



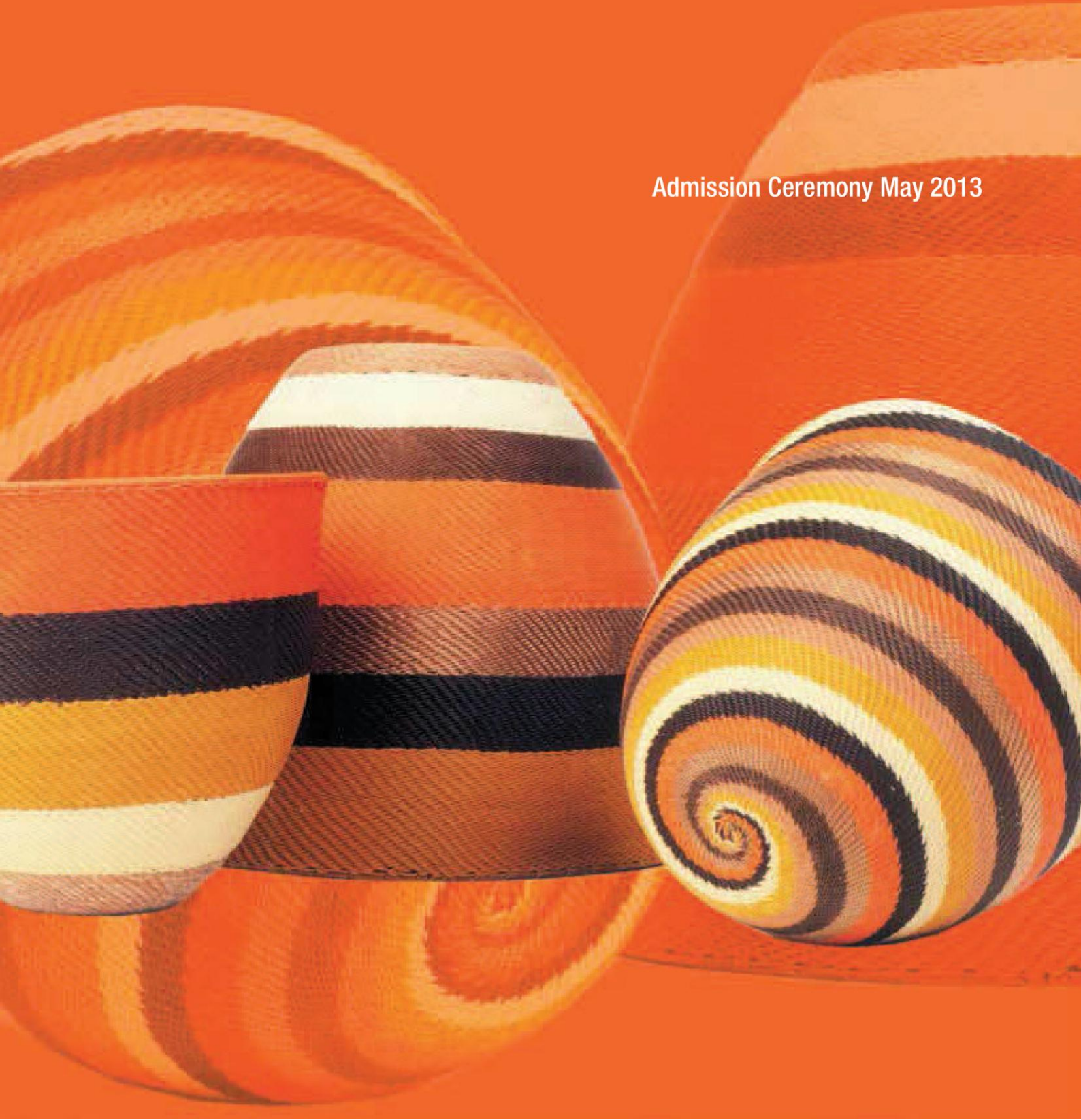
TRANSACTIONS

Journal of The Colleges of Medicine of South Africa (CMSA)

Volume 57 (2) July - December 2013

ISSN 0010-1095

Admission Ceremony May 2013



CMSA Executive

23 May 2013



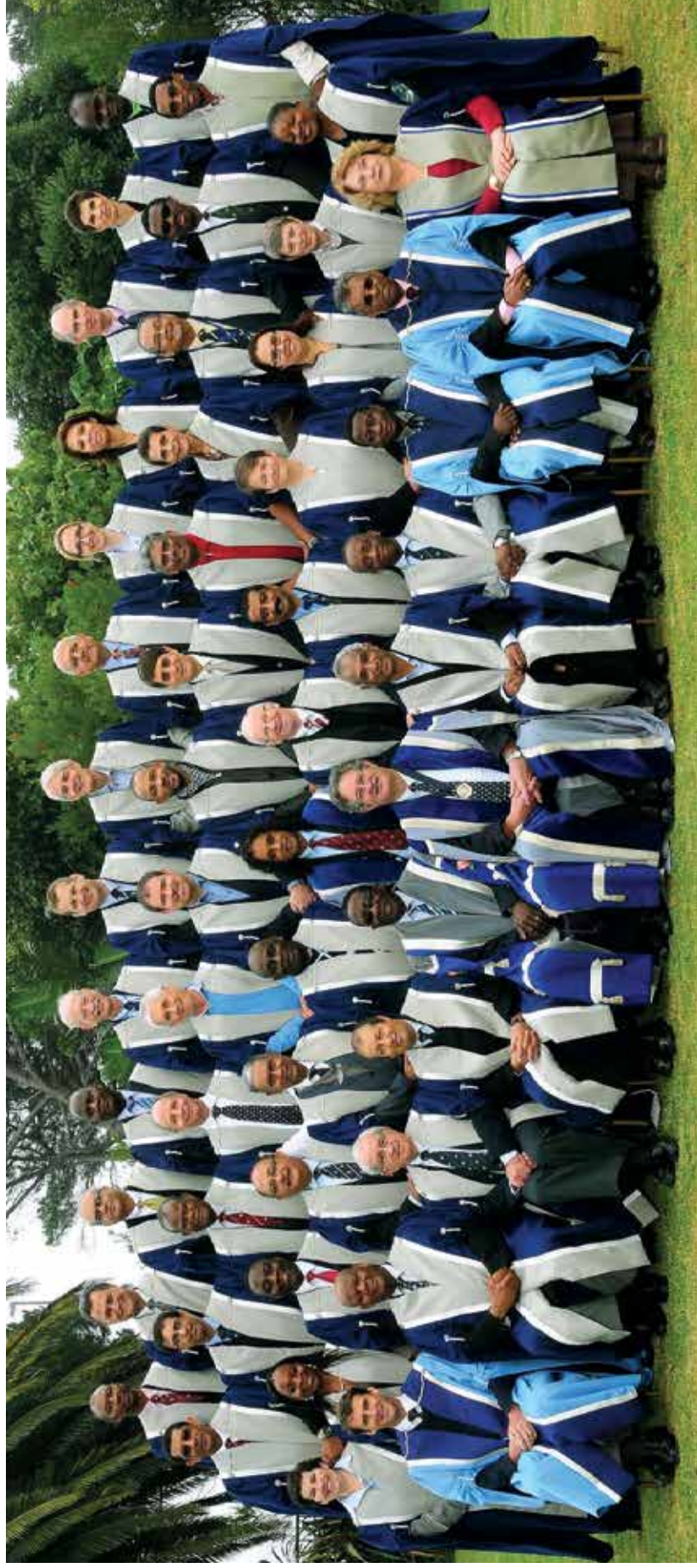
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Back row from the left: Prof A Segone; Prof J J Fagan (hon Registrar Finance and General Purposes Committee); Prof A Madaree (immediate Past President); Prof J S Bagratee (hon Registrar Education Committee); Mrs A Vorster (Academic Registrar)

Not present: Mrs B Bothma (CEO)

The Colleges of Medicine of South Africa Senate

23 May 2013



Front row from the left: Prof. J J Fagan (Hon Registrar Finance and General Purposes Committee); Prof A M Segone; Prof T Zabow (Hon Treasurer); Prof D Kahn (Chairman Finance and General Purposes Committee); Prof G A Ogunbanjo (Vice President); Prof B G Lindeque (President); Prof A Reddi (Chairman Education Committee); Prof J L A Rantsoane (Chairman Examinations and Credentials Committee); Prof M M Satheke (Hon Registrar Examinations and Credentials Committee); Prof J S Bagratee (Hon Registrar Education Committee); Mrs A Vorster (Academic Registrar)

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Not present: Dr R C Amodi; Prof S Andronikou; Mrs B Bothma (CEO); Prof B J S Diedericks; Prof R N Dunn; Prof A M P Harris; Dr M Heunis; Prof R J Green; Prof A Krause; Dr R J Lehloenyia; Prof G Maartens; Prof L J Martin; Prof R D Nicholson; Prof S Seedat; Prof P L Semple; Prof C P Szabo; Prof M G Veller

TRANSACTIONS

Volume 57 (2) July - December 2013



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Publisher: Dr Douw GS Greeff

Production: Ms Caryl de Meillon

Medpharm Publications (Pty) Ltd

Publisher: Medpharm Publications (Pty) Ltd

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Designer: Mrs Jenny Hattingh (X-Axiscc)

Printed by: Intrepid Printers (Pty) Ltd

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In support of contemporary Zulu telephone wire baskets

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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 CMSA office in Rondebosch is eager to establish the whereabouts of the following "lost members", some of whom may be deceased. Please e-mail Naomi Adams at members@colmedsa.co.za with any information that might be of assistance.

Azam, Muhammed (College of Paediatricians)

Bennett, Margaret Betty (College of Radiologists)

Chatora, Tsitsi Vimbayi (College of Family Physicians)

Gibson, John Hartley (College of Obstetricians and Gynaecologists)

Kok, Hendrik Willem Lindley (College of Neurologists)

Meyer, Julius (College of Psychiatrists)

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)

Segal, Dennis Selwyn (College of Family Physicians)

Teferi Woldetsadick, Nebiat (College of Otorhinolaryngologists)

Van Coller, Beulah Mariè (College of Paediatricians)

Van Greunen, Johannes Petrus (College of Obstetricians and Gynaecologists)

Information as at 21 August 2013



What is the status quo of South Africa's National Health Insurance pilot project?

This editorial was motivated by a colleague's recent criticism of the National Health Insurance (NHI) pilot project that was launched in April 2012. He claimed that patients have not experienced any tangible difference in health service delivery from

the pilot NHI districts, compared to that from other non-NHI pilot districts. The selection of 13 pilot NHI districts was based on audit findings, which included the district's health profile, demographics, income levels and other social factors that impact on health, health delivery performance, management of health institutions and compliance with quality standards.¹ I engaged my colleague by asking him if he knew the objectives of the NHI pilots, to which his response was: "No". Obviously, from this short interaction I asked myself the question: "How many other colleagues are ill- or uninformed about the objectives of the pilot sites and implementation plan of the NHI?"

NHI is supposed to be a "financing system" that will ensure that all citizens of South Africa, and legal long-term residents, are provided with essential health care, regardless of their employment status and ability to make a direct monetary contribution to the NHI fund.¹ Furthermore, the establishment of the pilot districts was to help the National Department of Health to finalise how the service benefits will be designed, how the population will be covered, and how the services will be delivered.¹ The 2012 budget had a special conditional grant to kick start the pilot project.

The objectives of the pilots are to assess:²

- The ability of districts to assume greater responsibility with a "purchaser-provider split".
- The feasibility, acceptability, effectiveness and affordability of engaging the private sector.
- The costs of introducing a fully-fledged district health authority and the implications for expansion.

The question to ask is: "What progress has been made on these objectives since April 2012?" The March 2013 editorial of the *South African Medical Journal* highlighted a number of achievements that have occurred, namely that approximately 25% of the 40 000 community health workers have been trained in the new, national approach to community-orientated primary health care; more mobile clinics were established to support the school health services, and 43% of the 364 posts created for district clinical specialist teams have been filled. Returning to my colleague's claim that patients have not experienced any tangible difference in health service delivery from the NHI pilot districts compared to that from other districts needs to be interrogated. Is this a justifiable claim?

The answer lies in a review of the three objectives of the pilots. The National Department of Health has attempted to bridge the public and private health systems divide by contracting private general practitioners (GPs) to provide sessional services within its primary healthcare clinics in the pilot NHI districts. It planned to contract approximately 600 GPs to provide these services.³ The success

of this initiative has not been publicised in terms of the number of GPs who have embraced and supported this healthcare reform strategy. In addition, pilot NHI districts that have assumed greater responsibility with a "purchaser-provider split" model are unknown.

The second objective of engaging the private sector should be unpacked to highlight what is expected. This is crucial if the private health sector, which is an important stakeholder, is to significantly contribute to the department's vision on NHI. It is heartening to note that the private health sector has openly given its support to the introduction of the NHI. But, this has to translate to the formulation of sustainable models of healthcare funding which are currently not in place. In South Africa, health care is financed in three ways, namely the public sector (funded by the government), the private sector (funded by the medical schemes), and out-of-pocket spending (funded by individual patients). Of these three funding streams, the major consumer of the health budget remains the private health sector, which caters to only 16.2% of the population. To accomplish the "feasibility, acceptability, effectiveness and affordability" of engaging the private health sector, private healthcare funders and providers need a mind shift which aims to provide "equity" in health. This is still a challenge and should be reported as such, and the National Department of Health has to craft innovative health reform strategies to deal with this challenge in collaboration with the private healthcare sector.

Finally, introducing and costing the ideal "fully-fledged" district health authority is long overdue. The National Department of Health owes us a progress report on this objective from the pilot NHI districts in terms of the number of district health authorities that have been established and are fully functional. The constant update of achievements on these three objectives will go a long way towards addressing the concerns of sceptics about the NHI project. On a positive note, the 2012 Statistics South Africa General Household Survey indicates that 79.2% of households were satisfied with services at public facilities, although this is 4.4% less than the 2011 survey which indicated that 83.6% of households were satisfied.⁴ The take-home message is that the nation needs regular progress reports from the National Department of Health on the successes and challenges linked to the three objectives of the pilot NHI districts. If strictly adhered to, the latter will provide the advocacy thrust for the impending nationwide NHI roll-out. I encourage colleagues to be part of this healthcare reform in redefining South Africa's health landscape, of which "health equity" for all should be the guiding principle.

Prof Gboyega A Ogunbanjo

Editor: *Transactions*

References

1. National Health Insurance. National Department of Health [homepage on the Internet]. c2013. Available from: <http://www.doh.gov.za/list.php?type=National%20Health%20Insurance>
2. Matsoso MP, Fryatt R. National Health Insurance: the first 18 months. *S Afr Med J*. 2013;103(3):156-158.
3. National Health Insurance: the first eighteen months. National Department of Health [homepage on the Internet]. c2013. Available from: http://www.doh.gov.za/docs/policy/2013/NHI_1st_eigh-teen_months.pdf
4. Kagiso Media. Stats SA's General Household Report for 2012 [homepage on the Internet]. c2013. Available from: <http://news.howzit.msn.com/news-features/stats-sas-general-household-report-for-2012-1>

Presidential Newsletter



It is an honour to contribute to this column for the first time.

The Colleges of Medicine of South Africa (CMSA) is a worthy and important role player in the field of postgraduate learning and assessment in Medicine and Dentistry. It has a proud history of contribution to South Africa through ensuring the delivery of specialists and subspecialists of high standing, and by encouraging study in many disciplines through various diploma examinations. This was, and is still, achieved, through the dedicated efforts of a rather small number of people.

At the outset, I thank the immediate Past President, Prof Anil Madaree, for his dedication to the CMSA, as well as CMSA members in decision-making positions, examiners and CMSA staff members for making certain that we have strong and lively Colleges.

The CMSA is a large organisation of significant complexity, and is a growing enterprise. There is a strong value system in place and it is being developed and intensified all the time. Its basic belief in justice, fairness, beneficial action, respect, loyalty, transparency

and voluntariness makes the CMSA an exceptional organisation, one of which every member should be proud.

Leading the CMSA as President is an enormous honour, and I accepted the role with humility. The CMSA requires leadership as before. More so, it requires support from everyone who has had an association with the CMSA, in particular those who have been successful in assessments and who have enjoyed career advances because of it. The CMSA is only as strong as it is allowed to be by its members.

From my side, I want to support the move by the CMSA “from good to great”. Its new role as the national examining body in the very near future is well known, but offers significant tasks and challenges, including crystal clear administration, excellent financial systems, guardianship on many fronts, and a common vision on how to approach the future. Senate and the Committees are spending considerable time on these issues, and I hope to continuously drive this forward. In particular, there is a need for a sustainable funding model. Excellence in the examinations is the bread and butter of the CMSA and must be nurtured, developed and modernised. Where possible, teaching enterprises will be investigated as well.

My big request is that the CMSA becomes, and stays, a part of all its members’ lives. The ways in which the CMSA communicates with “old”, as well as new, members (the various generations), will be crucial in reaching this objective.

Thank you for taking these tasks seriously. Let us enter a growth spurt that is worthy of our CMSA.

Thank you.

Gerhard Lindeque
President



Admission Ceremony 23 May 2013

The admission ceremony was held in the Durbanville High School Auditorium, Durbanville.

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

The Honorable Mr Justice DM Davis, of the Western Cape High Court, delivered the oration.

Twenty-six medallists were congratulated by the President on their outstanding performance in the CMSA examinations. The premier CMSA Phyllis Knocker/Bradlow Award was presented to Dr Carla Kotze. Medals were awarded in the following fellowship disciplines: Anaesthetics, Emergency Medicine, Internal Medicine, Maxillo-Facial and Oral Surgery, Neurology, Obstetrics and Gynaecology, Ophthalmology, Paediatrics, Pathology, Public Health Medicine, Surgery and Urology. Medals were also awarded in the following diploma disciplines: Allergology, Anaesthetics, HIV Management and Ophthalmology.

Honorary Fellowships were awarded to Professor Richard Santucci by the College of Urologists, and to Professor Prem Puri by the College of Paediatric Surgeons. The citations were written by Professor Chris Heyns, read by Professor Dick Barnes, and written and read by Professor Alastair Millar respectively.

A Fellowship Ad Eundem was awarded to Professor Athol Kent by the College of Obstetricians and Gynaecologists. The citation was written by Professor Zephne van der Spuy and read by Professor Franco Guidozi.

The President announced that he would proceed with the admission to the CMSA of the new Certificants, Fellows and Diplomates.

The new Certificants were announced and congratulated.

The Honorary Registrar - Examinations and Credentials, Professor Mike Sathekge, announced the candidates, in order, to be congratulated by the President. The Honorary Registrar – Education, Professor Jay Bagratee, individually hooded the new Fellows. The Honorary Registrar – Finance and General Purposes, Professor Johan Fagan, handed each graduate a scroll containing the Credo of the CMSA.

The new Diplomates were announced and congratulated.

In total, the President admitted 30 Certificants, 192 Fellows and 183 Diplomates.

At the end of the ceremony, the National Anthem was sung, after which the President led the recent graduates out of the hall. Refreshments were served to the graduates and their families.

GUEST SPEAKER



THE HONOURABLE MR JUSTICE D M DAVIS
WESTERN CAPE HIGH COURT, CAPE TOWN

FELLOWSHIP AD EUNDEM



FELLOWSHIP AD EUNDEM COLLEGE OF OBSTETRICANS
AND GYNAECOLOGISTS: PROF ATHOL KENT

HONORARY FELLOWSHIP



COLLEGE OF UROLOGISTS: PROF RICHARD A SANTUCCI



COLLEGE OF PAEDIATRIC SURGEONS: PROF PREM PURI

AWARDS/MEDALLISTS



PHYLLIS KNOCKER/BRADLOW
AWARD: DR CARLA KOTZE



JACK ABLESOHN MEDAL & BOOK PRIZE:
DYLAN ALEXANDER HEPBURN
FCA(SA) Part II



CAMPBELL MACFARLANE MEDAL:
VICTORIA SARAH STEPHEN
FCEM(SA) Part I



SA SOCIETY OF MAXILLO-FACIAL AND
ORAL SURGEONS MEDAL: EDUARDO
NUNO ALBURQUERQUE FERREIRA DA SILVA
FCMFOS(SA) Final



SIGÖ NIELSEN MEMORIAL PRIZE:
SUZAAN MARAIS
FC Neurol Part I



SIGÖ NIELSEN MEMORIAL PRIZE:
MIKE HUTH
FC Neurol Part I



NOVARTIS MEDAL:
LEIGH LUELLE VAN DEN HEUVEL
FC Psych(SA) Part II



DAUBENTON MEDAL:
LINDA RUTH VOLLMER
FCOG(SA) Part II



NEVILLE WELSH MEDAL:
THOMAS JOHANNES JORDAAN
FC Ophth(SA) Primary IA



OPHTHALMOLOGICAL SOCIETY MEDAL: STEVEN ROBERT JAN LAPERE
FC Ophth(SA) Intermediate IB



JUSTIN VAN SELM MEDAL:
CAROLINE GOODING
FC Ophth(SA) Final



JUSTIN VAN SELM MEDAL: MPOPI
NTHABISENG LEBOHANG LENAKE
FC Ophth(SA) Final



LESLIE RABINOWITZ MEDAL:
LINDSEY LEVIN
FC Paed(SA) Part I



COLTLER MEDAL:
BRYONY LYNN WALKER
FC Path(SA) Part I



AM MEYERS MEDAL:
TRUST ZARANYIKA
FCP(SA) Part I



SASOM MEDAL:
AMY DE HAVILLAND BURDZIK
FCPHM(SA) Occ Med



BREBNER AWARD:
PAUL STUART STEVENS
FCS(SA) Int



LIONEL B GOLDSCHMIDT MEDAL:
MARK RICHARD PURDY
FC Urol(SA) Final



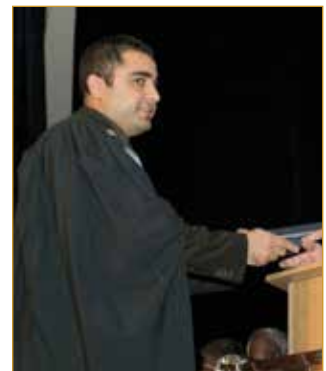
SASA JOHN COUPER MEDAL:
FREDERICK GEORGE OLIVIER
DA(SA)



HIV CLINICIANS SOCIETY MEDAL:
TRICIA LYN PICKARD
Dip HIV Man(SA)



GEOFF HOWES MEDAL:
SCHALK HUGO DU TOIT
Dip Ophth(SA)



GEOFF HOWES MEDAL:
SAYEED HAMZAH MUSTAK
Dip Ophth(SA)

CITATION: Prof Richard Santucci Honorary Fellowship of The Colleges of Medicine of South Africa

Prof Richard Santucci is currently Clinical Professor of Urology in the Department of Surgical Specialties at Michigan State University, and Specialist-in-Chief in Urology at the Detroit Medical Center, USA.

He qualified with a Bachelor of Science in Psychology with Honours at the University of Michigan in 1987, and as Doctor of Medicine at Baylor College of Medicine, Houston, Texas, in 1991. He completed his Residency in Surgery between 1991 and 1993, and his Residency in Urology at the University of Washington Medical Center, Seattle, from 1993-1997. He participated in a Research Fellowship in burns and trauma at the Scripps Research Institute, La Jolla, California, in 1999, and completed a Clinical Fellowship in urological trauma and reconstruction in 2000 at the University of California, San Francisco, under the mentorship of Dr Jack McAninch, one of the world's leading authorities on urogenital trauma and urethral reconstructive surgery. Dr McAninch also served as President of the American Urological Association, as well as the Société Internationale d'Urologie.

In 1999, Prof Santucci was Clinical Instructor in the Department of Urology at the University of California, San Francisco. He was appointed as Assistant Professor at the Wayne State University School of Medicine in August 2000, and promoted to Associate Professor in 2005. In January 2008, he was appointed as a full Clinical Professor of Urology at Michigan State University.

His professional appointments include:

- Specialist-in-Chief, Urology, Detroit Medical Center.
- Director, Center for Urologic Reconstruction.
- Chief of Urology, Detroit Receiving Hospital.
- Chief of Urology, Trauma Surgery, Sinai Grace Hospital.
- Director of Innovative Medicine, Detroit Receiving Hospital, Detroit.

Prof Santucci holds membership of numerous professional bodies, including the American Medical Association, the American Urological Association, the American College of Surgeons, the Society for Basic Urologic Research, the Society of Genitourinary Reconstructive Surgeons and the Société Internationale Urologie. He has received numerous awards in recognition of his research endeavours and publications, and serves as a reviewer for many prominent urological journals. He has also been on numerous international, national and local institutional committees.

He has authored, co-authored and published 39 original observations in refereed journals, 34 review articles, 37 books or chapters in books, 14 case reports and 28 editorials. He has presented 58 papers with published abstracts at congresses, and has presented 19 lectures which he was invited to deliver at urological meetings. He has appeared as an invited lecturer at 33 national and 36 regional meetings, and has presented more than 65 local lectures on a variety of subjects relating to urology.

Prof Santucci attended the biennial Congress of the South African Urological Association (SAUA) as an invited speaker in 2004, 2006 and 2008, and also visited our country to deliver the prestigious Guy de Klerk Memorial Lectures as invited guest of the SAUA in 2005. He became actively involved in the education and training of registrars in Urology in South Africa, and has performed hands-on teaching workshops on reconstructive urethral surgery in Cape Town, Bloemfontein, Johannesburg and Durban. He has also taken part in training workshops on urological surgery in Maputo, Mozambique.

Prof Santucci is highly esteemed in the urological community, both in the USA and internationally. In South Africa, he has established professional and collegial relationships with many urologists, both young and old, from all parts of the country. He has a lively interest in South African history, and has visited many of the historical battlefields in KwaZulu-Natal, the Free State and the Northern Cape. He has a great love of nature and wildlife, both on land and in the sea, and during trips to South Africa he visited our game parks and participated in shark diving because he has a special interest in aquatic life. During his most recent visit, he was accompanied by his wife, children and several family members, and while they conducted a self-drive guided tour from Durban to Cape Town, he conducted a reconstructive urology workshop in Bloemfontein.

The fact that Prof Santucci is relatively young should be considered as an advantage when conferring Honorary Fellowship on him at this stage of his career because he will be able to contribute to urological education in South Africa for a considerable time in the future, and will be in a position to strengthen the links of our College with the urological community in North America.

Prof Chris Heyns

CITATION: Prof Prem Puri

Honorary Fellowship of The Colleges of Medicine of South Africa

Prof Prem Puri is the Newman Clinical Research Professor at the University College and President of the Children's Research Centre at Our Lady's Children's Hospital in Dublin.

Having received his undergraduate training in India where he was born, he went on to specialise in Paediatric Surgery in Dublin under Barry O'Donnell, and at Great Ormond Street with Harold Nixon and Andrew Wilkinson.

The career of this remarkable and unassuming man has been distinguished by clinical and academic excellence. He has received global recognition for his standing as a paediatric surgeon, educator, innovative investigator and researcher. Prof Puri is known internationally for his research into underlying mechanisms that cause birth defects and innovative treatments which have benefited children all over the world. His research has spanned the field of paediatric surgery from the management of appendicitis and fertility after orchidopexy, to vesicourethral reflux, Hirschsprung's disease, congenital diaphragmatic hernia and oesophageal atresia. This research has fundamentally changed our concept of these abnormalities, and is a remarkable testimony to Prof Puri's dedication and contribution to clinical and experimental medicine. As an example, his innovative thinking led to a radical change in the management of vesicoureteral reflux, which subsequently became a gold standard of care worldwide.

Prof Puri is Secretary of the International Board of Paediatric Surgical Research and an Honorary Fellow of many international learned medical and scientific societies. He is Editor-in-Chief of *Paediatric Surgery International*, Associate Editor and a member of the *Journal of Paediatric Surgery*, and five other international journals. As Editor-in-Chief, he has upheld the clinical, experimental and ethical standards of the journal.

He has been awarded several research grants over the years. His publications contain 10 books or monographs, 127 chapters in textbooks, and over 500 articles in peer-reviewed journals. His books on *Neonatal surgery* and *Paediatric surgery: diagnosis and management* are standard textbooks for training and teaching. Prof Puri is also an external examiner for higher degrees from many international universities. He has supervised over 50 MD and PhD students. Over 60 paediatric surgeons from across the world trained under his auspices in Dublin. His organisational ability is underscored by being the organiser of 10 successful national and international congresses and meetings.

He is a multi-award-winning researcher, whose previous awards include:

- People of the Year Award, in Ireland.
- The prestigious Denis Browne Gold Medal, from the British Association of Paediatric Surgeons, for outstanding contributions to Paediatric Surgery.
- The Rehbein Medal, from the European Associations of Paediatric Surgeons, for his exceptional contribution to Paediatric Surgery.
- The Franco Soave Gold Medal, for outstanding contributions to Hirschsprung's disease.
- The Gandhi Gold Medal.
- The Paediatric Urology Progress Gold Medal, from the World Federation of Associations of Pediatric Surgeons.
- A Lifetime Achievement Award, from the Indian Association of Paediatric Surgeons.
- The Kafka Medal, for outstanding contributions to Pediatric Surgery.

Prof Puri's international standing as Paediatric Surgeon is further underlined by being selected President of the World Federation of Paediatric Surgeons, President of the European Paediatric Surgeons Association and Chairman of the Scientific Office of the European Association of Paediatric Surgeons.

He has been a visiting professor to many leading universities throughout the world and an invited speaker to 200 international scientific meetings. True to his nature, and having spent his early years in India where he realised the many disadvantages that children have in the developing world, throughout his life he has promoted and supported in person the spread of knowledge and new surgical advances that would benefit such children. Prof Puri has been a good friend, and over the years has fostered excellent relationships with South African paediatric surgeons.

He has never been satisfied with second best, and to him, the highest standard of child care is sacrosanct.

Throughout his career, he has been supported by his wife, Veena, who created an environment in which he could flourish. From their union, three children were born: Abir, Anita and Nicki, of whom they are very proud. His life and work have been remarkable, and have held immense significance for sick children.

Therefore, it is a great honour to ask you, Mr President, to confer an Honorary Fellowship in the College of Paediatric Surgeons on Prof Prem Puri.

Prof AJW Millar

CITATION: Prof Athol Parkes Kent Honorary Fellowship of The Colleges of Medicine of South Africa

Prof Athol Parkes Kent graduated with an MBChB in 1968 at the University of Cape Town (UCT), after a student career distinguished by extraordinary extramural activities, which included the role of cheerleader for UCT at the annual US-UCT rugby matches. He subsequently specialised in Obstetrics and Gynaecology at the John Radcliffe Hospital in Oxford from 1971-1975. He returned to South Africa in 1976, having obtained the MRCOG in 1975. He was actively involved within the Department of Obstetrics and Gynaecology at UCT as a full-time specialist until 1997. At this point in his career, he elected to leave the Department to develop an ongoing academic programme which provided an assessment of journals to colleagues around the world. This is now a well-regarded programme, and pays tribute to his insight into the need for continuing medical education.

From 1997, he remained an honorary lecturer, involved with undergraduate teaching within the Department of Obstetrics and Gynaecology at UCT. In 2005, he was appointed as a part-time senior lecturer, with particular responsibility for curriculum development and coordination in Obstetrics and Gynaecology. In 2008, this post was converted to a full-time appointment, which has continued to date. He was promoted *ad hominem* to Associate Professor within the Department of Obstetrics and Gynaecology in 2009 in recognition of his contribution to teaching and training, both in the discipline of Obstetrics and Gynaecology and more broadly within the Faculty.

Prof Kent has always displayed a particular interest in medical education, and in 1994 was awarded the degree MPhil (UCT) for a dissertation entitled *Medical education*. It reviewed the state of medical education in our institution, with particular reference to the teaching of students by students and the development of medical teachers.

While Prof Kent has been an active clinician within Obstetrics and Gynaecology, undoubtedly his main contribution to our discipline has been in educational activities locally, nationally and internationally. He has worked actively to maintain organisations that are involved in clinical teaching, has contributed enormously to educational developments in the Department of Obstetrics and Gynaecology and the Faculty of Health Sciences of UCT over many years, and has also been central to national teaching activities.

His achievements include the development of the online Journal Article Summary Service, of which he is the owner, publisher and editor-in-chief. This has proved to be an important resource,

both in South Africa and abroad. From 2006-2010, he edited the *South African Journal of Obstetrics and Gynaecology*, and recruited valuable input from distinguished colleagues, such as Prof James Drife, who contributed to the content of the journal.

While he was a full-time senior lecturer at Groote Schuur Hospital/UCT, he developed the concept of “teach-ins for teachers”. This has continued for many years. Initially, this was based within the local UCT faculty, but more recently expanded to include colleagues from other faculties. It recognises the need to offer established members of the clinical platform the opportunity for tuition and review of teaching practices. This innovation has been widely assessed as being of particular value to clinicians with teaching responsibilities, and recognises that clinicians need input and stimulation in order to develop good teaching skills. Prof Kent has developed educational collaborations with Namibia, and is undoubtedly regarded an outstanding educationalist in medical education in South Africa.

Possibly, his major achievement in South Africa was the introduction of the objective structured clinical examination to undergraduate examinations, and the development of this as a formal accepted examination format nationally, as well as stimulating ongoing medical education workshops and training within South Africa. He has been very active within the South African Association of Health Education (SAAHE), and remains someone who is highly respected and well regarded by all Health Science faculties within this country and within many departments outside of South Africa. Prof Kent was recognised locally in 2011 as the “Distinguished Educator of the Year” by SAAHE, and also internationally through invitations to participate in The Association for Medical Education in Europe meetings.

He has contributed significantly to medical education, particularly in the area of Obstetrics and Gynaecology, and our College wishes to recognise him for these achievements. Every faculty has benefited from his innovations, and he continues to be very active in medical education and to contribute to the development of undergraduate education.

Mr President, it is appropriate that Prof Athol Parkes Kent should be awarded the Fellowship *Ad Eundem* of The College of Obstetricians and Gynaecologists in recognition of his outstanding contribution to medical education in South Africa.

Prof Zephne M van der Spuy

List of successful candidates: March 2013

Fellowships					
Fellowship of the College of Anaesthetists of South Africa: FCA(SA)					
CLOETE Esther	UCT	SMITH Anne Beth	US	HANEKOM Gerhardus Jakobus	UFS
DE GOEDE Adele	US	Fellowship of the College of Family Physicians of South Africa: FCFP(SA)		KRICK Daniela	UCT
DUKHI Arusha	UKZN	DRAPER Claire Anne	UCT	MOHAMED Amenah MM	US
DUNPATH Ashveer	UKZN	MFEKA Nompumelelo Gloria		MOMBERG Zoe Louisa	UCT
DWYER Sean	US	Fellowship of the College of Forensic Pathologists of South Africa: FC For Path(SA)		MOODLEY Ashley Raman	US
ENDEMANN Theodor Martin Hemuth	UFS	QUARRIE Karisha Claudia	US	NDJAPA NDAMKOU Constant	UKZN
GILLILAND Lizil	WITS	Fellowship of the College of Maxillofacial & Oral Surgeons of South Africa: FCMFOS(SA)		NDLOVU Thembi Rinah	UP
KAY Jonathan	UCT	KARACHI Nadeem	WITS	OSMAN Ayesha	UCT
KOLLER Veronica Leigh	UCT	NAIDOO Sharan	UP	POTGIETER Johannes Frederik Andries	WITS
LISTON Lindie Susan	US	Fellowship of the College of Medical Geneticists of South Africa: FCMG(SA)		ROSSOUW Jana Nicolene	US
MARÉ Anna-Mart	WITS	LOCHAN Anneline	WITS	SEFANYETSO Lesego Blessing	WITS
MFEYA Loyiso Ndzondelelo	WSU	PRETORIUS Careni Elizabeth	UCT	Fellowship of the College of Ophthalmologists of South Africa: FC Ophth(SA)	
MITCHELL Colin	UKZN	Fellowship of the College of Neurologists of South Africa: FC Neurol(SA)		JAYA Yevukai Aquillina	
MOODLEY Dhesan	WITS	ABUSDERA Fuad Muftah	UKZN	JOUBERT Francois	UCT
MURRAY Albertus Adriaan	US	ALBERTYN Christine Herculine	UCT	MANN Tristan	UL
NOBBS Gareth	WITS	BREY Naeem	US	ROWJEE Taruna	WITS
NOLTE Dean Christopher	UCT	ROSSOUW Anastasia Claudia	US	SINGH Shaneel Mansingh	UKZN
PICKEN Guy	UCT	Fellowship of the College of Neurosurgeons of South Africa: FC Neurosurg(SA)		XULU Nozipho	UKZN
POULTNEY Shane Knott	WSU	ACKERMANN Derek	UFS	Fellowship of the College of Orthopaedic Surgeons of South Africa: FC Orth(SA)	
RAMSAMY Trisha	UKZN	AGYEN-MENSAH Kwasi	US	BABA Sachin Ramanlali	UKZN
RAMSON Veena	UKZN	EMEREOLE Obioma	WITS	BERTIE Julia Diana	UKZN
RYMER Darren Robert	WITS	MAKHAMBENI Wilheminah		BOMELA Lusanda Nomampondomise	UP
SYED Muhommed Ridwaan	WITS	MOGERE Edwin	UCT	BUKARA Emmanuel	WITS
VLOK Johannes Edward	WITS	Fellowship of the College of Nuclear Physicians of South Africa: FCNP(SA)		FLEMING Mark	UCT
Fellowship of the College of Cardiothoracic Surgeons of South Africa: FC Cardio(SA)		AREWA Foluso Emmanuel Olusegun	US	LAUBSCHER Maritz	UCT
NGHAAMWA Johannes Metumo Kaudife	UKZN	BEZUIDENHOUT Wilfred Nico	US	MOOLMAN Johan Adriaan	WITS
Fellowship of the College of Dermatologists of South Africa: FC Derm(SA)		MODEBE Emmanuel Obinna	US	MUGHAL Mohamed Assad	UCT
FAKIR Shafeeqa	US	ZINN Christa	UP	NAIDU Preyen	UKZN
MISRA Rupesh	UCT	Fellowship of the College of Obstetricians & Gynaecologists of South Africa: FCOG(SA)		PATERSON Richard Wingate	WITS
MONYEMANGENE Mantlekoane Francinah	UL	CLOETE Alrese	UCT	ROSE Selwyn Earl	WITS
NGOBENI Claudia Khensani	UL	GQIBA Luthando	WITS	SERFONTEIN Charles Jacobus	UKZN
Fellowship of the College of Emergency Medicine of South Africa: FCEM(SA)		GROENEWALD Gary Roland	UCT	STECK Heidi	WITS
FIANDEIRO Daniel	UKZN			Fellowship of the College of Otorhinolaryngologists of South Africa: FCORL(SA)	
FOLSCHER Lindy-Lee	WITS			ATIYA Yahya	WITS
MABASA Tiyiselani	UCT			KARRO Ryan Searle	US
				NAUDÉ Pieter Herbst	US
				RUDOLPH Mattheus Johannes	WITS

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

ALABI Olubunmi Onome	WITS
BASSIER Mardeyah	US
GESAMI-STEYTLER Lilian Moraa	WITS
GUMEDE Nhlanhla Marco	UKZN
JEEVARATHNUM Ashley Clement	UKZN
KALIMBA Edgar Mutebwa	WITS
LUTCHMAN Rabeen Ramjulam	US
MAGIDIMISA Ntoden Thelma	UP
MAKREXENI Zongezile	WSU
MASEKO Bhekizenzo	UP
MUNTHALI Sera Mirriam	WITS
NAIR Loshnee Meryl	WITS
NXUMALO-TOBA Buhle	WITS
POHL Berdine	US
QUVILE Tandokazi	WSU
REDDY Deveshni	UCT
SEOPA Matshelane Rose	UKZN
SPITTAL Graeme	UCT
STANDER Ruaan Johann	US
THOMAS Angeline	US
TSHABALALA Donald	WSU
WILES Jodi Isaacs	UCT

Fellowship of the College of Paediatric Surgeons of South Africa: FC Paed Surg(SA)

NUNN Lesley Marcia Maude	WITS
VON DELFT Dirk	UFS

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

COETZEE Kirstin Janine	WITS
NGWENYA Sharol Philile	WITS
ROBERTS Riyaadh	UCT

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

KILFOIL Kim Michelle	WITS
PILLAY Dashini	WITS
STEENKAMP Janami	US

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

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

AHMAD Fayyaz	
BOTHMA Salome	WITS
CASSIMJEE Zaheera	US
CHISHALA Chishala	UCT
CHIWEZA Kalovoto Boniface	UCT
COETZER Susan Franci	WITS
DIRE Kefilwe Victoria	WITS
DU PLESSIS Annari	US
DU TOIT Justin Rudolph	UCT

DUBE Farai	WITS
DUDGEON Kate	WITS
GOVENDER Ashnee	US
GREEFF Pieter Ludolf	UP
KHAN Mohamed Ali	UFS
KORB Anneli	WITS
MACHABA Mmololo	WITS
MADUNA Ephenia Rinky	WITS
MAHABAL Aveen Jiten Ramdukhi	UKZN
MOHUN Sudhir	UKZN
MYENI Nomcebo Nomthandazo	UKZN
NEL Jeremy Stephen	WITS
PADAYACHEE Avashini	WITS
PROMNITZ Geoffrey Craig	WITS
RAHMANIAN Sadaf	WITS
SELOISA Mapula Octavia	WITS
SEOLWANE Freddy Lesobolo	UL
SIBANDA Joshua	WITS

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

BREWIS Anton Eben	UP
CHOKOTHO Tiliinde Keith	UCT
GEOFFREYS Dale Alex	WITS
LAHER Saadia	WITS
VADIA Suleman	WITS

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

COCOLAS Elena	UCT
GANIE Jameela	UKZN
KHAN Zureida	US
LAKSHMANAN Priya Darshni Hema	WSU
LUCKHOFF Marlize Birgit	US
MAPATWANA Dumakazi	UKZN
NEL Yvette Margaret	WITS
RAS Johan	US

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

BROWN Taryn	WITS
CRAIB Shirley	UKZN
GAMIELDIEN Rufkah	UCT
KHOTA Ahmed	WITS
KUEHNAST Marianne	WITS
MALEK Liat	WITS
MOODLEY Halvani	WITS
ROUX Francois	US
SWARTZ Ronel Natacia	WITS
VEDAJALLAM Schadie	UP
VENTER Juan Anton	UFS

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

CONRADIE Wilhelmina	US
DU TOIT Johannes Marthinus	UCT
GOVENDER Nerisha	UKZN
GRABOWSKI Nicola	UP

HAMPTON Mark Ian	UCT
KIMMIE Faizel	UCT
KLOPPERS Jacobus Christoffel	UCT
MCCAUSLAND Adam David	WSU
NIETZ Sarah Lena	WITS
NQWENA Langa	UCT
SHANGASE Thobekile Nomcebo	UKZN
VAN ZYL Hendrik Petrus	US

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

BASSON Jacques	US
DASSAYE Yomesh	UKZN
FRIEDMAN Robin	WITS
MARAIS Charl Ferdinand	UP
NOTHNAGEL Cornelius Petrus	UP
PANACKAL Arun	UCT
QUBU Daniel	UP
URRY Ronald James	UKZN
VAN DEN HEEVER Andries Petrus	UCT
VAN ZYL Willem Jacobus Smit	WSU

Certificates

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

ROSSOUW Beyra	US
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Certificate in Cardiology of the College of Physicians of South Africa: Cert Cardiology(SA) Phys

CUPIDO Blanche Jeline	UCT
MOOSA Muhammad Zaid	WITS
PATEL Anupa	WITS
PECORARO Alfonso Jan Kemp	US
VACHIAT Ahmed Ismail	WITS

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

KLOECK David Andrew	WITS
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Certificate in Critical Care of the College of Physicians of South Africa: Cert Critical Care(SA) Phys

ALEKAR Shabbir	WITS
BÖSENBERG Liesel Hedwig	UP
VANDEWIELE Bert Lode Jozef	UP

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

SKELTON Joanna Jane	UCT
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Certificate in Gastroenterology of the College of Physicians of South Africa: Cert Gastroenterology(SA) Phys

LAMBIOTTE Marc Elmy Jacques	US
MOOLA Ismail	WITS

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

ALHARETHI Salem Nasser UCT
 DEVAR John Wesley Samuel WITS

Certificate in Infectious Diseases of the College of Physicians of South Africa: Cert ID(SA) Phys

BLACK John Maule UCT

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

ELLIDIR Rashid UCT

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

COKA Cedrick Sithembiso UKZN
 DE ANDRADE Roger John UCT
 GANGAT Zakaria WITS
 THOMAS Mathews WITS
 ZAKO Fikile Yvonne WITS

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

ALKHALDI Hani Mohammedsaheed M UCT
 BRINK Philippus Albertus Myburgh US

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

GRAY Taryn Catherine US
 NAIDOO Visva UKZN

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

SCHAR Bronwyn Elise WITS

Certificate in Reproductive Medicine of the College of Obstetricians and Gynaecologists of South Africa: Cert Reproductive Medicine(SA)

COETSEE Jacobus Lodewicus UKZN

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

MAKAN Kavita WITS

Certificate in Vascular Surgery of the College of Surgeons of South Africa: Cert Vascular Surgery(SA)

PEARCE Nicholas Ernest UFS

Part I, Primary and Intermediate Examinations

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

BIYASE Ntombiyethu WITS
 CHOONOO Janine Olivia US
 DOKOLWANA Banele Amanda WSU
 DU TOIT Leon
 GOKAL Nishan UKZN
 GOVENDER Pooveshni UKZN
 HORSTEN Garth UKZN
 JACA Nokwanda Penelope UKZN
 JANSE VAN RENSBURG Petrus Jacobus UCT
 LENHARD Bernd Georg UP
 MOGODI Morongoa Hazel
 MUMBA Jesse Musokota UCT
 NAIDOO Kathryn UKZN
 NKOSI Palesa WITS
 NXUMALO Mpucuko WITS
 POTGIETER Danielle UKZN
 RAIMAN Mohamed UKZN
 SIMMERS Dale UKZN
 VAN DER WALT Adele WITS
 YUDELOWITZ Bradley Joshua WITS

Part I of the Fellowship of the College of Clinical Pharmacologists of South Africa: FC Clin Pharm(SA) Part I

IRHUMA Mohamed Omar EM UCT

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

MOLOABI Claudia Boitshoko UL
 ZULU Thembelihle UKZN

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

CHARLES Robin Lester WITS
 CHATSIKA Grace Mayamiko WITS
 DE HAAN Sebastian US
 GEORGIOULAS Vanessa Gail WITS
 GROENEWALD Coenraad Christoffel
 KIBAMBA Crispin Ngoy UKZN
 NAICKER Bavani UKZN
 NKOMO Mzamo Robin
 SCHOEMAN David Hermanus UCT

Part I of the Fellowship of the College of Family Physicians of South Africa: FCFP(SA) Final Part A

ADENIYI Oladele Vincent WSU
 ALABI Adeyinka WSU
 BEUTEL Bernhard US
 DRAPER Claire Anne UCT
 EJEGI Anthony UKZN

HISCOCK Colleen Jean Bradfield UCT
 IKWEGBUE Joseph Nnaemeka UKZN
 INYANG-OTU Ukeme Sunday WITS
 MALAN Eloise UCT
 RAMLALL Rajiev UP

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

ALLI Iekram Hoosen UCT
 SHAMASE Nonhlanhla Benedicta UKZN

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

NAIDU Kireshnee UKZN
 NICHOL Rowan UFS
 PROSAD Nuren Bhagwath UKZN
 SIDDI GANIE Naazim UKZN

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

HAMMOND Emmanuel Nii Boye WITS
 MOKOALA Kgomotso Mosidi Goitsimang WITS
 YUNUSA Garba Haruna UCT

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

ANNOR Victor Agyekum UL
 BRYAN Michelle Cara US
 DLADLA Nonjabulo Sandra WITS
 DUBE Handsome UP
 ESTERHUIZEN Adelene UP
 FARAYI Sydney UKZN
 FRANK Nadiya UKZN
 GWALA Bhekuyise Richman Antony
 HARTELL Claudine Samantha
 KEKANA Lethabo Shadi UFS
 KHALEMA Rethabile Jane UFS
 KHUMALO Nozipho Rejoice
 MAGWEDE Tshividzo Yvonne
 MAKHELE Arabang
 MANAMELA Portia Kenalemang WITS
 MARAIS Colin US
 MLANDU Yandisa Philiswa WITS
 MLONZI Unathi
 MOGAKANE Rector Tebogo UL
 MOHAMED Tasneem
 MONARENG Hopewell Donald UP
 MOODLEY Theron UKZN
 MOSHOKWA Molatelo Linneth
 MPHANTSI Ntsindiso UKZN
 MUKHERJEE Rajib UKZN
 MUPFUPI Webster Tonderayi
 MURINGANI Gladys
 MUSHIANA Bonolo

MUTEVHE Chinamora	
MUYOTCHA Annie Fungai	
NANDLAL Vikesh	UKZN
NKANGANA Nontando Sinawo	WSU
OBIDIKE Fidelis Emeka	
OMILE Chukwudi Nwoye	
PARIKH Nitish Upendra	UKZN
PARKER Liaquat Ali	US
PILLAY Sunkaran	UKZN
SITHOLE Fikile	
SMITH Jaco	UFS

Part I of the Fellowship of the College of Ophthalmologists of South Africa: FC Ophth(SA) Primary 1A

ALLY Naseer	
ERASMUS Clayton Burt	
HASROD Irfaan	
KAWADZA Jane	
KRITZINGER Anine	
NAIK Kajal	WITS
PATEL Muhammad Masiullah	
VAN DER WESTHUIZEN Dean Andre	

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

LAMOLA Mogau Godfrey	WITS
MAHOMED Yaseer	WITS
MATHE Reneilwe Christina	UL
MLAUZI Raphael	
RANDERA Narosha	WITS
ROOS Maria Eleen	

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

ABAZA Ahmed Mohamed Kamel	UKZN
ABU-GUSA Esam	
ABUMHARA Salah Alsharief Ghiet	
ADENIYI Folasade Bunmi	US
AYODELE Zainab Oluwakemi	
BYEGEKA Robert	UFS
CARKEEK Katherine Janita	US
COPELYN Julie	UCT
DUSORUTH-TAUKOOR Vanessa	UKZN
EBRAHIM Hassina	UKZN
FRY Samantha	US
GHULAM HOOSAIN Shenaaz Banoo	
GOODFELLOW Heloise Elena	UKZN
GOOSSENS Carice Ann	WITS
GUMEDE Mbalenhle Purity	UCT
HABIBA Parvin Umme	
HARERIMANA Innocent	WITS
JARDINE Carla	WITS
JEY Dikeledi Mavis	WITS
JOSEPHS Tracey Lee	UCT
KATANGWE Thembi Janis	

KESTING Samantha Jane	
LEFOANE Simon Moikohlai	UL
MACHINGAIDZE Pamela Rudo	UCT
MAGADLA Yoliswa	WITS
MAHLABA Ntombizodwa	WITS
MANENZHE Phophi	
MBOWANE Ndziponile Thembelihle	UP
MENDES Jacqueline Faria	WITS
MOLATLHEGI Brenda Itumeleng	WITS
MONYAKE Palesa Mabatho	UP
MOREKE Refiloe Relebohile	WITS
MPHAPHULI Aripfani Veronica	
MPUTU Martha Bilema	
MUDAHEMUKA Jean Claude	WITS
MUKUNDAMAGO Nthambeleni Michael	UL
MUNGONI Khaukanani Neo	
MWANZA Zondiwe Victor	
MYEKO Zodidi	US
NJIRAM'MADZI Jenala Mphatso	
NKABI Thandeka Unathi	
PADAYACHEE Sandhia	UCT
PALARAM Bhreetisha Navrana Waneesha	UKZN
PHOLO Molefi Jonas	UP
PITIRI Mottalepula Portia	WITS
RAKOTSOANE David	WITS
SHIBAMBU Giyani Patrick	UL
SIGEDLE Nandipha	
SIMMONS Shereez	UFS
VAN DER MERWE Alva	UFS
VAN DER WESTHUIZEN Frans Petrus	WITS
VATHER Ashaylan	UKZN
VENTER Elizabeth Francina	UP

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

CHIGANGACHA Roger Kruger Hendrik	
DAVIES Gillian Elaine	WITS
DE JAGER Louis Johann	UCT
DU TOIT Charl de Villiers	US
EGAN Joanne	UCT
LIKUMBO Samuel Gusto Petro	UCT
MARITZ Robert Myles	WITS
NTSHWANTI Nozuko	WITS
PADAYACHEE Rushen Siva	WITS
SOLOMON Christa	UP
THEURI Mark Samuel Gachau	UCT
VAN DER BYL Dawn-Lee	WITS

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

KOLLER Anna Julia	UCT
MAKONDO Betty Tebogo	UP
MOORAD Zeenat Dawood	UKZN
MTYOBILE Andiswa Magdeline	UL

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

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

ADEFOLALU Adegoke Olusegun	
AL-NAILI Mahmoud Mustafa Mohamed	US
BALIKI Kgomotso	
BARNARD Dewald Adriaan	US
BRAUNS Raquel	US
BRUINS Joanne	
BULAYA Tela	
BULBULIA Saajidah	
DIRE Zodwa Nwabisa	UFS
DURAO Henrique	UP
DUVENHAGE Nadia	UP
GOLDSWAIN Jacqueline Anne	WITS
GOUNDEN Strinivasen	UKZN
GOVENDER Jaqueline Cindy	UKZN
GOVENDER Prevendri	UKZN
HASSEN Naeem	UKZN
JANSEN Moses Francois Louis	US
KAINGA Rumbidzai Patra	
KASUMBA Joseph	WITS
LAHER Muhammad	WITS
LETHO Phomolo Justice	WITS
LUFUNDO Nontuthuzelo	UFS
MAEPA Hlanjwa	WITS
MAHAHLE Ramahahle Clifford	UP
MAHARAJ Sharen	UKZN
MAMDOO Razinah	
MANYANGA Tinashe	
MAWILA Seva Daniel	UFS
MNYOMBOLO Yolanda Yoliswa	UKZN
MOKOTONG Placid Thabo Kobi	UP
MOSIA Qwako Jacob	
MOTHAPO Khutjo Peter	
NDLOVU Sukoluhle	
NELL Tanja	WITS
NONKALA Onke Rufus	UKZN
NTANDANE Vuyiswa	UP
NTSHALINTSHALI Siphon Duncan	UKZN
PANNELL Christopher Patrick	UP
RAMDASS Dustin Andrew	WITS
SADHABIRISS Dhiren	
SIRRRIRAM Sanvir	
SOMERS Keethal Jugdaswer	US
SONNEKUS Ambrentia Gertruida	
THUSI Mthunzi	
VAN DEVENTER Jacques Daniel	US
VINASITHAMBY Umathevan	
WIUM Lizemarie	

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

HECTOR Marc UCT

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

CHISAMA Evance Junior WITS
 DALVIE Shakeel UCT
 DU TOIT Francois
 GREYLING Abraham Gerhardus Wilhelmus UKZN
 HOLDT Frederik Carl UL
 MABANDLA Nikelo WITS
 MABUZA Sakhele Nhlanhla WITS
 MEYER Earl Ryan UCT
 NAIR Tamiya UCT
 PADI Josias
 PILLAY Parusha WITS
 RAJKUMAR Leisha
 SCHOOMBEE Hendrik
 SEMAKULA-KATENDE Namakula Sophinah WITS
 TIEMESMANN Tony Nicolas
 VAN DEN BERGH David Stephanus Lubbe US

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

DZIVHANI Ndivhuwo UL
 FORD Pelisa WSU
 HART Heide UCT
 MARK Yael WITS
 MNGUNI Lindiwe Angela UP
 MUSIWA Patience
 NAICKER Santuri UKZN
 NDAMASE Sibahle Nozuko Portia WITS
 NDIRITU Anthony Ndiritu WITS
 NKOSI Zanele UCT
 REDDY Jaishanthan UKZN

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

ABOUBAKAR Mohamed Raza UKZN
 ALVAREZ ARANDA Angel Luis UFS
 AWALA Ismael
 BIOWE Riemann Julius WITS
 BOSHOMANE Tlou Jermina WITS
 BOTES Jaco Herbert
 BRITZ Elsabe
 BYEBWA Rogers Besigye
 CHANGFOOT Chanel
 CHETTY Mahendren
 CONRADIE Gerhard Petrus UFS
 DE JAGER Chantele Raquel UFS
 DIALE Bernard Samson Globus
 DLAMINI Nkanyiso Freedom UKZN

DOCRAT Fathima UP
 DULLABH Kaylesh Jay
 FINESTONE Jack US
 GABLER Tarryn WITS
 GATHIRAM Chaiteshwar Vinodh UKZN
 GAUTAM Siddharth Ranjan
 GIGABHOY Ritesh
 GREEFF Wim UP
 GREEFF Wessel
 HAMUNYELA Kondjela
 HUSEIN Salah R M UKZN
 JARIO Michael Aaron
 KGABU Richard Danny WITS
 KHALUSHI Rudzani Enson UP
 KHOSA Vusi Silence
 LUKUSA Mpoyi Ruphin
 MAELA Desmond WITS
 MAGAGANE Cleopatra Nomhle
 MAGIDI Mpho
 MAJOLA Nkululeko
 MAMPA Eshely
 MANCHEV Vassil UKZN
 MARITZ Jan Paul Barnard
 MASHEGO Lehlogonolo UL
 MASIALA Dominique Nianga WITS
 MATHONSI Enock Zakhe
 MAZIBUKO Sifiso UP
 MBETE Pakamisa
 MISTRY Heeral Jayantilal WITS
 MNGUNI Mthandeni Nkosinathi UKZN
 MNIKI Thato Abednigo
 MOFOKENG Ntswa Geelbooi WITS
 MONGWE Nyikani Lott UP
 MOONDA Zaheer
 MOTLOLISI Prince-Stoffel Elias Thabiso Mosiuoa
 MSOMI Mduzuzi Brian UKZN
 MUDAU Muvhuso Obert
 NKGUDI Boitumelo
 ODUNTAN Akinola Olumide UP
 OWUSU SEKYERE Emmanuel UKZN
 PALWENI Sechaba Thabo
 PEFFER Meggan Lesley
 PRATT Tiffany Leigh
 RAJARAM Eileen UKZN
 RAJCOOMAR Manpreet Sharma UKZN
 RAMPERSHAD Shikar Rajendhra
 RANKIN Mario Thomas
 REDDY Kuvashan WITS
 REDDY Preshantha WITS
 SALUKAZANA Azola Samkele WSU
 SARDIWALLA Imraan Ismail WITS
 SCRIBA Matthias Frank UKZN
 SEKEITTO Allan Roy
 SEWLALL Janice UKZN
 SHAZI Bhekithemba
 SIDALI Lindiwe UKZN
 SINGH Virsen UKZN

SITHOLE Mfundo Siwelile Andile WITS
 SMITH Michelle Terry Dolores UKZN
 SOLOMON Zubrina Joan
 SPINAZZE Pier Andrea
 TASKER David Beaumont
 TJINJEKA Uamunovandu
 TSHISOLA Serge Kapenda
 TSHITE Lucky Mogapi WITS
 VAN DER WESTHUIZEN Frans Willem
 VAN GREUNEN Eduard
 VAN WYNGAARD Tirsia
 WEVER Gideon Stephanus
 ZIMBA Motheo Thabane

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

DUBE Nomthandazo Amanda UL
 ESSA Imraan Ebrahim UKZN
 MADUMO Hendrick Mothabane WITS
 MATHOLE Andrew Chiffen
 ODUNTAN Akinola Olumide UP
 SOLOMON Zubrina Joan
 WEGOYE Emmanuel UCT

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

FLEPU Muzile UKZN
 RADZUMA Mulalo Benedict

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

BOBAT Muhammad Ashraf WITS
 MUNSAMY Clinton WITS

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

ABOUBAKER Shaheer UCT
 BOAUOD Hamza M A UKZN
 COETZEE Ingrid Daniela US
 DU TOIT Linett UCT
 HAARHOFF Andre Willem US
 JANSE VAN RENSBURG Ernestus US
 JANSEN VAN RENSBURG Julia US
 KHANTSI Boitumelo WITS
 LE ROUX Etienne Philip
 POTGIETER Jacquese UP

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

ABUGHALYA Mohamed Salem UKZN
 AKINJOLIRE Akinwande Akinsola WITS

ALLIE Dean Gerard	WSU
BISMILLA Shaheen	WITS
BITHREY Jason William	UFS
DU TOIT Andries Louis Jacobus	UFS
GOSAI Mithen	UKZN
KHAN HUMZA	UKZN
MABUNDA Nokwanda Sibusisiwe	UP
MISEER Sanesh	UKZN
MKIZE Sandile Kenneth	UKZN
MNCINA Tiga Jacob	UP
NDLELA Sibusisiwe	WITS
PILLAI Shaun	UKZN
SIVNARAIN Amith Hiralal	UKZN

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

AL SAYARI Ahmed	UCT
ALLY Zain	WITS
BERNON Jessica	UCT
BUCHEL Otto Carl	UFS
CHAUKE Nkhensani	WITS
DAYANAND Avindra	UKZN
DE VOS Corne	US
DU PLESSIS Maré	US
GERSUN Dean	WITS
HARICHUNDER Saveer	UL
HARILAL Shamaman	UKZN
IRSIGLER Nils Gernot	UL
JAY-DU PREEZ Tonetha	WSU
KALANE Patrick Thabiso	UKZN
MAHARAJ Kameel	UKZN
MAKAULULE Prince Ratshili	WITS
MALITH Victor Jal	WITS
MENTOR Keno	UCT
MKHIZE Ziphozonke Mandela	UKZN
MOODLEY Kerusha	UKZN
MORGADO Natasha Alexandra Gaspar	WITS
MOSADI Bakang	UL
MUTHAMBI Tendani Theobald	WITS
MWENDA Kashasha	UKZN
NAIDOO Natasha	UKZN
NAIDOO Sachindrin Ramurthi	US
NASHIDENGO Pueya Mekondjo	UCT
NETSHIONGOLWE Thendo	
NKUEBE Tseliso	UKZN
NONDELA Babalwa	UKZN
NTSASA Serialong Muriel	WSU
PINTO Gregory Augustus	UCT
RAMGHULAM Sherwin	UKZN
RIDWAAN Essa	WITS
SANDAMELA Mpho	UP
SANTHIA Sheridan	US
SELLO Callisto	WITS
SINGH Kiran	UKZN
SINGH Kiyasha	WITS
SOFIANOS Chrysis	WITS

SPENCER Kalli	WITS
STEENKAMP Gerhard Jacobus	UFS
SUMBANA Thendo	UKZN
TJASINK Gareth Neville	WITS
VAN STRATEN Andries Francois	WSU
VILJOEN Jeremi Triegaardt	US
VOLKWYN Liana	UP
WALL Shelley	UKZN
ZULU Halalisani Goodman	UKZN

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

BALADAKIS John-Demetrios	WITS
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Higher Diplomas

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

ELASIR Haitham	UCT
GAILEY Karen	
SIKAZWE Mombo	UCT

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

HLONGWANE David Thulani Bonginkosi	UKZN
REDDY Praven	UKZN

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

ANYIKWA Anderson Chinedu	
ILUNGA Kayembe Eric	UL

Diplomas

Diploma in Allergology of the College of Family Physicians of South Africa: Dip Allerg(SA)

HOLTZHAUSEN Jeanette	UCT
LAURENCE Craig	UCT
MALIGAVHADA Ntshengedzeni Jeanette	
PENTZ Adele	UP

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

APELEHIN Adeolu	UKZN
ATRASH Ashraf Khalifa	UKZN
BARTLETT Garth	WITS
BASSON Wouie	
BAYEBAYE Caroline Tumelo	WITS
BAYINGANA Blaise	WITS
BHOLA Karundat Krishandat	UKZN
CARR Amy Elizabeth	
DADOO Faaizah	WITS
DE CASTRO Alexa	
DE KLERK-GREEN Elmari	
DOMINGO Abdurragmaan	WSU

DUNBAR Graeme Leslie	UCT
GERMANUS Farrah Josephine	
GOVINDASAMY Sarina	
GUMEDE Thembekile Patience	UKZN
HAGEMEISTER Dirk Thomas	UFS
JAGGA Marcelle	UKZN
JOOMA Zainub	WITS
JORDAAN Meandra	
LA GRANGE Louise Marianne	
LAWRIE Ruchi	
LESHABA Goleng Deborah Matshidiso	WITS
LINDY Merusha	WITS
MAHLALELA Nelsiwe Respect	
MAKALONI Kalam	
MANJOORAN Grace Rajan	WITS
MANYATHI Bongive	WITS
MAREYA Chenai Helen Wendy	
MAZIBUKO Sunday Nhlanhla	
MESSIAHS Bradwell Lindsay	
MOABELO Machuene Agnes	UKZN
MOLEPO Shirley Sejabaledi Delina	
MOLOI Mohale Joseph	UFS
MOTHIBI Motseothata Justice Johannes	
NDLOVU Zamagatsheni Welile	UKZN
NEL Steven Robert	
NONTSHE Mncedisi	UKZN
OKWUOSA Odili Sabastine	US
OLIVIER Margareth Ann	
ORJI Valentine Nnolum	
PHOKONTSI Kenyaditswe Charity Petronella	
PINGA Phillip	
PURCELL-JONES Jessica	UKZN
RIKHOTSO Mahlori Benedictor	WITS
SHABALALA Nhlakanippho Siphesihle	
THALE Thato	UP
TOY Brendan	WSU
VAN HEUKELUM Marcus	WSU
VAN WYK Rene	US
VENTER Mauritz	
WEVER Waldi	UL

Diploma in Child Health of the College of Paediatricians of South Africa: DCH(SA)

BAILLY Claude Didier	UCT
DLAMINI Sindiswa	WITS
DU PLOOY Elri	US
ESSA Sameera	UKZN
JOHAAR Rizqah	
KANNIGAN Yashodhara	
LOUW Byron Clarence	
MALAN Jacobus Johannes	US
MOLOKOANE Reratilwe	
MORGAN Nicole	
MUNSAMY Vishelan	UKZN
NDJOZE Lorraine	
NKE Hermina Mmabatho Tsholanang	
PAGE Megan Anne	US

SHAZI Renneth Senzeni		SONI Ellesh Narbharam		FERREIRA Yolandi	US
STRYDOM Gezina Maria		SONO Lino Lydia		GERBER Jenique	US
VAN DER LAAN Louvina Elizabeth		SWART Minette Johanna		GOLDSSTEIN Mars Marom	UCT
VAN STORMBROEK Ben		THOMAS Winifred Nancy	UP	GROENEWALD Marilize	US
Diploma in Forensic Medicine of the College of Forensic Pathologists of South Africa – Path: Dip For Med(SA) Path		TOP Gysbert	UFS	HODKINSON Katherine Elizabeth	
KRUGER Louise Mari	US	VAN ASWEGEN Marietjie	UFS	HUANG Hsin-Chi	
NIEUWOUDT Ilse	US	VAN DEVENTER Liezel		ISAACS Sadiaka	
Diploma in HIV Management of the College of Family Physicians of South Africa: Dip HIV Man(SA)		VAN ZYL Riana	UFS	KNOETZE Reynard	
ADEBUTU Olalekan James		VYTHILINGUM Priscilla Iswari		LAI KING Lauren Veronica	UCT
ALUKO Michael		WA KONE Olga Kone		MAAS Elizabeth Susanna	
BAMBO Leka Godfrey		WALKER Louise Stephanie		MIDGLEY Alexandra	UCT
UL		WEN Sheng-Chun		MILLER Yonina Michel	
BEZUIDENHOUT Jayne Denyse		WESSELS Amanda	WSU	PRETORIUS Johannes Jacobus	
BRAUER Marieke	UP	WISE Amy Juliet	WITS	RAI Alisha	
CHINGOMBE Byrone		Diploma in Mental Health of the College of Psychiatrists of South Africa: DMH(SA)		SALDULKER Nafeesa B	
CHIPPENDALE Sa-eeda	UCT	DU PLOOY Jean-Louis	UCT	SCHREVE Eberhard Johannes	
DA COSTA Dawood		FULS Christien		WARNER Christopher	UCT
DAVIDS Gail Beverley	US	GREFFRATH Johann Christiaan		Fellows by Peer Review	
DE GAMA Rene Yvette	UP	GROBLER Kathryn Anne		Dr Wayne Patrick SMITH	College of Pathologist
DEMAS Darryl Vincent		KRUGER Juan-Mari		Dr Darryl Ross WOOD	College of Emergency Medicine
GLOVER Eilitia		MABENGE Bethwell Mzingqaba	WSU	Prof Sonja Catharina BOY	College of Emergency Medicine
GWETU Thando	UKZN	MATETA-SILWANA Priscilla Zoleka			
HOWELL Pauline Janet Brigitte	WITS	MWATCHA Ernest Byasamba			
KAHLON Ravital Yael		MYBURG Janny	UFS		
KUDSK-IVERSEN Soren		Diploma in Obstetrics of the College of Obstetricians and Gynaecologists of South Africa: Dip Obst(SA)			
MABASO Nozipho		ADAMS Tasneem			
MADLALA Siindile Antonia		EZIOHURU Temple Nnamdi			
MAHACHI Nyikadzino		FOSTER Gertruida Susanna Magdalena			
MANGABA Mamafoko Glory		KALENGA Mukandila Alidor			
MANSOOR Ahmed Fazal		KAVARI Uariomundu Kavezembua			
MAPHALALA Lokuthula Angella	UCT	LEMBETHE Nelisiwe Margaret			
MARASIRO Tafadzwa		MUGANZA Kazinguvu Ghislain			
MATOLWENI Asanda		NODIKIDA Mzulungile			
MFENYANA Thembela		ODUNZE Samuel Uchenna			
MKHONDO Nkateko		PETERSEN Dylan Dale			
MNKANDLA-KHUMALO Clementine Sifiso		SLABBERT Helena	WSU		
Normalizo		SONDIYAZA Lucia Ntomelizwi			
MOLEFI-LITHEKO Motialepula Meriam		Diploma in Ophthalmology of the College of Ophthalmologists of South Africa: Dip Ophth(SA)			
MOTAU Refiloe Johana		JALDI Hojatollah			
MTHUPHA Nompumelelo Timisile		MCCLUNAN Daemon Bruce			
MUDAKA Tiyiselani		PUTTER Magdel	UFS		
MUKAHANANA Calistus Hatirarami		VERWEY Vincent Francois			
NCUBE Kwenzakwenkosi		Diploma in Primary Emergency Care of the College of Emergency Medicine of South Africa: Dip PEC(SA)			
NKOSI Nokwazi Pearl		ADAMS Tamsin Pinto			
ORI Akshmi Ramesh		DELPORT Kathleen Georgia			
OSEI-AMANKWAH Anima		DOUGALL Wesley	WITS		
RAUF Samina	WITS	EBRAHIM Mohamed Yaseen	US		
ROBERG Kim	WITS				
SACOOR Mohamed Farhaad					
SEEKANE Palesa Rose					
SEHLAPELO Mathabe					



Annual Report of the Senate of The Colleges of Medicine of South Africa for the period 2012-2013

The second Annual Report of the Nineteenth Senate gives an account of the business of Senate during the financial year 1 June 2012 to 31 May 2013.

The report is presented in two sections:

- The financial statements and matters pertaining to the appreciation of the state of affairs of the CMSA. Its business and profit and loss will be published separately, and the rest of the activities appear hereunder.
- The annual reports of the constituent Colleges, which cover activities during the period under review, appear as a section on their own, and as an extension of this report.

A general overview of the activities of the Senate during the period 1 June 2012 to 31 May 2013 is recorded as follows:

IN MEMORIAM

The President and Senate received notification of the deaths of the following members of the CMSA during the past year. Condolences are extended to their next of kin:

Honorary Fellow

TOBIAS, Phillip Vallentine

Associate Founders and Associates

ADNO, Jacob
 ALLAN, John Cameron
 BARNES, Donal Richard
 BERNSTEIN, Alicia Sheila
 BRINK, Andries Jacob
 CATZEL, Pincus
 CRONJÉ, Stephanus Lourens
 DURHAM, Francis James
 FOSTER, Patrick Anthony
 KLOPPER, Johannes Frederick
 KOTZÉ, Radie Louis Mostert
 KWIZERA, Enoch Nshakira
 LEVIN, Joseph
 NEL, Pieter Daniel
 NESER, Francois Nicholas
 PALMER, Philip Edward Stephen
 REYNDERS, Johannes Jurgens
 ROSENBERG, Edwin Robert
 VISSER, André Alexius

Fellows

ALLISON, John Graham
 AUGUSTINE, Nicolette Yolande Judith
 BLIGNAUT, Paul Balleine
 CLYDE, Jack Howard
 FERNANDES, Osvaldo Tomas
 FREEMANTLE, Aubrey Charles
 GOVENDER, Chandrakes Soobramany
 GROBLER, Lukas Cornelius
 HEITNER, René
 HOFFMANN, David Allen
 HYSLOP, Robert James
 IMMELMAN, Edward John
 KRIGE, Tobias Jacobus Cornelius
 LEASK, Anthony Raymond
 LE ROUX, Petrus Jacobus
 MacKENZIE, Donald Bernard
 MARAIS, Alit Liebenberg
 MARESKY, Abraham Leib
 MOETHILALH, Sachin
 OKREGLIICKI, Andrzej Michael

NEW OFFICERS ELECTED FOR THE CMSA

President

Prof Gerhard Lindeque was duly elected as President of The Colleges of Medicine of South Africa in October 2012, and officially resumed this office at the Senate meeting in Cape Town on 23 May 2013. Prof Lindeque will remain in office until May 2015.

Vice Presidents

Prof Gboyega Ogunbanjo was re-elected as Vice President, and also resumed office on 23 May 2013. We have an extraordinary situation in that the CMSA will only have one Vice President during the current tenure of office.

Constituent Colleges

College of Obstetricians and Gynaecologists

As CMSA Presidents were customarily not affiliated to any constituent College, the election of Prof Lindeque to the Presidency of the CMSA left a vacancy for the position of President in the College of Obstetricians and Gynaecologists, where he served in that capacity. Prof Franco Guidozi was duly elected as President of the College of Obstetricians and Gynaecologists for the remainder of the triennium

ending in October 2013. He will also be representing that College on Senate for the duration of the term.

MEMORANDUM OF INCORPORATION AND RULES OF THE CMSA

The new Memorandum of Incorporation and Rules of the CMSA were adopted at an Extraordinary General Meeting held in Johannesburg on 18 April 2013, and subsequently lodged for registration with the Companies and Intellectual Property Commission by the due date of 31 May 2013.

The new Memorandum of Incorporation and Rules will be published on the website as soon as confirmation of registration by the Companies and Intellectual Property Commission has been received. Hard copies are available upon request.

EXAMINATIONS AND RELATED MATTERS

The National Professional Examination

The CMSA is now the official examining body for specialists in South Africa, with the Memorandum of Understanding between the CMSA and the Health Professions Council of South Africa (HPCSA) having been duly signed.

The Service Level Agreement, which will form the working document and will supplement the Memorandum of Understanding, is in the process of being finalised.

Accreditation of hospital posts

The following hospital posts were accredited during the year under review:

DA(SA):

Khayelitsha Hospital
Vryburg Hospital

DCH(SA):

Khayelitsha Hospital

Dip PEC(SA):

Khayelitsha Hospital
Muelmed Medi-Clinic

DMH(SA):

Cecilia Makiwane Hospital
Port Shepstone Hospital

Dip Obst(SA):

Mamelodi Hospital

Dip Ophth(SA):

Stanger Hospital

Successful examination candidates

The names of candidates who pass the biannual CMSA examinations appear under a separate section.

Fellowships awarded by peer review

The candidates listed below were successfully considered for Fellowship by peer review during the period under review:

College of Cardiothoracic Surgeons

ZILLA, Peter

College of Dentistry

OWEN, Christopher Peter

College of Emergency Medicine

SMITH, Wayne Patrick

WOOD, Darryl Ross

College of Family Physicians

DE VRIES, Elma

GOVENDER, Romona Devi

ROSS, Andrew John

College of Pathologists

BOY, Sonia Catharina

Guideline booklet

All CMSA policies and guidelines were consolidated into one booklet that was e-mailed to the convenors and examiners appointed for each set of examinations. The booklet also contained a confidentiality agreement, which expressly excluded anyone from attending the examiners' meeting with Senate, held after the oral and clinical examinations, except for examiners, observers, moderators and convenors officially appointed by the CMSA.

Capping the number of attempts to write Fellowship examinations

It was agreed that the constituent Colleges would not be allowed to cap the number of times that a candidate can attempt the final Fellowship examination. However, all CMSA Part I examinations will only be valid for a period of six years, and this would be an automatic filter for entry to the final examination.

Qualifications and standards

Qualifications approved by the PETM, but not yet promulgated, include::

Cert Consultation-Liaison Psychiatry(SA)

Cert Addiction Psychiatry(SA)

Cert Comm Paed & Child Health(SA).

Qualifications submitted to the HPCSA

Diploma in Medical Management of the College of Public Health of South Africa [DMM(SA)]

Cert Hepatology and Liver Transplantation(SA)

Cert Urogynaecology(SA).

Qualifications approved by the HPCSA

Cert Allerg(SA) Fam Phys

Cert Allerg(SA) Paed

Cert Allerg(SA) Phys

Dip Oral Surg(SA)

H Dip Emerg Med(SA)

H Dip Fam Med(SA)

FC Clin Pharm(SA)Blueprints online.

Committees

Committees were formed for Critical Care, Infectious Diseases and Clinical Haematology.

Sub-specialty training validity

It was agreed that subspecialty trainees will be allowed entry to examinations up to three years after their training has been completed. Ad hoc exceptions will be accepted if a valid reason why the examination could not be attempted within the prescribed time is supplied, and which also verifies that the candidate has been working in the subspecialty since completion of his or her training.

Blueprints

Blueprints are in the process of being finalised for all examinations. Constituent colleges must have their blueprinting and standards setting documents completed by 2015, for implementation by 2017; the final non-negotiable date.

The implication of this will be that the blueprints and standard settings documents will be in the public domain by 1 July 2014, to be enforced for registrars entering training on 1 January 2015.

AWARDS AND MEDALS

Phyllis Knocker/Bradlow Award

The award is made to Fellows who achieve exceptional results in their final Fellowship examination, and whose professional careers continue to show evidence of valuable contributions to basic or clinical research, participation in community health projects, or advancement of the humanitarian aspects of medical or dental practice.

Dr Elizabeth Sarah Mayne [FC Path(SA)] received the award at the graduation ceremony in October 2012, and Dr Carla Kotzé [FC Psych(SA)] at the ceremony in May 2013.

Medals and book prize

The recipients of medals during the year under review were:

October 2012

Glaxosmithkline Medal FCA(SA) Part I	Scott James BANNAN
Campbell MacFarlane Memorial Medal FCEM(SA) Part I	Grace Wit BANDA
GP Charlewood Medal FCOG(SA) Part I	Anneen Bianca VENTER
Daubenton Medal FCOG(SA) Part II	Dominic Giles Dudley ICHARDS Catherine Anne CLUVER
Leslie Rabinowitz Medal FC Paed(SA) Part I	Hayley HUTTON
Henry Gluckman Medal FCPHM(SA) Part II	Jacqueline Faria MENDES
Trubshaw Medal FCS(SA) Primary	Shaaheen BISMILLA
YK Seedat Medal H Dip Int Med(SA)	Farouk PATEL

Eugene Weinberg Medal Dip Allerg(SA)	Salome ABBOTT
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Campbell MacFarlane Memorial Medal Dip PEC(SA)	David John MCALPINE
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May 2013

Jack Abelsohn Medal and Book Prize FCA(SA) Part II	Dylan Alexander HEPBURN
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Campbell MacFarlane Medal FCEM(SA) Part I	Victoria Sarah STEPHEN
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SA Society of Maxillo-Facial and Oral Surgeons Medal FCMFOS(SA) Final	Eduardo Nuno Albuquerque Ferreira DA SILVA
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Sigo Nielsen Memorial Prize FC Neurol(SA) Part I	Suzaan MARAIS Mike HUTH
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Novartis Medal FC Neurol(SA) Part II	Leigh Luella VAN DEN HEUVEL
--	-----------------------------

Daubenton Medal FCOG(SA) Part II	Linda Ruth VOLLMER
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Neville Welsh Medal FC Ophth(SA) Primary IA	Thomas Johannes JORDAAN
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Ophthalmological Society Medal FC Ophth(SA) Intermediate IB	Steven Robert Jan LAPERE
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Justin van Selm Medal FC Ophth(SA) Final	Caroline GOODING Mpopi Nthabiseng Lebohlang LENAKE
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Leslie Rabinowitz Medal FC Paed(SA) Part I	Lindsey LEVIN
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Coulter Medal FC Path(SA) Part II	Bryony Lynn WALKER
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AM Myers Medal FCP(SA) Part I	Trust ZARANYIKA
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SASOM Medal FCPHM(SA) Occ Med	Amy de Havilland BURDZIK
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Brebner Award FCS(SA) Int	Paul Stuart STEVENS
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Lionel B Goldschmidt Medal FC Urol(SA) Final	Mark Richard PURDY
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SASA John Couper Medal DA(SA)	Frederick George OLIVIER
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Eugene Weinberg Medal Dip Allerg(SA)	Tamara Charmian KERBELKER
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HIV Clinicians Society Medal Dip HIV Man(SA)	Tricia Lyn PICKARD
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Geoff Howes Medal Dip Ophth(SA)	Schalk Hugo DU TOIT Sayeed Hamzah MUSTAK
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SCHOLARSHIPS

YK Seedat Research Scholarship 2012/2013

An award was made to Dr N Wearne (Dave) for her study: *HIV and associated immune complex diseases: immune histochemical staining of biopsies to further understand pathogenesis.*

KM Browse Research Scholarship 2012/2013

The award was made to Dr AK Naidoo for her study, *A retrospective and descriptive study of epidemiological data, clinical presentation, neurophysiological features and laboratory features of patients with Guillain-Barré syndrome admissions to two tertiary referral neurology centres in KwaZulu-Natal, South Africa.*

Life Healthcare Scholarships

Prof Zephne van der Spuy, immediate past President of the CMSA, who continues to manage the scholarships, reported that of the final 16 doctors who were interviewed, 11 scholarships were awarded (four in Medicine, four in Paediatrics, and three in Obstetrics and Gynaecology). Life Healthcare requested the successful candidates to sign an agreement stating that once they qualified, they would remain in the state sector, provided posts were available. They could then enter the private sector and give Life Healthcare the first right of refusal regarding their practice. The next round of interviews will take place in 2015.

Life Healthcare also decided to top-slice the funding by giving a percentage of it to the CMSA project. This will enable the committee to continue with its research. Initial brainstorming meetings were held, and some areas identified, i.e. the logistics of retaining people in the public sector, and infrastructure required for specialist training.

It was critical for respective university heads of departments to speak to their CEOs to ensure that these candidates were either given two years leave without pay, or that an alternate arrangement was made whereby their positions would be secured in their unit after training.

Initially, the purpose of the CMSA project was to produce specialists for South Africa. This remains the main focus as there are still problems with trainees, such as vacant posts not being filled and the freezing of posts, for example, which interfere with the production of specialists.

NON-EXAMINATION-RELATED AWARDS

Margaret S Bell Award

There was no recipient for the 2012 award.

RWS Cheetham Award

Prof A Berg was granted the Cheetham Award for 2012, for her book entitled, *Connecting with South Africa – cultural communication and understanding.*

Maurice Weinbren Award

The award for 2012 was given to Dr AJ Lawson for his paper, *Percutaneous transhepatic self-expanding metal stents for the palliation of malignant biliary obstruction.*

EDUCATIONAL MATTERS

Educational Development Programme: Mthatha

31 May-June 2012

Updates on HIV and ethics were presented by Prof Sylvester Chima (Ethics) and Dr Halima Dawood (HIV).

23-25 August 2012

Updates on the prevention of noncommunicable diseases and public health for general practitioners were presented by Dr Ike Okpechi (noncommunicable diseases) and Dr Stephen Knight (public health for general practitioners).

21-23 February 2013

A very successful programme was presented by Drs Jon Naude and JD Sithlu, oncologists from East London; together with Ms Amanda Bessinger, an oncology social worker; Ms Michelle Martin, a radiotherapist; and Sr Anne Webster, an oncology nursing sister. The topics that were covered were gynaecological and prostate cancer, radiotherapy, palliative care and pain control.

30 May-1 June 2013

Trauma and emergency update

Talks were presented by Dr S Lahri and Dr K Vallabh from the College of Emergency Medicine and Prof Elias Degiannis Head of Trauma at Chris Hani Baragwanath Hospital.

Lectureships

Arthur Landau Lecturer for 2012

Prof Willie Mollentze delivered a lecture titled, *Three decades of obesity research: implications for clinicians*, at the University of the Witwatersrand on 13 July 2012; in East London on 15 August 2012; in Bloemfontein on 12 October 2012; and in Durban on 28 October 2012.

Francois P Fouché Lecture for 2012

Dr Peter Robertson from Auckland, New Zealand, delivered his lecture at the 58th Annual Congress of the South African Orthopaedic Association, held in Durban from 3-6 September 2012.

JN and WLS Jacobson Lectureship

Prof RD Pitcher delivered his lecture entitled, *Clinical and immunological correlates of chest X-ray abnormalities in HIV-infected South African children*, at the University of the Witwatersrand on 28 November, and in Durban on 29 November 2012.

JC Coetzee Lectureship in Family Medicine and KM Seedat Memorial Lecture

An appointment for both a JC Coetzee Lecturer and a KM Seedat Lecturer will be made for 2014.

Margaret Orford Memorial Lecture

An appointment will be made for 2014.

Educational funds

Robert McDonald Rural Paediatric Programme

Dr Ari Weinstein had a very successful visit to Letaba Hospital, Limpopo, in July 2012.

PROPERTIES

Durban

Commencement of the erection of an office block in Durban, on the existing land, was deferred because of an unfortunate delay in sourcing a judgement from the Town Planning Appeals Board, who 15 years ago, had given permission for the premises to be used as offices.

The current procedure is that the application to develop the property will be circulated to the various Departments of the Municipality for comment, after which the Development Planning Branch will oversee the notification process, which will include a notice in the local newspaper, giving potential objectors 30 days within which to lodge their objections.

It is anticipated that building operations will not commence before 2014.

Johannesburg

The examinations centre at 25 Rhodes Avenue, the building next to the current office block at No 27, has been completed, and will become fully functional early in the coming financial year.

CMSA MEMBERSHIP

It is the responsibility of members of the CMSA to ensure that their address details, e-mail addresses and personal particulars are updated with the CMSA at all times. The CMSA cannot be held responsible for the non-delivery of any legal or statutory documentation to any member whose information has not been updated.

A membership database update sheet appears in each edition of *Transactions*, which needs to be completed and e-mailed to: members@colmedsa.co.za, or faxed to +27 (0) 21 685 3766 in the event of changes to an address or contact details. On this form, members are also asked to provide certain information which is used for statistical purposes. However, there is a block that can be ticked by members who elect not to disclose personal information.

Honorary Fellowship

Three Honorary Fellowships were awarded during the year under review.

Dr MC Asuzu was admitted to Honorary Fellowship of the College of Public Health Medicine at the graduation ceremony in October 2012.

At the ceremony in May 2013, Prof Richard Santucci and Prof Prem Puri were admitted as Honorary Fellows of the College of Urologists, and the College of Paediatric Surgeons, respectively.

Fellowship *ad eundem*

Prof Athol Kent was the only person to be admitted to Fellowship *ad eundem* in the past year. He received this at the May 2013 ceremony, in the College of Obstetricians and Gynaecologists.

Associateship

The following registered as Associates in 2012/2013:

College of Maxillo-Facial and Oral Surgeons

HEIN, Gregory James
MCHENGA, James Maurice
REDELINGHUYS, Izak Frederick
VAN DER MERWE, Aloysia Elizabeth Anna

College of Radiation Oncologists

SHERRIFF, Alicia

MATTERS ALLUDED TO BY THE RISK, AND SOCIAL AND ETHICS COMMITTEES, RESPECTIVELY

Establishment of Management Committees for the Standing Committees

It was decided that a smaller group of individuals will ensure rapid, responsive management of the three standing committees (the Finance and General Purposes Committee in Cape Town, the Examinations and Credentials Committee in Johannesburg, and the Education Committee in Durban) which are responsible for the day-to-day running of the CMSA, without detracting from the inclusivity and wisdom that more occasional meetings of these committees brings. Also, the institutional memory will be preserved by appointing experienced Senators to these executive posts.

Risk registers

Risk registers were introduced for each of the standing committees and will be reviewed and updated at each meeting.

Reputational risk to the CMSA

The CMSA's ability to perform its functions effectively is based on the organisation's reputation. Therefore, the following philosophy was adopted by Senate in October 2012:

- "The value of reputation is an accumulation of perceptions and opinions about the CMSA.
- The CMSA will enjoy a good reputation when its behaviour and performance consistently meet or exceed the expectations of its members. Reputation will diminish if words and actions are perceived as failing to meet expectations.
- Reputation is an indicator of past performance and future prospects.

Reputation is based on stakeholders' perception of whether or not their experience of the CMSA matches their expectations.

"Reputational risk", often called "reputation risk", is the type of risk that relates to the trustworthiness of the organisation. Damage to reputation can result in destruction of "shareholder value". Reputational risk also serves as an important tool in crisis prevention. This type of risk can be informational in nature, or even financial.

Definition of "reputation risk"

A "reputation risk" occurs when the negative publicity triggered by certain events, whether accurate or not, compromises "reputation capital":

- Loss of reputation has been described as the "risk of risks".

Opinion is divided on whether or not reputational risk is an issue in its own right, or simply a consequence of other risks.

- Reputational risk is any risk to the CMSA reputation that is likely to destroy its actual or perceived value.
- Reputation declines when the experience of an organisation falls short of expectations.
- Reputational risk leads to negative publicity, loss of income, litigation, loss of client base (candidates and membership) and partners, the exit of key employees and officers, and difficulty in recruiting new talented employees and office bearers or examiners.
- Reputation risk is anything that could impact reputation, either negatively (a threat), but occasionally also positively (opportunities).

Threats to reputation include:

- Failure to comply with regulatory or legal obligations.
- Failure to deliver minimum standards of service and quality to consumers.
- The exposure of unethical practices in the organisation.

Responsibility for maintaining reputation

The CEO is regarded as the individual with primary responsibility for managing reputational risk by most organisations. The chief executive is pivotal in providing an ethical identity for the CMSA. The CEO is expected to co-ordinate the response of other senior managers and officers to reputational threats, and in times of crises.

The CMSA's responsibility is to a wide range of parties:

The candidates and members are the most important as between them, they provide the wherewithal that allows the CMSA to function.

Regulators, including the HPCSA, are key; setting and enforcing standards.

Employees' motivation feeds into productivity and service quality. Employees are the human face of the CMSA. They focus on pay and work conditions, and on the availability of training and opportunities for advancement. Such matters only loosely correlate with the quality of service provided to customers. Everyone working for an organisation bears some responsibility for upholding its reputation.

Members of the general public may be affected by the CMSA's actions directly or indirectly, and may respond unfavourably if they feel that their interests are being prejudiced.

These groups are neither mutually exclusive, nor independent of one another. The feedback mechanisms between them require special attention from the CMSA.

Good communication is vital to protecting against and repairing reputational damage. Appropriate communication becomes even more important once a crisis breaks.

Conclusion

Reputation is ultimately about how the CMSA is perceived by all role players, including candidates, membership, partners, investors (donors), regulators, the media and the wider public.

The following is worth noting:

- Risks to reputation should be integrated into the CMSA's risk

management framework so that they receive attention at the right level, and appropriate action is taken to manage them.

- Trust and confidence can be irrevocably damaged by a momentary lapse of judgment, or an inadvertent remark.
- Understanding reputation risks has become a key focus for businesses in all sectors. It is now recognised that reputation risks need to be managed as actively and rigorously as other more quantifiable risks.
- A strong reputation can help to attract and retain high-quality employees and future management generation.
- Reputation can also help to shape the attitude of regulators, partners and the media.
- The greatest benefit of a good reputation is the buffer of goodwill it provides, which can enable an organisation to withstand potential future shocks.
- This "reputational capital" underpins trust and confidence, and can persuade stakeholders to give the CMSA the benefit of the doubt and a second chance when an inevitable, unforeseen crisis strikes."

Reputational and functional risk to the CMSA and constituent Colleges

It was decided that the following decision of Senate would be brought to the attention of members:

In a case where any allegations are made against individual CMSA members, serving either as a senator and/or a member of any standing committee within the CMSA or a constituent College, the following criteria will apply:

- Matters should be brought to the attention of the CEO with complete supporting documentation, which will be reviewed, and brought to the attention of the relevant subcommittee.
- The subcommittee will gather any further information pertinent to the matter, and if deemed necessary, refer this for investigation to the Social and Ethics Committee, who, in turn, will submit its recommendations to the executive committee, and finally to Senate.

Matters should be considered carefully before responding.

The individual must be given an opportunity to defend him- or herself.

The CMSA should develop a culture of individual self-reflection when the individual is giving consideration to stepping down temporarily while the process unfolds. Thus, affected individuals should not necessarily defend the appointment that they hold within the CMSA until the matter has been resolved.

An emergency intervention plan has been put in place to deal with these matters.

REPORTS ON INTERACTION BETWEEN THE CMSA AND OTHER OUTSIDE BODIES

National Department of Health

Meeting with the Honorable Minister of Health, Dr Aaron Motsoaledi

A meeting was held with the Minister of Health on 13 September 20. The CMSA was represented by Prof Anil Madaree as President, Prof Alf

Segone, member of the Executive; Prof Del Kahn, Chair Finance and General Purposes Committee; and Prof Lizo Mazwai, past President.

The main issues discussed related to:

- The number of specialists employed in the provinces, and the dire need to increase these.
- The funding of registrars that is made available to the provinces, but is not utilised for that specific purpose.
- Inadequate infrastructure and equipment in certain departments in some hospitals, where specialists are being trained.
- The control of academic health complexes.

Following the meeting, Senate adopted a resolution that encapsulated all of the problems that were raised. This was submitted to the Honourable Minister to use as he deems appropriate.

Meetings on the “Central funding of academic health complexes” and the “Funding of health professional development and tertiary hospitals”

The Director General of Health had written to the CEO advising that the above two subcommittees were to be formed, and pointed out that the CMSA would be invited to participate. There have been no further developments.

Department of Higher Education and Training

Links have been established with the Department of Higher Education and Training with a view to a representative attending CMSA Senate meetings in the future. Details will follow in the next report.

Vice Chancellors of medical universities

The first of these meetings took place on 17 October 2012. In the absence of the President, Prof Anil Madaree, the delegation was led by Prof Tuviah Zabow, Honorary Treasurer. Other CMSA representatives were Prof Jeanine Vellema, Vice President; Prof Arthur Rantloane, Chair Examinations and Credentials Committee; Prof Alf Segone, Executive Committee member; Prof Mike Sathekge, Honorary Registrar Examinations and Credentials Committee; and Prof Johan Fagan, Honorary Registrar Finance and General Purposes Committee.

The meeting was favourably received by those who attended, and was the first of regular follow-up meetings. Various issues of mutual interest received attention, including the decision that there should be a single voice in the academic approaches, championed by the CMSA. It was also recognised that each university has to address weaknesses and staff problems, and should intervene when standards are unsatisfactory. Prof Max Price, Vice Chancellor of the University of Cape Town, offered to write a memorandum on the deliberations for transmission to the medical deans.

TRANSACTIONS: JOURNAL OF THE COLLEGES OF MEDICINE OF SOUTH AFRICA

Senate has been deliberating for some time on the excessive costs in respect of the publication, but particularly also the postal distribution of *Transactions*, to the point where it was recently decided that in future, the journal will be distributed electronically. Members who express a specific wish to receive a hard copy will be accommodated, but this will only be upon request. In this regard, a form for completion has been inserted in this issue of *Transactions*.

CMSA ATTENDANCE AT MEETINGS OF SISTER COLLEGES AND ACADEMIES

Academy of Medicine of Malaysia: 46th Malaysia-Singapore Congress of Medicine, Kuala Lumpur, Malaysia: 12-14 July 2012

Representative: The President.

International Liaison of the Presidents of Colleges of Pathologists, London: 1-2 September 2012

Representative: Prof Dhiren Govender, President, C PATH.

Royal College of Physicians of Ireland: St Luke’s Day Symposium: 20 October 2012

Representative: Prof Anil Madaree, President.

College of Physicians and Surgeons of Pakistan: Golden Jubilee Celebrations: 9-11 November 2012

CMSA representative: The President.

CFP representative: Prof Cyril Naidoo.

5th Global Paediatric Summit hosted by the American Board of Paediatrics in Chapel Hill, North Carolina, USA: 1-2 May 2013

Representative: Prof H Saloojee, C PAED.

Royal Australasian College of Surgeons: 82nd Annual Scientific Congress, Auckland, New Zealand: 6-10 May 2013

Representative: Prof A Madaree, retiring President.

Royal College of Pathologists of Australasia: ILPP Congress, Sydney, Australia: 26-28 May 2013

Representative: Prof Dhiren Govender, President, C PATH.

ACKNOWLEDGEMENTS

Senate wishes to place its gratitude on record to the immeasurable contribution of honorary officers, examiners, trustees, councillors of the constituent Colleges, and committee members who continue to render a valuable service to the CMSA.

A word of thanks is also given to members of the CMSA, and others who participated in the various activities of the College during this past year.

RETIREMENT

As this is my last annual report before I retire in December 2013, I wish to salute the truly wonderful, personal friends that I made during my sojourn at the College. I will always cherish the delightful memories, fun and laughter, despite all the hard work and deadlines.

Particularly, I would also like to pay tribute to the devoted and dedicated staff in the Cape Town office where I was based. Some of them were already at the CMSA when I joined the staff in 1977. Their loyalty, in particular, has been exceptional.

Bernise Bothma

CEO



Annual Reports of Constituent Colleges

COLLEGE OF ANAESTHETISTS

Examinations

The College of Anaesthetists had its normal examination activities in the second part of 2012, and again in the first half of 2013 [Diploma examination of the College of Anaesthetists (DA(SA) and Fellowship of the College of Anaesthetists (FCA(SA) Part 1 and 2].

Examination dates and pass rates were as follows:

Examination	Written examination	Oral/clinical examination	Pass rate
DA(SA) 2012	27 and 28 August 2012	4 and 5 September 2012	77/104
DA(SA) 2013	8 and 9 April 2013	16 and 17 April 2013	49/67
FCA(SA) Part 1	27-31 August 2012	None	19/45
FCA(SA) Part 1	8-12 April 2013	None	20/40
FCA(SA) Part 2	20-24 August 2012	8-11 October 2012	31/50
FCA(SA) Part 2	2-5 April 2013	20-23 May 2012	24/64

Meetings

The College of Anaesthetists Council meetings were held on 28 November 2012 and 29 May 2013.

Heads of Academic Department Subcommittee met and was formed on 29 July 2012. Council constituted them as a subcommittee who will advise on training, examination and applicable policy.

A small group met on 16 April 2013 (J Diedericks, D Gopalan, C Lundgren, I Joubert and A Rantloane). The current curriculum was blueprinted. Discussions on the revision of the curriculum were started, followed by specific areas updated by allocated people, and subsequent circulation to role players for input. The aim is to accept the new curriculum at the October 2013 council meeting. Detailed blueprinting and standard setting will follow.

Decisions, training and other processes

Dr Pieter le Roux, Councillor and College of Anaesthetists treasurer died. Condolences were expressed to his wife. Dr M Raff was elected new College of Anaesthetists treasurer.

A DA(SA) tutor programme was planned and is being implemented.

A DA(SA) examiners workshop was held in Johannesburg on 28-29 July 2012.

Examiner training sessions were planned in September 2013.

Part 1 examiner training occurred during observation. A formal workshop was planned for the second half of 2013.

Future FCA(SA) Part 2 examiners will be sponsored to attend clinical courses.

Prof B J S Diedericks
PRESIDENT

COLLEGE OF CLINICAL PHARMACOLOGISTS

The past year has seen the growth of clinical pharmacology in South Africa. Clinical Pharmacology was recently approved as a specialty in South Africa; the first country in Africa to do so. The recognition of this pivotal discipline in South Africa is a reflection of its recognition globally, as outlined in a recent position paper by the World Health Organization, together with the Council for International Organizations of Medical Sciences and International Union of Basic Pharmacology. This highlights the important role of clinical pharmacologists in health care, teaching and research.

Current members of the Council for the College of Clinical Pharmacologists of South Africa have followed-up these achievements with a *South African Medical Journal* publication, outlining the need for clinical pharmacologists, their role in advancing public health and potential benefits to South Africa.

Another recent achievement by College members is the selection of South Africa as the host for the World Congress of Basic and Clinical Pharmacology in 2014. This is the first time that this global congress will be hosted in a developing country.

Lastly, in May 2013, Dr Mohamed Irhuma became the first foreign national to pass Part 1 of the Clinical Pharmacology examination of our College.

Currently, five health science faculties have the capacity to train registrars in Clinical Pharmacology, but only one institution presently offers such training. There is an urgent need to expand training programmes and registrar posts for Clinical Pharmacology. This training needs to be matched with career progression opportunities for qualified clinical pharmacologists at tertiary and academic hospitals. Specialist clinical pharmacologists play key roles in training healthcare professionals to prescribe medicines rationally, guide management in complex cases, conduct clinical research and influence and inform drug policy.

Although there has been a rapid strengthening of this discipline recently, Clinical Pharmacology remains an extremely scarce skill in South Africa. Clinical pharmacologists with appropriate qualifications and experience are encouraged to apply to the Health Professions Council of South Africa (HPCSA) for registration as specialists under

the “grandfather clause”, and to become Associates of the College of Clinical Pharmacologists of South Africa.

Prof K Barnes
SECRETARY

COLLEGE OF CARDIOTHORACIC SURGEONS

The high failure rate of candidates in the final examination of the College of Cardiothoracic Surgeons remains a concern. It has formed a large part of formal and informal discussions at council level in the College of Cardiothoracic Surgeons. The main problem lies in the written portion of the examination, and particularly in the thoracic surgical discipline. In addition, low caseloads in the training institutions make it impossible to achieve sufficient exposure in the four-year period that is allocated to train a registrar to a satisfactory level. This low caseload is also associated with a limited spread of pathologies, which, in turn, negatively impacts on the development of a full surgical repertoire.

The examination issue raised concerns in the Colleges of Medicine of South Africa (CMSA), and this led to the appointment of two external moderators to sit in on the examinations that were held in Pretoria and Stellenbosch in October 2012 and May 2013, respectively. The findings, reported to us informally, were that the process of our examinations was thorough and fair to the candidates. No criticism was levelled at the College of Cardiothoracic Surgeons. We still have to receive a formal report of their audit.

A recent proposal adopted by the council (August 2013) was to add a phrase to the traditional statement that a candidate is considered to be ready for the exit examination, of: “and is ready for independent practice”. It was decided to implement the clause with immediate effect. This will be the responsibility of the relevant head of the candidate’s department when certifying the candidate’s readiness to take the final examination.

The concept of independent practice was defined as follows: “The candidate is able to perform all basic procedures in adult cardiac and thoracic surgery that would normally be required of a surgeon working in day-to-day practice in the field”. This naturally requires a more diligent application of the logbook system, both on the part of head of departments and registrars than has been the case up to now.

The required standard of being fit for independent practice will impact on training times, as most training units do not have sufficient caseload to fulfil requirements to develop independent surgeons within the four years of training time currently provided. On the other hand, it has the potential to improve training from the perspective of both the candidate and the training department. It will certainly make the documentation of measureable educational targets more important.

We understand that there are moves afoot by other Colleges to increase the registrar training periods to longer than four years, and this would be strongly supported by our College as well.

Prof A Linegar
SECRETARY

COLLEGE OF DENTISTRY

In the past year, committee members of the College of Dentistry continued with their campaign to enrol more specialists as Associates and were pleased to have 11 new Associates ratified by the Senate in May 2013.

The Council also embarked on a countrywide campaign of meeting with heads of departments at all four dental schools, and to brief them on the role of the CMSA as an examining body in the envisaged unitary exit examination process.

At the same time, the College of Dentistry has been writing and appealing to the Medical and Dental Professions Board (PETD) to have representation on its council, but this has not met with success. A meeting was subsequently called by the PETD in May 2013, to which all heads of departments were invited to discuss the proposed unitary examinations. Initially, the College of Dentistry was not included, until we requested participation. The invitation that we received was for the morning session only. Thereafter, only heads of department and PETD members remained for further debate.

A suggestion that the various dental specialities split into separate Colleges emanated from these discussions. However, these may be very small in some cases. Other suggestions included the pairing of specialities with each other, or with allied medical specialities. These options will be discussed in depth with the CMSA Executive and College Councillors, as well as interested departmental heads. Possible working solutions can then be found.

Orthodontics has been the mainstay of the College of Dentistry, having had candidates register and write examinations in this speciality for the past 25 years. However, in 2012/2013, we were pleased that an increased number of students registered for the primary examinations, as well as for the Diploma in Dentistry. Most of the examiners and moderators were novices, but handled the examination process smoothly, and are now well prepared for the upcoming examination period. The examiner panels were selected to include new and old examiners to allow the latter to help guide new Associates through the examination process. One candidate passed the FCD(SA), (Orthodontics), one Fellow was welcomed by peer review, as were 11 new Associates.

Prof L Sykes
PRESIDENT

Dr R Chamda
SECRETARY

COLLEGE OF DERMATOLOGISTS

The College of Dermatologists has progressed with regard to CMSA commitments and activities.

We had our first national meeting in which all examiners, including future examiners from the seven established academic universities, met in April 2013, and discussed the present and future of the examinations. We discussed our shortfalls, addressed relevant issues with both the FC Derm(SA) Part I and Part II, and implemented a constructive plan. Part of these deliberations has led to changing the rules and regulations of our College, which are now on the website.

We have acknowledged the crucial role of the moderator and convener, which has been neglected in the past. Despite this, the

problems regarding Part I of the FC Derm(SA) during this timeframe were resolved professionally with the guidance of the Examinations and Credentials Committee. We haven't had any problems with regard to Part II. The pass rate for both examinations has been over 60% consistently and standards have been maintained. Our College Council members recently met again and discussed blueprinting and plans for the near future.

Prof D Modi
PRESIDENT

COLLEGE OF EMERGENCY MEDICINE

Midway through the current Council triennium, it is a great privilege to present the 9th Annual Report of the College of Emergency Medicine of South Africa. The discipline of Emergency Medicine continues to grow from strength to strength, as reflected in the following activities and achievements.

Elected Councillors

- Prof Roger Dickerson, President and Senate Representative
- Dr Heike Geduld, Secretary and Senate Representative
- Dr Annemarie Kropman
- Dr Sa'ad Lahri
- Dr Kamil Vallabh
- Dr Caryn Frith, Diplomate Representative and CMSA Senate Diplomate Representative
- Dr Jalaluddin Soni, Diplomate Representative.

Immediate Past President

- Prof Walter Kloeck

University representation

Six South African medical universities offer postgraduate registrar training in Emergency Medicine. Representatives of all six universities have been co-opted onto the Council of the College of Emergency Medicine.

These are:

- Prof Lee Wallis, University of Cape Town and Stellenbosch University
- Prof Efraim Kramer, University of the Witwatersrand
- Prof Andreas Engelbrecht, University of Pretoria
- Dr William Lubinga, University of Limpopo
- Dr Darryl Wood, University of KwaZulu-Natal.

The University of Botswana has recently established a postgraduate Emergency Medicine training programme. This programme has been evaluated by our College with a view to assisting in the training and evaluation of its candidates. The University of Botswana is represented on Council by Dr Megan Cox.

Our College actively pursues a policy of close co-operation and consensus between all major academic institutions involved in the training of specialist emergency physicians, a goal which is essential for the uniformity and development of our relatively new specialty. Our College also enjoys close ties with the Emergency Medicine Society of

South Africa, the Emergency Nurses Society of South Africa and the Emergency Care Society of South Africa. This ensures continued input in the practice of Emergency Medicine in the pre-hospital and intra-hospital environments.

Diploma in Primary Emergency Care [Dip PEC(SA)]

The regulations for the Dip PEC(SA) have been revised, allowing the Diploma examination to be more accessible to medical practitioners with an active interest and involvement in emergency care, and not only those based in selected casualty and emergency departments. Doctors based at any hospital accredited by the HPCSA for intern training, as well as numerous private hospitals, are now able to submit a comprehensive "portfolio of learning" in support of their application to write the examination.

The syllabus for the Diploma has also been revised, with less emphasis on basic sciences and greater emphasis on clinical and environmental aspects of emergency care. A formal resuscitation skills assessment has been added to the objective structured clinical examination component of the examination, further enhancing the practical competence of successful candidates.

Many thanks are extended to our Diplomate representatives, Dr Caryn Frith and Dr Jalauddin Soni, for revising and updating this exciting Diploma. Sincerest thanks again to Dr Caryn Frith for her continued assessment of hospitals applying for Dip PEC(SA) training accreditation.

Congratulations are extended to the medal recipients for the Dip PEC(SA) examination in 2012:

- Dr VL Roets, Campbell MacFarlane Memorial Medal for the best candidate in the practical component of the Dip PEC(SA) examination
- Dr VL Roets, Walter Kloeck Medal for the best overall candidate in the Dip PEC(SA) examination.

Higher Diploma in Emergency Medicine

The College of Emergency Medicine has introduced a Higher Diploma in Emergency Medicine. The Higher Diploma is open to candidates who have held the Diploma in Primary Emergency Care for at least two years, and is intended to empower medical practitioners who are actively involved in the practice of Emergency Medicine to supervise and train junior doctors in the skills and procedures required to practise safe and effective acute medical care. This Diploma has been approved by the CMSA Senate and the HPCSA.

Fellowship of the College of Emergency Medicine [FCEM(SA)]

Congratulations are extended to the medal recipients for the FCEM(SA) examination in 2012:

FCEM (SA) Part 1:

Dr VS Stephen, The Campbell MacFarlane Memorial Medal.

Training in emergency ultrasonography has become a compulsory entry requirement for candidates attempting the FCEM(SA) Part 2 examination as from July 2010, in line with international trends that advocate the importance of this valuable diagnostic tool in emergency care. Dr Mike Wells, Dr Hein Lamprecht and Dr Stevan

Brujins are thanked for the extensive preparatory documentation that was provided in this regard, and for agreeing to co-ordinate training programmes and certification in emergency ultrasonography countrywide.

Blueprints and guidelines

Council has embarked on exciting programmes to help candidates prepare for the examinations that are overseen by the College of Emergency Medicine of South Africa.

The syllabus has been blueprinted and is available to all candidates.

The examination processes have also been blueprinted. A guideline for candidates is in the final stage of editing and should be available soon.

Subspecialty in Paediatric Emergency Medicine

In order to raise the standard of emergency care for children presenting to emergency departments in South Africa, the College is in the process of creating a subspecialty in Paediatric Emergency Medicine, in line with international trends in this regard. The subspecialty proposal has been approved by the Senate of the CMSA and the Postgraduate Education and Training Medical Committee of the HPCSA, and is now awaiting promulgation in the *Government Gazette*.

New Fellows by peer review

Congratulations to Dr Darryl Wood, University of KwaZulu-Natal; and Dr Wayne Smith, University of the Western Cape; on their recent election to Fellowship by peer review of the College of Emergency Medicine of South Africa. We have no doubt that these remarkable individuals will continue to contribute significantly to the development of academic emergency medicine in South and southern Africa.

Emergency-related short courses

A comprehensive and updated list of emergency-related short courses that are being offered in South Africa is available on the CMSA website to assist candidates in their preparation for College of Emergency Medicine examinations, as well as to provide a useful resource for all postgraduate doctors practising in South Africa.

As a membership benefit, a discount of R100 is offered to all paid-up members of the CMSA on many of the listed courses. The College of Emergency Medicine extends its appreciation to these training organisations for their continued support, and encourages members to take advantage of this offer.

Emergency Medicine Society of South Africa

It is very pleasing to note that many recipients of the Dip PEC(SA) and the FCEM(SA) have joined the Emergency Medicine Society of South Africa (EMSSA), adding strength to the growing discipline of Emergency Medicine in South Africa. Medical practitioners with an interest in Emergency Medicine are encouraged to join EMSSA, and benefit from the wide range of activities, practice guidelines, congresses, courses and learning opportunities that it has to offer. Details are available from the EMSSA website at www.emssa.org.za. It is pleasing to note that three members of the new Council have been elected to the EMSSA Executive.

African Federation of Emergency Medicine

Several universities in other parts of Africa, such as Botswana, Malawi and Ghana, are developing formal Emergency Medicine training programmes. This interest in developing emergency care has promoted the establishment of the African Federation for Emergency Medicine. Our College is fully supportive of this venture and is actively involved in assisting in this regard.

Education: Mthatha Outreach

Under the auspices of the CMSA education office in Durban, the College of Emergency Medicine was invited to present a three-day symposium on Emergency Medicine in Mthatha in May 2013. A very enthusiastic group of specialists, including Dr Sa'ad Lahri and Dr Kamil Vallabh, the College of Emergency Medicine; and Prof Elias Degiannis, the College of Surgeons; devised a fantastic programme which educated and enthralled a diverse audience of healthcare professionals. Drs Lahri and Vallabh also conducted teaching ward rounds at Mthatha General Hospital. Our sincerest thanks go to those who were involved in the success of this event.

The College of Emergency Medicine is proud of medical practitioners who strive to raise the practice of emergency care in our country and beyond, and is pleased to be able to honour and reward colleagues who achieve excellence in this vast discipline.

Prof R Dickerson
PRESIDENT

Dr H Geduld
SECRETARY

COLLEGE OF FAMILY PHYSICIANS

The College of Family Physicians had two Council meetings, each preceding the CMSA clinical examinations at the University of Pretoria on 14 October 2012, and Stellenbosch University on 19 May 2013. Important and relevant issues were discussed, and the following decisions made.

Submission of dissertations for FCFP(SA) Final, Part B

A standardised template is now available on the College of Family Physicians' webpage for completion by candidates, and is to be signed by the respective heads of department. It was stressed that a copy of the dissertation, plus the external examiners' reports and marks, should be submitted to the Academic Registrar's office at least 60 days before the next examination. The release of dissertation results varies between the universities. Clarity has been provided on the updated College of Family Physicians' regulations under Section 6 on what is required to be submitted to fulfil the FCFP(SA) Final Part B. In addition, a letter and results to indicate that the dissertation has been passed by the relevant university authority, e.g. examinations office, postgraduate committee and research committee, with the percentage scores, is required for submission in order to fulfil the FCFP(SA) Final part B. Furthermore, the College of Family Physicians has now designed a template that is available on the College of Family Physicians' webpage which captures evidence of completion of registrar training, including completed portfolio, Basic Life Support/Advanced Cardiovascular Life Support certificate and 36 months' training time.

Changes in the FCFP(SA) nomenclature

The changes were effected on the recommendation of the Examinations and Credentials Committee as follows: Final Part A (final exit examination) and Final Part B (research component) must be in line with other specialities. The changes were ratified at the CMSA October 2012 Senate meeting.

Future College of Family Physicians' examinations

College of Family Physicians' examinations will be an ongoing process. The President, Secretary and second Senator will form part of the examiner panels at the various centres. It was also agreed that future examiners' and College of Family Physicians' Council meetings will be scheduled for the Sunday before the main clinical examination (whole day).

Convenors for future FCFP(SA) Final Part A examinations are as follows:

- *March/May 2013 (Clinical: 20-22 May 2013, Cape Town):* Convenor: Prof Julia Blitz, Stellenbosch University.
- *August/October 2013 (Clinical: 21-23 October 2013, Durban):* Convenor: Dr Mergan Naidoo, University of KwaZulu-Natal.
- *March/May 2014 (Clinical: 12-14 May 2014, Gauteng):* Convenor: Prof Ian Couper, University of the Witwatersrand, was initially selected, but has been replaced by Prof Gboyega Ogunbanjo, as the former will be on sabbatical leave preceding the March/May 2014 examinations.
- *August/October 2014 (Clinical: 13-15 October 2014, Bloemfontein):* Convenor: Prof Hannes Steinberg, University of the Free State.

FCFP(SA) portfolio template

The updated FCFP(SA) portfolio was extensively discussed. A few changes were made and the previous draft was replaced with effect from January 2013. The registrars who started before 1 January 2013 are still allowed to submit previous logbooks or portfolios to qualify for the Final Part A examination.

Update on the HPCSA national exit examination

The College of Family Physicians Council was reminded that the cut-off date for MMed examinations was December 2013, after which it will be mandatory for all registrars who commenced training on 1 January 2011 to write the national exit examination, i.e. FCFP(SA) examination.

FCFP by peer review

A number of applications were considered from the various departments of Family Medicine, and recommendations made by the College of Family Physicians' Council to the Examinations and Credentials Committee during the year. Subsequently, the CMSA Senate ratified the following Fellowships by peer review: Dr Elma de Vries, University of Cape Town; Dr Andrew Ross, University of KwaZulu-Natal; and Dr Romona Govender, University of KwaZulu-Natal. Congratulations to the new College of Family Physicians Fellows. All councillors were informed that it is essential that they familiarise themselves with the criteria for election to Fellowship by peer review.

West African College of Physicians

At the October 2012 clinical examination in Pretoria, the President and Chief Examiner of the Faculty of Family Medicine, West African College of Physicians, attended the examination as "observers". Valuable feedback was given on the conduct and standard of our examination, and it was agreed that a joint training-of-trainers workshop should be conducted in Ibadan before their clinical examination in October 2013.

University of Botswana MMed (FamMed) programme evaluation visit

Profs Naidoo and Ogunbanjo reported on their site visit which took place on 20-22 July 2012. The outcome of the visit was positive for Family Medicine registrar training in Botswana. The report was forwarded to the Examinations and Credentials Committee, and the CMSA Senate subsequently ratified the recommendations for its Family Medicine registrars to write the FCFP(SA) exit examination with effect from 2014. A review of the programme was proposed before May 2014, as this will provide sufficient time for the assessment of eligible University of Botswana applicants to sit the FCFP(SA) August/October 2014 examination.

BHF tariffs (family physicians)

The matter of Board of Health Funders tariffs for family physicians was referred to the South African Academy of Family Physicians as a process has to be followed in order to address the matter urgently.

FCFP(SA) Final Part A blueprint

The developed FCFP(SA) Final Part A blueprint document was submitted and accepted by the Examinations and Credentials Committee. The objective structured clinical examination blueprint was modified at the College of Family Physicians Council May 2013 meeting to provide more clarity, detail and understanding. The latter has been sent to the Examinations and Credentials Committee and to the Education Committee for review and update.

Higher Diploma in Family Medicine

This has been gazetted by the HPCSA. The College of Family Physicians Council agreed to a number of steps relating to commencement of this higher diploma, including:

- Reviewing the process of accreditation of sites based on criteria to be provided by Prof Jannie Hugo.
- Sending the revised requirements for trainers, trainees and accredited sites (Prof Bob Mash).
- *Meeting criteria:* The candidate must be in a family practice or family medicine clinical post, and must meet regularly (in service training) with a Family Medicine-accredited trainer. The setting must be part of an accredited training complex for Family Medicine.
- Accrediting the sites and trainers as a matter of urgency (College of Family Physicians). The tentative date for the first examination will be August/October 2014.

Co-option of family medicine acting heads of Department to the College of Family Physicians Council

The College of Family Physicians Council comprises elected councillors, plus the heads of department or acting heads of department who have not been elected on the council. The approved principle is as follows: whoever is the acting head of department will be co-opted on an ad hoc basis to College of Family Physicians Council until a formal appointment of the head of department is made. There will be a new College of Family Physicians Council following elections by October 2014.

Other matters to note

RCGP(UK)

A Memorandum of Understanding was signed by the South African Academy of Family Physicians (SAAFP) and the Royal College of General Practitioners in November 2012 at the 3rd Wonca Africa Conference, Victoria Falls, Zimbabwe. One of the activities is to build trainer capacity in "assessments", and the College of Family Physicians will be involved in the various training workshops.

Europe Aid

The application call for access to primary healthcare workers closed on 4 June 2013. SAAFP and the College of Family Physicians are Associates, while the eight Family Medicine departments are co-applicants for the application.

Prof S S Naidoo
PRESIDENT

Prof G A Ogunbanjo
SECRETARY

COLLEGE OF FORENSIC PATHOLOGISTS

In the past year, the College of Forensic Pathologists conducted two sets of examinations. These events occurred without incident.

The successful candidates were:

FC For Path(SA) Final

DATE CHONG, Mandy
KHAN, Akmal
QUARRIE, Karisha Claudia

FC For Path(SA) Part I

ALLI, Iekram Hoosen
SHAMASE, Nonhlanhla Benedicta

Dip For Med(SA) Path

BYARUHANGA, Moses Elly
CHIKWAVA, Simbarashe Kumurai
FUZANI, Ephraim Zimamele
JARAVAZA, Rufaro Diana
KALUNGI, Sam
KHUBANA, Unarine Munei
MALE, William Mutumba
MEDAR, Sajida
MEDDOWS-TAYLOR, Jessica Clair
NKOSI, Solomon Zephania
RAMORABI, Boitumelo Brenda
KRUGER, Louise Mari
NIEUWOUDT, Ilse

At its annual meeting, the College of Forensic Pathologists Council took a decision to amend the regulations concerning the subminimum mark for the practical (slide) examination for both the FC For Path(SA) Part I and FC For Path(SA) final examination. These proposed changes will be submitted to the Examinations and Credentials Committee for approval and incorporation into the regulations.

Dr S Aiyer
PRESIDENT

COLLEGE OF MAXILLO-FACIAL AND ORAL SURGEONS

It is a pleasure to present the annual report of the College of Maxillo-Facial and Oral Surgeons for the period 1 June 2012 to 31 May 2013.

The Council met twice, on 17 October 2012 and 22 May 2013. The regulations for admission to Fellowship of the College of Maxillo-Facial and Oral Surgeons have been updated again. Regulations for a Diploma in Oral Surgery have been approved by the HPCSA, and the first examination held in August or October 2013.

Council discussed several issues relating to examinations, including a review of the results over the last three years, in particular, for the Part IA examination; and examination techniques in support of the direction of the CMSA. The Council will implement the SBA examination in the second part of 2013 for Part I: Anatomy (Diploma and Fellowship) and Part II (Diploma and Fellowship). The blueprint for Anatomy and the final examination for the FCMFOS(SA) have been submitted to the Academic Registrar of the CMSA.

Professor Bütow presented a paper about the CMSA and the College of Maxillo-Facial and Oral Surgeons at the 3rd Pan-African Congress of Oral and Maxillofacial Surgeons, in Cape Town, in October 2012. The relationship of the FCMFOS(SA) and the university masters (MChD/MDent) examinations was explained. This lecture was attended by delegates from South Africa, Africa, and executive members of the International Association of Oral and Maxillo-Facial Surgeons, and was very well received.

A combined meeting of African Colleges, chaired by Professor Bütow, was held in Cape Town in October 2012. The College of Maxillo-Facial and Oral Surgeons Councillors met College representatives from Ghana, Nigeria, West Africa and East Africa, as well as the President of the Society of Maxillo-Facial and Oral Surgeons of Egypt. At this meeting, we were informed of an international Christian College that is involved with training in Africa. Contact has been made with this College.

There were two successful candidates in the final examinations of the FCMFOS(SA) in each of the October 2012 and May 2013 sessions.

On behalf of the Council of the College of Maxillo-Facial and Oral Surgeons, we express appreciation to staff in the Cape Town, Durban and Johannesburg offices of the CMSA for their ongoing help and support.

Dr S Singh
SECRETARY

Prof Kurt-W Bütow
PRESIDENT

COLLEGE OF MEDICAL GENETICISTS

The College of Medical Geneticists was constituted in 2008. The College remains very small as the number of medical geneticists is very limited.

The first FCMG(SA) Part II examinations were written in August 2012 by two candidates, and in March 2013 by another two. All four candidates were successful. This will boost the number of qualified medical geneticists in the country significantly. Unfortunately, at present, their job prospects seem poor.

A productive meeting was held in Johannesburg in October 2013. Blueprints for Part 1 and 2 were revised and some changes were made to the FCMG(SA) regulations, logbook requirements and the examination structure.

The serious shortage of consultant medical geneticists and the difficulties in obtaining posts for medical geneticists and training posts for registrars are severely limiting our ability to train, and threatening the survival of the specialty. There is a desperate need for a national plan, with the creation of a structure that includes consultant and training posts.

Prof A Krause
PRESIDENT

COLLEGE OF NEUROLOGISTS

The annual meeting took place on 16 March 2013.

The examination process came under scrutiny. Subcommittees were appointed to review the syllabus, to develop a blueprinting document to align the syllabi and the examinations, and to initiate a single, best answer paper for the Part 2 examination in the first instance.

Following the general CMSA guidelines, the need for an examination moderator was accepted, and the duties of this post established. It was also decided that in the future, examiners for the Part 2 examination would consist of three persons as before, but that two of these examiners must be external to the examining centre. A registrar survey was conducted to investigate their views on training and teaching. It appears that there is a perceived need for further training in clinical neurophysiology techniques, such as electroencephalograms and electromyograms/nerve conduction studies. The annual national registrar teaching weekend will continue to focus on topics that it has previously, but in addition, we will now investigate the creation of an online teaching resource on these topics.

Prof R Eastman
PRESIDENT

COLLEGE OF NEUROSURGEONS

The last year has been busy, but successful, for the College of Neurosurgeons.

The CMSA examinations were hosted by the University of the Witwatersrand in October 2012, and Stellenbosch University in May 2013. The examination pass rate increased in the last two examinations, with a pass rate of 67% and 71%, respectively. This is higher than the 50% of the previous year. In addition there is an

increased number of candidates writing the examinations with 16 people doing the written examinations. This is thought to be the result of the single-exit examination policy. It is also interesting to note that all of the 11 candidates who attended the clinical or oral part of the examination, passed. This suggests that the written component of the examination is accurately assessing candidates' suitability to progress to the clinical or oral component of the examination.

The annual meeting of the College took place in February 2013. The blueprinting process was discussed and Prof Semple undertook to carry it out. This has subsequently been successfully completed and was handed to the CMSA for display on the website. Clarification on the role of the memorandum for examination marking and the role of the moderator was discussed and decided upon, and this has been communicated to the CMSA for inclusion in the regulations. Examiners will now produce memorandums for the marking of the written papers, and will return the marked paper with an attached memorandum for each marked question. The role of the moderator will be extended to attend the clinical part of the examination. HPCSA rules on supernumerary registrars, honorary Fellowships, some of the rules pertaining to the time requirements relating to writing the final examination, and a brief discussion on a postgraduate certificate in spinal surgery, also received attention.

Dr A Makanjee from East London, and Dr I Vlok, the new Head of Stellenbosch University, were unanimously co-opted onto the College Council.

Finally, I would like to thank all the examiners for the time and effort that they put into the examinations.

Prof P Semple
PRESIDENT

COLLEGE OF NUCLEAR PHYSICIANS

Following a collaborative meeting of representatives of academic departments at the end of 2012, a single Nuclear Medicine blueprint and curriculum is being finalised. The College of Nuclear Physicians would like to thank the CMSA for affording our smaller College the necessary support in developing the blueprint. Together, we have managed to update our curriculum and regulations. Departments and registrars are encouraged to visit the CMSA website for details. Of importance, all registrars are reminded that a subminimum of 50% for both Part I and Part II is required in the written examination in order for the candidate to be invited to the oral. A subminimum of 50% will also be needed for the objective structured clinical examinations and oral examinations for the candidate to pass.

The College of Nuclear Physicians is experiencing steady growth with regard to candidates applying to take the FCNP(SA) examinations. We would like to congratulate and welcome the following successful candidates:

September 2012

DORUYTER, Alexander Govert George
HATUTALE, Anni-Liina N
MSHELIA, Dahiru Saleh
SONDAY, Zarina
TAG, Naima

May 2013

AREWA, Foluso Emmanuel Olusegun

BEZUIDENHOUT, Wilfred Nico

MODEBE, Emmanuel Obinna

ZINN, Christa.

Lastly, the College of Nuclear Physicians Council would like to encourage the Nuclear Medicine community to engage the relevant stakeholders in order to expand nuclear medicine services to secondary hospitals.

Prof M M Sathekge
PRESIDENT

Prof J M Warwick
SECRETARY

COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

The College of Obstetricians and Gynaecologists continues to fulfil its function as the examining body for the specialist discipline of Obstetrics and Gynaecology, and the related subspecialities, namely Maternal and Foetal Medicine, Gynaecological Oncology and Reproductive Medicine and the Diploma in Obstetrics.

Our Council meets twice a year. In addition, our Part 1 Committee meets twice a year to formally set the examinations, while the Part 2 Committee meets once a year, over and above the Council meetings. A number of innovations have been implemented, or agreed upon, during the last 12 months to accommodate the ever-increasing number of candidates who wish to write the examinations and because of the constant evolvement of basic sciences over the last decade. This has resulted in the need to assess the knowledge of the basic sciences, and also the clinical application of these sciences. Twelve examiners are now appointed twice a year for the Part 2 examinations. Recently, we started using two moderators for each of these examinations to deal with the numbers as appropriately as possible. The Part 1 examination will now consist of two parts, namely, Part 1A, which will purely examine the basic sciences, and Part 1B, which will examine the applied basic sciences and the pathology of diseases in obstetrics and gynaecology. Candidates can write both examinations over one, or two, sets of examination dates. From 2014, assessment will be solely through single, best-answer, multiple-choice questions.

The College of Obstetrics and Gynaecology has also recently appointed subcommittees to formally blueprint all our examinations, which will hopefully be achieved within the next 6-9 months.

The College wishes to acknowledge the significant contribution that its Fellows make so that the examinations to take place, particularly marking examination scripts and conducting numerous oral examinations, which take place twice a year. Fellows who are invited to examine Part 1 are not known to the rest of College members. Therefore, I wish to acknowledge and thank Drs T Smith, S Norsarka, TJ Mashamba, NC Sigcu, E Bera, L Cebekulu, N Masgan, VV Thomas, MM du Toit, RB Nyakoe, CM Stewart, H van Zyl, FH van der Merwe, J Jogessar, SC Moodley, N Dwarka, S Jackson, L Matsela, and Profs J Bagratee and LC Snyman, for being prepared to examine the candidates who entered the Part 1 examinations during 2012. The College also wishes to acknowledge the significant contribution made by Dr SR Ramphal and Prof BG Lindeque, who convened the Part 2 examinations in 2012; to Dr T Smith and to Prof J Bagratee, for

convening the Part 1 examinations; and Drs CH Maise and Prof TS Monokoane, for convening the Diploma in Obstetrics.

The College of Obstetricians and Gynaecologists continues to utilise the JC Coetzee fund to ensure that our outreach programme persists as a College priority. Our College also continues to have representation on the Essential Steps in the Management of Obstetric Emergencies advisory board. The great news is that Urogynaecology has been approved by the HPSCA, although the whole concept still needs to be promulgated. We look forward to being one of the Colleges that will offer training in this subspeciality.

Prof F Guidozi
PRESIDENT

COLLEGE OF OPHTHALMOLOGISTS

In order to achieve maximal representation on the Council of the College of Ophthalmologists, it was agreed to invite Dr Jan Olivier from the University of Limpopo and Dr Priscilla Makunyane, the current Acting Administrative Head of Department at the University of Pretoria, to join as councillors, thus expanding the number of councillors to 14.

The Council also proposed the names of Dr Christopher Tinley and Dr Travis Pollock, both from the University of Cape Town, as Associates. Both applications were approved by the E & C Committee and they are already actively involved as examiners.

Both the Fellowship (November 2012) and Diploma (January 2013) regulations were revised, updated and placed on our website.

Council resolved to arrange annual pre-examination workshops for registrars taking the final examination. Sponsorship will be sought from the pharmaceutical industry. These workshops will precede annual ophthalmology society congresses. Prof Andries Stulting is to arrange the first workshop in 2014.

Finally, we are grateful to report that the finances of the College of Ophthalmologists, as reflected in our levy account, are healthy. This allows Council to conduct its business without material restraints.

Prof D Meyer
PRESIDENT

COLLEGE OF ORTHOPAEDIC SURGEONS

The Orthopaedic College Council met twice in this period. The AGM was held at the time of the annual South African Orthopaedic Association Congress, which took place in Durban in September 2012.

The examinations were well run, without incident. Efforts are being made to expand the examiners pool and to ensure wide and varied representation, especially in the light of many heads of department recently retiring.

A consolidated logbook template is now given to final candidates. This was found to be far more useful than the previous list of cases. It also helps to identify possible training deficiencies.

Ongoing challenges remain in the intermediate examination, and we are moving towards single best answers for the written one.

The Edelstein Medal for the best candidate in 2012 was awarded to Dr N Goldstein of the University of the Witwatersrand.

The Francois P Fouché lecture for 2013 will be delivered at the upcoming South African Orthopaedic Association meeting in Sun City by Prof Theo le Roux, 1 Military Hospital/University of Pretoria.

The College Council wishes to thank Mrs Bernise Bothma, the CEO and Mrs Ann Vorster, the Academic Registrar and their team, for their efficient and hard work during the past year.

Prof Robert Dunn
PRESIDENT

COLLEGE OF OTORHINOLARYNGOLOGISTS

Primary examination

The format of the dedicated primary examination has now been standardised, and results have improved.

Final examinations

The College of Otorhinolaryngologists has continued to improve the standardisation of the conduct of the oral examinations, and has adopted the recommendations of the CMSA of using multiple clinical stations and an objective structured clinical examination station. It also now rigidly applies the minimum logbook requirements, as set out on the CMSA website, because of concerns about the adequacy of training platforms. At the most recent examination (May 2013), three out of seven candidates did not meet the minimum logbook requirements, and were not permitted to write the examination.

The ENT Registrars' Society organised a training day in November 2012 to prepare registrars for the final examinations. It is hoped that this will continue in the future.

Prof J J Fagan
PRESIDENT

Prof R Y Seedat
SECRETARY

COLLEGE OF PAEDIATRIC SURGEONS

The main focus of the Council's activities for the past year has been restructuring the FC Paed Surg(SA) Final examination. The intention of this restructuring is to ensure the testing of core knowledge, clinical acumen and approach to management in the field of Paediatric Surgery, in a manner that is demonstrably accurate and fair.

The following paediatric surgeons with outstanding contributions in the field of Paediatric Surgery have been nominated by the College, confirmed by Senate, and accepted by the nominees as Honorary Fellows of the College of Paediatric Surgeons of South Africa:

- Professor Jay Grosfeld, USA
- Professor Prem Puri, Ireland
- Professor Takeshi Miyano, Japan.

Successful candidates in the FC Paed Surg(SA) examination in 2012/2013 were:

ARNOLD, M
HARRISON, D
NUNN, L
VON DELFT, D.

Prof C Lazarus
SECRETARY

COLLEGE OF PAEDIATRICIANS

Blueprinting of examinations

Blueprinting of examinations was concluded over the last year. The examiners who were selected by the College for both FC Paed(SA) I and II were asked to provide the convenor with a range of questions (different types and different topics). The convenor provided examiners with the blueprint, which showed which topics were covered in previous examinations, and in what proportions. This guided them in terms of choice of topic and allowed the convenor to blueprint the current examination paper, thereby always covering a proportion of core topics, and ensuring a spread of topics within and between examinations.

The papers were reviewed by an Examinations Review Committee, tasked with advising the convenor on the balance in the papers, as well as taking relevance, validity, style and comprehensibility into consideration.

Once questions were selected, examiners were asked to submit marking memoranda, against which they were expected to mark the papers.

Colloquium: the paediatrician of the future

In 2009, the College of Paediatricians and the South African Paediatric Association started the "Training the Paediatrician of 2015" initiative. The aim was to review current registrar training nationally, and thus better define the training needs of the paediatric graduate of 2015. The goal was to assist in the development of the rotation and curriculum for paediatricians that will meet the needs of graduates, society, and ultimately the children of South Africa.

Five meetings were held to continually assess training programmes around the country. A registrar association, The South African Paediatric Registrar Association (SAPRA), was developed, which has assisted in many areas of improvement of registrar training throughout the country. Issues that were dealt with included staff shortages, registrar rotations, protected teaching time, the research project, maternity and study leave, outreach and the portfolio/logbook.

In 2012, we ran a "Paediatric Colloquium" in conjunction with the South African Paediatric Association and departments of paediatrics from around the country. We met to discuss the ideal product desired in our paediatric training programmes. I will highlight the item on registrar training for South Africa.

Registrar training

Standardising registrar training around the country is not simply a question of "clinical exposure equivalence". Some universities have problems with subspecialty exposure for some, or all, registrars. Teaching and supervision or mentoring may be different, and better or worse at some institutions. The new research component of training that is required by the HPCSA has, and will, create additional problems.

Some of the identified problems were:

- Lack of experienced supervisors.
- Difficulty in identifying topics.
- Difficulty in balancing Part I study and the research component.

Additional problems in registrar training were identified:

- Some registrars are poorly equipped academically to embark on a specialist career. In part, this may be reflective of a change in undergraduate curricula.
- Frequent failures.
- Delays in starting research.
- Registrars do not read enough, and hence the research component has been created in an attempt to address this.
- Poor block assessments.
- Poor attendance at tutorials or inadequate teaching opportunities.
- Registrars want rotations to occur before the final exams, i.e. by 3.5 years, and this is sometimes difficult to enforce.
- At some institutions, the academic platform is deteriorating. Both secondary and tertiary facilities are required for training.
- The staffing configuration often leads to burnout, especially among female registrars.
- Medical officer posts are often inadequate, and the service load falls to registrars.

The delegates identified potential solutions that paediatric departments could use to promote the teaching and training of registrars:

- Better use of the portfolio. It is a perfect tool for supervision, particularly if a reflective summary is included.
- Implement a study protocol or ethics approval prior to obtaining a study block.
- Implement a structured pre-registrar or foundation programme.
- An Academic Steering Committee has been established at the University of the Witwatersrand. This committee meets regularly with registrars to inform and scrutinise logbooks.
- The Advanced Paediatric Life Support/Newborn Life Support should be seen as an entry criterion, or completed within the first six months of registrar training. It is valid for five years.
- Consultants must support registrar training. This requires a paradigm shift in consultant thinking.
- Capacity building is required for junior consultants, such as training courses in research, for example.
- Mentorship is important for registrars in all aspects, including research.
- Pre- and post-rotation tests in various blocks should be instituted.
- In our modern world of litigation, it is important to document all processes of registrar review in the logbook.
- Academic paediatricians should help to motivate for a broad training platform.

Finally, the Paediatric Colloquium identified that the training of registrars was important enough for a task team to meet and provide a document that could be offered to universities as a road map for many of the problems that registrars face. The most important of these was to try to create a uniform structure for research, and especially requirements for the marking of dissertations. The College of Paediatricians should take a proactive role in this regard. Dr R Thejpal was identified to lead this task team.

Examination regulations

The College of Paediatricians examination rules and regulations were reviewed and modified as appropriate.

College newsletter

In early 2012, our College introduced a quarterly newsletter to communicate with our members. Five issues were published.

Marking memoranda for paediatric examinations of the College of Paediatricians

The College of Paediatricians standardised the approach to marking memoranda. Each examiner is expected to compile and submit a marking memorandum for each of their accepted questions. The marking memorandum will appear on the CMSA website to assist candidates in preparation for future examinations.

It is not intended to be a model answer. Candidates are able to access factual information elsewhere, and so the aim of the marking memorandum is to indicate to candidates how their responses are going to be marked.

Examiners will be expected to submit the marking memorandum at the same time that they submit the marks to the examination convenor.

In addition, examiners are asked to include a few comments of reflection on how candidates performed and whether or not their expectations were met.

Prof R Green
PRESIDENT

COLLEGE OF PATHOLOGISTS

The first meeting of the new Council of the College of Pathologists was held at the Federation of South African Societies of Pathology Congress in September 2012 in Cape Town. Dr Jaya George was co-opted onto Council to ensure that all pathology disciplines are represented on Council.

A number of candidates were successful in the Fellowships and Certificate examinations in the past 12 months. We wish to congratulate and welcome these new members to the pathology fraternity.

The College of Pathologists continued to engage with its international counterparts at the annual international liaison of pathology presidents meeting. The 2012 meeting was held in the UK, and included discussions on a number of issues, including the practice of pathology and the role of pathologists in health care and advocacy.

The College of Pathologists' blueprints, syllabi and portfolios have now been completed for all monospecialty disciplines. The syllabi and portfolios are available on the CMSA website. Submission of a portfolio of learning will be mandatory from the second semester of 2014 for all Part 2 candidates who commenced training in January 2011 or later.

We continue to expand the examiners panel in the various pathology disciplines in response to the limited number of available examiners needed to conduct the two CMSA examinations each year.

In conclusion, we wish to thank councillors and examiners for their contributions and continued commitment. We must also acknowledge the various CMSA offices for their assistance, continued support and efficiency over the last year. Thank you.

Prof D Govender
PRESIDENT

Prof J Mahlangu
SECRETARY

COLLEGE OF PHYSICIANS

The College of Physicians reflected a financial deficit in the levy account. The balance of the levy account in March 2013 was -R22 217.87 (R109 064.23 in March 2012). This deficit was caused by the increasing number of workshops that are needed to develop the examination papers for the Part I MCQs, the Objective Test and the Part II MCQ. The incurred expenses were over and above the allocations by the CMSA. This financial situation has several implications for the College of Physicians. Firstly, I believe that the College of Physicians needs to appoint a treasurer from among the Councillors. The role of the treasurer will be to work closely with the College accountant to monitor expenditure and avoid a deficit in the future. The second implication is that we need to develop a 12-month budget to plan for essential activities, such as workshops and Council meetings, and to fund the attendance of subspecialty representatives at our meetings. This will allow us to determine the shortfall in funding ahead of the time, and to apply for additional funding from the CMSA. Finally, we need to actively raise external funding for our activities, and possibly find new mechanisms to generate revenue, such as offering courses to trainees and physicians in the future.

We are entering the final year of the term of office of this Council. I believe that we can be proud of the new initiatives and reforms that have been launched since 2011, including:

- The new process for the revision of subspecialty regulations by the national representatives who attend our meetings by invitation on a regular basis.
- The introduction of multiple-choice questions for Part I and Part II papers, and the standard setting method to determine the pass mark.
- The proposal to form a new subspecialty of Advanced Internal Medicine.
- The planning for the joint conference with the Royal College of Physicians of London, which will be held in Cape Town on 20-24 February 2013 in the Cape Town International Convention Centre.

I am calling on councillors and heads of departments to make the joint conference of the College of Physicians of South Africa and the Royal College of Physicians of London a truly national and continental event. These funds will be used to sponsor national speakers to attend the meeting. The local organising committee, which is chaired by Dr Gillian Watermeyer, will interact with departmental representatives over the next few months on speakers, the programme and marketing of the meeting.

Prof B M Mayosi
PRESIDENT

COLLEGE OF PLASTIC SURGEONS

The College of Plastic Surgeons had a busy year in 2012/2013.

Following the poor results in the College examinations in October 2011 and March 2012, the College initiated a programme managed by Prof F Jooste, whereby senior registrars in their final year attended an examination symposia in Bloemfontein. The registrar symposia continue to be run very successfully. They expose registrars (junior and senior) to academic departments, and seek to create uniformity in teaching and exposure.

In the October 2012 examination, of a total of 12 candidates, six were successful, and in March 2013, of the six candidates who attempted the examination, five passed.

Dr R Nicholson was re-elected as President and Prof E Ndobe elected as Secretary of the College of Plastic Surgeons for the current triennium.

Dr G Morrison, Dr M Pillay, Dr C Snijman, Dr E Siolo and Dr W Kleintjes remained as elected Councillors.

The AGM of the College of Plastic Surgeons was held on 15 October 2012 at the annual Association of Plastic and Reconstructive Surgeons of Southern Africa congress.

Dr R D Nicholson
PRESIDENT

Prof E Ndobe
SECRETARY

COLLEGE OF PSYCHIATRISTS

The College of Psychiatrists is actively involved in curriculum review, and the blueprinting process is well underway, with task teams for each qualification within the College. In addition, special attention has been given to regulation review. Registering new subspecialties, while welcomed as evidence of the ongoing development of the discipline, also presents new challenges for curricula, blueprinting and regulations.

There were a number of activities in the period, October 2012 to June 2013.

Examinations

Clinical and oral examinations were hosted (FC Psych II, Cert Child Psych and DMH) in Gauteng at the University of the Witwatersrand (October 2012), and written examinations (FC Psych I and II, Cert Child Psych and DMH) in March 2013. Hosting of the clinical and oral examinations (FC Psych II, Cert Child Psych and DMH) took place in the Western Cape at the University of Cape Town and Stellenbosch University.

The most recent FC Psych II examinations were held with the new regulations in place regarding requirements to advance from the written examination to the clinical and oral examinations. These regulations have set a minimum requirement of 50% overall, with nine of 12 questions over three papers requiring a minimum of 50%. This reduced the number of candidates invited to participate in the clinical and oral examinations, but resulted in 80% of those who were invited, passing. The overall pass mark was 44%.

Recipients of awards

Awards were given to the best candidates in FC Psych I and II for 2012.

Meetings

Academic registrar workshop, 1-2 February 2013

The academic registrar workshop, that was held from 1-2 February 2013, was well attended by registrars from around the country who were eligible to write the FC Psych II. Generally, positive feedback was received. The event was sponsored by Servier, who has committed sponsorship to the workshop in 2014.

Council meetings (face to face and teleconferences, October 2012 and February, March and May 2013)

At the council meetings, a number of key items were noted:

- Decision on independent practice by a Dutch-registered psychiatrist.
- Ongoing review of the regulations.
- Appeals of failed candidates (FC Psych II).
- Outcome of the RWS Cheetham Award.
- Delays in the administrative process pertaining to nominations for Fellowship by peer review.
- Policy for examiner withdrawal.
- Promulgation of subspecialties, i.e. Forensic, Neuropsychiatry and Old Age Psychiatry.
- Agenda for the 2013 Annual General Meeting.
- Preparations for the 2014 registrar workshop.
- Challenges regarding moderation of papers within tight timelines.
- Challenges around Psychiatry's new classification system (DSM 5) and the impact on the curriculum and examinations.
- *Examiner database*: The need for recruitment and capacitating more examiners.
- *Subspecialties*: Challenges around the training of subspecialists because of a lack of registered subspecialists, and the implications for scope of practice if the subspecialties are registered.

Prof C P Szabo

PRESIDENT

COLLEGE OF PUBLIC HEALTH MEDICINE

Over the 2012/2013 period, the College of Public Health Medicine focused on improving the assessment process, strengthening relationships with international colleagues, and increasing recognition of the discipline. Three candidates graduated with Fellowships of the College of Public Health Medicine in Occupational Medicine in the last year. These were Drs Shumani Phaswana, University of KwaZulu-Natal; and Mokgadi Mothemela and Amy Burdzik, University of Cape Town. Dr Burdzik was nominated for the SASOM Medal.

Two blueprinting and examination workshops, with follow-up meetings, were held for the Public Health Medicine and Occupational Medicine divisions. These covered an extensive review and revision

of the regulation and guideline documents, where the learning outcomes, and knowledge and skill requirements were amended. The final documents will be submitted to the CMSA when completed. The assessment process for both disciplines has also been revised, based on the international standards that were presented at the CMSA examination Workshops, and a review of the assessment processes of internal counterparts. Major changes include an increase in the number of multiple-choice questions, and a move towards replacing the oral component of the examination with an objective structured practical examination. Consequently, efforts have also been made to establish and collate a bank of single, best-answer, multiple-choice questions. Finally, blueprinting templates have been developed, and are being tested before they are submitted to the CMSA for approval.

In the last year, the College of Public Health Medicine received and provided support to a number of international counterparts. Following Prof Shan Naidoo's election as a Fellow of the Faculty of Public Health of the Royal Colleges of Physicians in 2011, the UK Faculty of Public Health provided support and guidance to the Council. Numerous visits were made by colleagues from the University of Botswana to gain insight into, and to provide assistance with regard to, the establishment of its specialist training programme. Dr Ruxana Jina visited the University of Botswana to evaluate its experiential learning activities. Work with the University of Botswana is ongoing. Prof Asuzu from Nigeria was awarded an Honorary Fellowship in October 2012. Subsequently, Dr Flavia Senkubuge acted as an external observer for the National Postgraduate Medical College of Nigeria, Faculty of Public Health examination. She returned with considerable insight and ideas on how to improve our assessment process, which will feed into ongoing work on changes in the assessment process.

The Public Health Medicine and Occupational Medicine division has felt the need to better define our role in the healthcare system. The scope of practice for both disciplines was developed and submitted to the HPCSA through the CMSA. National processes are also ongoing. Council members have successfully affiliated the South African Public Health Medicine Association with the South African Medical Association, while the National Department of Health's Human Resources for Health Strategy has specified that national and provincial public health units should be established and managed by public health medicine specialists. Thus far, two such units are being piloted in districts in Gauteng. The Department of Health is also still in the process of stakeholder analysis regarding the establishment of a national public health institute. This will result in a critical need and defined future role for public health medicine specialists. The process of reengineering primary health care has identified key gaps in the public health knowledge of managers, both at district and hospital level. Accordingly, there is an expanding need for more specific training in aspects of public health medicine. The Diploma in Medical Management has been approved by both the CMSA and the HPCSA. Efforts are now underway to prepare for a new intake of students in the forthcoming years. The discipline has never been in a stronger position!

Dr R Jina
SECRETARY

COLLEGE OF RADIATION ONCOLOGISTS

The College of Radiation Oncologists has fully implemented its revised syllabus and examination process with the use of blueprints for the written examinations, as well as short question and answer memoranda. The candidates have produced fine learning portfolios, of which they are justifiably proud. A feature of the Part II examination is the 12-station objective, structured clinical examination. The first cohort of registrars who completed both their College degree and a university MMed degree have graduated.

A meeting of College examiners was held in Cape Town on 22 May 2013, prior to the oral examinations. The examination papers were systematically reviewed, and questions that were poorly answered were reviewed as to whether or not they were within the blueprints and fair. The review panel included representatives of examiners in basic sciences. There was consensus that the questions were fair and fell within the blueprint.

It was noted that the most difficulty was encountered with Radiobiology and Cancer Biology. A suggestion was made that the study books for the Basic Sciences in Part I should be made more specific. Once the students have passed Part I, they can be expected to read more broadly. Note was also taken of areas in which better training of candidates was needed, for example, knowledge of clinical tumour volume and planned tumour volumes was considered to be inadequate in the era of modern radiation oncology.

Further minor modifications were made to the regulations and the learning portfolio template.

There was a marked increase in the number of candidates being examined by the College, as can be expected, as it is now the single national examination for Radiation Oncology.

Prof R Abratt
PRESIDENT

COLLEGE OF RADIOLOGISTS

Executive

President and Senate Representative: Prof Savvas Andronikou

Secretary: Prod Richard Pitcher

Senate Representative: Prof Victor Mngomezulu

Elected Councillors

Prof Stephen Beningfield, University of Cape Town

Prof Coert de Vries, University of the Free State

Dr Mayuri Govind, University of KwaZulu-Natal

Prof Elaine Joseph, University of the Witwatersrand

Dr Margaret Kisansa, Medunsa

Prof Zarina Lockhat, University of Pretoria

Dr Priya Parag, University of KwaZulu-Natal

Co-opted Councillors

Dr Christelle Ackermann, Stellenbosch University

Dr Vicci du Plessis, University of KwaZulu-Natal

Dr Fekade Gebremariam, University of the Free State

Dr Linda Tebogo Hlabangana, University of the Witwatersrand

Dr Farzana Ismail, University of Pretoria

Dr Dibuseng Ramaema, University of KwaZulu-Natal

Dr Darius Tsatsi, University of Limpopo

Dr M Modishi, University of Limpopo

Composition of Council

Dr Aisne Stoker resigned from Council on retirement from her position as Chief Specialist at Grey's Hospital, Pietermaritzburg. Dr Dibuseng Ramaema, Acting Head of the Department of Radiology at the University of KwaZulu-Natal, and Dr Darius Tsatsi, were co-opted to Council.

Digital examination platform

After carefully researching the capacity of various systems to meet the requirements of the FC Rad(Diag) Part II digital examination, Council resolved to run the examination on the iSite PACS® platform, and officially appointed Mr Clive Daniell as IT Consultant to customise the system according to Council requirements. The appointment of a single consultant was seen as integral to meeting the continuity, consistency and quality assurance imperatives of the new digital examination format. The substantial costs of the digital transformation were borne by the College of Radiologists from its levy fund. This is an unsustainable situation which needs to be worked into the cost of the examination. However, the College of Radiologists has set a precedent, and this model may be replicated by other specialities, such as Pathology and Dermatology, in which the viewing of clinical images is required.

To ensure that FC Rad(Diag) Part II candidates were familiar with the digital examination format, the College convened pre-examination courses in the month preceding the October 2012 and May 2013 Fellowship examinations, respectively.

The examination IT consultant was also tasked with the collation of a digital examination database to serve as a repository of suitable cases for use in future examinations. Potential cases are forwarded to the consultant on a regular basis from College examiners. Again, this new expenditure has to be addressed in a new model that needs to consider the ongoing costs of the examination.

Blueprinting

Blueprinting of the College of Radiologists examinations was formally undertaken and completed during a dedicated session. The blueprint is already in use for the setting of the 2013 examination.

Facebook

The use of the facebook page of the College of Radiologists was restricted to advertising the pre-examination courses and alerting relevant parties about rule changes. This will continue, especially in light of anticipated further rule changes to accommodate new technology and blueprinting.

JN and WLS Jacobson Lecturer 2012

Prof Richard Pitcher was the JN and WLS Jacobson Lecturer for 2012 and presented his lecture, *The chest radiograph in HIV-infected children*, at Stellenbosch University in September 2012, and at the University of the Witwatersrand and the University of KwaZulu-Natal in November 2012.

Maurice Weinbren Award 2012

Dr AJ Lawson was the recipient of the Maurice Weinbren Award for

2012, for his paper, *Percutaneous transhepatic self-expanding metal stents for palliation of malignant biliary obstruction*.

Prof S Andronikou **Prof R Pitcher**
PRESIDENT **SECRETARY**

COLLEGE OF SURGEONS

The goals that the Council of the College of Surgeons set for itself for the triennium 2011-2014 are steadily being implemented.

In order to ensure that the examinations are of a consistently high standard, examinations boards have been appointed for examinations for the period of the triennium. The examination boards' responsibilities are to set all parts of the examinations that can be prepared in advance. This includes determining the examination matrix, setting the written papers and the objective structured clinical examination. In addition, the chairperson of the examination board also chairs the examination commission, which at the end of the examination process, evaluates the marks obtained by each candidate. It is the College of Surgeons Councils' opinion that the primary aim of this initiative, to ensure that there is standardisation and consistency in the examination processes, is succeeding.

The other role of the examination board is to introduce measures to ensure that the examinations conform to modern standards of assessment, and include the progressive introduction of measures that ensure greater objectivity and standard setting. The intention is that these measures will be in place by the middle of 2014.

As indicated in last year's report, the role of the examination moderators has now also been accurately defined to ensure that there is fairness and consistency in the examination process, and that predetermined standards are followed. These individuals, who report to the College of Surgeons Council, are expected to strongly express their opinion during the examination process if they believe that standards are not met, the assessment is unfair, or objectivity compromised.

During the 2007-2009 triennium, the College of Surgeons Council recognised that experience in research was of importance in the training of high-quality clinicians. As a consequence, from the middle of 2012, it became a requirement for individuals applying to write the FCS(SA) final examination to provide evidence of having undertaken such work. The extent and quality of the research work needs to conform to the standards set by the university at which the candidate is conducting his or her training. The introduction of this requirement has not been without problems. However, as a consequence, the general surgery training departments are now in a position to manage this process well ahead of the introduction of the unitary examination requirements set by the HPCSA, whereby a completed research project will be a prerequisite for specialist registration in South Africa.

Work performed on behalf of the College of Surgeons, using the logbooks submitted to the College prior to the FCS(SA) final examination, and which is taking into consideration the number and type of procedures being performed by general surgical trainees in South Africa, is nearing completion. This information, which will be used to evaluate the skills training to which South African trainees are exposed, and the value of the current logbook, will be included in the next report.

Prof M Veller
PRESIDENT

COLLEGE OF UROLOGISTS

Subspeciality Certificate in Urogynaecology

The Subspeciality Certificate in Urogynaecology, previously called "Urogynaecology", was approved by the HPCSA in April 2013.

Honorary Fellowship

At the CMSA graduation ceremony on 23 May 2013 in Cape Town, Prof Richard Santucci was admitted as an Honorary Fellow of the College of Urologists.

Apart from his many other achievements, Prof Santucci was particularly honoured for his training of South African urology registrars in the field of urethral stricture surgery.

Fellowship of the College of Urologists of South Africa

A general meeting of Fellows of the College of Urologists was held in November 2012 at Sun City, during the biennial South African Urology Congress. Dr Preg Chetty proposed that the criteria for assessment in the written part of the FC Urol(SA) Part II should be stricter than before. Successful completion of the written part of the examination is essential in order for invitation to the clinical part to follow.

After a lively discussion, members of the meeting decided that the overall mark for passing the papers should be 50%, and that the candidates should pass a minimum of five out of the eight questions.

This ruling will apply to the examination in March/May 2014.

The Lionel B Goldschmidt Medal

The Lionel B Goldschmidt Medal for the best candidate in the final examination in the year under review was won by Dr Mark Purdy.

The successful candidates in the two final examinations in the year under review were:

Dr A Adam
Dr J Basson
Dr E Esterhuizen
Dr R Friedman
Dr CF Marais
Dr CP Nothnagel
Dr NA October
Dr A Panackal
Dr MR Purdy
Dr D Qubu
Dr RJ Urry
Dr AP van den Heever
Dr WJS van Zyl
Dr PJL Venter.

The College of Urologists is indebted to those Fellows and Associates in full-time and private practice who contribute valuable time to make themselves available as examiners. Their invaluable contribution is paramount to maintaining a high standard in our speciality.

Prof R D Barnes
PRESIDENT

Recommendations for the acute and long-term medical management of low-trauma hip fractures

Cassim B, MBChB, FCP(SA), MD, FRCP(UK)

Associate Professor and Chief Specialist, Department of Geriatrics, School of Clinical Medicine, University of KwaZulu-Natal
Member of National Osteoporosis Foundation of South Africa Council and Executive Committee of the South African Geriatrics Society

Lipschitz S, MBChB, FRACP(NZ)

Private Practice, Member of the National Osteoporosis Foundation of South Africa Council and the South African Geriatrics Society

Paruk F, MBChB, FCP(SA), Cert.Rheumatology(SA)

Lecturer and Specialist, Division of Medicine, School of Clinical Medicine, University of KwaZulu-Natal

Tipping B, MBChB, FCP(SA), CertGeriatrics(SA), MPhil

Honorary Lecturer, Division of Geriatric Medicine, Department of Medicine, University of the Witwatersrand
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Keywords: osteoporosis, hip fractures, mortality, morbidity, management

Abstract

Hip fractures are the most serious complication of osteoporosis and are associated with high morbidity and mortality. Generally, patients who sustain osteoporotic hip fractures are older adults who have a number of co-morbid diseases which predispose them to perioperative complications, disability and death. Furthermore, patients who survive a hip fracture are at higher risk of a subsequent fracture. The morbidity and mortality of hip fractures can be substantially reduced by a structured multidisciplinary approach to pre- and postoperative management. This review will focus on the epidemiology of hip fractures, predictors of mortality and the acute and long-term management of hip fractures.

Peer reviewed. (Submitted: 2012-12-21. Accepted: 2013-01-07.) © NOFSA and SAGS

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Introduction

The association between hip fractures and an age-related reduction in bone mass and quality was first recognised over 160 years ago by Sir Astley Cooper.¹ It is estimated that one in two women and one in five men over the age of 50 years will sustain an osteoporotic fracture in their lifetime.² The wrist, spine and hip are common fracture sites.

The global prevalence of hip fractures is rising. Of the global 9 million osteoporotic fractures that occurred in 2000, 1.6 million were hip fractures.³ It is estimated that this number will increase to 2.6 million in 2025 and to 6.3 million by the year 2050.⁴ While part of this increase can be explained by the worldwide increase in life expectancy, longevity alone does not entirely explain the increase, and several other factors, such as a decline in physical activity and increasing frailty, have been implicated.

Fractures at the hip represent the most severe consequence of osteoporosis as they require admission and are associated with significant morbidity and mortality. In the first year following hip fractures, 20-24% of patients die, either owing to the fracture itself or to co-morbid disease. Fifty per cent are unable to walk without assistance and 33% are totally dependent or live in a nursing home. Mortality is significantly higher in men.

The combined annual cost of hip fractures was estimated to be €30 billion in the European Union and US\$20 billion in the USA in 2002.⁵ Sixty-three per cent of the latter was for management of the hip fractures.⁶ Drug therapy and hospital admissions further added to this expense.⁷ Fifteen years ago, the acute cost of treating a hip fracture in South Africa was estimated to be R50 000.⁸ Currently, it is approximately R150 000.

Epidemiology of hip fractures

There are significant variations in hip fracture rates according to different geographic areas, and ethnic and gender groups.

Geographic and ethnic variations

The highest hip fracture rates, at greater than 6 per 1 000 per year, are seen in the white Scandinavian and North American populations, followed by a rate of 4-6 per 1 000 per year in England, Scotland, New Zealand and Finland.⁹ In Europe, the incident rate varies from the north, where it is highest, to lower rates in France and Switzerland. The lowest rates are in the Mediterranean countries.¹⁰ Intermediate fracture rates have been reported in Turkey, Kuwait and Iran, and the Asian communities of Singapore, Hong Kong and Japan.¹⁰⁻¹³ The lowest rates have been described in developing countries and in black populations in Africa.

There have been limited studies on osteoporotic fractures in Africa. In earlier studies, no minimal trauma fractures were identified in rural Gambia,¹⁴ and an age-related increase in hip fractures was not observed in Nigeria.¹⁵ However, in a more recent study from Cameroon, hip fractures were identified in 40 subjects (27 women and 13 men) aged 50 years and above.¹⁶ Compared to the USA, the substantially lower fracture rate was attributed to the significantly lower life expectancy. Similarly, the lower incidence of osteoporotic fractures in Morocco has also been ascribed to a lower life expectancy.¹⁷ However, these studies do show that osteoporotic fractures occur in Africa.

In South Africa, studies have examined risk factors and the prevalence of osteoporosis in the different ethnic groups. Until recently, there has been only one study on the prevalence of hip fractures. This study¹⁸ reported an extremely low prevalence of hip fractures in black South Africans, which could not be explained by differences in bone mass.

Bone mineral density (BMD) has been reported to be the same or higher in blacks than whites^{19, 20} and persons of mixed ancestry.²¹ However, a recent study reported hip fractures in all ethnic groups in South Africa and supports clinical experience that hip fractures are more common than previously thought.²²

While the incidence of hip fractures appears to be stabilising in the more developed countries, it is projected that the burden of osteoporotic hip fractures will shift to Latin American, Asia and Africa, where the population are rapidly ageing. It is predicted that in the year 2050, 70% of over 6-million predicted fractures will occur in these populations.

Within countries, ethnic differences have also been reported in the incidence of hip fractures. In the USA, the age-adjusted incidence rates of hip fractures were higher in whites than Asians, blacks and Hispanics.²³ Higher bone mass and shorter hip-axis lengths in black and Hispanic populations may explain these differences.²⁴ Similarly, differences in hip-axis length have also been suggested as a cause of the lower adjusted fracture rates in Indians than in Chinese and Malay subjects in Singapore.²⁵ Other contributing factors for ethnic differences include variations in bone size, levels of physical activity, diet, neuromuscular functioning and frequency of falls.

Age and gender

The exponential rise in the prevalence of osteoporotic hip fractures with advancing age is explained by the age-related decrease in bone strength and the increase in frequency of falls in the elderly, especially women. Over their lifetime, bone density at the femoral neck is estimated to decrease by 58% in women and 39% in men, and by 53% and 35% at the proximal femur, in women and men respectively.²⁶

The female to male ratio of osteoporotic hip fractures in countries with a high incidence rate of osteoporosis is 2:1, but approaches 1:1 with advancing age²⁷ and in countries with a low hip fracture incidence.¹⁷ Hip fractures generally occur at a later age in men, but regional differences have been reported. In an Australian study, the burden of hip fractures was shown to occur at an earlier age in men, than in women.²⁸ In this study, the incidence of fractures peaked at 84 years in men. Forty-eight per cent experienced fractures before the age of 80 years, compared to 66% of women who had fractures before the age of 85 years.²⁸ Analysts predict that by the year 2040, with increasing life expectancy in men, there will be as many hip fractures in men as there are in women today.

Other risk factors for hip fractures

Numerous large epidemiological studies have identified risk factors for hip fractures. In addition to age, gender and ethnicity, these include:

- Low BMD.
- Frequency of falls.
- Prior fractures.
- Low bodyweight.
- Excessive alcohol intake and smoking.
- Cognitive impairment.
- Vitamin D deficiency or insufficiency.
- Secondary causes of osteoporosis.

BMD is one of the most important determinants of fracture. Although geometry, micro-architectural integrity, length and cross-section of the

proximal femur all contribute to bone strength, the relationship between BMD and fracture has been best established. For every one standard deviation decrease in BMD, there is a 2.4 to threefold increase in age-adjusted hip fractures.²⁹ The existence of a prevalent fracture is also a strong predictor of future hip fractures. The presence of a prior distal arm or vertebral fracture has been shown to increase the risk of hip fractures^{30, 31} and a person with one hip fracture has a 60% increased risk of having a subsequent hip fracture.³² Previous childhood fractures and a maternal history of hip fractures are also strongly associated with increased risk.³³

Almost all hip fractures are preceded by a fall. Important risk factors for falls include advanced age, frailty, cognitive impairment, postural hypotension, visual, gait and balance disturbances, use of drugs such as sedatives and alcohol, and environmental hazards.³⁴

The World Health Organization recognised that clinical risk factors increase risk fractures independently of BMD, and that the risk of fracture increases with the number of risk factors present. It developed a fracture risk assessment tool called FRAX[®].³⁵ This tool integrates the risk associated with clinical risk factors that were identified from meta-analyses of large epidemiological studies, as well as BMD at the femoral neck, to calculate the 10-year probability of fractures for men and women. The FRAX[®] score improves the prediction of future fractures. However, the derived intervention thresholds are dependent on epidemiological and health economic data, and are therefore country-specific. While a study is underway, there are no available incidence data on hip fractures in South Africa. Consequently, the FRAX[®] cannot be applied to South African populations at present.

Morbidity and mortality post hip fractures

Osteoporotic hip fractures account for more disability-adjusted life years (DALYs) than most cancers, asthma and rheumatoid arthritis.³ Up to 50% of patients have permanent disability post a hip fracture, and only 30% regain full function. One year post a hip fracture, 40% of patients are unable to walk independently, 60% require assistance with one essential daily living activity (such as dressing), and 80% require assistance with at least one instrumental daily living activity (such as shopping).³⁶

Globally, there is a 10-20% mortality rate following hip fractures. Mortality and morbidity rates increase with increasing age, the presence of co-existing diseases and poor functional status prior to the fracture. Mortality is highest within the first six months, and relates to the fracture itself, whereas after six months, it is more likely to be due to pre-existing diseases and functional status.³⁷ In a prospective study in Britain, the mortality rate post hip fracture was 33% at 12 months, and 15% of patients died in hospital prior to discharge.³⁸

Predictors of mortality

A higher mortality rate has been reported in men than in women. In one study, 14% of men died in hospital in the immediate period following a hip fracture, compared to 6% of women.³⁹ Hospital stay is also longer for men and days spent in hospital by men for osteoporotic hip fractures exceed those for carcinoma of the prostate.²⁷

Strong evidence of 12 predictors of mortality was reported following a recent large meta-analysis of 64 316 patients, where overall in-patient

or one-month mortality was 13.3%, and 15.8%, 24.5% and 34.5% at 3-6 months, one year and two years, respectively.⁴⁰ The predictors were advanced age, male gender, nursing home or facility residence, poor preoperative walking capacity, poor daily living activities, poorer global physical status and fitness for surgery (as defined by a higher American Society of Anesthesiologists grading), poor mental state, multiple comorbidities, dementia or cognitive impairment, diabetes, cancer and cardiac disease.⁴¹ Other studies have also identified low albumin levels on admission and a delay in surgery as predictors of a poor outcome.⁴²

Acute management of hip fractures

Patients who sustain hip fractures are usually of advanced age with multiple co-morbidities and are therefore at high risk of peri- and postoperative complications, which can be mitigated by appropriate pre- and postoperative management, ideally by a multidisciplinary team (Table I).

Timing of surgery

Timing of surgery refers to the time from the fracture to the time of surgical fixation. There is no consistent definition as to what constitutes early surgery, but most studies have used a period of between 24 and 72 hours. (The International Osteoporosis Foundation (IOF) recommends 24 hours). In a meta-analysis of 16 observational studies, earlier surgery was associated with a significantly lower mortality rate [relative risk (RR) 0.81, 95% confidence interval (CI): 0.68-0.96, p-value = 0.01]. Earlier surgery also significantly reduced in-hospital pneumonia (RR 0.59, 95% CI: 0.37-0.93, p-value = 0.02) and pressure sores (RR 0.48, 95% CI: 0.34-0.69, p-value < 0.001). By contrast, earlier surgery has not been shown to reduce the risk of deep venous thrombosis (DVT) or pulmonary embolism.⁴²

It is recommended that patients who are admitted with a hip fracture and who are medically fit should undergo surgical fracture management within 24 hours of fracture in non-after hours operating time (generally accepted as 08h00 to 20h00, seven days a week).⁴³

Delaying surgery for medical stabilisation

More than 60% of older patients who are admitted with a hip fracture will have significant co-existent medical pathology.⁴⁴ Briefly delaying surgery, but still aiming for its occurrence within 72 hours post fracture, is recommended for the medically unstable patient to allow for maximal medical optimisation.

Classes of major abnormalities associated with poor postoperative outcomes include:⁴⁵

- **Cardiovascular disease:** Cardiovascular disease encompasses systolic blood pressure < 90 mmHg, ventricular tachycardia or supraventricular tachycardia (a rate > 120/minute), a third-degree heart block or heart rate of < 45/minute, a new myocardial infarction on electrocardiogram (ECG), or chest pain with an abnormal ECG, pulmonary oedema or heart failure confirmed on a chest X-ray.
- **Respiratory conditions:** These are defined by a temperature < 35°C. (This emphasises the need for special low-reading thermometers in the trauma unit) or ≥ 38.5°C plus a clinical diagnosis of pneumonia or chest infiltrates on radiograph, respiratory failure with oxygen saturation of < 90% on pulse oximetry, or oxygen partial pressure (pO₂)

< 60 mmHg or carbon dioxide partial pressure (pCO₂) of > 55 mmHg).

- **Haematological abnormalities:** These are classified as an international normalised ratio > 1.6 and haemoglobin < 7.5 g/dl.
- **Serum electrolytes and/or renal abnormalities:** This refers to sodium < 125 mmol/l or potassium < 2.5 mmol/l, urea > 18 mmol/l, creatinine > 225 µmol/l or serum glucose > 33 mmol/l. It is recommended that the aim should be a serum glucose level of 6-10 mmol/l during the perioperative period.

Type of anaesthesia: regional (spinal or epidural) versus general

There is no evidence to support a preference for regional over general anaesthesia.⁴⁶ On the contrary, the Scottish Hip Fracture Audit showed a very small, but statistically significant, lower absolute mortality in patients who received general versus regional anaesthesia.⁴⁴

Managing cardiac risk: beta blockers, statins and anti-platelet agents

Death from cardiovascular disease occurs 90 times more commonly than that from fatal pulmonary embolism within the first six months of hip fracture.⁴⁷

Cardioselective beta blockers

Orthopaedic surgery is considered to be intermediate risk surgery, with a reported risk of cardiac death or nonfatal myocardial infarction of up to 5%.⁴⁸ The American College of Cardiology and the American Heart Association recommends that patients who are scheduled to undergo intermediate-risk surgery with more than one clinical risk factor should be treated with cardioselective beta blockers such as atenolol, bisoprolol and metoprolol, and that the dose should be titrated to achieve a heart rate between 60 and 80 beats per minute. Clinical risk factors include ischaemic heart disease, a history of congestive cardiac failure, a history of cerebrovascular disease, diabetes mellitus with insulin therapy and renal impairment. Extended release beta blockers should be avoided in these patients as they may increase the risk of sustained significant perioperative hypotension. Therapy should be continued for at least seven days postoperatively, unless the patient develops significant hypotension or bradycardia.⁴⁹

Perioperative statins

Patients with established coronary artery or other vascular disease should be considered for statin use, if not already on statin therapy. A meta-analysis to determine the influence of statin treatment on adverse postoperative outcomes (including patients undergoing noncardiovascular surgery) showed a significant reduction in mortality and in acute coronary syndromes in patients taking statins.⁵⁰ Patients who are already taking statins should continue this therapy during the perioperative period. However, presently there is not sufficient evidence to support the routine use of statin therapy for all patients undergoing hip-fracture repair surgery.⁵⁰

Anti-platelet agents

- **Aspirin:** Patients taking aspirin for cardiovascular risk reduction should continue therapy throughout the perioperative period as this benefit outweighs the risk of bleeding.⁵¹ Used alone, aspirin does not appear to increase the risk of spinal haematoma during regional anaesthesia.⁵² A meta-analysis of 10 orthopaedic trauma

Table I: Recommendations for acute orthogeriatric fracture management in South Africa**Emergency department or casualty**

- Emergency resuscitation should be carried out, if needed.
- A patient with a suspected hip fracture should receive an appropriate X-ray of the hip, pelvis and chest.
- Intravenous fluids can be started.
- Blood should be sent for analysis. (This includes a full blood count, international normalised ratio/partial thromboplastin time, type and screen, urea, creatinine and electrolytes, and corrected calcium).
- An electrocardiograph must be carried out.
- Pain should be assessed at regular intervals, according to a standard pain treatment regimen.
- A urinary catheter needs to be placed, with drainage to gravity.
- Once the fracture has been confirmed, an urgent referral or transferral to a definitive orthopaedic service must be carried out.
- An associate geriatric physician team should be notified.
- An initial orthopaedic assessment can be performed.

Preoperative management

- The patient can be admitted preferentially to a designated unit or ward.
- Old records should be obtained as soon as possible.
- A physician or geriatrician assessment must be carried out, anaesthetics notified of the surgical plan and theatre booked.
- Assessments or vital signs must be taken 4-6 hourly, including blood pressure, pulse, temperature, pain, pulse oximetry, orientation or confusion, as well as neurovascular checks. Intake and output should be monitored.
- Bed rest is important and should encompass two-hourly pressure care, including heel protectors, anti-embolic compression devices and use of pressure-relief mattresses and an overhead trapeze, if available.
- Foot and ankle exercises can be conducted every 1-2 hours, as well as incentive spirometry (sustained maximal inspiration with visual feedback on a spirometer) every hour when awake.
- An assessment should be made of cardiac and thrombotic risk and the need for a beta blocker and/or statin.
- Team collaboration is important regarding anticoagulant (aspirin, warfarin or clopidogrel) issues.
- Low-molecular-weight heparins should be commenced, unless contraindicated.
- The standardised pain regimen should continue.
- A normal diet is allowed until six hours before surgery. Water, lemonade and clear carbohydrate-enriched drinks may be considered until two hours before surgery, if permitted by the anaesthetics' team.
- An assessment should be carried out of nutritional status, and supplementation provided for patients with poor nutrition, or those who are at-risk of poor nutrition.
- A bowel regimen can be commenced.
- Delirigenic medications, such as hypnotics, antihistamines, anticholinergics and benzodiazepines, should be avoided or withdrawn. Low-dose haloperidol prophylaxis should be considered for high-delirium-risk patients who have no contraindication to neuroleptics.
- Low-dose maintenance hypnotics can be contemplated in hypnotic-dependent patients.
- An antiemetic regimen should be started, if needed.
- Continuous oxygen therapy can be implemented at 2 l/minute, or higher flows to keep saturations > 93%.
- Brochures may be handed over and discussions commenced with the patient and his or her family on hip fracture care, including aspects of rehabilitation and discharge planning.
- Cefazolin 1 g can be given preoperatively to nonallergic patients in the operating room.

trials found that aspirin significantly reduced the rate of DVT and pulmonary embolism, compared with placebo. However, this reduction was significantly less when compared with other agents, such as warfarin and a low-molecular-weight heparin.⁵³

- **Clopidogrel:** The use of clopidogrel, either alone or in combination with aspirin, is associated with increased perioperative blood loss. This risk is further enhanced with a shorter time between the last dose and surgery and longer operative times.⁵⁴ Patients taking clopidogrel require careful individualised assessment of perioperative bleeding risk versus the risk of vascular events. Options include delaying surgery for five days post clopidogrel cessation when the bleeding risk will be lower. However, the risks of thrombosis and immobility complications will be higher. Alternatively, surgery may be performed 48 hours after cessation of clopidogrel, when although antiplatelet activity persists, active metabolites will have been cleared, allowing for platelet transfusion in the event of severe bleeding.⁵⁵
- **Warfarin:** Rapid correction of warfarin anticoagulation is possible with the use of fresh frozen plasma and vitamin K infusion. Ongoing perioperative anticoagulation, with either unfractionated or a low-molecular-weight heparin, is recommended for high-risk patients, e.g. patients with metal prosthetic heart valves.

Prevention of deep vein thrombosis and pulmonary thromboembolic disease

The prevalence of DVT in patients with hip fractures is as high as 40-60%. The risk occurs from the time of fracture. Mechanical pumping devices may protect against DVT. Handoll et al reported a significantly lower prevalence of DVT in patients when mechanical pumping devices were used, than when they were not (7% vs. 22%, RR 0.31, 95% CI: 0.19-0.51). Problems with skin abrasion and compliance have been reported.⁵⁶

Prophylaxis, with an unfractionated heparin or a low-molecular-weight heparin, has been shown to reduce the incidence of lower-limb DVT (26% vs. 42%, RR 0.60, 95% CI: 0.50-0.71). There was no mortality difference between treatment and placebo. There is insufficient evidence to establish if low-molecular-weight heparins are superior to unfractionated heparins in the acute hip-fracture setting.⁵⁷ Excessive bleeding, or the need for transfusion, is significantly increased (6% vs. 3.8%) with the use of subcutaneous heparin prophylaxis.⁵⁸ Prospective large-scale observational cohort studies from France and Norway show that the use of heparin prophylaxis reduces the incidence of DVT to 1.3-2.7%, and that of pulmonary embolism to 0.25-1.7%.^{47,59}

Table I: Recommendations for acute orthogeriatric fracture management in South Africa cont.**Postoperative management**

- The patient should be seen daily by the orthopaedic surgeon and a physician or geriatrician, with frequent communication between the teams.
- The patient can then be started on clear fluids and the diet advanced, according to tolerance. The diet should include additional supplementation for malnourished or at-risk patients. Dentures must be used properly, and patients properly positioned for and assisted with meals, if necessary.
- Oxygen therapy can be implemented through a nasal catheter when the patient is resting and during the first four nights postoperatively. The patient should turn, cough and breathe deeply every 1-2 hours, while awake.
- Transfusion may take place to keep the haemoglobin > 10 g/dl.
- Prophylactic antibiotics can be continued for 24 hours postoperatively (cefazolin 1 g eight-hourly).
- An assessment should be made of the patient's vital signs 4-6 hourly, including blood pressure, pulse, temperature, pain, pulse oximetry, orientation and confusion, as well as neurovascular checks. Intake and output must also be monitored.
- The standardised pain regimen can be continued.
- Anticoagulation should be continued or commenced with unfractionated or a low-molecular-weight heparin, and the dose adjusted according to renal function. The duration of the anticoagulation will need to be individualised and may be from 2-6 weeks.
- The bowel regimen must be continued, with the aim for a bowel movement by postoperative day two and every 48 hours thereafter.
- The catheter may be removed by 10h00 on day one postoperatively. If retention is suspected, this should be confirmed using either an immediate ultrasound bladder scan or single catheterisation to measure the residual volume. (There is retention if there is > 300 ml). If a second episode of retention occurs, then scheduled intermittent catheterisation should either be sustained 4-6 hourly, or continuous catheterisation for 1-2 days. It is important to screen for and treat urinary tract infections. A skin care programme can be implemented for patients with established incontinence.
- Intake and output must be recorded to assess fluid balance.
- Activity should comprise the patient walking from the bed to the chair twice a day by day one postoperatively. Further activity is dependent on the patient's weight-bearing status.
- Occupational and physiotherapy should be commenced on day one postoperatively. Pre-emptive analgesia is recommended before mobilisation takes place.
- Use of adaptive devices, such as glasses and hearing aids, should be ensured, as well as regular orientation.
- Calm reassurance, the family presence or a sitter should be used to assist with agitation.
- Appropriate postoperative surgical films can be ordered.
- Rehabilitation or social services consultation can take place for the purposes of discharge planning.
- An assessment of recurrent fall risk should be carried out and a fall prevention programme devised.
- Management, and additional investigation of the underlying cause, of established severe osteoporosis should be implemented. This must include vitamin D and calcium supplementation, as well as specific bone therapies. In-patient vitamin D repletion is recommended with three daily doses of 50 000 iu of calciferol, or a 150 000 iu loading dose of calciferol. Specific bone therapy should be commenced in stable patients within 48 hours of discharge. Detailed referral is necessary on discharge, including written instructions and follow-up arrangements.

Standard pain treatment regimen

- Paracetamol 1g, six-hourly orally or intravenously, should be given.
- Tramadol is an intermediate-efficacy atypical opioid. Dose adjustment is necessary in older persons. Dosage is 50-100 mg intravenously or orally, at 12-hourly intervals.
- Morphine 5-10 mg can be used 4-6 hourly subcutaneously or intramuscularly, or sustained-release given orally, initially at 10 mg twice daily. Intravenous morphine should only be utilised in high care or intensive care settings. A naloxone injection must be immediately available if morphine is utilised.
- Nonsteroidal anti-inflammatories should only be given to non-frail patients (generally those who are younger than 75 years old), without cardiovascular co-morbidity, and who are haemodynamically stable with normal renal function. If necessary, ibuprofen 200-400 mg eight-hourly can be considered. Regular monitoring of renal function and prophylactic anti-acid therapy with a proton-pump inhibitor is recommended. Intramuscular preparations should never be used.
- Dihydrocodeine is an intermediate-efficacy opioid. Doses of 30 mg should be given orally 4-6 hourly, or 50 mg intramuscularly or subcutaneously 4-6 hourly.

Nutrition

All patients should undergo an assessment of nutritional status on admission, using validated bedside nutritional tools, such as the Mini-Nutritional Assessment[®],⁶⁰ or an assessment by a dietitian. Measures to alleviate poor food intake during hospital admission aim to prevent malnutrition which may hinder recovery. One systematic review has found that oral protein and energy feeds reduced unfavourable outcomes after surgery for a hip fracture.⁶¹

Perioperative antibiotics

Perioperative antibiotics, either single- or multiple-dose regimens (Table I), reduce the incidence of deep wound, superficial wound, urinary tract and respiratory tract infections. Adverse effects, such as an allergy, rash or gastrointestinal complaints, are rare (< 2%).⁶²

Delirium

Delirium is an acute brain failure syndrome or confusional state. It is associated with acute hip fractures, as both a potential contributor to

sustaining the fracture, as well as a complication of the physiological stress of the fracture, its surgical repair and the associated hospital care and environment. Delirium occurs in 35-65% of patients with hip fractures and is associated with adverse outcomes, high morbidity and mortality, longer length of hospital stay, greater functional decline and a high rate of institutionalisation after discharge.⁶³⁻⁶⁵ Risk factors for delirium in patients with hip fractures include visual impairment, severe illness, pre-existing cognitive impairment, use of anticholinergic drugs, dehydration, perioperative blood pressure falls and infection.⁶⁴ Proactive geriatric or physician consultation to facilitate multicomponent nonpharmacological interventions, i.e. multidisciplinary interventions which integrate supportive, environmental, nursing and other components of care, have been shown to reduce both delirium incidence (by over one third), and severity (severe delirium was reduced by over a half) in older in-patients.^{66,67} Specific pharmacological therapy with low-dose (1.5 mg daily) haloperidol prophylaxis in high-risk, older patients undergoing hip surgery was shown to significantly reduce the severity and duration (by 6.4 days, 95% CI: 4-8 days), but not the incidence of postoperative delirium. No haloperidol-related side-effects

were noted in this double-blind, placebo-controlled randomised trial with 430 participants.⁶⁸

Pressure sores

Measures to prevent the development of pressure sores should commence from the time of fracture. High-specification foam mattresses and pressure-relieving mattresses on operating tables prevent pressure sores (RR 0.29, 95% CI: 0.19-0.43).⁶² Earlier surgery also reduces pressure sores.⁴²

Urinary retention

Older patients with hip fractures have a high risk of urinary retention (80% pre- and 50% post-surgery). Risk factors for urinary retention include advanced age, spinal anaesthesia, delirium, immobility, a previous history of bladder problems, prostatic hyperplasia, urethral strictures, pain, large amount of intravenous fluids, surgery of a long duration, longstanding diabetes (> 15 years), and use of anticholinergic medications and analgesics, and constipation. General evidence supports the removal of urinary catheters within 24 hours postoperatively with a programme to detect and then prevent retention. Should retention develop, short-duration urethral catheterisation or scheduled intermittent catheterisation is recommended. This programme reduces the 25% rate of urinary tract infection that is associated with hip fracture.⁶⁹

Pain control

Uncontrolled pain is a major impediment to postoperative functional recovery and is associated with longer hospital admission, more complications (such as delirium), a delay in ambulation, impaired functional recovery and greater suffering. Multi-component intervention, including pain assessment, protocols for standing analgesia and pre-emptive analgesia before physiotherapy, has been shown to improve postoperative pain, reduce chronic pain and improve function. The multi-component intervention also results in a small but significant reduction in hospital stay duration.⁷⁰

Recommended analgesic agents for the management of hip-fracture-associated pain include opioids, weaker opioids, paracetamol and nonsteroidal anti-inflammatory drugs (NSAIDs). Prescribers need to be cognisant of the higher risk of adverse drug events in frail older persons.

Specific care regarding use of NSAIDs is required to avoid normotensive ischaemic renal failure. NSAIDs should be avoided in high-risk patients who have one or more of the following risk factors: older age (> 75 years), chronic renal disease, atherosclerosis, chronic hypertension, sepsis, perioperative hypotension, dehydration, excessive bleeding, heart failure, cardiac arrhythmias and concomitant use of angiotensin-receptor blockers or angiotensin-converting enzyme inhibitors.⁷¹ There is also concern from animal and retrospective studies that NSAIDs may delay fracture healing. However, this is controversial and one randomised controlled trial has shown no delay in fracture healing in patients who were given an NSAID.⁷²

Use of femoral nerve blocks is advocated in some hip-fracture programmes.⁷³ Experience with this technique in the South African setting is limited.

Pharmacological therapy for osteoporosis in patients with post hip fractures

It is well established that a prior fracture increases the risk of subsequent fractures.^{74, 75} Importantly, the interval between fractures, even after a hip fracture, for those who survive, generally warrants intervention and treatment in order to reduce the risk of subsequent fracture.^{76,77} Despite this, osteoporosis is seldom diagnosed, investigated or treated in patients after a hip fracture.^{78, 79} The figure is as low as 10% in most studies.

Historically, the diagnosis of osteoporosis and even the therapeutic threshold, has been based on BMD criteria with a T-score of ≤ -2.5 considered to be diagnostic of osteoporosis. However, approximately 50% of patients who present with a hip fracture do not satisfy this criterion. This can partly be explained by the fact that 98% of hip fractures occur following a fall. Therefore, the risk of fracture is determined by bone strength, the risk of falling and other factors. Prevention of subsequent fractures, in particular at the hip and nonvertebral sites, is best achieved by interventions which focus on strengthening bone, as well as those that aim to reduce the risk of falls.

Elderly patients with a prevalent fracture should receive treatment for osteoporosis regardless of the BMD. Therefore, all patients who survive a hip fracture should receive treatment to reduce future fracture risk. Unfortunately, this is rarely the case in the elderly who are the most frail and who are at the greatest risk.

Protein supplementation

Intervention studies, where protein intake was normalised by nasogastric feeding, parenteral nutrition or even oral dietary supplements, have reported an improved outcome after hip fracture. A daily oral protein supplement of 0.8 g/kg bodyweight has been shown to improve rehabilitation outcomes and reduce the risk of complications such as bed sores, anaemia, and respiratory and renal infections.^{80,81} This simple intervention reduced the total length of stay in hospital and rehabilitation units by 25% in patients who received protein supplementation compared to controls.

Calcium and vitamin D

Calcium and vitamin D are essential for bone throughout life. Deficiencies are common in the elderly, and especially in the institutionalised and frail elderly, and in patients presenting with hip fractures.^{82,83} Adequate calcium and vitamin D intake, in the elderly in particular, will prevent secondary hyperparathyroidism, maintain bone mass and architecture, improve muscle strength and reduce fracture risk. Therefore, vitamin D and calcium supplementation is a simple and inexpensive method of improving bone strength and reducing the risk of falling.

In a meta-analysis of double-blind studies of vitamin D supplementation with or without calcium, high-dose vitamin D (800 IU per day) reduced the risk of falls by 19%, and by 23% when vitamin D levels of > 60 nmol/l were achieved.⁸⁴ Calcium and vitamin D supplementation has also been shown to reduce the risk of falls and fractures in elderly women (with a mean age of 81 years) with a recent hip fracture.⁸⁵ The relative risk of fracture was also reduced by 43% and 32% at hip and nonvertebral sites, respectively, in ambulatory institutionalised women (mean age 84 years) with severe calcium and vitamin D deficiency,

after 18 months treatment with calcium 1 200 mg/day and vitamin D 800 IU/day, in a randomised, placebo-controlled study. The hip and nonvertebral fracture risk was reduced by 29% and 24%, respectively, after 36 months.^{86, 87}

Supplementation of calcium and vitamin D in community living persons has shown smaller reductions in fracture risk. However, the baseline deficiencies of calcium and vitamin D in these subjects were less severe.^{88, 89} Three other community-based studies have shown no reduction in fracture risk in this population.⁹⁰⁻⁹² These conflicting results are likely to be the consequence of targeting low-risk populations of younger women who did not have baseline deficiencies of calcium and vitamin D.

Based on the available evidence, calcium and vitamin D should be supplemented in patients with known deficiency or those who are at high risk of insufficiency, using the correct dose and regimen. Patients who are in hospital after a hip fracture represent an extremely high-risk group and routine supplementation of calcium and vitamin D would be appropriate.

The recently published National Osteoporosis Foundation of South Africa (NOFSA) guidelines suggest a dose of vitamin D 800-1000 IU/day and calcium 1 000-1 200mg/day (a dose which is considered to be safe).⁸ Meta-analyses indicate that a dose of 800 IU vitamin D is required for optimal benefit in terms of preventing falls and reducing fracture risk.⁹³ In addition, it is important to combine vitamin D with calcium in order to maximise outcomes post hip fracture, especially in elderly patients.⁹⁴ Compliance with calcium and vitamin D is essential to maintain benefit. Compliance is a challenge in this population. Clinicians should focus the same degree of energy that they would to maximise compliance with any other chronic medication.

Anti-osteoporosis medication

Several therapies, currently available in South Africa, have been proved in well-designed, placebo-controlled studies to increase bone strength and reduce fracture risk in postmenopausal women. Limited fracture data are available on men with osteoporosis, although BMD responses in men to the bisphosphonates, teriparatide and strontium ranelate have been similar to those observed in women. Studies on zoledronate and strontium ranelate to determine fracture reduction in men are currently underway. There has been only one trial on fracture reduction in patients who have recently suffered a hip fracture. Most other randomised controlled trials have included a small percentage of elderly patients only; the population that is most at risk of sustaining a hip fracture. It is also least likely for anti-osteoporosis medication to be initiated in the elderly. Data from the USA National Health and Nutrition Examination Survey (NHANES) showed that only 12% of women > 85 years who had a history of fracture received medication for osteoporosis.⁹⁵

Bisphosphonates

The efficacy of bisphosphonates (alendronate, risedronate and zoledronate) in preventing bone loss and reducing fracture risk is well established from large, randomised, placebo-controlled studies. However, limited data are available on elderly patients and patients who have experienced a hip fracture and those with osteopenia, as opposed to that on patients with osteoporosis following BMD measurement.

However, limited data are available on elderly patients, patients with hip fractures, and those who have been diagnosed with osteopenia rather than osteoporosis on BMD measurement.

In a post hoc analysis of the Fracture Intervention Trial (FIT), there was a 38% reduction in vertebral fracture risk in women > 75 years who were treated with alendronate for three years.⁹⁶ There are no data for patients > 80 years.

Risedronate had no significant effect in preventing hip fractures in a subgroup of women aged > 80 years and recruited according to clinical risk factors only without a BMD diagnosis of osteoporosis, in the Hip Intervention Program Study Group.⁹⁷ In a pooled analysis from three clinical studies, risedronate reduced the risk of vertebral fracture by 44% after three years in women > 80 years, but had no effect on nonvertebral fractures.⁹⁸

In a retrospective analysis of 20 664 patients with hip fracture, little benefit of antiresorptive agents in the prevention of hip fractures was seen in patients > 80 years, compared to those < 80 years (hazard ratio of 0.92 vs. 0.53).⁹⁹ These findings need to be interpreted with caution, as there was no suggestion of blunting of treatment efficacy with age in the randomised controlled trials of bisphosphonates. However, the overall numbers of patients > 80 years were extremely low.

Evidence which supports the treatment efficacy of bisphosphonates in older patients post hip fractures is provided from the Health Outcomes and Reduced Incidence with Zoledronic Acid Once Yearly Recurrent Fracture Trial (HORIZON-RFT). A once-yearly infusion of zoledronate 5 mg significantly reduced the risk of both vertebral and nonvertebral fractures in patients with a mean age of 74.5 years with a recent hip fracture. The reduction in recurrent hip fractures was not significant, but the study was not powered to show this effect. In addition, zoledronate reduced the risk of death by 28%. This highlights the impact of osteoporotic fractures on mortality in this very frail and high risk population.¹⁰⁰

In general, there is no apparent difference in the anti-fracture efficacy of the three bisphosphonates (alendronate, risedronate or zoledronate) that are registered for patients in this country. Therefore, no particular bisphosphonate is recommended. Until further safety and efficacy data become available, the use of generic bisphosphonates is not recommended.⁸ There are also no convincing data to suggest that antiresorptives, such as the bisphosphonates, impair fracture healing.

Teriparatide

Teriparatide is an anabolic bone agent that is administered by daily subcutaneous injection to patients with severe osteoporosis. Because of cost constraints, its use is limited to patients with severe osteoporosis as defined by a very low BMD, significant bone loss on treatment, and the presence of more than two vertebral fractures. A hip fracture is regarded as one of the most severe end-points of osteoporosis. A potent anabolic agent is an attractive option. Limited data on this agent are available. Teriparatide was shown to significantly reduce the risk of vertebral fractures by 65% in women > 75 years in a subgroup analysis. This effect is similar to that observed in women < 75 years. No significant effect on nonvertebral fractures was recorded after a median treatment duration of 19 months.¹⁰¹ There are no available data on patients > 80 years and those post hip fractures.

There is mounting evidence that teriparatide significantly improves the healing of nonvertebral fractures (the long bones and pelvis). However, following a fracture, its routine administration cannot be recommended yet.

Strontium ranelate

Pre-planned pooling of patients > 80 years from two major randomised controlled trials on strontium ranelate [The Spinal Osteoporosis Therapeutic Intervention (SOTI) and The Treatment Of Peripheral Osteoporosis (TROPOS)] showed an increase in BMD, as well as a reduced risk for vertebral and nonvertebral fractures after 1.3 and 5 years. Vertebral fractures were reduced by 59% at one year, 32% at three years and 31% at five years; all highly significant. Significant reductions in nonvertebral fractures (which included hip fractures) by 41% at one year, 31% at three years and 26% at five years, were also noted. After three years, there was a nonsignificant 32% reduction in the risk of hip fracture in patients > 80 years. A statistically significant reduction in hip fracture of 43% was noted in a subset of women aged > 74 years (a mean age of 79.2 years), and who were at high risk of fracture based on BMD (T-score < -2.5). This effect continued for up to five years.¹⁰²⁻¹⁰⁴

No studies have been carried out on strontium ranelate in patients who have suffered a previous hip fracture. However, strontium ranelate is the only agent with documented efficacy against vertebral and nonvertebral fractures in women > 80 years. Fracture risk reduction has been documented within one year and sustained over five years, even in the very elderly. The safety profile of strontium ranelate in people > 80 years is favourable and similar to that observed in younger patients.

Choice of agent

Given the lack of comparative data, it is difficult to make specific, evidence-based recommendations pertaining to choice of an anti-osteoporotic agent for patients post hip fracture. NOFSA recommends a bisphosphonate or strontium ranelate as the first choice for postmenopausal osteoporosis. Based on the only available evidence (HORIZON-RFT), it would be prudent and convenient to offer all patients who have survived a hip fracture an infusion of zoledronic acid 5 mg, in conjunction with adequate calcium and vitamin D. This can be repeated after one year, and again, after two years. Alternatively, an oral bisphosphonate or strontium ranelate could be considered. This would depend on several patient criteria, such as age. Strontium ranelate has been shown to be effective in patients > 80 years.⁸ However, strontium ranelate should be avoided in patients with prior DVT, or in those who are at high risk of DVT.

Benefits of dedicated orthogeriatric fracture unit/hip fracture programmes

The acute orthogeriatric unit is a model which provides joint care by geriatricians and orthopaedic surgeons and includes immediate geriatric assessment, coordinated daily clinical care, combined ward rounds, joint planning of the surgical schedule, initial mobilisation and discharge date and destination (discharge planning). Protocol-driven geriatric-focused care is inherent in this model. It has been replicated in multiple (generally developed) countries, using the expertise of geriatricians. Most published studies confirm the benefits of this approach, which

include reduced length of hospital stay, costs and time to surgery; lower readmission rates and in-patient complication rates such as pneumonia, urinary tract infections and confusion or delirium; functional improvement (short-term OR 2.33, 95% CI: 1.62-3.34), reduced mortality (long-term RR 0.77, 95% CI: 0.61-0.96, numbers needed to treat: 21), and reduced risk of nursing home admission (RR 0.72, 95% CI: 0.56-0.91, numbers needed to treat: 14).^{71,105-111} Patients with mild or moderate cognitive impairment may show the most benefit.¹⁰⁹ It is likely that patients in a country such as South Africa would derive significant benefit from this approach. Given the shortage of geriatricians in this country, a physician who has an interest or experience in the field should be part of the multidisciplinary team.

Summary and conclusion

Hip fractures generally occur in older patients who often have multiple co-morbidities, and who are at high risk of adverse outcomes and of incurring high medical costs. Increased morbidity and mortality can be reduced by a structured acute management plan and appropriate control of the risk factors. Ideally, a team-based approach should be employed. Patients with hip fractures should be assessed to exclude a secondary cause of osteoporosis and considered for specific osteoporosis therapy to prevent the next fracture.

References

- Cooper AP. A treatise on dislocation and fractures of the joints. London: John Churchill; 1842.
- Van Staa TP, Dennison EM, Leufkens HGM, Cooper C. Epidemiology of fractures in England and Wales. *Bone*. 2001;29(6):517-522.
- Johnell O, Kanis JA. An estimate of the worldwide prevalence and disability associated with osteoporotic fractures. *Osteoporos Int*. 2006;17(12):1726-1733.
- Cooper C, Campion G, Melton LJ 3rd. Hip fractures in the elderly: a worldwide projection. *Osteoporos Int*. 1992;2(6):285-289.
- Cummings SR, Melton LJ. Epidemiology and outcomes of osteoporotic fractures. *Lancet*. 2002;359(9319):1761-1767.
- Ray NF, Chan JK, Thamer M, Melton LJ. Medical expenditures for the treatment of osteoporotic fractures in the United States in 1995: report from the National Osteoporosis Foundation. *J Bone Miner Res*. 1997;12(1):24-35.
- De Laet CE, van Hout BA, Burger H, et al. Incremental cost of medical care after hip fracture and first vertebral fracture: the Rotterdam Study. *Osteoporos Int*. 1999;10(1):66-72.
- Hough S, Ascott-Evans B, Brown S, et al. NOFSA guideline for the diagnosis and management of osteoporosis. *JEMDSA*. 2010;15(2)(Supplement 1): S1-S48.
- Cumming RG, Nevitt MC, Cummings SR. Epidemiology of hip fractures. *Epidemiol Rev*. 1997;19(2): 244-257.
- Tuzun SN, Eskiuyurt N, Akarimak U, et al. Incidence of hip fracture and prevalence of osteoporosis in Turkey: the FRACTURK study. *Osteoporos Int*. 2012; 23(3):949-955.
- Memon A, Pospula WM, Tantawy AY, et al. Incidence of hip fracture in Kuwait. *Int J Epidemiol*. 1998;27(5):860-865.
- Moayyeri A, Soltani A, Larjani B, et al. Epidemiology of hip fracture in Iran: results from the Iranian Multicenter Study on Accidental Injuries. *Osteoporos Int*. 2006;17(8):1252-1257.
- Dhanwal DK, Dennison EM, Harvey NC, Cooper C. Epidemiology of hip fracture: worldwide geographic variation. *Indian J Orthop*. 2011;45(1):15-22.
- Aspray TJ, Prentice A, Cole TJ, et al. Low bone mineral content is common but osteoporotic fractures are rare in elderly rural Gambian women. *J Bone Miner Res*. 1996;11(7):1019-1025.
- Adebajo AO, Cooper C, Ewans JG. Fractures of the hip and distal forearm in West Africa and the United Kingdom. *Age Ageing*. 1991;20(6):435-438.
- Zebaze RM, Seeman E. Epidemiology of hip and wrist fractures in Cameroon, Africa. *Osteoporos Int*. 2003;14(4):301-305.
- El Maghraoui A, Koumba BA, Jroundi I, et al. Epidemiology of hip fractures in 2002 in Rabat, Morocco. *Osteoporos Int*. 2005;16(6):597-602.
- Solomon L. Osteoporosis and fracture of the femoral neck in the South African Bantu. *J Bone Joint Surg Br*. 1968;50(1):2-13.
- Solomon L. Bone density in ageing Caucasians and African populations. *Lancet*. 1979;2(8156-8157):1326-1330.
- Chantler S, Dickie K, Goedecke JH, et al. Site-specific differences in bone mineral density in black and white premenopausal South African women. *Osteoporos Int*. 2011;23(2):533-542.
- Kalla AA, Fataar AB, Beverunge L. Assessment of age related bone loss in normal South

- African woman by means of Hologic 1000 system. *S Afr Med J*. 1994;84(7):398-408.
22. Paruk F, Cassim B. Ethnic and gender distribution and early outcomes of osteoporotic hip fractures in the public health sector in the Ethekevin municipality, KwaZulu-Natal, South Africa. *Osteoporos Int*. 2011;22(Suppl 5):447-451.
 23. Silverman SL, Madison RE. Decreased incidence of hip fracture in Hispanics, Asians, and blacks: California Hospital discharge data. *Am J Public Health*. 1988;78(11):1482-1483.
 24. Cummings SR, Cauley JA, Palermo L, et al. Racial differences in hip axis lengths might explain racial differences in rates of hip fracture. Study of Osteoporotic Fractures Research Group. *Osteoporos Int*. 1994;4(4):226-229.
 25. Goh JC, Low SL, Das De S. Bone mineral density and hip axis length in Singapore's multiracial population. *J Clin Densitom*. 2004;7(4):406-412.
 26. Riggs BL, Wahner HW, Seeman E, et al. Changes in bone mineral density of the femur and spine with aging: differences between the postmenopausal and senile osteoporosis syndromes. *J Clin Invest*. 1982;70:716-723.
 27. Kanis JA, Johnell O, Oden A, et al. Epidemiology of osteoporosis and fracture in men. *Calcif Tissue Int*. 2004;75(2):90-99.
 28. Chang KP, Center JR, Nguyen TV, Eisman JA. Incidence of hip and other osteoporotic fractures in elderly men and women: Dubbo Osteoporosis Epidemiology Study. *J Bone Miner Res*. 2004;19(4):532-536.
 29. Marshall D, Johnell O, Wedel H. Meta-analysis of how well measures of bone mineral density predict occurrence of osteoporotic fractures. *BMJ*. 1996;312(7041):1254-1259.
 30. Cuddihy MT, Gabriel SE, Crowson CS, et al. Forearm fractures as predictors of subsequent osteoporotic fractures. *Osteoporos Int*. 1999;9(6):469-475.
 31. Black DM, Arden NK, Palermo L, et al. Prevalent vertebral deformities predict hip fractures and new vertebral deformities but not wrist fractures. *J Bone Miner Res*. 1999;14(5):821-828.
 32. Johnell O, Nilsson BE. Hip fracture and accident disposition. *Acta Orthop Scand*. 1985;56(4):302-304.
 33. Dargent-Molina P, Favier F, Grandjean H, et al. Fall-related factors and risk of hip fracture: the EPIDOS prospective study. *Lancet*. 1996;348(9021):145-149.
 34. Tinetti ME. Preventing falls in elderly persons. *N Engl J Med*. 2003;348(1):42-49.
 35. FRAX® WHO fracture risk assessment tool. The University of Sheffield [homepage on the Internet]. c2013. Available from: <http://www.shef.ac.uk/FRAX/>
 36. Office of Technology Assessment, Congress of the United States. Hip fracture outcomes in people aged fifty and over: mortality, service use, expenditures and long-term functional impairment. Washington, DC: US Department of Commerce; 1993.
 37. Tosteson AN, Gottlieb DJ, Radley DC, et al. Excess mortality following hip fracture: the role of underlying health status. *Osteoporos Int*. 2007;18(11):1463-1472.
 38. Keene GS, Parker MJ, Pryor GA. Mortality and morbidity after hip fractures. *BMJ*. 1993;307(6914):1248-1250.
 39. Diamond TH, Thornley SW, Sekel R, Smerdely P. Hip fracture in elderly men: prognostic factors and outcomes. *Med J Aust*. 1997;167(8):412-415.
 40. Hu F, Jiang C, Shen J, et al. Preoperative predictors for mortality following hip fracture surgery: a systematic review and meta-analysis. *Injury*. 2012;43(6):676-685.
 41. Hershkovitz A, Polatov I, Belousoesky Y, Brill S. Factors affecting mortality of frail hip-fractured elderly patients. *Arch Gerontol Geriatr*. 2010;51(2):113-116.
 42. Simunovic N, Devereaux PJ, Sprague S, et al. Effect of early surgery after hip fracture on mortality and complications: systematic review and meta-analysis. *CMAJ*. 2010;182(15):1609-1616.
 43. McKeown D. Clinical decision-making: is the patient fit for theatre? A report from the Scottish Hip Fracture Audit/National Services Scotland [homepage on the Internet]. Please insert citation date. 2008. Available from: http://www.shfa.scot.nhs.uk/Theatre_Delay_Report.pdf
 44. Holt G, Smith R, Duncan K, et al. Early mortality after surgical fixation of hip fractures in the elderly. *J Bone Joint Surg Br*. 2008;90(10):1357-1363.
 45. McLaughlin MA, Orosz GM, Magaziner J, et al. Preoperative status and risk of complications in patients with hip fracture. *J Gen Intern Med*. 2006;21(3):219-225.
 46. Parker MJ, Hayton HHG, Griffiths R. Anaesthesia for hip fracture surgery in adults. [Cochrane review]. In: The Cochrane Library, Issue 4, 2004. Oxford: Update Software.
 47. Rosencher N, Vielpeau C, Emmerich J, et al. Venous thromboembolism and mortality after hip fracture surgery: the ESCORTE study. *J Thromb Haemost*. 2005 3(9):2006-2014.
 48. Fleisher LA, Beckman JA, Brown KA, et al. ACC/AHA 2007 guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery. *J Am Coll Cardiol*. 2007;50(17):159-241.
 49. Fleischmann KE, Beckman JA, Buller CE, et al. 2009 ACCF/AHA focused update on perioperative beta blockade. *J Am Coll Cardiol*. 2009;54(22):2102-2128.
 50. Kapoor AS, Kanji H, Buckingham J, et al. Strength of evidence for perioperative use of statins to reduce cardiovascular risk: systematic review of controlled studies. *BMJ*. 2006;333(7579):1149.
 51. Merritt JC, Bhatt DL. The efficacy and safety of perioperative antiplatelet therapy. *J Thromb Thrombolysis*. 2004;17(1):21-27.
 52. Ho HH, Lau TW, Leung F, et al. Peri-operative management of anti-platelet agents and anti-thrombotic agents in geriatric patients undergoing semi-urgent hip fracture surgery. *Osteoporos Int*. 2010;21(Suppl 4):S573-S577.
 53. Collaborative overview of randomized trials of anti-platelet therapy III: reduction in venous thrombosis and pulmonary embolism by antiplatelet prophylaxis among surgical and medical patients. Antiplatelet Trialists' Collaboration. *BMJ*. 2004;308(6923):235-246.
 54. Chechok O, Thein R, Fichman G, et al. The effect of clopidogrel and aspirin on blood loss in hip fracture surgery. *Injury*. 2011;42(11):1277-1282.
 55. Johansen A, White J, Turk A. Clopidogrel therapy: implications for hip fracture. *Injury*. 2008;39(10):1188-1190.
 56. Handoll HHG, Farrar MJ, McBirnie J, et al. Heparin, low molecular weight heparin and physical methods for preventing deep vein thrombosis and pulmonary embolism following surgery for hip fractures. [Cochrane review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.
 57. Handoll HHG, Farrar MJ, McBirnie J, et al. Heparin, low molecular weight heparin and physical methods for preventing deep vein thrombosis and pulmonary embolism following surgery for hip fractures. [Cochrane review]. In: The Cochrane Library, Issue 4, 2002. Oxford: Update Software.
 58. Collins R, Scrimogour A, Yusuf S, Peto R. Reduction in fatal pulmonary embolism and venous thrombosis by perioperative administration of subcutaneous heparin. *N Engl J Med*. 1988;318(18):1162-1173.
 59. Björnå BT, Gudmundsen TE, Dahl OE. Frequency and timing of clinical venous thromboembolism after major joint surgery. *J Bone Joint Surg Br*. 2006;88(3):386-391.
 60. Kaiser MJ, Bauer JM, Ramsch C, et al. Validation of the Mini Nutritional Assessment Short-Form (MNA®-SF): a practical tool for identification of nutritional status. *J Nutr Health Aging*. 2009;13(9):782-788.
 61. Avenell A, Handoll HHG. Nutritional supplementation for hip fracture aftercare in older people. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2010. Oxford: Update Software.
 62. Gillespie WJ. Extracts from "clinical evidence" hip fracture. *BMJ*. 2001;322(7292):968-975.
 63. Givens JL, Sanft TB, Marcantonio ER. Functional recovery after hip fracture: The combined effects of depressive symptoms, cognitive impairment, and delirium. *J Am Geriatr Soc*. 2008;56(6):1075-1079.
 64. Edlund A, Lundström M, Brännström B, et al. Delirium before and after operation for femoral neck fracture. *J Am Geriatr Soc*. 2001;49(10):1335-1340.
 65. Marcantonio ER, Flacker JM, Michaels M, Resnick NM. Delirium is independently associated with poor functional recovery after hip fracture. *J Am Geriatr Soc*. 2000;48(6):618-624.
 66. Inouye SK, Bogardus ST Jr, Charpentier PA, et al. A multicomponent intervention to prevent delirium in hospitalized older patients. *N Engl J Med*. 1999;340(9):669-676.
 67. Marcantonio ER, Flacker JM, Wright RJ, Resnick NM. Reducing delirium after hip fracture: a randomized trial. *J Am Geriatr Soc*. 2001;49(5):516-522.
 68. Kalisvaart KJ, de Jonghe JF, Bogaards MJ, et al. Haloperidol prophylaxis for elderly hip-surgery patients at risk for delirium. A randomized placebo-controlled study. *J Am Geriatr Soc*. 2005;53(10):1658-1666.
 69. Johansson R-M, Christensson L. Urinary retention in older patients in connection with hip fracture surgery. *J Clin Nursing*. 2010;19(15-16):2110-2116.
 70. Morrison RS, Flanagan S, Fischberg D, et al. A novel interdisciplinary analgesic program reduces pain and improves function in older adults after orthopedic surgery. *J Am Geriatr Soc*. 2009;57(1):1-10.
 71. Abuelo JG. Normotensive ischemic acute renal failure. *N Engl J Med*. 2007;357(8):797-805.
 72. Yates JE, Blackwell JC. Do NSAIDs impede fracture healing? *J Fam Pract*. 2011;60(1):41-42.
 73. Pedersen SJ, Borgbjerg FM, Schousboe B, et al. A comprehensive hip fracture program reduces complication rates and mortality. *J Am Geriatr Soc*. 2008;56(10):1831-1838.
 74. Kanis JA, Johnell O, De Laet C, et al. A meta-analysis of previous fractures and subsequent fracture risk. *Bone*. 2004;35(2):375-382.
 75. Klotzbuecher CM, Ross PD, Landsman PB, et al. Patients with prior fractures have an elevated risk of future fractures: a review of the literature and statistical synthesis. *J Bone Min Res*. 2000;15(4):721-739.
 76. Berry SD, Samelson EJ, Hannan MT, et al. Second hip fracture in older men and women: The Framingham study. *Arch Intern Med*. 2007;167(18):1971-1976.
 77. Ryg J, Rejmark L, Overgaard S, et al. Hip fracture patients at risk of second hip fractures: a nationwide population-based cohort study of 169,145 cases during 1997-2001. *J Bone Miner Res*. 2009;24(7):1299-1307.
 78. Kamel HK, Hussain MS, Tariq S, et al. Failure to diagnose and treat osteoporosis in elderly patients hospitalised with hip fractures. *Am J Med*. 2000;109(4):326-328.
 79. Elliot-Gibson V, Bogoch ER, Jamal SA, Beaton DE. Practice patterns in the diagnosis and treatment of osteoporosis after a fragility fracture: a systematic review. *Osteoporos Int*. 2004;15(10):767-778.
 80. Delmi M, Rapin CH, Bengoa JM, et al. Dietary supplementation in elderly patients with fractured neck of the femur. *Lancet*. 1990;335(8696):1013-1016.
 81. Tkatch L, Rapin CH, Rizzoli R, et al. Benefits of oral protein supplementation in elderly patients with fractures of the proximal femur. *J Am Coll Nutr*. 1992;11(5):519-525.
 82. Chapuy MC, Preziosi P, Maamer M, et al. Prevalence of vitamin D insufficiency in an adult normal population. *Osteoporos Int*. 1997;7(5):439-443.
 83. Lips P. Vitamin D deficiency and secondary hyperparathyroidism in the elderly. *Endocr Rev*. 2001;22(4):477-501.
 84. Bischoff-Ferrari HA, Dawson-Hughes B, Staehelin HB, et al. Fall prevention with supplemental and active forms of Vitamin D: a meta-analysis of randomised controlled trials. *BMJ*. 2009;339b:3692.
 85. Harwood RH, Sahota O, Gaynor K, et al. A randomised, controlled comparison of different calcium and vitamin D supplementation regimens in elderly women after hip fractures: the Nottingham Neck of Femur (NONOF) study. *Age Ageing*. 2004;33(1):45-51.

86. Chapuy MC, Arlot ME, Duboeuf F, et al. Vitamin D and calcium to prevent hip fractures in elderly women. *N Engl J Med.* 1992;327(23):1637-1642.
87. Chapuy MC, Arlot ME, Delmas PD, Meunier PJ. Effect of calcium and cholecalciferol treatment for three years on hip fractures in elderly women. *BMJ.* 1994;308(6936):1081-1082.
88. Dawson-Hughes B, Harris SS, Krall EA, Dallal GE. Effect of calcium and vitamin D supplementation on bone density in men and women 65 years of age or older. *N Engl J Med.* 1997;337(10):670-676.
89. Larsen ER, Mosekilde L, Foldspang A. Vitamin D and calcium supplementation prevents osteoporosis fractures in elderly community dwelling residents: a pragmatic population-based three year intervention study. *J Bone Min Res.* 2004;19(3):370-378.
90. Porthouse J, Cockayne C, King C, et al. Randomized-controlled trial of supplementation with calcium and cholecalciferol (Vitamin D3) for prevention of fractures in primary care. *BMJ.* 2005;330(7498):1003-1008.
91. Bischoff-Ferrari HA, Dawson-Hughes B, Willett WC, et al. Effect of vitamin D on falls: a meta-analysis. *JAMA.* 2004;291(16):1999-2006.
92. Grand AM, Avenell A, Campbell MK, et al. Oral vitamin D3 and calcium for secondary prevention of low-trauma fractures in elderly people (Randomised Evaluation of Calcium Or vitamin D, RECORD): a randomised placebo-controlled trial. *Lancet.* 2005;365(9471):1621-1628.
93. Bischoff-Ferrari HA, Willett WC, Wong JB, et al. Fracture prevention with vitamin D supplementation: a meta-analysis of randomized controlled trials. *JAMA.* 2005;293(18):2257-2264.
94. Boonen S, Lips P, Bouillon R, et al. Need for additional calcium to reduce the risk of hip fractures with vitamin D supplementation: evidence from a comparative meta-analysis of randomized controlled trials. *J Clin Endocrinol Metab.* 2007;92(4):1415-1423.
95. Gehlbach SH, Avrunin JS, Puleo E, Spaeth R. Fracture risk and antiresorptive medication use in older women in the USA. *Osteoporosis Int.* 2007;18(6):805-810.
96. Ensrud KE, Black DM, Palermo L, et al. Treatment with alendronate prevents fractures in women with highest risk: results from the F1T. *Arch Int Med.* 1997;157(22):2617-2624.
97. McClung MR, Geusens P, Miller PD, et al. Effect of risedronate on the risk of hip fracture in elderly women. Hip Intervention Programme Study Group. *N Engl J Med.* 2001;344(5):333-340.
98. Boonen S, McClung MR, Eastell R, et al. Safety and efficacy of risedronate in reducing fracture risk in osteoporotic women aged 80 and older: implications for the use of antiresorptive agents in the old and oldest old. *J Am Geriatr Soc.* 2004;52(11):1832-1839.
99. Morin S, Rahme E, Behloul H, et al. Effectiveness of antiresorptive agents in the prevention of recurrent hip fractures. *Osteoporos Int.* 2007;18(12):1625-1632.
100. Lyles KW, Colon-Emeric CS, Magaziner JS, et al. Zoledronic acid and clinical fractures and mortality after hip fracture. *N Engl J Med.* 2007;357(18):1799-1809.
101. Boonen S, Marin F, Mellstrom D, et al. Safety and efficacy of teriparatide in elderly women with established osteoporosis: bone anabolic therapy from a geriatric perspective. *J Am Geriatric Society.* 2006;54(5):782-789.
102. Seeman E, Vellas B, Benhamou CL, et al. Strontium ranelate reduces the risk of vertebral and non vertebral fractures in women aged 80 years and over. *J Bone Mineral Res.* 2006;21(7):1113-1120.
103. Reginster J-Y, Brixen K, Cormier C, Cannata J. Strontium ranelate demonstrates vertebral and non-vertebral anti-fracture efficacy including hip fractures over 5 years in postmenopausal osteoporotic women. *Osteoporos Int.* 2007;18(Suppl):S5-S27.
104. Elliot JR, Wilkinson TJ, Hanger HC, et al. The added effectiveness of early geriatrician involvement on acute orthopaedic wards to orthogeriatric rehabilitation. *NZ Med J.* 1996;8;109(1017):72-73.
105. Thwaites JH, Mann F, Gilchrist N, et al. Shared care between geriatricians and orthopaedic surgeons as a model of care for older patients with hip fractures. *NZ Med J.* 2005;118(1214):U1438.
106. Miura LN, DiPiero AR, Homer LD. Effects of a geriatrician-led hip fracture program: improvements in clinical and economic outcomes. *J Am Geriatr Soc.* 2009;57(1):159-167.
107. González-Montalvo JI, Alarcón T, Mauleón JL, et al. The orthogeriatric unit for acute patients: a new model of care that improves efficiency in the management of patients with hip fracture. *Hip Int.* 2010;20(2):229-235.
108. Naglie G, Tansey C, Kirkland JL, et al. Interdisciplinary inpatient care for elderly people with hip fracture: a randomized controlled trial. *CMAJ.* 2002;167(1):25-32.
109. Bachmann S, Finger C, Huss A, et al. Inpatient rehabilitation specifically designed for geriatric patients: systematic review and meta-analysis of randomised controlled trials. *BMJ.* 2010;20;340:c1718.
110. Friedman SM, Mendelson DA, Kates SL, McCann RM. Geriatric co-management of proximal femur fractures: total quality management and protocol-driven care result in better outcomes for a frail patient population. *J Am Geriatr Soc.* 2008;56(7):1349-1356.

CMSA Announcements and Notices

Fellowship Ad Eundem (As at 12 August 2013)

Bowie Malcolm David (C PAED) (2007)	Knysna	Makgoba Malegapuru W (CP) (2003)	Durban
Cleaton-Jones Peter Eiddon (CD) (2005)	Johannesburg	Moodley Jagidesa (COG) (2010)	Durban
Corder Robert Franklin (CEM) (2007)	Maryland, USA	Ncayiyana Daniel JM (CMSA) (2002)	Durban
Davey Dennis Albert (COG) (2008)	Cape Town	Odendaal Hendrik Johannes (COG) (2009)	Cape Town
Davies John Carol Anthony (CPHM) (2007)	Johannesburg	Padayachee Gopalan N (CPHM) (2004)	Cape Town
Gear John Spencer Sutherland (CPHM) (2005)	Still Bay	Philpott Hugh Robert (COG) (2008)	Durban
Gevers Wieland (CP) (2001)	Cape Town	Price Max Rodney (CPHM) (2004)	Cape Town
Keet Marie Paulowna (C PAED) (2007)	Cape Town	Saffer Seelig David (C NEUROL) (2004)	Johannesburg
Kent Athol Parks (COG) (2013)	Cape Town	Sutcliffe Thomas James (C PSYCH) (2008)	Cape Town
Lemmer Johan (CMSA) (2003)	Johannesburg	Welsh Neville Hepburn (C OPHTH) (2006)	Johannesburg
Levin Solomon Elias (C PAED) (2007)	Johannesburg	(Deceased members not listed but on record).	

Honorary Fellows

The College of Medicine of South Africa (As at 12 August 2013)

Acquaye Joseph Kpakpo (CP) (2004)	Accra, Ghana	De Laey Jean-Jacques (C OPHTH) (2000)	Gent, Belgium
Adamson Fryhofer Sandra (CP) (2003)	Atlanta, USA	De Swiet Michael (COG) (2004)	London, UK
Akande Ebenezer Oluwole (COG) (2002)	Ibadan, Nigeria	Deschênes Luc (CS) (1998)	Quebec, Canada
Alberti Kurt George MM (CP) (1998)	London, UK	Deutman August (C OPHTH) (2000)	Nijmegen, Netherlands
Arulkumaran Sabaratnam (COG) (2005)	London, UK	Dinsdale Henry B (CP) (1996)	Ontario, Canada
Asuzu Michael Chiemeli (CPHM) (2012)	Ibadan, Nigeria	Douglas Neil James (CP) (2005)	Edinburgh, UK
Azubuike Jonathan C (C PAED) (2005)	Enugu, Nigeria	Drife James Owen (COG) (2002)	Leeds, UK
Bailey Susan Mary (C PSYCH) (2012)	Manchester, UK	Elkington Andrew R (C OPHTH) (1997)	Hampshire, UK
Baird David (COG) (2009)	Edinburgh, UK	English Terence Alexander H (CS) (1991)	London, UK
Baltzan Richard (CP) (2001)	Saskatoon, Canada	Falconer Anthony Dale (COG) (2012)	London, UK
Becklake Margaret R (CP) (1994)	Montreal, Canada	Farooqui Muhammad S (CP) (2001)	Karachi, Pakistan
Benatar Solomon Robert (CP) (2001)	Cape Town, SA	Fitzpatrick John Michael (C UROL) (2002)	Dublin, Ireland
Bird Alan Charles (C OPHTH) (2006)	London, UK	Foëx Pierre (CA) (2007)	Oxford, UK
Boix-Ochoa Josè (CS) (2006)	Barcelona, Spain	Foulds Wallace Stewart (C OPHTH) (1992)	Glasgow, UK
Bothwell Thomas Hamilton (CP) (1994)	Johannesburg, SA	Francescutti Louis Hugo (CP) (2012)	Alberta, Canada
Britt LD (CS) (2012)	Virginia, USA	Fritz Vivian Una (C NEUROL) (1972)	Johannesburg, SA
Brobbly George Wireko (C ORL) (2012)	Kumasi, Ghana	Galasko Charles S B (C ORTH) (2003)	Cheshire, UK
Brown Thomas C K (Kester) (CA) (2002)	Victoria, Australia	Genest Jacques (CP) (1970)	Montreal, Canada
Browse Norman (CS) (1996)	London, UK	Gill Geoffrey Victor (CP) (2007)	Wirral, UK
Burger Henry (CP) (1984)	Victoria, Australia	Gilmore Ian Thomas (CP) (2007)	London, UK
Burgess John H (CP) (1991)	Westmount, Canada	Giwa-Osagie Osato O F (COG) (2005)	Lagos, Nigeria
Calder Andrew (COG) (2005)	Edinburgh, UK	Greenberger Norton J (CP) (1991)	Massachusetts, USA
Cameron Donald Patrick (CP) (1998)	Queensland, Australia	Hamilton Andrew M P (C OPHTH) (2001)	Middlesex, UK
Caruso Vincent (C PATH) (2005)	NSW, Australia	Hamilton Stewart (CS) (2005)	Alberta, Canada
Chalmers Iain Geoffrey (COG) (2001)	Oxford, UK	Hanrahan John Chadwick (CS) (1992)	Peppermint Gr. WA
Chang Keng Wee (CS) (2012)	Kuala Lumpur, Malaysia	Hederman William Patrick (CS) (1992)	Dublin, Ireland
Chaudhry Zafar Ullah (CS) (2012)	Karachi, Pakistan	Hennessy Thomas Patrick J (CS) (1997)	Dublin, Ireland
Clewlow Warren (CMSA) (2006)	Sandton, SA	Hollins Sheila (C PSYCH) (2005)	London, UK
Collin John Richard Olaf (C OPHTH) (2007)	London, UK	Hudson Alan Roy (C NEUROSURG) (1992)	Ontario, Canada
Conti Charles Richard (CP) (1991)	Florida, USA	Hume Robert (CS) (1992)	Glasgow, UK
Courtemanche Albert Douglas (CS) (1992)	British Columbia, Canada	Huskisson Ian Douglas (CMSA) (1997)	Cape Town, SA
Couture Jean (CS) (1979)	Quebec, Canada	Hutton Peter (CA) (2003)	Birmingham, UK
Cox John (C PSYCH) (2000)	London, UK	Joubert Peter Gowar (CMSA) (1999)	Johannesburg, SA
Crowe John Patrick (CP) (2012)	Dublin, Ireland	Kaaya Ephata Elikana (C PATH) (2012)	Dar-Es-Salaam, Tanzania
Cunningham Anthony Andrew (CA) (2004)	Dublin, Ireland	Keogh Joseph Anthony Brian (CP) (1998)	Dublin, Ireland
Cywes Sidney (CS) (1998)	Cape Town, SA	Kerr David Nicol Sharp (CP) (1992)	London, UK
De Klerk Frederick Willem (CMSA) (1994)	Cape Town, SA	Keys Derek Lyle (CMSA) (1993)	Johannesburg, SA

Kuku Sonny F (CP) (2001)	Lagos, Nigeria	Rosholt Anon Michael (CMSA) (1980)	Johanneburg, SA
Langer Bernard (CS) (2001)	Ontario, Canada	Salyer K Everett (C PLAST) (2007)	Texas, USA
Leffall LaSalle D (CS) (1996)	Washington, USA	Sankange Christopher A (C UROL) (2012)	Harare, Zimbabwe
Lekamwasam L K L S (CP) (2012)	Galle, Sri Lanka	Santucci Richard Anthony (C UROL) (2013)	Michigan, USA
Lemmer Johan (CMSA) (2006)	Sandton, SA	Saunders Stuart John (CMSA) (1989)	Cape Town, SA
Levett Michael John (CMSA) (1999)	Cape Town, SA	Schulz Eleonora Joy (C DERM) (2006)	Pretoria, SA
Levin Lawrence Scott (C PLAST) (2006)	North Carolina, USA	Seedat Yackoob Kassim (CMSA) (1998)	Durban, SA
Looi Lai Meng (C PATH) (2005)	Kuala Lumpur, Malaysia	Segal Anthony Walter (CP) (2008)	London, UK
Lorimer Andrew Ross (CP) (2004)	Glasgow, UK	Sewell Jill (CP) (2005)	Victoria, Australia
Luntz Maurice Harold (C OPHTH) (1999)	New York, USA	Shear Mervyn (CD) (1999); (C PATH) (2004)	Cape Town, SA
Mackay Colin (CS) (1998)	Glasgow, UK	Sherwood Rupert (COG) (2012)	Victoria, Australia
MacLean Lloyd Douglas (CS) (1996)	Quebec, Canada	Siker Ephraim S (CA) (1983)	Pennsylvania, USA
MacSween Roderick N M (C PATH) (1998)	London, UK	Sims Andrew C Peter (C PSYCH) (1997)	Leeds, UK
Mandela Nelson Rohlihlala (CMSA) (1995)	Johannesburg, SA	Slaney Geoffrey (CS) (1986)	London, UK
Maryon-Davis Alan (CPHM) (2010)	London, UK	Smith Edward Durham (CS) (1990)	Victoria, Australia
Mazwai Ebden Lizo (CMSA) (2011)	Mthatha, SA	Smith John Allan Raymond (CS) (2005)	Sheffield, UK
McDonald John W David (CP) (2004)	Ontario, Canada	Soothill Peter William (COG) (2004)	Bristol, UK
McKenna Terence Joseph (CP) (2005)	Dun Laoghaire, Dublin	Sparks Bruce Louis W (CFP) (2006)	Parktown, SA
McLean Peter (CS) (1998)	Dublin, Ireland	Spitz Lewis (CS) (2005)	London, UK
Meakins Jonathan Larmonth (CS) (2004)	Oxford, UK	Steer Phillip James (COG) (2004)	London, UK
Mensah George A (CP) (2005)	Georgia, USA	Strunin Leo (CA) (2000)	London, UK
Meursing Anneke Elina Elvira (CA) (2003)	Blantyre, Malawi	Stulting , Andries Andriessen (CMSA) (2011)	Bloemfontein, SA
Mieny Carel Johannes (CMSA) (1996)	Pretoria, SA	Sweetnam Sir Rodney (CS) (1998)	London, UK
Mokgokong Ephraim T (COG) (2006)	Medunsa, SA	Sykes Malcolm Keith (CA) (1989)	Oxford, UK
Molteno Anthony C B (C OPHTH) (2001)	Otago, New Zealand	Tan Kok Chai (C PLAST) (2012)	Singapore
Morrell David Francis (CMSA) (2004)	Kenton on Sea, SA	Tan Ser-Kiat (CS) (1998)	Singapore
Mortimer Robin Hampton (CP) (2004)	NSW, Australia	Tan Walter Tiang Lee (CP) (2001)	Singapore
Mutyaba Frederick A (C ORTH) (2012)	Kampala, Uganda	Terblanche John (CMSA) (1995)	Cape Town, SA
Myers Eugene Nicholas (C ORL) (1989)	Pennsylvania, USA	Thomas William Ernest Ghinn (CS) (2006)	Sheffield, UK
Ngu Victor Anomah (CS) (2008)	Yacunde, Cameroon	Thomson Gerald Edmund (CP) (1996)	New York, USA
Norman Geoffrey Ross (CMSA) (2003)	Ontario, Canada	Trunkey Donald Dean (CS) (1990)	Oregon, USA
O'Donnell Barry (CS) (2001)	Dublin, Ireland	Tucker Ronald BK (CMSA) (1997)	Cape Town, SA
Ogedengbe Olasurubomi K (COG) (2012)	Lagos, Nigeria	Turnberg Leslie Arnold (CP) (1995)	Cheshire, UK
Ogilvie Thompson Julian (CMSA) (2009)	Johannesburg, SA	Turner-Warwick Margaret (CP) (1991)	London, UK
Oh Teik Ewe (CA) (2003)	Perth, West Australia	Underwood James C E (C PATH) (2006)	Sheffield, UK
O'Higgins Niall (CS) (2005)	Dublin, Ireland	Van Heerden Jonathan A (CS) (1989)	S Carolina, USA
Opie Lionel Henry (CP) (2008)	Cape Town, SA	Vaughan Ralph S (CA) (2003)	Cardiff, UK
Pasnau Robert O (C PSYCH) (1988)	California, USA	Visser Gerard (COG) (1999)	Utrecht, Netherlands
Pinker George (COG) (1991)	London, UK	Wakwe Victor C (C PATH) (2012)	Delta State, Nigeria
Prentice Archie G (C PATH) (2012)	London, UK	Wijesiriwardena Bandula C (CP) (2005)	Kalubowila, Sri Lanka
Prys-Roberts Cedric (CA) (1996)	Bristol, UK	Yeoh Poh-Hong (CS) (1998)	Kuala Lumpur, Malaysia
Puri Prem (C PAED) (2013)	Dublin, Ireland	Yip Cheng-Har (CS) (2012)	Kuala Lumpur, Malaysia
Ramphele Mamphela Aletta (CMSA) (2005)	Cape Town, SA		
Reeve Thomas Smith (CS) (1991)	NSW, Australia		
Retief Daniel Hugo (CD) (1995)	Alabama, USA		
Richmond John (CP) (1991)	Edinburgh, UK		

Deceased members are not listed, but are on record

CMSA Active Life Members (As at 7 October 2013)

Abdulla Mohamed Abdul Latif
Abell David Alan
Aboobaker Jamilabibi
Abrahams Cyril
Abramowitz Israel
Adams Ganief
Adhikari Mariam
Ahmed Yusuf
Aitken Robert James
Alderton Norman
Alison Andrew Roy
Allen Peter John
Allerton Kerry Edwin Glen
Allie Abduraghiem
Allison Hugo Frederick
Allwood Clifford William
Allwright George Tunley
Anderton Edward Townsend
Andre Nellie Mary
Andrew William Kelvin
Appleberg Michael
Archer Graham Geoffrey
Asmal Aboobaker
Aucamp Carel
Baillie Peter
Baines Richard E Mackinnon
Baise Gershan
Baker Lynne Wilford
Baker Peter Michael
Bane Roy Errol
Barbezat Gilbert Olivier
Barday Abdul Wahab
Barnard Philip Grant
Barnes Richard David
Barnetson Bruce James
Barry Michael Emmet
Bax Geoffrey Charles
Bean Eric
Beatty David William
Becker Herbert
Becker Jan Hendrik Reynor
Becker Ryk Massyn
Bell George Murray
Benatar Solly Robert

Benatar Victor
Benjamin Ephraim Sheftel
Benjamin John David
Bennett Michael Julian
Bérard Raymond Michael Francis
Berkowitz Leslie
Berson Solomon David
Bethlehem Brian H James
Beukes Hendrik Johannes Stefanus
Beyer Elke Johanna Inge
Bezwoda Werner Robert
Biddulph Sydney Lionel
Biebuyck Julien Francois
Binnewald Bertram R Arnim
Bird Arthur Richard
Birkett Michael Ross
Blair Ronald Mc Allister
Blaylock Roger Selwyn Moffat
Bleloch John Andrew
Bloch Cecil Emanuel
Bloch Harold Michael
Bloch Hymen Joshua
Blum Lionel
Bock Ortwin A Alwin
Bolton Keith Duncan
Booker Henry Thomas
Borchers Trevor Michael
Bosman Christopher Kay
Botha Jan Barend Christiaan
Botha Jean René
Bothwell Thomas Hamilton
Boulle Trevor Paul
Bowen Robert Mitford
Bowie Malcolm David
Braude Basil
Bremer Paul MacKenzie
Bremner Cedric Gordon
Briedé Wilhelmus M Hendrik
Brink Garth Kuys
Brink Stefanie
Brits Jacobus Johannes
Brock-Utne John Gerhard
Broude Abraham Mendel
Brown Basil Geoffrey

Brown Raymond Solomon
Brueckner Roberta Mildred
Bruk Morris Isaac
Bruwer André Daniel
Bruwer Ignatius Marthinus Stephanus
Buchan Terry
Buchel Elwin Herbert
Burger Marius Sydney
Burger Thomas Francois
Burgess John Digby
Burgin Solomon
Burns Derrick Graham
Butler George Parker
Butt Anthony Dan
Buys Anna Catherina
Byrne James Peter
Caldwell Michael William
Caldwell Robert Ian
Cameron Neil Andrew
Campbell Derek Gilliland
Carim Abdool Samad
Carim Suliman
Carman Hilary Alison
Cassel Graham Anthony
Cassim Reezwana
Catterall Robert Desmond
Cavvadas Aikaterine
Chaimowitz Meyer Alexander
Charles David Michael
Charles Lionel Robert
Charlton Robert William
Chin Wu Wai Nin
Chothia Khatija
Cilliers Pieter Hendrik Krynauw
Cinman Arnold Clive
Claassens Hermanus JH
Clarke Simon Domara
Clausen Lavinia
Cleaton-Jones Peter Eiddon
Cochrane Raymond Ivan
Coetzee Daniël
Coetzer Hendrik Martin
Cohen Brian Michael
Cohen Colin Koppel

Cohen David
Cohen Eric
Cohen Leon Allan
Cohen Michael
Cohen Morris Michael
Cohen Philip Lester
Coller Julian Somerset
Combrink Johanna Elizabeth
Combrink Johanna Ida Lilly
Comfort Peter Thomas
Commerford Patrick Josep
Conway Sean Stephen
Cooke Paul Anthony
Cooke Richard Dale
Cooper Cedric Kenneth Norman
Coote Nigel Penley
Coovadia Hoosen Mahomed
Coovadia Mohamed Abdool Hak
Cowie Robert Lawrence
Coxon John Duncan
Craig Cecil John Tainton
Craig Denham Davida
Cretikos Michael Dionisios Emmanuel Perandonikis
Crewe-Brown Heather Helen
Crichton Eric Derk
Cronjé Hendrik Stefanus
Crosier James Herbert
Crosley Anthony Ian
Croucamp Petrus C Hendrik
Cullis Sydney Neville Raynor
Cumes David Michael
Cywes Sidney
Dalby Anthony John
Dalgleish Christopher Ian Philip
Dalrymple Rhidian Blake
Danchin Jack Errol
Daneel Alexander Bertin
Daniel Clive Herberta
Daniels André Riad
Danilewitz Daniel
Darlison Michael Tatlow
Daubenton François
Daubenton John David
Davey Dennis Albert
Davey Helen Elizabeth
Davidge-Pitts Keith James
Davidson Aaron
Davies David
Davies Michael Ross Quail
Davis Charles Pierre
Davis Martin David
Dawes Marion Elizabeth
Dawood Aysha Amod
De Beer Hardie Alfred
De Jager Lourens Christiaan
De Klerk Daniel Johannes Janse

De Swardt Stephanus Raynier
De Villiers Jacques Charl
De Villiers Pieter Ackerman
De Villiers Stefanus Johannes
De Wet Jacobus Johannes
De Zeeuw Paul
Dean Joseph G Kerfoot
Dennehy Patrick J Pearce
Dent David Marshall
Derman Henry Jack
Desai Farid Mahomed
Desai Farieda
Dhansay Jalaluddin
Dhansay Yumna
Diers Garth Ruben
Digby Rodney Mark
Distiller Lawrence Allen
Docrat Rookayia
Donald Peter Roderick
Dornfest Franklyn David
Douglas-Henry Dorothea
Dove Ephraim
Dowdeswell Robert Joseph
Dower Peter Rory
Dreyer Wynand Pieter
Du Plessis Dionisius Johann
Du Plessis Hendrik Pienaar
Du Plessis Hennie Lodewia
Du Toit Donald Francois
Du Toit Johan Jakob
Du Toit Johan Loots
Du Toit Pierre F Mulvihai
Duncan Gordon Alexander
Duncan Harold James
Dunning Richard Edwin Frank
Duursma Rienk Willem
Duys Pieter Jan
Eathorne Allan James
Ebrahim Allie
Edge Kenneth Roger
Ehrlich Hyman
Elk Errol Ivan
Enslin Ronald
Epstein Brian Martin
Erasmus Frederick Rudolph
Erasmus Philip Daniel Christoffel
Essack Maimona
Esterhuysen Stephen Philip
Etellin Pierre Anthony
Evans Herbert Campbell Barrow
Evans Warwick Llewellyn
Fanarof Gerald
Faul Helena
Fehler Boris Michael
Fergusson David J Guillemard
Fernandes Carlos Manuel Coelho

Ferreira Anton Leopold
Findlay Cornelius Delfos
Fine Julius
Fine Leon Arthur
Fine Stuart Hamilton
Fisher-Jeffes Donald Leonard
Fleishman Solomon Joel
Flynn Michael Anthony
Forman Allan
Forman Robert
Förtsch Hagen E Armin
Foster Nathaniel E George
Franco Mardochee Marc
Frank Joachim Roelof
Frankel Freddy Harold
Freedman Jeffrey
Freiman Ida
Friedmann Allan Isodore
Fritz Vivian Una
Froese Steven Philip
Furman Saville Nathan
Gajjar Pravinchandra Dhirajlal
Galatis Chrisostomos
Galloway Peter Allan
Gani Akbar
Garb Minnie
Gardiner Victor Burberow
Gardner Jacqueline Elizabeth
Garisch James Archibald MacKenzie
Gaylis Hyman
Gentin Benjamin
Gerard Clifford Leslie
Germon Lawrence
Gersh Bernard John
Gildenhuis Jacobus Johannes
Gillis Lynn Sinclair
Glazer Harry
Glyn Thomas Raymond
Goeller Errol Andrew
Goldberg Barbara Sheila
Goldin Martin
Goldschmidt Reith Bernard
Goldstein Bertie
Golele Robert
Goodley Robert Henry
Goodman Hillel Tuvia
Goosen Felicity
Goosen Jacques
Gordon Peter Crichton
Gordon Robert John
Govender Perisamy Neelapithambaran
Govind Suryakant Kasan
Govind Uttam
Graham Kathleen Mary
Grave Christopher John Hadley
Greeff Ooppel Bernhardt Wilhelm

- Greyling** Jacobus Arnoldus
Grimbeek Johannes Fredericus
Grobbelaar Nicolaas Johannes
Grobler Gregory Martinus
Grobler Johannes Lodewikus
Grobler Marthinus
Groenewald Lukas Johannes
Groenewald Marcelle
Grotepass Frans Willem
Haffejee Ismail Ebrahim
Hammer Alan John
Hangelbroek Peter
Hansen Denys Arthur
Harpur Peter James
Harris Ian Michael
Harrison Anthony Carleton
Harrison Neville Alan
Hartdegen Richard Gerhardus
Hartley Patricia Staunton
Hartman Ella
Hassan Mohamed Saeed
Hawthorne Henry Francis
Hayward Frederick
Head Mark Stephen
Hefer Adam Gottlieb
Helman Isaac
Henderson Linda Grantham
Henderson Rex Scott
Heyns Anthon du Plessis
Higgs Stephen Charles
Hill John William
Hill Paul Villiers
Hillock Andrew John
Hirschowitz Jack Sydney
Hirschson Herman
Hitchcock Peter John
Hockly Jacqueline Douglas Lawton
Hockman Maurice Harold
Hoffman Eduard Bernard
Hoffmann Vivian Jack
Hofmeyr Nicholas Gall
Holdsworth Louis David
Holland Victor Bernard
Holloway Alison Mary
Horak Adrian Rousseau
Horak Lindley Rousseau
Horowitz Stephen Dan
Hougaard Melodie
Hough Frans Stephanus
Hovis Arthur Jehiel
Howell Michael E Oram
Howes Neville Edward
Hugo André Paul
Hundleby Christopher J Bretherton
Hurwitz Charles Hillel
Hurwitz Mervyn Bernard
Hurwitz Solomon Simon
Huskisson Ian Douglas
Ichim Camelia Vasilica
Ichim Liviu
Isaacson Charles
Ismail Khalid Hajee
Israelstam Dennis Manfred
Jackpersad Ramesh
Jacobs Daniel Pieter Sydney
Jacobs Miguel Adrian
Jacobs Peter
Jacobson Merwyn Jack
Jammy Joel Tobias
Jan Farida
Janse van Rensburg Johan Helgard
Jansen van Rensburg Martinus
Jassat Essop Essak
Jedeikin Leon Victor
Jeena Hansa
Jeffery Peter Colin
Jersky Jechiel
Jessop Susan Jane Dorothy
Jöckel Wolfgang Heinrich
Joffe Leonard
Joffe Stephen Neal
Johnson Sylvia
Jonker Edmund
Jonker Michael Angelo Theodore
Jooste Edmund
Jordaan James Charles
Jordaan Johann Petrus
Jordaan Robert
Joubert James Rattray
Joynt Gavin Matthew
Kaiser Gerhard Hans Robert
Kaiser Walter
Kalombo Augustin Ngalamulume
Kane-Berman Jocelyne Denise Lambie
Kaplan Neville Lewis
Karlsson Eric Lennart
Karusseit Victor Otho Ludwig
Kassner Grant William
Katz Ian Ariel
Katzke Dieter
Katzeff Stanley Norman
Keet Marie Paulowna
Keet Robert Arthur
Keeton Godfrey Roy
Kemp Donald Harold Maxwell
Kenyon Michael Robert
Kernoff Leslie Maurice
Kessler Edmund
Kew Michael Charles
Key Jillian Jane Aston
Kieck Charles Frederick
Kimberg Matti
King Jennifer Ann
King John Frederick
Kinsley Robin Howard
Klein Hymie Ronald
Klevansky Hyman
Kling Kenneth George
Klugman Leon Hyam
Knobel John
Knoetze Gerald Casparus
Koch Johann Augustinus
Koller Anthony Bruce
König Harold Leith Edward
Kotton Bernard
Koz Gabriel
Kramer Brian David
Kranold Dorothea Helene
Krengel Biniomin
Kriel Jacques Ryno
Krige Louis Edmund
Kruger Theunis Frans
Kussel Jack Josiah
Kussman Barry David
Kuyl Johannes Marinus
Labuschagne Izak
Lachman Anthony Simon
La Grange Jacobus Johannes Christiaan
Laing John Gordon Dacomb
Lake Walter Thomas
Laloo Maneklal
Lamont Alastair
Lampert Jack Arthur
Landsberg Pieter Guillaume
Lantermans Elizabeth Cornelia
Large Robert George
Lasich Angelo John
Latif Ahmed Suliman
Laubscher Willem M Lötter
Laurence John Egerton
Lautenbach Earle E Gerard
Lawson Hugh Hill
Leader Leo Robin
Leary Peter Michael
Leary William P Pepperrell
Leaver Roy
Leeb Julius
Lejuste Michel JL Remi
Lemmer Johan
Lemmer Lourens Badenhorst
Lennox Gordon Stuart
Le Roex René Denyssen
Le Roux Petrus A Jacobus
Lessing Abraham J Petrus
Levenstein Stanley
Levin Jonathan
Levin Solomon Elias
Levy Ernest Ronald

- Levy** Wallace Michael
Levy Walter Jack
Lewin Arthur
Lewin Jack Roy
Lewis Dorothy
L'Heureux Renton
Liebetau Carl Roux
Linde Stuart Allen
Lion-Cachet Ethelwyn Antoinette
Lipper Maurice Harold
Lloyd David Alden
Lloyd Elwyn Alden
Lochner Jan de Villiers
Locketz Maxwell Ivan
Lodemann Heide Katharina
Loening Walter E Karl
Loest Hellmut Claudius
Lombard Hermanus Egbertus
Long John Walter
Loot Sayyed M Hosain
Loots Petrus Beaufort
Losken Hans Wolfgang
Losman Elma
Lotz Jan Willem
Lotzof Samuel
Loubser Johannes Samuel
Lurie Russel
Macdonald Angus Peter
MacEwan Ian Campbell
MacKenzie Basil Louis
MacLeod Ian Nevis
MacPhail Andrew Patrick
Maharaj Ishwarlall Chiranjilall
Maharaj Udeeth
Maharajh Jaynund
Mahomed Abdullah Eshaak
Mair Michael John Hayes
Maitin Charles Thabo
Malan Atties Fourie
Malan Christina
Malan Daniel Francois
Maliza Andile
Mangera Ismail
Mankowitz Emmanuel
Mann Solly
Marais Ian Philip
Marais Johannes Stephanus
Margolis Frank
Margolis Kenneth
Marivate Martin
Marivate Russell
Markman Philip
Marks Charles
Marks Richard Kearns
Marx Johan Hendrik
Matisonn Rodney Earl
- Mauff** Alfred Carl
Maxwell William Graeme
May Abraham Bernard
Mayet Fatima Goolam Hoosen
Mayet Zubeida
Maytham Dermine
McCosh Christopher John
McCutcheon John Peter
McDonald Michael Charles Edward
McDonald Robert
McIntosh William Andrew
McKenzie Malcolm Bett
McKibbin Joseph Kerr
Mears Jasper W Walter
Meer Farooq Moosa
Meeran Mooideen Kader
Meiring Johannes Cornelius Engelbrecht
Melville Roger Laidman
Melville Ronald George
Mendelsohn Huntley Jonathan
Mennen Ulrich
Mervis Benjamin
Meyer Anthonie Christoffel
Meyer Bernhardt Heinrich
Meyer David
Meyer De Bruto Laporta Cavalier
Meyer Roland Martin
Meyers Anthony Molyneux
Meyersohn Sidney Jacob
Meyerson Louis
Michaelides Basil Andrew
Michaels Maureen Jeanne
Michalowsky Aubrey Michael
Michell William Lancelot
Michelow Maurice Cecil
Midgley Franklin John
Miemy Carel Johannes
Miles Anthony Ernest
Millar Robert Norman Scott
Milne Anthony Tracey
Milne Frank John
Milner Selwyn
Misnuner Zelik
Mitchell Peter John
Mitha Abdul Sater
Mogale Saxon Cholohelo
Mokhobo Kubeni Patrick
Molapo Jonathan Lepoqa
Molteno Christopher David
Moodley Dhanapalan Patchay
Moodley Jagidesa
Moodley Thirugnanasumburanam
Moola Yousoof Mahomed
Moosa Abdool-Sattar
Moosa Muhammed-Ameen
Morar Champaklal
- Morley** Eric Clyde
Morrell David Francis
Morris Charles David Wilkie
Morris Edel
Morris Warwick Montague Molteno
Morrison Gavin
Moti Abdool Razack
Movsowitz Leon
Mullan Bertram Strancham
Muller Edward Julius
Muller Frederick Eybers
Mulligan Terence P Simpson
Mullineux John David
Myers Leonard
Naidoo Balagaru Narsimaloo
Naidoo Lutchan Perumal
Naidoo Neetheanathan
Naidoo Premilla Devi
Naidu Pithambram Nadamuni
Nair Gonasegrie Puckree
Nanabhay Sayed Suliman
Nash Eleanor Scarborough
Naude Johannes Hendrik
Nauhaus Carl Norman
Neifeld Hyman
Nel Elias Albertus
Nel Jacques Bernadus Anton
Nel Jan Gideon
Nel Julien Robert
Nel Philippus Jacobus
Nel Wilhelm Stephanus
Newbury Claude Edward
Nicholson Melanie Eugene
Noble Clive Allister
Noll Brian Julian
Norman-Smith Jack
Novis Bernard
Nurick Ivan James
Obel Israel Woolf Promund
Odendaal Hendrik Johannes
Odes Harold Selwyn
Olinsky Anthony
Omar Goolam Mahomed
Omar Yunoos
Omardien Yusuf
Orelowitz Manney Sidney
Orford Alastair Leask
Ospovat Norman Theodore
OSSIP Mervyn Seymour
Padayatchi Perumal
Palmer Raymond Ivor
Pantanowitz Desmond
Parkes John Ryan
Parsons Arthur Charles
Parsoo Ishwarlall
Pascoe Michael Danby

Patel Prabhakant Laloo
Pather Runganayagum
Pearlman Theodore
Peer Dawood Goolam Hoosen
Pelser Frank Blignaut
Peters Ralph Leslie
Pettifor John Morley
Philcox Derek Vincent
Phillips Gerald Isaac
Phillips Keith Radburn
Phillips Louisa Marilyn
Pillay George Permall
Pillay Govindasamy Sokalingum
Pillay Rathinasabapathy Arumugam
Pillay Thiagarajan Sundragasen
Pillay Veerasamy K Govinda
Planer Meyer
Plit Michael
Polakow Everard Stanley
Politzky Nathan
Pollak Ottilie
Polley Neville Alfred
Pompe van Meerdervoort Hjalmar Frans
Porteous Paul Henry
Porter Christopher Michael
Potgieter Hermanus Jacobus
Power David John
Prentice Bernard Ross
Pretorius David H Schalk
Pretorius Hendrik Petrus Jacobus
Pretorius Jack
Pretorius Johannes Adam
Pretorius Johannes Jacobus
Pretorius Johannes Lodewikus
Price Stephen Kennedy
Prinsloo Frances
Prinsloo Simon Frederik
Prinsloo Simon Lodewyk
Prosser Geoffrey Leslie
Prowse Clive Morley
Przybojewski Jerzy Zbigniew
Pudifin Dennis James
Quan Tim
Quantock Owen Peter
Quinlan Desmond Kluge
Quirke Peter Dathy Grace
Rabie Johannes
Radford Geoffrey
Raftopoulos Paris
Raga Jairaj
Raghavjee Indira Vaghjee
Raine Edgar Raymond
Rajput Mangoo Chhaggan
Rankin Anthony Mottram
Ransome Olliver James
Rawlings James

Read Geoffrey Oliver
Reardon Colin Michael
Rebstein Stephen Eric
Redfern Michael John
Reichman Leslie
Reichman Percy
Reidy Jeremy Charles
Reif Simon
Reinach Werner
Renton Maurice Ashley
Retief Daniel Hugo
Retief Francois Jacobus
Retief Francois Pieter
Reyneke Philippus Johannes
Rice Gordon Clarke
Richards Alan Trevor
Ritchken Harry David
Roberts William A Brooksbank
Robins-Browne Roy Michael
Robinson Brian Stanley
Rode Heinz
Roediger Wolf Ernst Wilhelm
Roelofse Hendrik Johannes
Rogaly Elgar
Rogan Ian MacKenzie
Rogers Raymond Alan
Roman Horatio E Hereward
Roman Trevor Errol
Rome Paul
Roos Charles Phillipus
Roos Nicolaas Jacobus
Roose Patricia Garfield
Rosenberg Basil
Rossouw Dennis Pieter
Rothberg Alan Dan
Rousseau Theodore Emile
Rudolph Isidore
Rush Peter Sidney
Ryan Raymond
Sacks William
Saffer Seelig David
Safro Ivor Lawrence
Sagor Jason Solomon
Salant David John
Samson Ian David
Samson John Monteith
Sanders Hannah-Reeve
Sapire David Warren
Saunders Stuart John
Saxe Norma Phyllis
Scallan Michael John Herbert
Schaetzing Albrecht Eberhard
Schepers Anton
Scher Alan Theodore
Schneider Cecil Max
Schneider Herbert Rodney

Schneier Felix Theodore
Schoeman Adam Barnard
Schoeman Johannes Feuth
Scholtz Roelof
Schultz Claude Bernhard
Schutte Philippus Johannes
Schwär Theodor Gottfried
Schwarz Kurt
Schwersenski Jeffrey
Scott Bruce William Haigh
Scott Neil Petrie
Scott Quentin John
Scragg Joan Noelle
Seaward Percival Douglas
Sedgwick Jerome
Seedat Suleman Mahomed
Seedat Yackoob Kassim
Seidel Wilhelm Friedrich
Sellars Sean Liam
Sender Mervyn David
Senior Boris
Serfontein Jacobus Hendrik
Shapiro Benjamin Leon
Sharpe Jean Mary
Shear Mervyn
Sher Gerald
Sher Geoffrey
Sher Mary Ann
Sher Rickard Charles
Shété Charudutt Dattatraya
Shuttleworth Richard Dalton
Shweni Phila Michael
Siebert Peter Robin de Vos
Siew Shirley
Sifris Dennis
Silbert Maurice Vivian
Simons George Arthur
Simonsz Charles Anthony
Simson Ian Wark
Singer Martin
Skudowitz Reuben Benjamin
Slion Cyril Meyer
Smit John Nicholas
Smit Wilhelm Michiel
Smith Alan Nathaniel
Smith Lionel Ralph
Smith Michael Ewart
Sneider Paul
Snyman Adam Johannes
Snyman Hendrick G Abraham
Solarsh Stanley Monash
Somera Satiadev
Sonnendecker Ernest W Walter
Sparks Bruce Louis Walsh
Spies Sarel Jacob
Spilg Harold

Stander Dudley	Van der Merwe Gideon Daniel	Weehuizen John Peter Albert
Stannard Clare Elizabeth	Van der Merwe Hendrik Johannes	Weich Dirk Jacobus Visser
Steenkamp Edward Clarkson	Van der Merwe Jacobus Petrus	Weinberg Eugene Godfrey
Steenkamp Lucas Petrus	Van der Merwe Jan Abraham	Weinbrenn Clifford
Stein Aaron (Archie)	Van der Merwe Pieter-Luttig	Wellsted Michael Dennis
Stein Abraham	Van der Merwe Schalk W Petrus	Welsh Ian Bransby
Stein Mannie	Van der Meyden Cornelis Hendrikus	Welsh Neville Hepburn
Steyn Izak Stefanus	Van der Spuy Johan Wilhelm	Westaway Joan Lorraine
Steynberg Fans Hendrik	Van der Walt André	Westerman David Elliot
Stronkhorst Johannes Hendrikus	Van der Walt Pieter Johannes	Weston Neville Anthony
Styger Viktor	Van der Wat Jacobus JH Botha	Whiffler Kurt
Suliman Abdoorahaman Ebrahim	Van Drimmelen Bertha	White Ronald Gilchrist
Sur Monalisa	Van Drimmelen Pieter	Whiting David Ashby
Sur Ranjan Kumar	Van Gelderen Cyril Jack	Whittaker David Ernest
Svensson Lars Georg	Van Graan Nico Jacobus	Wickens Johannes Tromp
Swanepoel André	Van Greunen Francois	Wienand Adolf Johann
Swart Jacob Jacobus	Van Heerden Schalk Petrus	Wiggelinkhuizen Jan
Swart Johannes Gerhardus	Van Helsdingen Jacobus O Tertius	Wilkinson Lynton Dallas
Swartz Jack	Van Leenhoff Johannes Willem	Willemse Pieter
Swiegers Wotan Reynier Siegfried	Van Niekerk Christopher	Willers Petrus Salmon
Swift Peter John	Van Niekerk Christoffel Hendrik	Williams Margaret Ethel
Tang Kenneth	Van Niekerk Gilbert André	Williams Robert Edward
Tarboton Peter Vaughan	Van Niekerk Johannes Philippus de Villiers	Wilson Peter James
Taylor Robert Kay Nixon	Van Niekerk William Stephen	Wilson Timothy Dover
Tayob Ismail Suleman	Van Rooyen Gert Ignatius	Wilson William
Te Groen Frans Wilhelmus	Van Schalkwyk Derrick	Wilton Thomas Derrick
Terblanche John	Van Schalkwyk Herman Eben	Wingreen Basil
Terespolsky Percy Samuel	Van Schouwenburg Johan Andries Michiel Heyns	Wise Roy Oliver
Thaning Niels-Otto	Van Selm Christopher Denys	Wittenberg Dankwart Friedrich
Theron Eduard Stanley	Van Wyk Chris	Wolfsdorf Jack
Theron Jakobus L Luttig	Van Wyk Frederick A Kelly	Wootton John Barry Leif
Theron Willem	Van Wyk Johannes Adriaan Louw	Wrantz Peter Anthony Bernhard
Thompson Michael Wilson Balfour	Van Zyl-Smit Roal	Wright Ian James Spencer
Thompson Roderick Mark McGregor	Veldman Michael Hendrik	Wright Michael
Thomson Alan J George	Velzeboer Sally Jane	Wunsh Louis
Thomson Morley Peter	Venter Jacobus Frederik	Yakoob Hamid Ismail
Thomson Peter Drummond	Venter Louis André	Yeats John Raymond
Thorburn Kentigern	Venter Pieter Ferdinand	Yudaken Israel Reuwen
Thornington Roger Edgar	Vermaak Etienne Johan	Zaacks Philip Louis
Thorp Marc Alexander	Vermeulen Jan Hendrik	Zaaijman John du Toit
Toker Eugene	Viljoen Denis Lowe	Zabow Tuviah
Treisman Oswald Selwyn	Viljoen Ignatius Michael	Zent Clive Steven
Trichard Louis C G Lennox	Visser Daniel	Zent Roy
Tucker Ronald B Kidger	Von Varendorff Edeltraud Mathilde	Zieff Solly
Turner Peter James	Von Wielligh Gysbertus Johannes	Ziervogel Carel Frederick
Tyrrell Joseph Clonard Harcourt	Vosloo Johan Christian	Zion Monty Mordecai
Underwood Ronald Arthur	Wade Harry	Zwonnkoff George Alexander
Ungerer Matthys Johannes	Wagenfeld Derrick John Henry	
Utian Hessel Lionel	Wahl Jacobus Johannes	
Vahed Abdul Khalek Ahmed	Walele Abdul Aziz	
Valjee Ashwin	Walker David Anthony	
Van Bever Donker Sophie Carla	Walker Kathleen Gwen	
Van Coeverden de Groot Herman A	Walls Ronald Stewart	
Van den Bergh Cornelius Jacob	Walton Russell John	
Van den Ende Jan	Watt Keith Alexander	
Van der Merwe Christiaan	Webber Bruce Leonard	

The Maurice Weinbren Award in radiology

The Maurice Weinbren Award in radiology, which consists of a medal and certificate, is offered annually, in respect of a calendar year, by the Senate of The Colleges of Medicine of South Africa (CMSA) for a paper of sufficient merit that deals with radiodiagnosis, radiotherapy, nuclear medicine or diagnostic ultrasound.

The closing date for submission of papers is 15 January 2014. The guidelines pertaining to the award can be requested from Mrs Sharleen Stone via telephone: (0) 31 260 4438, facsimile: (0) 31 260 4439, and e-mail: cmsa-edu@ukzn.ac.za

RWS Cheetham Award in psychiatry

The RWS Cheetham Award in psychiatry award is offered annually, in respect of a calendar year, by the Senate of the CMSA for a published essay of sufficient merit on trans- or cross-cultural psychiatry, which may include a research or review article. All family physicians who are registered and practising in South Africa qualify for the award which consists of a medal and certificate.

The closing date for submissions of essays is 15 January 2014. The guidelines pertaining to the award can be requested from Mrs Sharleen Stone, via telephone: (0) 31 260 4438, facsimile: (0) 31 260 4439, and e-mail: cmsa-edu@ukzn.ac.za

Robert McDonald rural paediatrics programme

The late Prof Robert McDonald founded the above programme in 1974 for "the propagation of paediatrics in the more remote and underprivileged parts of the Republic of South Africa, by an occasional lecture or visit by someone in the field of the care of children".

Requests for funding are invited from teams of medical practitioners and senior nursing staff to travel to remote centres and areas to promote paediatrics, child health, and the better care of children, and to disseminate knowledge in that field, especially in underprivileged

communities. This can also include visits by medical practitioners or nurses working in remote areas to larger centres or centres of excellence.

The closing dates for applications are 15 July and 15 January of each year. The guidelines pertaining to the programme can be requested from Mrs Sharleen Stone, via telephone: (0) 31 260 4438, facsimile: (0) 31 260 4439, and e-mail: cmsa-edu@ukzn.ac.za

South African SIMS Fellowship sub-Saharan Africa 2014

Nominations are invited from Presidents of eligible Colleges for the above fellowship. The objective of the Fellowship is to establish and maintain educational development programmes in sub-Saharan Africa. The disciplines of medicine that are eligible for the South African SIMS Fellowship are the same as those that are eligible for the Sir Arthur SIMS Commonwealth Professorship, i.e. Anaesthesia, Cardiothoracic Surgery, Medicine, Neurology, Neurosurgery, Ophthalmology, Orthopaedics, Otorhinolaryngology, Paediatrics, Plastic Surgery, Surgery (General) and Urology.

The nomination must be submitted with the curriculum vitae of the nominee, a motivation from the President of the College, as above, and an outline of the proposed visit.

Nominations should reach the Chairman, Education Committee, CMSA, P O Box 59185, Umbilo, 4075, by 31 May 2014. Electronic submissions will also be accepted. These should be sent to Mrs Sharleen Stone via e-mail: cmsa-edu@ukzn.ac.za

Further information on the Fellowship can also be obtained from Mrs Sharleen Stone via telephone: (0) 31 260 4438, facsimile: (0) 31 260 4439, and e-mail: cmsa-edu@ukzn.ac.za

New examinations office in Johannesburg

For a number of years, the examinations office of the CMSA, Johannesburg, has needed renovating. The project to convert 25 Rhodes Ave from residential accommodation to office space has been a long and sometimes depressing journey, which began in March 2011.

With having to receive permission from the Heritage Association, the Parktown Association, the Municipality (Roads, Parks and Water) and the residents in Rhodes Ave, there were times when I despaired of the project for our new offices ever reaching fruition. Finally, in January 2013, 21 months after the process was initiated, we started the dramatic process of dismantling the inside of the house, and have since converted it into a fantastic workspace for the staff who work in the Examinations Office.

There were many restrictions, from both the Heritage and Parktown Associations, so the exterior is not markedly different, but has been given a well deserved face lift. In short, the interior has been transformed from a very old and dilapidated building to a state-of-the-art office space.

The official opening of the new Examination Office, by the Examinations and Credentials Committee, was held on 19 July 2013, and was viewed by the Executive Committee on 19 September 2013.

In addition to inhabiting this new workspace, staff from the CMSA, Johannesburg, have undertaken a monthly internal charity drive, and have already supported Reach for a Dream Slipper Day, Casual Day and Children of Fire.

Team spirit is vital to an enthusiastic workforce, and this was evident from the wonderful photographs of the Johannesburg office staff at our Casual Day function this year.

Ann Vorster
Academic Registrar, CMSA, Johannesburg



Insignia for sale: CMSA Members

1. Ties:

1.1 Polyester material in navy, maroon or bottle green:

1.1.1 Crest in colour as single under-knot design..... R 100

1.1.2 Rows of shields separated by silver-grey stripes..... R 100

1.1.3 Wildlife (Two designs: enquire)..... R 100

1.2 Silk material Fellow's tie in navy only, in design 1.1.2 R 180

2. Scarves (long):

The Big 5 (small animals) attractive design on soft navy fabric R 230

3. Blazer badges in black or navy, with crest embroidered in colour R 100

4. Cuff-links (enquire about prices):

4.1 Sterling silver crested R 100

4.2 Baked enamel with crest in colour on cream, gold or navy background..... R 100

5. Lapel badges/brooches (enquire about prices) R 100

Crest in colour, baked enamel on cream, gold or navy background R 100

6. Key rings (black/brown leather) (enquire about prices):

Crest in colour, baked enamel on cream, gold or navy background..... R 100

7. Paper-weights (enquire about prices):

Nickel or gold plated, with gold-plated crest R 100

8. Paper-knives (enquire about prices):

Silver plated, with gold-plated crest..... R 100

9. Wall plaque (enquire about prices):

Crest in colour, on imbuia or oak R 100

10. Purse: leather, with wildlife material inlay..... R 300

11. History of the CMSA written by Dr Ian Huskisson R 130

R30 per item to be included with order to cover postage

