Elements to a Solution

Any solution to the crisis in academic health centres and in tertiary medicine, quaternary care and teaching, training and research must

meet certain conditions. It must be consistent with the Constitution, the Public Finance Management Act (PFMA), the National Health Act, the Public Service Act and all other legislation appropriate to the delivery of health care, teaching, training and research. It must be driven and guided by its own enabling legislation and regulatory framework; must be consistent with national health and provincial health policies (unless these policies are in conflict with the core business strategies and approved objectives of an academic health centre); be consistent with all the requirements of labour law and be fully accountable to all its stakeholders. It must be consistent with the requirements of higher education authorities, including the Department of Education, the university health science faculties and the CMSA. It must meet the requirements of the HPCSA; the service and training obligations set by the National Department of Health and the Provincial Departments of Health, including the need for outreach and to continue servicing expanded teaching, training and research platforms. It must comply with treasury regulations and legislation and provide sound business structures and principles, including the best practice principles of the King 2 Report. It must ensure equity between all the provinces in terms of access to services and to all universities and colleges in terms of teaching, training and research opportunities. Finally it must provide for meaningful public participation and consultation before it is approved and implemented.

Proposed Draft Model

The proposed model envisages that all existing academic health centres become national assets, falling under the control of the National Minister of Health and run and managed as Public Entities in accordance with their own enabling legislation and regulatory framework (the Academic Health Centres Act) and the PFMA. This immediately brings consistency across the board.

There will be a Central Academic Health Centres Board appointed by the Ministers of Health and Education, in consultation with the other stakeholders including the Ministries of Science and Technology and Finance. The Board will conform to the structure, requirements and authorities of a public entity. In accordance with the requirements of the proposed academic health centres act, appointments will reflect the skills and representation required for the Board to function with insight, independence and without conflict of interest. Each stakeholder may have one or more places on the both the central or academic health centre Board, subject to the determination of the Act and its regulations in this regard. The Ministers of Health and Education in consultation with the other stakeholders will appoint a Chairperson of the Board. The Board will appoint a CEO who will be an executive member of the Board. Together with the Chairperson of the Board, the CEO will provide full accountability to the Ministers, key stakeholders and to Parliament.

The Board will determine all matters relating to, teaching, training, research and service in the best interests of both the academic and the health needs of the country as a whole. The Board will have full executive authority and will report regularly to the Minister of Health and through its members, to its various stakeholders.

The operational costs of the Central Academic Health Centres Board will be jointly funded on a proportionate basis by the National Departments of Health and Education. Additional funding for the operation of the Board will be provided by National and Provincial Departments of Health (in the cases of provinces from the equitable share) on a proportional basis.

In respect of the National Tertiary Services Grant (NTSG) and the Health Professions and Training and Development Grant (HPTDG) it should be noted that the HPTDG is currently under revision as a future clinical education grant. The HPTDG will be revised to properly fund realistic clinical education costs. These funding streams will, in part, be used to cover the operational costs of the Board.

The intention of running the Central Academic Health Centres Board as an autonomous, public entity is to bring about greater management flexibility, to enhance efficiencies, to strengthen controls, to establish sustainable and affordable policies, goals and objectives and thereby to improve the prospects for maintaining and improving academic health services, teaching, training and research in South and southern Africa.

In addition, each existing academic health centre, or complex will be an autonomous organisation run by a board of directors and a CEO precisely in line with the structure, requirements and authorities of a public entity described above and in line with the proposed academic health centres act. The Board will be accountable and report regularly to the Central Academic Health Centres Board, as well as to the Ministers of Health and Education or the National Parliament if required. The Board will determine all matters relating to, teaching, training, research and service in the best interests of the academic health centre that they serve, as well as contributing to the tertiary and quaternary needs of the country as a whole where required.

The intention of running academic health centres as autonomous public entities is again to bring about greater management flexibility, to enhance efficiencies, to strengthen controls and thereby to improve the prospects for maintaining and improving academic health services, teaching, training and research in the centre or complex.

The National Departments of Health and Education, together with the university, the HPCSA, Provincial Department of Health, higher education authorities, and the CMSA, will determine the required teaching, training and research outcomes for each academic health centre/complex, in concert with service, research and training needs for the whole country. These outcomes will be secured through Service Level Agreements (SLA) with the Central Academic Health Centres Board.

Flowing from the above, the National Departments of Health and Education in consultation with the Ministers of Health, Education, and Finance, the Central Academic Health Centres Board and the provinces, will establish funding streams to individual academic health centres in respect of the National Tertiary Services Grant (NTSG), the Health Professions Training and Development Grant (HPTDG) and provincial equitable share. These revenue streams are likely to remain roughly equivalent to current levels of funding with the exception of the HPTDG, but will be augmented by a portion of the equitable share from provinces without academic health centres.

In line with the above, provincial departments of health will determine their tertiary and quaternary service and training needs and will secure these through SLAs with one or other of the Academic Health Centres Boards and will fund them accordingly from the equitable share.

Provinces without academic health centres or health science faculties will also enter SLAs with selected academic health centres. However, they will be required to come to an agreement with the National Minister of Health and National Treasury on what percentage of

their health budget is to be spent covering the costs of tertiary and quaternary care for their provinces and which the academic health centres will provide them.

Revenue streams will thus include the revised HPTDG, the NTSG, the provincial equitable shares, the full retention of own revenue and the acquisition of private funding through donations. Academic health centres will be required to provide at least the existing level of tertiary beds, but will be free to expand this service within affordability limits. Secondary level beds as identified, for example, in a province's comprehensive, five year service plan, must be provided by each academic health centre to assist the province to meet its secondary bed needs. This arrangement and its funding will also be accommodated in the SLA.

Since teaching, training and service provision at primary health care level will be a vital component of the functioning of Academic Health Centres they must include certain district or regional health facilities.

Health sciences faculties will have access to all academic health centres by agreement, for the purposes of teaching, training and research.

Academic health centres must remain committed to maintaining existing outreach programmes and where possible, in concert with relevant spheres of government, seek ways to expand these services both locally and across our borders. Currently certain academic health centres provide valuable training and teaching programmes to many countries on the African continent. These services should be expanded where possible, with a focus on telemedicine, teaching, training and particularly African based research. Academic health centres must also remain committed to providing essential quaternary care health services in line with inter-governmental protocols and agreements.

Academic health centres will be given the right to purchase goods or services on State tenders or from preferred providers, such as the NHLS, but this will not be obligatory if such goods and services can be procured elsewhere more favourably. Academic health centres will be BEE compliant.

Constraints

There are constraints to the implementation of a successful autonomous, business entity academic health centres model. These will need to be resolved by agreement and include altering the conditions of employment of staff. This is a major constraint. Staff are currently employed on provincial conditions of service, with a few members of staff holding joint appointments with a province and an associated health science faculty/university. For the model to work, and indeed for the model to obtain its fullest efficacy and efficiency gains, all staff will have to be on the establishment of the academic health centre. This involves offering each current member of staff a choice. In accordance with existing law, current members have the right to be retained on provincial conditions of service if they so choose and to be appropriately accommodated elsewhere in the public service if they can not be accommodated in the academic health centre in question. However, there are precedents to this that have been put into effect smoothly in other parts of the health services, such as in the integration of Forensic Services, Emergency Medical Services and local authority primary health care services into the Western Cape Province's Department of Health.

All staff benefits will need to be retained, including continuity in pension benefits with the possible transfer from the state pension fund to another pension fund. Again there are precedents already set.

Any future academic health centres act, and its regulations, must define a co-operative relationship between the Academic Health Centres Boards and existing Health Facility Boards. This is important as the role of the facility boards is, *inter alia*, to provide a conduit to raise public funds by donation and to represent the voice of the community in the activities of the institution. If the Red Cross War Memorial Children's Hospital is taken as an example, the extent to which the Facility Board, through the Children's Hospital Trust, has been able to encourage corporate and community philanthropy is considerable and can therefore not be overlooked as a significant funding stream for future health care.

The dispersal and reconciliation of all assets will require complex and involved negotiations between the new entity and the hospital concerned. Again there are precedents, the most notable being the dispersal of assets between the various provinces in post 1994.

Implementing this model is a far reaching step and will require considerable consultation, research, skills, funding and time, particularly in so far as drafting own legislation is concerned.

Currently the psychiatric hospitals form part of the academic health centres teaching and service platform but are removed from it. A way will need to be found to accommodate psychiatric teaching, training and research and tertiary services in the final solution. A similar constraint may well be inherent in other aspects of the health services, such as some obstetric services and forensic services generally.

Existing information technology systems in academic health centres shows a lack of capacity and refinement, particularly in so far as management data and management controls are concerned. In addition, BAS and PERSAL (standard government financing and human resource management IT systems) are not effective instruments. As such, autonomous academic health centres should be free to introduce business management IT systems to suit the requirements of the Board.

Similarly, the government accounting system is cash based (GRAP, or Generally Recognised Accounting Practices) which is not ideal in a business environment. An accrual accounting system (GAAP, or Generally Accepted Accounting Practices) is being planned for the public sector, but will take many years to implement. The Board should be free to implement GAAP.

Conclusion

Academic Complexes are currently suffering from more than 30 years of relative neglect. The model described in this paper would allow their resuscitation and would restore the service, teaching, training and research capacity vital for the continued provision of health services in South and southern Africa.

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Respect for autonomy as a Prima Facie Right: Overriding patients' autonomy in medical practice

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Keywords: Autonomy-Best Interests-Medical Paternalism-Mental Capacity-Necessity-Public Policy-Therapeutic Privilege

Abstract

Prima facie, every competent adult has the right to decide whether to consent or refuse any medical treatment, even if such refusal could lead to death. However, this right to respect for autonomy is a rebuttable right, which could be overridden where there is temporary or permanent mental incapacity, such as due to unconsciousness, infancy, or mental retardation. On these occasions, an individual's right to informed consent could be overridden based on the doctrines of best interests, necessity, therapeutic privilege, or as a matter of public policy. In view of ongoing controversies and contemporary ethical dilemmas surrounding the withdrawal of life sustaining nutrition and hydration from patients in a persistent vegetative state (PVS), compulsory immunization of children, and detention of mental health patients. The quarantine and treatment of patients with infectious diseases, such as extremely drug resistant tuberculosis (X-DR TB), or during routine management of unconscious patients in medical emergencies. It is imperative that physicians and healthcare users are aware of those circumstances, where a patient's right to respect for autonomy may be ethically and legally overridden, without descending down the 'slippery slopes' of medical paternalism. This essay analyzes the relevant case law and ethical principles, to find instances where an individual's right to respect for autonomy may be considered to have only a prima facie standing and could be overridden when in conflict with other equally compelling moral considerations.

Abstract

Prima facie, every competent adult has the right to decide whether to consent or refuse any medical treatment, even if such refusal could lead to death. However, this right to respect for autonomy is a rebuttable right, which could be overridden where there is temporary or permanent mental incapacity, such as due to unconsciousness, infancy, or mental retardation. On these occasions, an individual's right to informed consent could be overridden based on the doctrines of best interests, necessity, therapeutic privilege, or as a matter of public policy. In view of ongoing controversies and contemporary ethical dilemmas surrounding the withdrawal of life sustaining nutrition and hydration from patients in a persistent vegetative state (PVS), compulsory immunization of children, and detention of mental health patients. The quarantine and treatment of patients with infectious diseases, such as extremely drug resistant tuberculosis (X-DR TB), or during routine management of unconscious patients in medical emergencies. It is imperative that physicians and healthcare users are aware of those circumstances, where a patient's right to respect for autonomy may be ethically and legally overridden, without descending down the 'slippery slopes' of medical paternalism. This essay analyzes the relevant case law and ethical principles, to find instances where an individual's right to respect for autonomy may be considered to have only a prima facie standing and could be overridden when in conflict with other equally compelling moral considerations.

The Concept of Autonomy

'I am autonomous if I rule me and no one else rules I'.¹ To put this another way, "I act autonomously if I, as the agent, am the power

that freely and competently achieves my own ends by choosing what I have good grounds to believe to be, the best means to my ends".² Autonomy as a concept was initially introduced to describe self-governing nation states. In medical law and ethics it refers to self-determination or freedom of choice. This ethical principle that each person has a right to decide what can be done to his or her own body during medical treatment has found expression in some legal statutes^{3,4} and international ethical codes⁵ through the doctrine of informed consent. Autonomy by itself has never been fully recognized as a legally enforceable right. Instead two other rights, derived from the principle of respect for autonomy, have been universally accorded legal protection. The first is the right to bodily integrity, protected by legal rules against assault or battery. The second is the right to bodily well being, protected by professional negligence laws.⁶ According to Keith LJ in *Airedale NHS Trust v Bland*⁷: "The first point to make is that it is unlawful so as to constitute both the tort and crime of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent... such a patient is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die."

As explained further by Watermeyer J in the South African case of *Stoffberg v Elliot*⁸: "A man by entering a hospital does not submit himself to such surgical operations as the doctors in attendance upon him might think necessary... by going into hospital he does not waive or give up his right of absolute security of the person... he retains his rights of control and disposal of his own body; he still has the right to say what operation he will submit to, and unless consent to an operation is expressly obtained, any operation performed on him without his consent is an unlawful interference with his right of security and control of his own body."

Cardozo J classically summarized a patient's right to autonomy during medical treatment in *Schloendorf v Society of New York Hospital*⁹ where he opined: "Every person being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patients consent commits an assault, for which he is liable in damages."

Rehnquist CJ of the US Supreme Court later reaffirmed these sentiments in the Cruzan case¹⁰ when he noted that: "No right is held more sacred or is more carefully guarded by the common law. Than the right of every individual to the possession and control of his own person, free from all restraint or interference of another".

Therefore a physician who exceeds the consent given by a patient will be guilty of infringing the patients' right to bodily integrity and well being.¹¹

Principled Autonomy v Utilitarianism

The 18th century philosopher, Immanuel Kant, postulated the moral basis for the principle of respect for autonomy.¹² Kant argued that the ability of humans to consider the possible consequences of their actions, form intentions, and then act on them, rather than reacting to circumstances, are what distinguish humans from machines or lower animals. Therefore unthinking choices do not represent autonomy. Kant argued that autonomous action can be theoretically harnessed for universal good. This is based on his identification of a 'categorical imperative', which he formulated into two major maxims. The first of these maxims asks us to, 'Act only on that maxim which you can at the same time will that it becomes a universal law'. In the second maxim he urges us to, 'Act as to treat humanity, whether in your own person or in that of any other, never solely as a means but always as an end.' This idea that people should be treated as 'ends in themselves' has influenced liberal political philosophy by stressing the principle that people should not have their individual freedoms compromised for the sake of others or for the good of society in general. Kant believed that 'categorical imperatives', which may be described as duties that should never be renounced, could be used to derive the specific moral duties that make up a complete ethical framework. To illustrate this he derived the following argument for the duty of keeping promises: 'Suppose one is considering breaking his promise. One could not will that breaking promises would become universal law because that would result in a total breakdown of the trust needed for promises to mean anything at all'.

Therefore based on Kant's theory, immoral actions such as telling lies, coercion, deception and control or enslavement of others, are not universalisable, because if everybody acted in this way, the end result would be a breakdown in societal morals. This Kantian form of autonomy has been described as *principled autonomy*.¹³ By contrast to Kant, another philosophical school of thought based on Consequentialism argues that right or wrong actions should be balanced on their good or bad consequences. The proponents of this moral philosophy postulate that the right act in any circumstance is that which produces the best overall good as determined by an impersonal perspective that gives equal weight to the interests of each affected party. This moral philosophy, called *utilitarianism*, accepts a significant role for the principle of utility in formulating public policy. According to one of its greatest proponents John Stuart Mill¹⁴: 'The creed which accepts as the foundation of morals, utility, or the greatest happiness principle, holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness.'

Justifications for the doctrine of informed consent in medical practice.

Current arguments on informed consent in healthcare, are based on libertarian rights-based autonomy, designed to safeguard individual freedoms and liberty, above considerations related to the rights of others and society. As illustrated by this statement referring to the rights of human subjects in biomedical research: "It is essential to recognize that society's interest in knowledge may not coincide with an individual subject's interest; the individual subject stands to gain nothing and may lose everything, including his or her right of self-determination".¹⁵

The doctrine of informed consent is essentially derived from two moral principles. One being respect for autonomy; the second is liberty, which some consider to be synonymous with autonomy. Some scholars distinguish between liberty as the condition of being independent from controlling influences and autonomy as having both liberty and agency, that is, the capacity for intentional action.¹⁶ The idea of liberty can be surmised from this statement attributed to Isaiah Berlin¹⁷: "Those who have ever valued liberty for its own sake believed that to be free to choose, and not to be chosen for, is an inalienable ingredient, in what makes human beings human, and that this underlies... the demand... to be accorded an area... in which one is one's own master, a 'negative' area in which man is not obliged to account for his activities to any man so far as this is compatible with the existence of organized society."

Other justifications for informed consent include patients, who in exercising their right as healthcare consumers have demanded more involvement in medical decision-making. To explain further, as medical care has become more industrialized and sophisticated, patients have become consumers rather than involuntary recipients of benevolent healthcare services. Patients have begun to ask questions and demand consumer rights, resulting in increasing ethical and legal analyses of healthcare decision-making.^{18,19} As a consequence of these questions and demands by patients and analysts, modern medical practice is evolving from a practice based on beneficence, towards rights based autonomy.

Consent to Treatment

Consent may be defined generally, as the voluntary and continuing permission of an individual for a particular purpose. In its ideal context; informed consent requires five key elements to establish validity. These key components are (a) competence, (b) Voluntariness, (c) information disclosure, (d) understanding, and finally (e) authorization.²⁰ Expressed differently informed consent could be described as the social rules of consent in institutions that must legally obtain consent. In medical practice, informed consent should ideally consist of a conversation between a physician and his patient. This conversation, preferably initiated by the physician, would involve complete transparency, engagement by both parties and continuity. It may require evidence that it occurred, such as witnesses or a signed consent form.²¹

Consent could be withdrawn at anytime by the giver, and may be vitiated by change in circumstances, which are not approved by the giver. According to some legal statutes, exculpatory statements intended to deny any claims of the individual giving consent in order to protect the physician, sponsors, or host institutions, are expressly forbidden and may vitiate consent.²² Valid consent also requires the

absence of coercion or undue influence as shown in *Re T*.²³ Here the Court held that a Jehovah's Witness patient was being unduly influenced by her mother and authorized blood transfusion against her mother's wish. Some scholars have noted that courts now disfavor consent-based defenses, such as assumption of risk and product warning as a form of defense to negligence or battery.¹⁹ In general, common law jurisdictions tend to uphold the principles of respect for autonomy as shown in cases such as *Re JT*²⁴, where it was held that a mentally ill patient could rightly refuse renal dialysis, even though failure to carry out the procedure would ultimately lead to her death. Similarly, a schizophrenic patient detained for treatment under the UK Mental Health Act²⁵ refused to have surgical amputation of his gangrenous leg.

The English Court of Appeal (CA) held that since the gangrenous leg was not associated with his mental illness, the patient had the autonomous right to refuse such amputation *Re C*.²⁶ Similarly in *St. George's Healthcare Trust v S*²⁷, the CA overruled a lower court, which had authorized the detention and forceful treatment of a pregnant woman in the best interests of her unborn child. The woman in question had declined recommended treatment for severe pre-eclampsia. Despite the woman's refusal, medical staff in charge of her care, contrived to detain her under the Mental Health Act²⁵ and obtained court permission to deliver her baby by cesarean section. The CA held against the defendant medical practitioners and in its judgment referred to the American case of *McFall v Shimp*²⁸.

In the latter case, a defendant had refused to serve as a bone marrow donor, needed to treat his cousin for Aplastic anemia. The claimant thereby sought court intervention in order to compel the defendant to submit to further medical tests and possible bone marrow donation for the treatment of the claimant's disease. In denying this request Flaherty J said: "*Our society, contrary to many others, has as its first principle, the respect for the individual, and that society and government exist to protect the individual from being invaded and hurt by another. Many societies adopt a contrary view, which has the individual existing to serve the society as a whole. In preserving such a society as we have, it is bound to happen that great moral conflicts will arise and will appear harsh in a given instance. In this case, the chancellor is being asked to force one member of society to undergo a medical procedure, which would provide that part of that individual's body would be removed from him and given to another so that the other could live. For our law to COMPEL (emphasis mine) the Defendant to submit to an intrusion of his body would change the very concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual and would impose a rule which would know no limits and one could not imagine where the line would be drawn*".

Similarly, in the Canadian case of *Malette v Shulman*,²⁹ an appeals court upheld the principle of respect for autonomy in the form of advance directives. Here, the court found against a defendant physician, who transfused an unconscious patient against her religious views. The patient had been brought to the emergency room in an unconscious state after a road traffic accident, but carried on her person an unsigned card identifying herself as a Jehovah's Witness and setting out her express objections against blood transfusion. Despite this, the physician on duty transfused the patient in her best interests. After recovery, the claimant sued the doctor, and the Court held that the Jehovah's Witness card validly restricted the physician's right to treat the patient by blood transfusion, concluding that the patient had informed the physician of her objection to blood transfusions in the

only way she could in an emergency. This affirmation of patient's right to self-determination was aptly summarized in *Airedale NHS Trust v Bland* by Goff LJ as follows: "*It is established that the principle of self determination requires that respect must be given to the wishes of the patient, so that if a patient of sound mind refuses, however unreasonably to consent to treatment or care by which life would be or might be prolonged, the doctors responsible for his case must give effect to his wishes, even though they do not consider it to be in his best interests to do so*".⁷

Overriding Patient Autonomy as a Moral Dilemma

Despite numerous cases, some cited above which illustrate the principle of respect for autonomy. There may arise in the practice of medicine, ethical and moral dilemmas, where physicians and even courts of law, may encounter problems in upholding the principle of respect for autonomy. Instead there may be a need to abandon rights-based autonomy, in favor of utilitarian principles, either on the basis of necessity, best interests or public policy, especially where a conflict arises between equally compelling moral principles. This is despite the fact that when prima facie obligations are overridden, they frequently leave moral traces and residual obligations. For example, in the form of compensation and damages. It has been argued that attitudes of regret, contrition and sorrow would be appropriate moral obligations in such circumstances.²⁰ The second part of this essay examines those circumstances where a patient's autonomy could be ethically and legally overridden in the course of medical practice.

The Doctrine of Necessity

Necessity is an established doctrine in common law jurisdictions, where it is routinely applied during the emergency treatment of patients. It is considered lawful to treat such patients, within the limits of what is medically necessary, until such a patient is in a position to consent to further treatment. As explained by Goff LJ in *F v Berkshire Health Authority*³⁰: "That there exists in the common law a principle of necessity which may justify action, which would otherwise be unlawful, is not in doubt". Brooke LJ summarized three requirements for the application of the doctrine of necessity in *Re A*³¹ as follows:

- a. The act is needed to avoid inevitable or irreparable evil
- b. No more should be done than is reasonably necessary for the purpose to be achieved
- c. The evil inflicted must be disproportionate to the evil avoided.

Based on these criteria he supported the surgical separation of twins joined at birth, resulting in the safety of the one, and the demise of the other. The Roman Catholic moral doctrine of double-effect has been used in an attempt to resolve such dilemmas. This Catholic doctrine argues that if the intent of the action is to affect overriding good, then the action is defensible, even if unintended harm occurs. Some authorities have suggested that harm should be weighed against the potential benefit before deciding on the best course of action via a risk/benefit analysis.³² This approach has sometimes been adopted when considering issues of 'necessity' and 'best interests' as shown by Brandon LJ in *Re F*³³: "*In many cases, it will not only be lawful for doctors on the ground of necessity, to operate on or give other medical treatment to adult patients disabled from giving their consent; it will be their common law duty to do so. In the case of adult patients made unconscious by an accident or otherwise, they will normally be received into the casualty department of a hospital,*

which thereby undertakes the care of them. It will then be the duty of the doctors at that hospital to use their best endeavors to do, by way of an operation or other treatment, that, which is in the best interests of such patients”.

However as explained by Goff LJ in the same case: “Emergency is however not the criterion or even a pre-requisite: it is simply a frequent origin of the necessity, which impels intervention. The principle is one of necessity, not of emergency. The doctrine should strictly be confined to action taken to preserve the life, health or well being of another, who is unable to consent to it.”

Based on these considerations two basic requirements for applications of the doctrine of necessity were outlined:

- a. There must be necessity to act when it is not practicable to communicate with the assisted person.
- b. The action taken must be such as a reasonable person would in all circumstances take, acting in the best interests of the assisted person.³⁴

The Best Interests Standard

It has been stated that the legal concept of best interests is centered primarily around respecting and promoting patients autonomy and is aligned with the desire-fulfillment theory which subscribes to the position that well-being consists in having one's desires fulfilled. In other words, to maximize a person's well-being, one ought to give them whatever they want. Opponents of this theory have argued that there could be a conflict between what an individual wants and what is actually good for them. Based on this conflict between wants and needs, the best interests' argument can be divided into 'subjective' and 'objective' categories.

Best interests: Objective view

Advocates of an 'objective' best interest's standard argue that the concept of best interests can be explained in terms of maximizing the individuals' welfare, well being or good. Based on this view, the action or omission that brings about the maximization of the relevant consideration in a particular situation is that which are in the individual's best interests.³⁵ Others have argued that the decision arrived at can only be judged to be 'best' if such an action would bring about the most good for the individual concerned.³⁶

The objective view of best interests is the idea that judgments are based on what can be determined independently of the view or wishes of the individual concerned. Opponents of the objective view have argued against it on the basis of which parameters or competing factors would be taken into consideration in determining what would be in the best interests of the individual. However, the defining argument for the objective view is that it should be based on independent parameters, which are combined to maximize the good, even if we do not know what those parameters are, or even how to determine them. So long as it is clear that when those parameters are determined, they will lead to maximization of the good and the individual's best interests.

Best interests: Subjective view

Advocates of a subjective view of best interests on the other hand tend to argue that the concept of best interests should be determined by what that particular individual would choose if they were competent. Or if incompetent, what could be determined of what they would

have chosen were they in a position to do so. In its moderate form, it could be argued that where knowledge is available of the individual's wishes-best interests should be determined based on these. In practice this would be in the form of advance directives or the opinion of surrogates. The extreme argument in the subjective view would be that whatever the individual deems to be in their best interests, if this is known, is what is in their best interests. Adoption of the moderate form of the subjective best interests' standard would arguably tend to enhance autonomy. The central idea in the subjective argument would be that if I value certain types of beliefs, for example, religious beliefs. Actions that tend to take account of these views would be in my best interests and enhance my autonomy, while actions that tend to ignore these beliefs would not, and would tend to compromise my best interests.³⁵

Best Interests and Public Policy

Globally, legal statutes supporting human rights generally guarantee a right to life. For example, the Human Rights Act³⁷ states: “Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law”.

However, this prima facie right appears to have been overridden where legal authorities have sanctioned the withholding or withdrawing of life sustaining nutrition and hydration, from patients in PVS. As demonstrated by the English cases of *NHS Trust A v M*, and *NHS Trust B v H*³⁸, the American cases of Karen Quinlan and Terry Schiavo,³⁹ and the South African case of *Clarke v Hurst*.⁴⁰ In such cases it was held these acts of omission, were not incompatible, with the fundamental right to life outlined in the European Convention on Human Rights (ECHR)⁴¹, or similar international statutes, and were therefore not unlawful.

During court arguments, legal authorities have stated that it might even be in the best interests of society, to conserve the resources, being utilized to maintain such patients at public expense, by using those resources instead for those individuals in society who might be better positioned to benefit from them. Thereby invoking the principle of distributive justice to moral dilemmas associated with overriding autonomy in healthcare. In support of this view, the Health Professions Council of South Africa (HPCSA) has stated that there are circumstances when withholding treatment, even if it is not in the best interest of the patient, is permissible, especially in the context of resource scarcity.⁴² Further, the ECHR guarantees the right to liberty and security of the person, but gives exceptions, where such liberty could be curtailed, including: “the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrancy.”⁴³ Justifications for the detention of patients for the treatment of infectious diseases have recently been advocated in the treatment of South African patients with extremely drug resistant tuberculosis (X-DR TB).⁴⁴ This is based on the legitimate principle of limiting an individual's autonomy and liberty rights to prevent harm to another.⁴⁵ It has also been argued that such quarantine or detention is not incompatible with Article 5 of the ECHR, which guarantees a right to liberty of the person.⁴³ In *Association X v UK*⁴⁶, the European Court of Human Rights (ECtHR) held that where a small number of children had died as a result of a vaccination scheme, whose purpose was to protect the health of society by eliminating infectious diseases. It could not be said that there had been an intentional deprivation of life within the meaning of article 2 of the ECHR.⁴³

The Doctrine of Therapeutic Privilege

By contrast to best interests, necessity or public policy, a more controversial basis for the overriding of patient's autonomy is in the area of 'therapeutic privilege'. This doctrine contends that a physician may legitimately withhold information, based on a sound judgment that divulging such information could be potentially harmful to the patient. Especially where such patients are depressed or emotionally unstable. The concept of therapeutic privilege was famously introduced as an exception to informed consent in *Canterbury v Spence*⁴⁷ where the Court held that: "*The patient's right to self-determination can be effectively exercised only if the patient possesses enough information to enable intelligent choice... informed consent is a basic social policy for which exceptions are permitted. These exceptions would include intellectual capability such as unconsciousness and extreme psychological threat...*"

Although the Court in *Canterbury v Spence* rightly reversed the prevailing practice of using the reasonable doctor standard in determining information disclosure to patients, it appears to have undermined its position by recognizing 'therapeutic privilege' as an exception to informed consent. The precise use of therapeutic privilege varies across legal jurisdictions. While some jurisdictions permit a physician to withhold information where it would be contrary to the therapeutic intent and lead to deterioration in the patient's condition. Others permit the withholding of information only if the patient's knowledge of the information would have health-related consequences, by impairing the patient's mental capacity.

Some authorities have argued that the doctrine of therapeutic privilege can be legitimately invoked where the physician has sufficient reason to believe that disclosure would render the patient incompetent to render consent or refusal. To invoke this privilege under this condition does not, it is argued, conflict with respect for autonomy, because at this point, the patient is not capable of making an autonomous decision. Other authorities have argued that therapeutic privilege, as an exemption from informed consent, is a frank exercise in medical paternalism.⁴⁸ The American Medical Association (AMA) Code of Ethics⁴⁹ suggests that physicians may withhold information about a patient's diagnosis or treatment when disclosing it would pose such a serious psychological threat, as to be medically contraindicated. However, it warns that therapeutic privilege should not be used to prevent patients from exercising their right of free choice. The defense of therapeutic privilege has been recently entrenched in South African legislation as s6 of the National Health Act⁵⁰ states: "*Every healthcare provider must inform a user of the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user.*"

However it has been argued that the defense of therapeutic privilege should also comply with the requirements for the defense of necessity, in other words it should only be used in emergency situations where there is a necessity to override informed consent. In addition, it should also comply with the safeguards for patient's rights. So that therapeutic privilege will not be an applicable defense where treatment is administered against the patient's will. For example, where the physician knows that the patient is likely to refuse treatment once properly informed, and such a physician is seeking to override the patient's autonomy by resorting to the doctrine of therapeutic privilege.⁵¹

Decision-Making Capacity (DMC) v Autonomy

In the legal and ethical analysis of treating people against their will, a great deal depends on whether the patient is legally competent or has mental capacity. In common law there is a presumption of capacity in that any adult is presumed to have the capacity to consent or refuse medical treatment unless proven otherwise by acceptable evidence. The onus lies on demonstrating that someone does not have capacity, even in the presence a known mental illness as shown in *Re C*²⁶. In other words, incompetence in one area does not mean incompetence in all areas; one can only talk of competence to do a particular thing as explained in *Richmond v Richmond*⁵²: "*Capacity is ultimately a legal not a medical decision... it is for the court to decide the question of capacity, although the court must pay attention to the evidence of experts in the medical profession who can indicate the meaning of symptoms and give some idea of the mental deterioration which takes place in cases of this kind...*"

The common law test for the establishment of the patient's mental capacity was outlined by the CA in *Re MB*⁵³ as follows:

"A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or to refuse treatment. That inability to make a decision will occur when:

- The person is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question.
- The patient is unable to use the information and weigh it in the balance as part of the process of arriving at a decision."

Thorpe J later summarized this test as follows in *Re C*.²⁶ The patient must be able to:

- Comprehend and retain the information (b) believe it (c) weight it in the balance so as to arrive at a choice.

The above test has been frequently applied in English case law, however due to conflicting interpretations; the recent Mental Capacity Act⁵⁴ has attempted to further simplify this into a single test. The current test states that a person is deemed incapable of making a decision and exercising autonomy rights where the person is unable:

- To understand the information relevant to the decision,
- To retain that information
- To use or weigh that information as part of the process of making the decision, or
- To communicate his decision (whether by talking, using sign language or any other means). It should be noted that the Mental Capacity Act⁵⁴ only applies to persons above 16 years of age, who are considered adults accorded presumption of capacity. Further, a basic understanding demonstrated through the use of simple language, visual aids or any other means will suffice to satisfy the first part of the test.

Moreover in the case of refusal of medical treatment by a competent patient, it has been stated that the reasons for refusal need not be rationally defensible. As explained by Donaldson LJ in *Re T*⁵⁵: "*It matters not whether the reasons are rational or irrational, unknown or even nonexistent-this is so not withstanding the very strong public interest in preserving life and health of all citizens...*"

To further elaborate Butler-Sloss LJ said in *Re MB*⁵³: “A competent woman who has the capacity to decide may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death. In that event the courts do not have the jurisdiction to declare medical intervention lawful and the question of her own interests objectively considered, does not arise...”

Other legal authorities have suggested that one must take other factors into consideration when assessing an individual's capacity to consent to or refuse treatment. For example:

- a. A person must be assumed to have capacity unless it is established that he or she lacks capacity.
- b. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- c. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- d. An act done or decision made for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- e. Before such an act is done, or decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's autonomy.

Finally, a lack of capacity cannot be established merely by reference to a person's age, appearance, intelligence, level of education, or any condition or aspect of behavior, which might lead others to make unjustified assumptions about capacity.⁵⁶ It has been argued that judgments about DMC are pivotal in health care, since they determine the ability of patients to make choices about their care. Physicians should understand the concept of DMC and how to assess it. Many patients clearly have the capacity to make health care decisions, and others, such as unconscious patients lack this capacity. In other cases, physicians may disagree about whether a patient has sufficient capacity. DMC is a complex concept, since it is based on four abilities: (a) the ability to express a choice, (b) the ability to understanding relevant information, (c) the ability to appreciate the significance of that information for one's own situation, and (d) the ability to engage in basic reasoning regarding treatment options. There is no simple algorithm for determining DMC, since the capacity to make a decision varies with the complexity of the choice. DMC must be assessed relative to the decision at hand. Physicians must strive to avoid commonly held misconceptions about DMC—for example, that any patient with cognitive impairment or mental illness lacks DMC.⁵⁷

Medical Paternalism v Autonomy

Paternalism may be defined as interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, and interests of the person. In a medical context it can be described as interference by a physician with a patient's autonomy, justified on the grounds of acting in the patients best interests.

One criticism of medical paternalism is that the physician usually does not know enough about the patient's best interests or hopes and fears to make decisions on their behalf. Another argument is that there could be potential conflicts of interest between the physician's

own motives and the best interests of the patient.⁵⁸ However, the most important criticism against medical paternalism focuses on the question of whether the ethical principle of respect for autonomy should have priority over the principle of beneficence.

Based on this premise, proponents of some form of medical paternalism have divided medical paternalism into strong and weak formats. Where 'strong' paternalism refers to overriding of concrete patients directives such as 'do not resuscitate' (DNR) orders, while 'weak' paternalism may refer to surrogate decision making or substituted judgment decisions. In the latter a direct effort is made by the physician to ascertain what the patient would have wanted before making decisions on their behalf. This 'weak' mode of paternalism claims to enhance patient autonomy, while the 'strong' directly annihilates it.

Case Study: Forced rectal examination stirs up ethics questions

One example of this constant dilemma between respect for autonomy and medical paternalism or the overriding of patient autonomy is illustrated by a recent case reported in the New York Times.⁵⁹ Here an adult patient refused to undergo rectal examination which is considered standard practice in patients admitted with head injury. This resulted in the physician ordering physical restraint of the patient while the examination was performed. Subsequently the patient claimed post-traumatic stress disorder and inability to work or lead a normal life. The doctors who treated him have advanced a defense that there are special considerations in emergency medicine because of the need to make rapid assessment. That failure of such examination could have masked life-threatening injury, and the rectal examination was done in the patient's best interest. In support of the patient an expert neurologist and psychiatrist stated that although rectal examination is part of routine emergency evaluations, this patient clearly refused the proposed examination. His life was not in danger. He did not have any signs of abdominal trauma. He had full range of motion and movement of all four extremities. A reasonable analysis of his situation could have been obtained without checking for 'rectal tone.' Analysis of this case brings to fore issues of necessity, best interests, and medical paternalism. The most important point to be determined in this case would be whether the patient had the capacity to refuse the prescribed examination. Was the rectal examination medically necessary? Were there alternative modes of arriving at the necessary diagnosis and were these fully explored? Was the patient's capacity fluctuating to the extent that it thereby rendered him incompetent?

Concluding Comments

The case described above illustrates some of the challenges facing physicians in modern medical practice who are confronted with the need to enhance patient autonomy while striving to provide the best medical care to patients with expectations of consumers. One author has suggested that physicians need to move towards the practice of 'modern paternalism' or soft paternalism in order to achieve maximum patient benefit.⁵⁸ Since the Nuremberg trials of the 1940s, medical practice has gradually moved away from the 'reasonable doctor standard' towards respect for individual autonomy and 'prudent patient standards'. Societal pressures in the areas of civil rights, equality movements and consumerism have influenced these shifts from beneficent paternalism to libertarian

rights based practice. It has been emphasized that people should be treated as self-determining agents with free choice. This change in approach means that physicians must recognize that what is 'best' may vary from patient to patient, in part because of the different cultural values held by each patient. It has also been suggested that the easiest way of determining patient values would be by asking the patients themselves, thereby involving patients in the decision-making process.

Numerous decisions by the courts and current legal statutes have emphasized the need to value patient's rights. However, it must be emphasized that the recognition of patient's rights in every situation is difficult because of the conflict that may arise between the need to treat patients in their best interests and the need to respect autonomy. Patients also need to recognize that 'rights' are only *prima facie* claims that individuals can make upon society. Claiming such rights is governed by rules and such rights exist or fail to exist because the relevant rules either allow or disallow the claim in question. As such, rights are not absolute, but only assert *prima facie* claims which could be overridden when in competition with other equally compelling moral considerations.²⁰ To paraphrase Lord Donaldson MR in *Re T*³⁵: *Prima facie every adult has a right and capacity to decide whether or not he will accept medical treatment, even if refusal may risk permanent injury to his health or even lead to premature death... However, the presumption of capacity to decide, which stems from the fact that he person is adult is rebuttable... An adult may be deprived of his capacity to decide either by long-term incapacity, or retarded development, or temporary factors such as unconsciousness or confusion, or the effects of fatigue, pain or drugs*".

From the foregoing analysis one can conclude that patient autonomy is a desirable moral obligation that needs to be enhanced in medical practice. However, this ethical principle as protected by the laws on informed consent and bodily integrity is only a *prima facie* right, which, when in competition with other equally important ethical considerations, may be overridden, in the best interest of the patient, due to necessity, or as a matter of public policy, either for the good of the individual concerned or for the benefit of society in general. Finally, it must be noted that because of the frequent occurrence of these ethical dilemmas in modern medical practice, and as a consequence of advances in emergency medical treatment, the continuous improvement in artificial life sustaining technology, and the need to recognize the ethical principle of distributive justice in resource allocation. It is very important that physicians are aware of the legal and ethical principles that may support the occasional need to override patient autonomy, even when they result in residual obligations such as damages and the need for compensation. It has been suggested that attitudes of regret are the appropriate ethical obligation for the physician whenever confronted by such ethical dilemmas necessitating the overriding of patient autonomy.

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Assessor recruitment, training and validation – experience from the UK

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Introduction

The past 20 years have seen significant changes in post-graduate and under-graduate medical education and training. Although still clearly an apprentice style of training, the approach and content of teaching, and the assessment thereof, has become increasingly formalized. Learning objectives of training should be identified and the assessments linked to these aims. Gone are the days when examining candidates was a social pastime or chance to compete with colleagues by creating esoteric questions... Educational principles around fairness and repeatability, as well as legal challenges, have led to increasing scrutiny of the processes used for recruitment of assessors, as well as ensuring they understand the procedures in which they are involved. This involves training the examiners both in the development of questions as well as undertaking the assessments themselves. Ensuring ongoing high standards of examining is a further challenge with the need to identify the 'doves and hawks' a perennial issue.

Overview of Structured Training in Obstetrics and Gynaecology

Post-graduate training in the United Kingdom has been transformed over the past decade or so with the introduction of "Calman" training for the later stages of what used to be called registrar and senior registrar training and more recently Modernising Medical Careers (MMC) which has led to restructuring of the more junior levels of training. Since 2007, newly qualified doctors need to complete a two year 'Foundation' course, with usually 6 four month posts, covering a far wider range of specialities than the traditional medicine and surgery house jobs of the past.

Obstetrics and gynaecology, for example, as well as general practice, psychiatry and research are all offered as "tasters" and it is hoped that through these more varied opportunities, recruitment into some of these less popular specialities may be improved.

General Medical Council (GMC) registration is obtained after the first year and appointment to the specialist training programmes occurs mid way through the second year with the acquisition of a National Training Number (NTN). So called "basic training" is then undertaken for 2 years, by the end of which time part 1 MRCOG is a prerequisite to passage through to intermediate training which lasts a further 3 years. (See diagram 1)

Part 2 MRCOG is the hurdle which must be passed before progress to advanced training which is undertaken for a further 2 years, making the whole training programme a minimum of 7 years. At the end of this time, a certificate of completion of training (CCT) will be issued. These obstetricians and gynaecologists will then appear on the specialist register and will be eligible for independent practice.



Diagram 1

Throughout the training years, there are annual formative assessments and a detailed log book is signed off for the varying modules of training, details of which can be obtained on the RCOG website (www.RCOG.org.uk).

MRCOG Part 1

There is an oft quoted statement in medical education circles "the assessment drives the learning". Part 1 MRCOG is a perfect example of this in that, without examining the basic sciences of anatomy, physiology, embryology, statistics and epidemiology, endocrinology, microbiology, immunology, pharmacology etc, trainees are extremely unlikely to refer back to their text books from medical school, however hard senior staff try to convince them that this knowledge forms the basis for the practice of modern medicine. To ensure validity, a wide variety of subjects needs to be examined and the Part 1 examination consists of two papers of two hours with 40 extended matching questions (EMQs) and 96 multiple true false questions (MT/FQs). Extended matching questions have recently been introduced to the Part 1 examination in an attempt to assess scientific knowledge in a clinical setting appropriate to the understanding of trainees in the first year or two of their course. Approximately 1000 candidates every 6 months attempt the Part 1 MRCOG in 15 centres throughout the world. The overall pass rate is about 30% with no involvement of assessors as marking is done electronically.

MRCOG Part 2

Having now formally linked the Part 2 examination to a particular phase of the training, the Royal College has been able to clarify the exact purpose of the examination. The Part 2 exam is thus used to assess the knowledge and skills, relating to UK practice, at the end

of core training (year 5 of specialist training), recognising that further training will be required before independent practice. Consolidation of clinical skills, as well as the development of areas of special interest, will take place in years 6 and 7.

At present the MRCOG Part 2 examination may be attempted by any trainee throughout the world but the standards of UK practice define the pass mark. Similar to many post-graduate examinations the assessment is divided into 2 parts, a more knowledge based part (the written examination) with the approximately 25% of successful candidates going on to a clinically based examination, the Structured Oral Examination (SOE). This is designed to test the use of clinical knowledge, as well as the assessment of specific skills.

The written examination

Historically, the Part 2 MRCOG written examination consisted of multiple true false questions and essays. Over the last few years, however, the structure of the examination has been modified and the multiple true false questions are being replaced by EMQs. Eight short answer questions are also written with a highly structured answer sheet being produced by an examination sub-committee of approximately 12 practitioners. The current format of the examination is of 225 MT/FQs, 40 EMQs and 4 gynaecology and 4 obstetric short answer questions. Approximately 800 candidates sit the examination in 4 UK and 11 overseas centres twice a year. The pass rate for UK graduates is approximately 50-65% with much lower rates for some overseas centres. In many cases the high failure rate for these candidates relates to their inexperience in using their knowledge in the contemporary management of patients in the UK setting.

Process of marking the SAQs

For the structured answer questions, the essay title is printed onto an A4 sheet with a maximum of 2 sides allowed for writing. The clinical scenario and the related questions are divided onto the paper and the distribution of marks between the sections is identified. A highly detailed answer sheet structures the marks, with the total being out of 20. There is also the ability to subtract marks for persistent factual error or dangerous clinical practice. After collation of the papers each of the 8 questions is marked by a group of about 10-12 examiners and all 800 papers will be marked by that group. Examiners are randomly distributed to one of the 8 large tables at the RCOG in London and for the first hour or so, the question and its marking is discussed. In an attempt to ensure reliability (and moderating the “hawks” and “doves” among the examiners) 3 papers which were previously identified as being good, borderline and fail are marked using the structured sheet and then for each of the 3 papers a discussion takes place as to why the marks were allocated by each examiner. Those examiners giving the more extreme marks, either high or low for each of 3 papers then justifies that mark and the group debates their results.

In general this leads to the markers with the outlying results recognising where they differ from the median and with this insight they are hopefully more likely to mark the subsequent papers fairly. Each examiner marks approximately 80 papers and there is an enforced break mid way through the day to ensure the examiners do not get too tired. Team working is essential and rushing through the marking to be able to get away early is discouraged. (See Diagram 2)



Diagram 2

The marks for each candidate's answer are added up and then transferred to a computer mark sheet. Errors in addition and transferring over to the computer sheet were identified a few years ago with nearly 70% of examiners making at least one error. Because of this, all mark sheets are now double checked and the computer mark sheets are also cross checked with a co-examiner.

Standard setting

A well produced examination should relate to the syllabus and the curriculum of training. A blue print is produced for every examination to ensure that as many varied topics as possible are tested and that there is minimal repetition between the different sections of the exam.

In the past, a set pass mark of 183 out of 300 had been established irrespective of the difficulty of that particular examination. The RCOG now uses the Angoff method for establishing the pass mark for the MT/FQs and EMQs paper and the Limen reference group system for the SAQs. The standard setting procedure takes place the day before marking and a different pass mark is thereby established for each diet of the examinations. If candidates were all of the same standard but sitting examinations at different diets with varying degrees of difficulty, by varying the pass mark appropriately, this should ensure the same pass rate. Although it will never be possible to establish a completely scientific system for this varying pass mark, the use of these standard setting procedures does ensure a greater degree of fairness between examinations.

Structured Oral Examination

Following the results of the written papers, the 200 or so successful candidates are invited to one of two centres in either London or Hong Kong/Singapore. The aim of the Structured Oral Examination (SOE) is to test the use and application of knowledge and skills. The ideal SOE or OSCE or OSPE should not test anything that could be examined in a written examination and must use its assessors' time and experience to the maximum.

The candidates rotate around 12 stations, 2 of which are preparatory and 10 of which are interactive. Each station is 14 minutes with one minute for the assessor to mark in between candidates; in 10 of these stations this one minute is used by the candidates to prepare for the next station. Each station has one examiner and half of the stations involve an actor being a simulated patient. These are professional actors who are highly trained to ensure as much reliability as possible, repeating as near as to identical performances with each candidate.

The examination is designed to test communication and counselling skills, clinical management, data interpretation, prioritisation and logical thought and also practical skills involving instruments and/or models. Again a detailed structured mark sheet has been produced by an examination subcommittee, with marks out of 20. The pass rate for UK graduates is over 95% and the overall rate is about 75-80%.

Problems with the SOEs

Examinations can only test a small part of clinical performance and it is well recognised that there are many areas which are not able to be assessed in these types of settings. Examination should, however, try to test areas of practice as closely related as possible to the clinical environment and merely asking for lists of facts is not a useful part of these forms of assessment.

Examiner interaction with the candidates should be as objective and reliable as possible. Examiner fatigue and boredom is a huge problem and so understanding the responsibility of the task is an important aspect of being an examiner. Also important is professional behaviour on the examiners' behalf, which includes concentrating, respecting the candidate by not answering mobile phones, pages etc, awareness of prejudice and not in any way engaging in social conversation or teaching the candidates. The stress levels experienced by examinees are well known and they certainly are in no state to be open to either being told off nor being given a mini-tutorial! It is important that the candidates feel that they are being assessed as objectively as possible and therefore any personal references to where they are working, how many times they have taken their exam, where they

come from etc should be discouraged. Conversations involving these subjects may appear to be supportive to the candidate but may be interpreted adversely and, should the candidate fail, may be used in court against the examination process.

With increasing numbers of legal challenges, it is essential that assessors are well trained and accountable and that the documentation about decisions is rigorous and transparent. "Society" expects the Colleges to define (and apply) the standards of its members and the examiners have responsibility for identifying the safe, and the not safe, specialists of the future. Passing or failing the examinations is life altering to the candidates and their families and valid, reliable and fair assessments must be seen to be undertaken by competent and well trained examiners.

Examiner selection

In the ideal world, examiners should be recruited on the basis of their skills and attributes, trained to the best of their ability, with their performance evaluated and constantly improved upon. Unfortunately, many forms of practical constraints mean that examiner selection can involve complex political and pragmatic complexities but in general we should be aiming for a transparent and objective process. Many of the Royal Colleges in the UK are now establishing identified competences and most have changed to self-nomination of examiners, with supporting references. (See diagrams 3, 4, 5)



Diagram 3



Diagram 4



Diagram 5

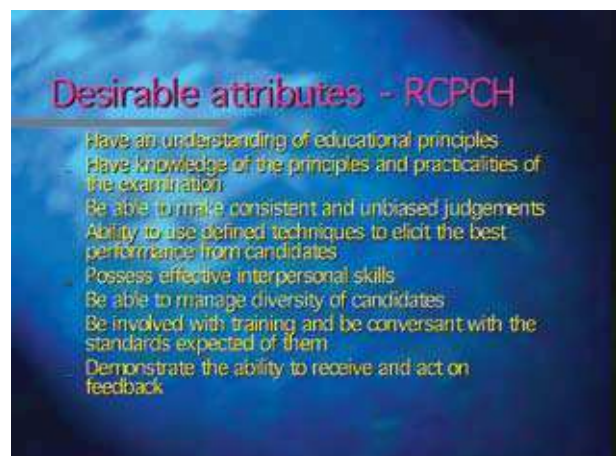


Diagram 6

As examiners are not paid, often with no-one else to cover the routine clinical work, it is hard to imagine why anybody would want to undertake this, often seemingly thankless, task! On the other hand, there is a perceived element of kudos and a reflection or recognition of seniority in being appointed and it also helps if continual professional development (CPD) points can be awarded for these activities. Examiners do gain greater insight into trainees' needs and their expected level of performance, and they therefore can help their junior colleagues by their experiences. The social side of meeting up with the colleagues is also an important aspect of being an examiner and most enjoy the banter over drinks and dinner...

Examiner training

Whether formal training has to be undertaken to be a post graduate examiner has been the subject of recent research and it does appear from occupational psychology literature that simply feeding back on performance has no useful effect. Other studies do however demonstrate that untrained examiners give higher marks and favour female candidates (International Journal of Medical Education 2008) and even short intervention has been shown to give more congruent ratings (Teaching and Learning in Medicine 2007). The aim of examiner training should be to ensure consistence and reproducible results, that the examiners are seen to be fair and objective ('faceless interaction') and that the examiners understand the scoring system and its standard setting process. Discrimination awareness on the ground of sex, race, disability etc must also to be discussed. By understanding the importance of the assessment process and their role within it, it is hoped the examiners will be able to cope better with the repetitiveness and boredom of these new style exams.

Training Courses

The content of training courses will need to vary depending on practical constraints but ideally should cover areas such as the principles of assessment and examination design as a background to the examiners' involvement in the process. Videos or actors can demonstrate good interviewing and communication skills, with particular awareness around the borderline candidate. It is important that the examiners understand the complexity of organising these types of exams and that they need to be punctual and committed to the smooth running of the process. The examiners need to understand the scoring systems and be prepared to enter into discussion and negotiation and subsequent agreement about the marking. Discrimination and diversity training is essential, as is paralinguistic awareness and other examining factors. (See Diagrams 7 and 8)

Issues around consent and patient autonomy, ethics and accountability will be more culturally sensitive but ideally should also be discussed as part of examiner training. Involvement and training in writing questions may also be included but ideally a separate group should write and set the questions and answers. Ongoing evaluation is important and may involve feedback on examiner marking results or assessment of individual performances undertaken by senior examiners. At the RCOG the examiners are evaluated on issues of communications, for example whether they ask the questions in the approved manner, whether they refrain from additional prompting but do give appropriate indication regarding the timing of the station. They are assessed whether they give the candidate enough time to complete the question and whether or not they refrain from

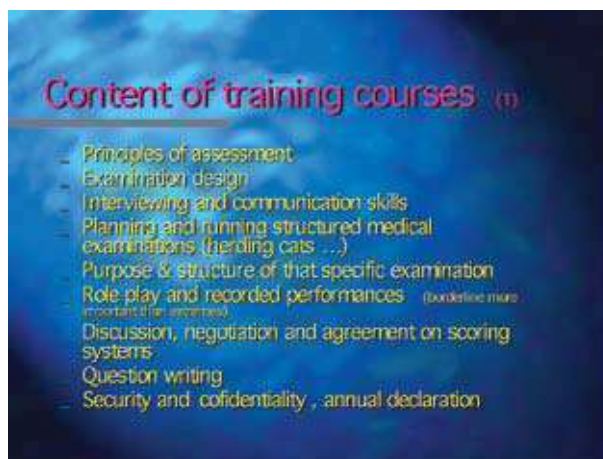


Diagram 7



Diagram 8

conversing with the candidate if the question has been completed early. Furthermore there is an assessment of whether they make inappropriate comments or say things that might be considered discriminatory.

During the training courses inconsistent examiners need to be identified and potentially even eliminated from examining. Being "a hawk or a dove" can be adjusted for statistically when the marks are analysed but the biggest problems involve personalities who are dominant and assertive and insist on getting their own way, particularly if they disagree with their peers about what is a good or bad performance.

Summary

In summary, therefore, assessors are an essential part of any examination involving non-computerised marking of oral or written examinations. Responsibility to undertake this role in a reliable and fair way needs to be emphasised and examiner training is an inherent part of this process. How training can be developed in different settings needs to be looked at by individual groups. As a minimum, it should contain elements around the principles of education and assessment, some form of mock interviews and discrimination awareness.

The production and marking of examinations will never be perfect and mistakes will continue to happen but systems need to be developed and implemented to ensure the risks are minimised. Good documentation and transparency of all processes will be all the more defensible.

Margaret Orford Memorial Lecture (2008): Surgical Options for obstetric complications arising during delivery

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Keywords: childbirth, pregnancy, obstetric complications

It is indeed a great honour for me to give the Margaret Orford Memorial Lecture. I wish to thank Professor Zephne van der Spuy, Professor Silke Dyer and the Organizing Committee of the 33rd Congress of the South African Society of Obstetricians and Gynaecologists for nominating me to give the lecture and for the Colleges of Medicine of South Africa for endorsing the nomination.

Childbirth will invariably result in a significant amount of joy for pregnant women and their families, be it at the end of a long labour or following a caesarean section and, in general, is associated with a healthy mother and a healthy baby. Although this is the outcome in the vast majority of cases, childbirth can unfortunately be associated with complications which not only result in morbidity of varying severity, but can result in maternal death. In the year 2000, about 530,000 women died globally as a result of pregnancy and childbirth. Almost 99% of these maternal deaths occurred in developing countries, the vast majority being in sub-Saharan Africa and Southern Asia. Africa still has the highest maternal mortality rate of about 830 per 100,000 deliveries, followed by Southern Asia, where the maternal mortality rate is about 540 per 100,000 deliveries. For every woman who dies globally as a result of pregnancy and childbirth, about 20 more will suffer serious injury or disability leading to another 8-20 million women who will have morbidity of varying significance. Wealth distribution is a major determinant of care during pregnancy. In Ethiopia, the rich are 20 times more likely than the poor to have a skilled attendant during delivery. In India the ratio is 7 to 1, while in Chad and Nigeria the difference is 14 fold or more. In Sub-Saharan Africa less than 40% of women deliver with the assistance of a skilled attendant. The odds that a woman will die from pregnancy or childbirth in sub-Saharan Africa are 1 in 16 over her lifetime, compared to 1 in 3,800 in the developed world.¹

Obstetric haemorrhage, of which postpartum haemorrhage is the most important, is the single most common cause of maternal mortality globally, and will account for about 25-33% of all maternal deaths globally. The occurrence of postpartum haemorrhage globally is still appallingly high and has an annual incidence of about 10.5%. In the developed world, maternal death from bleeding is exceedingly rare mainly because of all the initiatives taken to eliminate the complication. Active management of the third stage of labour, availability of blood transfusion and blood clotting factors, teaching of resuscitative and emergency management skills and refinement of surgical strategies for the management of obstetric haemorrhage have all very successfully decreased maternal mortality.² This is all in glaring contrast to what is happening in South Africa. In 2005-2006, 240 women died of postpartum haemorrhage of which 205 or 82% were said to have been avoidable and died because of substandard care.³

The primary intention of this presentation is to provide some of the important surgical options which must be considered for some of the more common complications which may occur during labour. It will only focus on surgical options and their implementation. The assumption is made that all conventional resuscitative measures have been instituted and all conservative initiatives have failed to correct the complication and the only option is some surgical intervention. It will also not allude to arterial embolisation.

Surgical options to manage the following complications will be discussed.

- a. ANAL SPHINCTER DAMAGE - Third and Fourth degree tears
- b. POSTPARTUM HAEMORRHAGE
 - Those that decrease blood supply to the uterus
 - Those aimed at compressing the uterus
 - Those that tamponade the uterus
 - Hysterectomy
- c. URINARY BLADDER INJURIES
- d. LOWER GENITAL TRACT INJURIES
- e. RETAINED PLACENTA
- f. INVERTED UTERUS
- g. ANAL SPHINCTER DAMAGE

The anal sphincter complex is composed of the internal (IAS) and external (EAS) anal sphincters, together with the puborectalis portion of the levator ani. The IAS itself is a direct continuation of the longitudinal muscle of the rectum or the inner circular layer of the rectal muscle and surrounds the anal canal for 2-4 cm and is 1.5-5 mm thick. The EAS consists of the subcutaneous, the superficial and the deep components. The deep component lies at the uppermost aspect of the sphincter complex and is in continuity with the puborectalis which lies above it. The superficial component lies caudal to the deep component and together they surround the IAS. The sphincter complex needs to be structurally and functionally intact to maintain continence at rest and during rises in intra abdominal pressure.⁴

A structural and functionally intact anal sphincter complex is essential to maintain continence both at rest and during rises in intra- abdominal pressure. The anus is normally closed by tonic activity of the IAS, which contributes about 70-85% of the resting anal sphincter pressure. This is reduced to about 40% after sudden distention of the rectum and to 65% during constant rectal distention. Hence the IAS is primarily responsible for anal continence at rest. The EAS is active at rest, during sleep, activity and varies with posture. It is responsible for the majority of the squeeze pressure

which maintains fecal incontinence during laughing, coughing and sneezing. The peak pressure is about 2 cm from the anal verge. The anorectal complex receives its innervations from sensory, motor and autonomic nerves and by the enteric nervous system. The pudendal nerve supplies the EAS providing both sensory and motor function.⁵⁻⁷

The overall risk of obstetric anal sphincter injury is 1% of all vaginal deliveries and encompasses

THIRD DEGREE tears which are sub divided into

3a <50% EAS thickness is torn

3b >50% EAS thickness is torn

3c where both IAS and EAS are torn.

FOURTH DEGREE tears are where the IAS, EAS and anal epithelium are torn.

Surprisingly, data pertaining to best practice initiatives for the surgical correction of anal sphincter tears are not extensive, but generally support two specific techniques. These include the OVERLAP technique and the END-TO-END technique. In both, the torn ends of the sphincter are identified and mobilized freely. In the OVERLAP technique about 2 cm of the one end of the EAS is laid over the other end in a “double-breasted jacket” fashion and then sutured at both ends. In the END-TO-END technique, the torn ends of the sphincter are repaired in apposition with 3 or 4 interrupted mattress sutures without any overlap. In both techniques, the vaginal epithelium, the anal mucosa and perineal muscles should then be repaired using vicryl 2/0 either in a continuous non locking fashion for each layer or in place of the latter, interrupted sutures can be used. Suture material options include PDS or Vicryl, although Prolene is not recommended as it is associated with increased risk of suture sinuses and a 30% suture migration. The available literature tends to support the OVERLAP technique as the preferred method of repair even though 4 randomized trials and 11 observational studies have not shown significant difference between the two modalities with view to perineal pain, dyspareunia, or flatus incontinence at 12 months. There was however a trend to better outcome with the OVERLAP technique with view to anal incontinence for stool and anal urgency. Unfortunately, irrespective of the technique used to repair the tears, at 12 months follow up, about 9-29% of women will have persistent anal incontinence, 11-40% will have flatus incontinence, 9-11% stool incontinence and endoanal sonography will reveal persistent sphincter defects in 19-36%. Faecal urgency will persist in about 26% of the women.⁸⁻¹¹

Postpartum Haemorrhage (PPH)

Postpartum haemorrhage has killed more women than any other obstetric complication and annually accounts for about 150,000 maternal deaths globally.¹² Although AIDS related sepsis is the commonest cause of maternal death in South Africa, PPH is still the leading cause of pregnancy-related mortality.

For reasons provided previously, in the developed world this occurrence is most uncommon. The surgical management options to manage post partum haemorrhage include

- Those that decrease blood supply to the uterus
- Those aimed at causing uterine compression
- Those that tamponade the uterine cavity
- Hysterectomy

In order to perform any of the above mentioned procedures confidently, it is vital to know and appreciate the blood supply of the uterus. Blood flow to the uterus is elaborate and extensive and at term is about 750-1000 ml per minute. The major supply is from the ovarian arteries, branches from the aorta which extend retroperitoneally into the broad ligament and finally into the uterus, and the uterine arteries, branches of the anterior division of the internal iliac artery. The uterus furthermore has a blood supply from the vaginal and the internal pudendal arteries, both arteries of the anterior division of the internal iliac artery. The arteries not only anastomose with each other on the ipsilateral side of the uterus but they form an elaborate anastomotic network of vessels crossing over the uterus, cervix, vagina and communicating with the contralateral blood supply of the uterus, cervix and vagina. This network of vessels extends from the fundus of the uterus to the cervix and vagina. The common iliac artery divides into the external and internal iliac arteries within the pelvis and after about 3cm; the internal iliac artery divides into the anterior and posterior divisions. After a further 2-3cm, the anterior division gives off 7 and the posterior division 3 branches respectively, all of which will provide the vast majority of the pelvic blood supply. The branches of the anterior division are the obturator, umbilical, uterine, vaginal, superior vesical, middle rectal and internal pudendal arteries. The branches of the posterior division include the iliolumbar, superior gluteal and the lateral sacral arteries.

In order to gain access to the internal iliac artery, and particularly to the anterior division and all its branches, I routinely clamp and incise the round ligament about 3 cm medially from its attachment to the pelvic sidewall. The retroperitoneal space is then entered by inserting the index finger of both hands into the space created by the incision into the broad ligament and gently pushing down towards the lateral sidewall and then sweeping one finger upwards and the other finger downwards. This will allow exposure of the common iliac artery bifurcation, the internal iliac artery and visualization of the anterior and the posterior divisions of the internal iliac artery about 2-3 cm from the origin of the internal iliac artery. The branches of the anterior division occur about 2-3 cm from its origin. The ureter will almost exclusively reflect medially in the medial half of the incised broad ligament leaflet above the branches of the internal iliac artery.

Surgical options to decrease blood supply to uterus

a. Uterine artery ligation

After the broad ligament has been opened, the index finger of both hands should be directed medially towards the lateral border of uterus with gentle forward pressure in the opening made and at the same time sweeping the fingers upwards and downwards for about 3-5cm. This will separate the tissue along the lateral border of the uterus. The uterine artery and ureter should be visible. Insert a vicryl /1 suture around the uterine artery incorporating with it about 1.5cm of myometrium either at the level of the internal cervical os or about 1.5cm above it. One suture is invariably sufficient and the artery need not be transected. One must always look out for the ureter that runs towards the urinary bladder below the uterine artery about 1-1.5cm lateral to the uterus. Invariably bilateral uterine artery occlusion is necessary, although occasionally, unilateral occlusion may be sufficient to stop bleeding (Figure 1)

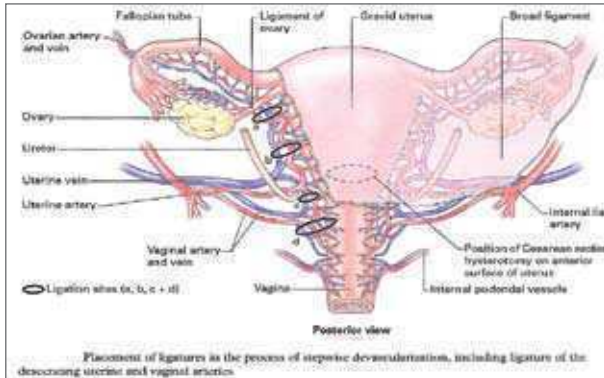


Figure 1

b. Ovarian artery ligation

The ovarian artery can be ligated by placing a suture about 1-1.5cm below the medial attachment of the suspensory ligament of the ovary to the uterus again incorporating about 1.5cm of myometrium. Stepwise combination of unilateral and then bilateral ligatures starting with the uterine arteries and working to the ovarian vessels can be an orderly and effective strategy.

c. Internal iliac artery ligation

Access to the internal iliac artery has been described previously. Continue reflecting the areolar tissue in retroperitoneal space with fingers now directed towards pelvic sidewalls. Identify the common iliac artery and follow it inferiorly to the point where it divides into external and internal iliac arteries. The internal iliac artery proceeds inferiorly for about 3 cm and then divides into the anterior and posterior divisions. "Ligation of the artery" may include ligating the "common branch" of the internal iliac artery or ligating only the anterior division of the internal iliac artery. With gentle pressure and an associated "opening and closing motion" place the tip of either a Roberts-type artery forceps or a Lahey forceps between the proximal 2 cm of either the "common branch" of the internal iliac artery or of the anterior division only and the iliac vein, which is postero-lateral to the artery. This must continue until a separation is made between the artery and vein. Loop a vicryl 1 suture through the partition and tie it around the artery. Two sutures can be used, although one is invariably enough. The arteries need not be cut^{13,14} (Figures 2 and 3).

Surgical options to compress the uterus

In 1997, Christopher B- Lynch reported for the first time his experience with the "Brace suture" and its role in the management of postpartum haemorrhage due to an atonic uterus. The basic principle being that the suture will exert continuous vertical compression on the vascular system and as a result will stop the bleeding... "A contracted uterus does not bleed." The original report described inserting the suture at the time of caesarean section, although there are now variations that have been described which can be inserted in the intact postpartum uterus.¹⁵⁻¹⁸ Both these options will be addressed. Overwhelmingly the suture will be placed at the time of caesarean section, and if not at caesarean section, a laparotomy is always necessary to exteriorize the uterus followed by digital exploration of the uterine cavity to exclude retained products of conception.

In both cases, the whole uterus should then be compressed by placing one hand posteriorly along the length of the uterus extending the fingers to the level of the cervix and the other hand anteriorly, also along the length of the uterus to just below the bladder reflection

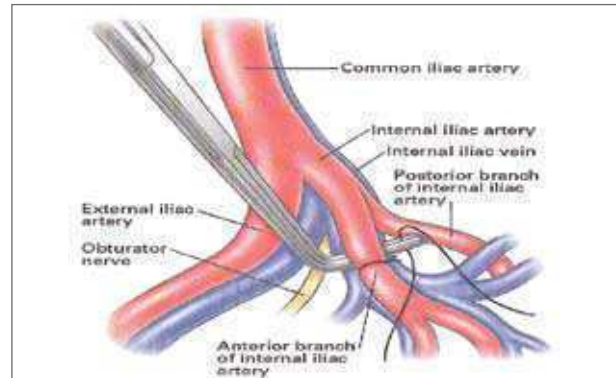


Figure 2

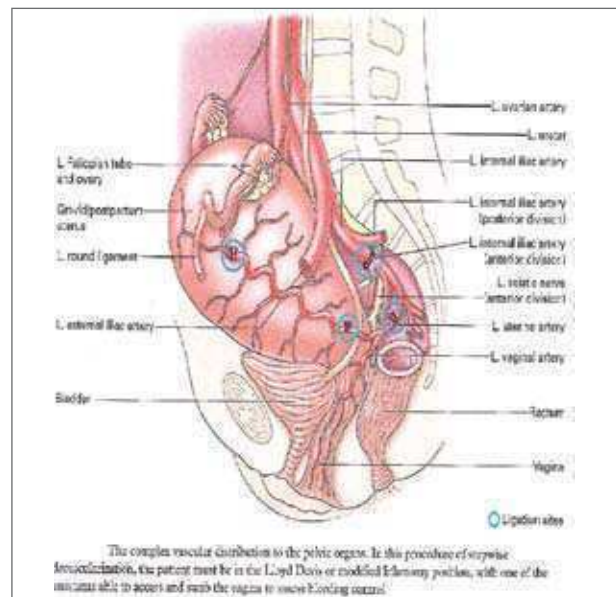


Figure 3

and forcefully compressing the walls of the uterus together. Even in the presence of a coagulopathy, bimanual compression will control diffuse bleeding points. If the bleeding stops on applying such compression, there is a good chance that application of the suture will work and stop the bleeding. With the bladder displaced inferiorly, the suture is commenced about 3cm from the lateral border of the uterus about 3cm below the caesarean/hysterotomy incision on the left side and threaded through the uterine cavity to emerge about 3cm above the incision. The suture is then looped over the fundus of the uterus, about 4cm from the cornual end of the fallopian tube, and continued along the posterior surface of the uterus where a deep "bite" of myometrium is taken horizontally through the upper portion of the uterosacral ligament attachment, looped across the uterus to the opposite side and again through myometrium at the upper portion of uterosacral ligament attachment on the opposite side. The suture is looped over the posterior surface, the fundus of the uterus and again over onto the anterior surface on the right side of the uterus. The needle then enters the cavity about 3cm from the lateral border about 3cm above the caesarean section incision and exits about 3cm below the incision. The suture is tied about 3cm below the caesarean section incision, and the caesarean section incision itself is sutured.

Throughout the procedure, the assistant maintains compression of the uterus and should try and minimize sutures slipping. The brace

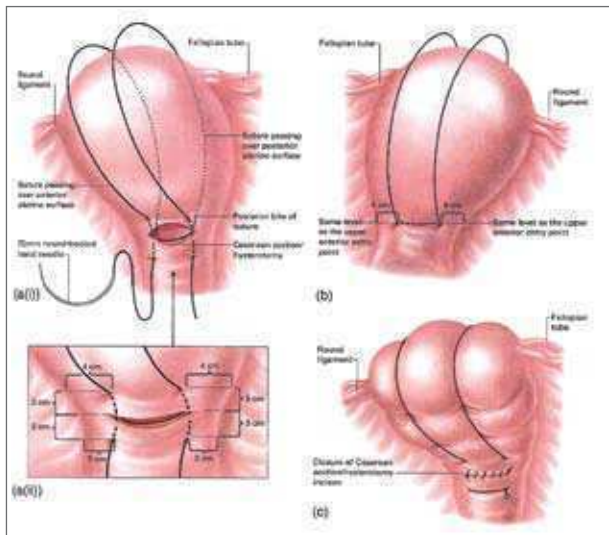


Figure 4

suture itself need not be tied tightly. The intention is to provide compression but not necrosis of or tearing through the myometrium¹⁹ (Figure 4).

Modifications have naturally evolved and two of these have received some attention. In 2002, Hayman described the placement of vertical apposition sutures commencing about 3 cm from the lateral border of the uterus passing the suture from the anterior through the posterior surface of the uterus starting at the level of the internal cervical os and looping the suture over the fundus and tying the suture with a three-knot technique. Up to 4 such sutures can be applied.

The most obvious benefits of this suture include that the lower uterine segment or uterine cavity need not be opened and that the uterine cavity need not be explored under direct vision. Instead of inserting the suture in a vertical direction it can also be inserted horizontally in the isthmic-cervical area in a similar fashion as described above. This may well be of importance in the patient with a placenta praevia who is bleeding.¹⁶

The "Box" suturing technique proposed by Cho in 2003 entails passing the suture from the anterior wall through the posterior wall in a box like application of about 4 cm in size from the fundus of the uterus to the lower segment so that the uterine cavity is eliminated. Multiple through and through square sutures may be used to cover the whole body of the uterus. It may be useful for placenta praevia.¹⁷ The world-wide cumulative success rate of the B-Lynch suture is between 91-98%, is associated with acceptable morbidity and has preservation of fertility with subsequent reported pregnancies. All this data pertaining to the Hayman technique and the Cho technique is still lacking (Figure 5).

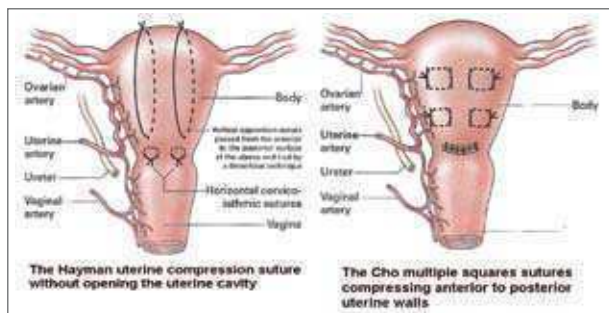


Figure 5

The author has also used a modification of the above mentioned technique. The B-Lynch type suture is placed as described previously, although on the fundus, a "bite" of myometrium 3cm from the cornual end of the fallopian tubes is taken to prevent the suture from slipping. After the suture has been inserted, an almost circular, continuous "in-out, in-out" suture from external to a depth of about two thirds thickness of myometrium in a purse-like fashion of about 5cm in diameter is placed in the anterior and posterior wall of the uterus between the brace sutures. The suture does not extend through the myometrium into the uterine cavity or through the cavity as described in the other modifications. The assistant presses in the centre of the purse-like suture, which is then tied. This modification of the B-Lynch suture has been used by the author on 20 occasions in 18 patients over the last 10 years. During their management, 14 patients required blood products postpartum, an average of 3 (2-9) units blood, 3 (2-4) units Fresh Frozen Plasma and in 9 patients the addition of 2 (1-3) units of platelets. All patients survived the procedure, retained their uterus, did not need a repeat laparotomy and 4 patients have subsequently fallen pregnant and delivered live babies.

Caesarean section and placenta praevia

Placenta praevia will complicate about 1 in 200 pregnancies, but with the advances of ultrasonography in antenatal monitoring, the likelihood of placenta praevia causing maternal death has decreased significantly in the developed world, but not in the developing world. The mode of delivery should be based on clinical judgement supplemented by sonographic information—a placental edge less than 2 cm from the internal os is likely to need delivery by caesarean section, especially if it posterior and thick (greater than 1 cm). Whenever an anterior placenta praevia is diagnosed, there is always the concern of an associated placenta accrete, particularly if there has been a previous caesarean section. Ultrasonographic features strongly suggestive of placenta accrete include (1) prominent echolucent vascular spaces in the placenta giving it a "swiss-cheese" appearance, (2) thinning of the placenta-myometrial border (3) protrusion of the placenta into the bladder (4) abnormal turbulent doppler flow in the vascular spaces and on the surface of the bladder.²⁰⁻²² Two surgical approaches have been described with view to caesarean section and placenta praevia. Whatever technique is chosen, it is imperative to ensure that the intrauterine fetus is longitudinal before any attempt is made to perform the caesarean section. This may require an external cephalic version on the uterus itself. A transverse lie of the fetus will make the delivery particularly hazardous and very likely to have a poor outcome for both mother and baby:

- A. After the uterine incision has been made, swiftly pierce the placenta with the index and middle fingers, tear the placenta, immediately clamp the cord and deliver the baby. This technique requires speed and can result in substantial fetal blood loss
- B. Define the edge of the placenta, gently press on the placenta with the flat of the fingers, stripping it off the uterus and enter the amniotic cavity through the membranes above or below the placenta and deliver the baby. This technique may be associated with undue delay in delivery of the fetus which can lead to troublesome bleeding from a partially separated placenta and therefore fetal blood loss.

Although there is some support for this technique in the literature as the more preferred modality of delivery, the preference of the author is the previously described technique. Continuous bleeding from the site of the placenta praevia can be profuse and at an alarming rate. Strategies to overcome this will include.²²

- Figure 8 or purse-string type sutures deep into myometrium of the bleeding site
- Intra-myometrial prostaglandin F 2 alpha
- Localized modified compression sutures
- B-Lynch type suture
- Internal iliac artery ligation
- Hysterectomy

If a true placenta accrete is encountered, be it as the only complication or in association with placenta praevia, the only definitive surgical option is a hysterectomy if the placenta is totally adherent. Although this strategy will be sufficient in most occasions, there may be the need to additionally perform a bilateral internal iliac artery ligation. Even though leaving the placenta in-situ if there is no associated bleeding and fertility is an absolute priority has been described in the literature with favourable outcome and subsequent pregnancies having been reported, the author has never taken this option and does not have any experience to advocate or denounce its use.

Surgical techniques for uterine tamponade

This can be accomplished in two ways:

1. A balloon can be inserted into the uterus which distends in the uterine cavity and occupies the entire space, thereby creating an intrauterine pressure that is greater than the systemic arterial pressure. In the absence of lacerations, the blood flow into the uterus should stop the moment the pressure in the tamponade balloon is greater than that of the systemic arterial pressure.
2. Balloons that are commercially available to tamponade the uterus include the Sengstaken-Blakemore, the Rusch and the Bakri balloons. These balloons can be inflated to volumes greater than 500 ml after being inserted into the uterine cavity. These volumes are generally able to provide sufficient intrauterine pressure to stop bleeding.²³ The "tamponade test" was first described in 2003 by Condous et al, and was proposed as a prognostic index to determine whether laparotomy would be necessary in patients with major postpartum bleeding unresponsive to medical therapy.²⁴ In the original description, a Sengstaken-Blakemore oesophageal catheter was inserted into the uterine cavity via the cervix, using ultrasound guidance where possible, and filled with about 250-500 ml of warm saline until the distended balloon was palpable per abdomen, surrounded by the well-contracted uterus. If bleeding stopped or was only minimal, the test was considered positive and surgery, with possible hysterectomy, was avoided. If bleeding persisted, the test was negative and a laparotomy was necessary. In their original study, 82% of their patients responded positively and a laparotomy was avoided. Other tamponade instruments include foley catheters and the hydrostatic condom catheter
3. The other option for uterine tamponade is the insertion of a uterine pack consisting of a gauze roll that is tightly packed into the uterus in such a manner that pressure is applied directly on capillary/venous bleeding vessels or surface oozing from within

the uterus, resulting in either a significant reduction or cessation of uterine bleeding. The author uses a packing forceps to insert the material into the uterus and favours using between 3- 4 sanitary pads which have had the looped attachments tied together "end to end" instead of the gauze roll. Under general anaesthesia, the anterior lip of the cervix is clasped using a sponge holding forceps and the material is packed tightly into the uterus using the packing forceps with the concave curvature of the packing forceps facing anteriorly. The pads are soaked in hot saline contained some hydrogen peroxide. Excess fluid is squeezed out of the pads before insertion. Needless to say one must take care not to scald the perineum. Other modalities of uterine packing have previously been described.²⁵

Hysterectomy

Hysterectomy is required in about 1 in 1000 deliveries in the treatment of postpartum haemorrhage. The procedure should obviously only be performed once all other options have been tried and have had no success in resolving the problem, especially if it is associated with placenta accrete. About 70% of peripartum hysterectomies are after caesarean section and 30% will be after a vaginal delivery. There has been a significant increase in rate of post-partum hysterectomy because of the increased rate in caesarean sections and the accompanying increased rate in placenta accrete. Unfortunately peripartum hysterectomy has an associated mortality rate of about 5%.²⁶⁻²⁸ The technique is similar to that performed routinely, but because of the significantly increased blood flow, the priority is to complete the procedure as soon as possible. The pedicles should be kept small and it is recommended to clamp, cut, clamp, cut along the lateral borders of the uterus until the bleeding has stopped and only once the bleeding has been controlled is it advisable to suture all the pedicles. In the presence of excessive bleeding, it is prudent to perform a subtotal hysterectomy, which is a much quicker procedure and does not require reflection of the urinary bladder. If one is going to persist with performing a total hysterectomy, a finger can be placed through the caesarean section incision, hooking it between the cervical rim and the vaginal wall so as to be able to cut into the vagina and hence be able to remove the cervix. A fairly simple way to control bleeding and still proceed to radical surgery is to place two non-crushing bowel clamps along the entire lateral border of the uterus on both sides to control the bleeding and then proceed with the surgery. The other option is to loop a "Jacques catheter" around the uterus incorporating within the loop all the lateral attachments of the uterus which as discussed previously will also include a major component of the uterine blood supply. Despite hysterectomy, bleeding from the pelvis may persist, particularly if associated with a coagulopathy. One can resort to packing the abdomen with dry laparotomy packs rapped in large Opsite dressings to prevent adhesions between the packs and pelvic organs.

These methods, however, require re-laparotomy after initial stabilization and volume control to remove the packing materials. In 1926, Logothetopoulos described a pack for the management of uncontrolled pelvic bleeding after hysterectomy referred to as the mushroom, parachute, umbrella, pelvic pressure or Logothetopoulos pack. The pelvic pressure pack controls haemorrhage from large raw surfaces, venous plexuses and inaccessible areas by exerting well-distributed pressure, compressing bleeding areas against the bony and fascial resistance of the pelvis. The pack is introduced transabdominally into the pelvis after the hysterectomy and the

neck of the pack is delivered transvaginally through the introitus by passing a surgical clamp from below through the vagina. Traction is provided by tying a drip set to the neck of the pack and suspending a 1-liter fluid bag over the foot of the bed which will in turn produce the necessary intra-pelvic pressure. At the same time an intra-abdominal drain must be inserted to monitor for postoperative bleeding. After stabilization of the patient, an attempt to remove the pack transvaginally is made by slowly removing the gauze rolls under intravenous sedation to allow gradual decompression without inciting bleeding and avoiding another laparotomy. The optimal time to leave the pack in situ will vary according to the different scenarios and response.²⁹

Urinary tract injuries at caesarean section

The urinary bladder is displaced anteriorly and superiorly as the uterus enlarges during pregnancy due to the intimate anatomical relationship between the bladder, the cervix and the lower uterine segment. The bladder becomes more of an abdominal organ as the pregnancy advances. As term approaches and with the descent of the presenting part, the base of the urinary bladder broadens. Naturally, because of this intimate relationship between the bladder and the lower segment of the uterus, bladder injury at the time of caesarean section is possible.

The reported incidence of bladder injury is 0.14% at the time of a primary caesarean section and 0.56% at the time of a repeat section. Most injuries will involve the dome of the bladder and rarely the trigone.³⁰ Strategies to minimize bladder injuries include having adequate drainage at the time of the surgery, entering the peritoneal cavity at the most superior aspect of the abdominal incision especially in patients having repeat caesarean sections, careful sharp dissection to mobilize the bladder flap adequately especially if extensive scarring is present between the bladder and the lower segment of the uterus. The lower uterine segment incision should always point upwards at each end and when trying to get haemostasis, it is best to use compression on the bleeding area rather than inserting blind haemostatic sutures. Most injuries are apparent intraoperatively. If one suspects an injury and it is not apparent, one can always insert methylene blue or indigo carmine into the bladder via the transurethral catheter. Leakage of either into the peritoneal cavity would confirm the suspicion. Repair of the injury should be in two layers. The first layer should be a simple running suture of 2/0 vicryl material which apposes the mucosa. The second layer should consist of interrupted sutures of 2/0 vicryl material which incorporates the muscularis and serosal surface. Free drainage for about 5 days postoperatively is advocated.

Lower genital tract injuries

Possible sources of bleeding from the lower genital tract include cervical, vaginal, vulval, and perineal tears and episiotomies. Vaginal bleeding that persists despite a well contracted uterus indicates the source is very likely to be the lower genital tract. With the exception of cervical tears without vaginal extension, all the above tears can lead to paravaginal haematomas, which in turn can be either below or above the levator ani muscle, namely infra- or supra-levator haematomas respectively. Infra-levator haematomas will arise as a result of bleeding into the vulva, the perineum, the paravaginal space and/or ischioanal fossa. Supra-levator bleeding is more dangerous and blood loss into the retroperitoneal space can be massive.

Overwhelmingly, the source of bleeding is not only more difficult to identify, it is more difficult to control. Significant infra-levator haematomas will occur in about 1 in 500-1000 deliveries whilst significant supra-levator haematomas will occur in 1 in 1000-20000 deliveries.³¹ Management of the infra-levator haematoma depends on size and whether it is bleeding actively or obviously expanding or not. If the haematoma is <5 cm and not expanding, treatment is analgesia, ice packs and pressure packs. If the haematoma is >5 cm or expanding, then it is advisable to incise the haematoma via the vagina, tie off any obvious bleeders, obliterate the cavity by inserting figure 8 sutures, insert a drain and pack the vagina with vaginal gauze rolls soaked in acroflavine or placed in sterile plastic drapes to facilitate removal without precipitating further bleeding. Generally, the pressure packs should be left in the vagina for about 24-36 hours before removal.

All these patients need a urinary catheter and broad spectrum antibiotics. Inserting a blood pressure cuff into a glove or condom and then into the vagina can stop bleeding by blowing up the cuff until compression of the vagina is obvious. This can be left in-situ for 8-10 hours after which it can be deflated slowly over 4 hours. Any cervical tear which extends above the internal os of the cervix warrants a laparotomy. Approximately 50% of supra-levator haematomas, and particularly broad ligament haematomas, present early with symptoms of lower abdominal pain, haemorrhage and in severe cases, shock. The remaining will present after 24 hours. Broad ligament and retroperitoneal haematomas are initially managed conservatively if the patient is stable and the lesions are not expanding. Ultrasound, CAT scan and MRI may all be used to assess the size and progress of these haematomas. If it is not possible to maintain a stable haemodynamic state, active intervention is indicated. Invariably hysterectomy with bilateral internal iliac artery ligation is the most effective modality to deal with the problem, particularly where there is any possibility that the supralevator or broad ligament haematoma is due to a ruptured uterus or where a cervical tear appears to have extended up into the uterus.

Invariably the tissue will be friable and care must be taken to ensure haemostasis as stitch material may well tear through tissue pedicles when trying to tie them. It is also important to identify the ureters before proceeding with the surgery as blind placement of sutures can easily injure the ureters.³¹

Retained Placenta

Opinion is divided about the timing of manual removal of the placenta. In the presence of haemorrhage, it is obviously unreasonable to wait for spontaneous separation and manual removal should be undertaken without delay. In the absence of bleeding, many would advocate removal 30 minutes after delivery of the infant. Thereafter it is reasonable in every case, particularly if bleeding is not an issue, to draw up 20-30 IU syntocinon in about 25 ml of normal saline in a syringe, clamp the cord and inject the contents of the syringe into one of the umbilical vessels, wait about 5 minutes and then deliver the placenta. This strategy may be effective in causing the adherent placenta to separate and hence allow delivery of the placenta by the modified Brandt-Andrews method only.³² If this is not possible, then manual removal must be undertaken. The uterus is stabilized by grasping the fundus with a hand over the abdomen. The other hand follows the course of the umbilical cord through the vagina and the cervix into the uterus to palpate the edge of the placenta. The membranes at the placental margin are perforated, and the hand

is inserted between the placenta and the uterine wall, palmar side toward the placenta. The hand is then swept side to side to peel the placenta from its attachment to the uterus. When the placenta has been completely separated from the uterus, it is grasped and pulled from the uterus. It is important to confirm that the placenta and membranes are complete. The author does not have firm data to support the practice but he will always follow the manual removal with a gentle sharp curettage, using the largest possible curette. All patients are all given broad spectrum antibiotics and either intravenous or rectal uterine medication.

Surgical management of the inverted uterus

Acute uterine inversion is a rare but serious complication of the third stage of labour, with an estimated incidence of 1 in 2000-20000 deliveries.³³ It may be complete or incomplete, depending on whether the fundus has passed through the cervix. In the case when all conservative measures have failed to correct the complication, which may have included, on its own or in combination, gentle forceful digital replacement, a tocolytic agent, intravenous magnesium sulphate or hydrostatic replacement, a mid-line laparotomy with the patient in the Trendelenburg position must be performed. A self retaining retractor must be inserted into the abdominal incision in order to adequately expose the inverted uterus. An important strategy that inevitably improves the chance of successfully correcting the inverted uterus is the Huntington procedure, whereby the ends of the round ligaments, mostly embedded within the inverted uterus, are grasped with Allis forceps bilaterally. The surgeon should then place his/her hands along the anterior and posterior wall of the inverted uterus as far inferiorly as possible.

The surgeon must gently compress his/her fingers towards each other and at the same time sweeping the fingers superiorly trying to drag the inverted uterus to its normal position. At the same time, the assistant is to put gentle traction on the two Allis forceps attached to the round ligaments so as to "pull" on the uterus while the fingers of the surgeon are trying to "drag" the uterus into its normal shape. These manoeuvres continue until the uterine inversion is corrected. Should this be impossible, the Haultain technique should be undertaken. An incision is made through the posterior wall of the uterus through the cervical ring. A finger is inserted into the uterine cavity and by digital manipulation the inverted uterus is corrected. Once corrected, a uterotonic drug is administered to facilitate and maintain a well contracted uterus which in turn, will prevent for inversion.^{34,35}

In conclusion, even though pregnancy and childbirth are generally most rewarding and result in much happiness, there will nevertheless be occasions when "THINGS" go wrong. The aim of this presentation has been to provide some surgical options to manage these unforeseen occurrences.

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Welcoming Function for 2008 Graduates

Dr Max Price, Vice-Chancellor of the University of Cape Town was the guest speaker at the annual meeting of the Association of Members in the Western Cape held in the Smith & Nephew Foundation Room, CMSA, 17 Milner Road, Rondebosch on 18 November 2008. The topic of his thought-provoking address was “Why should doctors

have a special responsibility to society?” The function is held annually to welcome new graduates into the CMSA and to give them an opportunity to meet informally with the President and some of the established members.



Prof Max Price giving the oration



Prof Zephne van der Spuy (President) with a few of the new members who received their Fellowships or Diploma qualifications in 2008



The group of new members

A Tribute to the CMSA

I have had a long association with the CMSA, starting as a Fellow in 1979, followed by 6 years as Secretary to the College of Physicians in the late nineties and 2 terms as its President from 2002 to date. It has been a most enjoyable association, one which I value highly. It has been a pleasure interacting at different levels with colleagues from around the country, and participating in the many activities associated with the CMSA. At the College of Physicians' level it has been a most fulfilling experience, participating in curriculum development and the examination process. Our most important asset, the Registrars, have appreciated our efforts at streamlining these

processes for their benefit. We are also blessed with a warm and efficient administrative staff at the CMSA, who perform Herculean tasks with equanimity.

In view of my many positive experiences, I thought it appropriate that I give something back to the CMSA. Being a keen gardener, I thought a suitable gift would be a serene and attractive water feature for the garden of the CMSA facility in Parktown, Johannesburg. A memorial plaque has been placed above the water feature:



Before



After



**IN RECOGNITION OF THE CUSTODIANS
OF MEDICINE**

Professor Ken Huddle July 2008

This is to pay tribute to the vital role the CMSA plays in maintaining standards and guiding the profession.

Prof. K.R.L. Huddle
President: CP(SA)

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