THE CAPE DOCTOR

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CAPE WESTERN BRANCH NEWSLETTER VOL 52 No. 5 AUGUST 2019 TAK WESKAAPLAND NUUSBLAD

Yes, we did fail Bongani Mayosi and Tim Noakes

John Steer

In this issue we feature two of the most eminent colleagues South Africa has ever produced.

Bongani Mayosi and Tim Noakes. Both, to our disappointment and dismay, have been massively let down.

Bongani Mayosi, the like of whom we may never see again, was so abused by student protests that his "soul was vandalised and unravelled" leading to major depression. He fully supported the student aims. Sadly, he was not supported by senior colleagues when, literally within a week of being appointed Dean, his office was occupied for some two weeks by student protesters who abused him on every level, including abusive phone calls and emails to his home 24 hours a day. In this embattled situation he received no meaningful support from the UCT hierarchy who had declined his request to resign. It was this situation that caused his depression requiring medical assistance which might have produced a different end result, if handled differently. This unfailingly courteous, massively talented, locally and internationally highly respected man, took his life consequent to what he had endured and one repeats the sad fact "we may not see his like again." He was exceptional in the fullest sense of the word. The ultimate role model. He was regarded as the "Black Messiah".

My anger, and I imagine that of many, at those who precipitated his death, is deep and unforgiving.

To deny that the invasion of his office and the abusive environ surrounding him did not affect him is incorrect. His sister points out that these actions, not only "vandalised his soul but unravelled him." And for "student rightists" to deny this, despite comments from surgeon Lydia Cairncross, a significant activist supporter, is totally unacceptable and in contempt of Bongani's demise.

Read Daily Maverick on 31-7-2018 on Day by Day https://www.dailymaverick.co.za/article/2018-07-31-thoughts-on-the-death-of-professor-bongani-mayosi/- and recall Cairncross claiming he was "never disrespected, called names, or denigrated and that the two weeks occupation of his offices were a transformative second in our history. Seldom had she seen a political protest unfold so spontaneously, so respectfully, so superbly as that specific protest." And then read her self-serving, description of the unbelievable pressure under which she and her colleagues work. Lydia, there is a move to strike you a medal. For bravery, survival and clinical judgement. You are truly amazing in a very special way. Do you for one moment think that you had the majority support of the medical students at Medical School in accepting this abusive invasion. Bongani was a gentle man, a leader in his field, and this abuse you deny was seminal in his unravelling.

Inform yourself and read "Reflections on suicide of Professor Bongani Mayosi, persecuted to death."

https://www.biznews.com/thought-leaders/2018/08/07/suicide-professor-bongani-mayosi-death-ed-herbst

It's magnificent and important and recall the new Vice Chancellor admitting student protests were the most significant factor in Bongani's demise. She's a lady of presence, eloquence and undoubted strength accepting his death has focused us on the significance of depression.

But one needs remember Bongani's depression did not predate the protests. It was consequent. And now hear how UCT has promised to set up .... wait for it ... a subcommittee to investigate the causes of his death. But only 8 months later, is it constituted. There was clearly no urgency or is this how UCT handles urgency, and as van Niekerk comments in his ensuing article, " it's unlikely to offer anything realistic except evasion. " We watch this space with cynicism.

Also recollect internationally respected Professor Jonathan Jansen regards Fallists as "fascists" while Professor Dennis Davis has little regard for their actions.

We reprint van Niekerk's article as well as the remarkable piece by Bongani's wife encouraging you to read both, with concentration and insight.

Realise that in this embattled situation he received no meaningful support from UCT hierarchy who basically viewed the "rights" of student protests as "untouchable". Unlike at Wits, no poll was taken to assess student support. UCT watched a colleague in one of its most prestigious Departments being massively abused essentially watching Bongani "drowning," while doing nothing except doubtless being involved in philosophic academic discussion while ignoring his need for urgent security support, Wits knew when to draw the line and bring them in, whilst facing a massive and complex challenge. There was a tragic end result. How do you feel "Leslie London?" Clearly you can't, as some people allege, have been no more than "virtue signalling" with everything that implies.

UCT has failed to address the essential question of staff rights and note the case at a similar

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CAPE RADIOLOGY

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EDITORIAL

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American campus where Professor Brett Weinstein is forced to resign due to student protest and successfully sues the institution for non-protection of his rights. The case was settled for $500,000.00. What "price" UCT? It makes interesting reading to see what he faced at the Evergreen Equity standoff.

In local terms I'm reminded by a campus colleague in a similar situation that when protesting to Max Price he was simply told of his need to develop a thicker skin, with no practical support offered. If he wished to take legal action, it would be to his account. But, just as students have rights, so do staff, something which evaded the attention of UCT hierarchy. Or was it just too sensitive?

Bongani's funeral was nationally respected https://www.youtube.com/watch?V=6VzxWoYpcM I recommend you view it. Not only was it wonderful and sadly moving, but one experiences the full resonance of this exceptional man.

Adam Habib the Wits Vice Chancellor has written a remarkable book on student protests called "Rebels and Rage" where he discusses the widespread deliberations between the different Vice Chancellors and in doing so contrasts his approach to that at UCT. They are significant. While accepting distaste at bringing security and police onto campus, there is a reality that when this group, who are essentially small in numbers, not representing a majority of student opinion, overstep the bounds, of shall we say civility, then a line needs be drawn and acted upon. Essentially UCT eschewed this principle allowing "free reign". They were "untouchable," and it's well known student activism in South Africa is, in international terms, far more violent than elsewhere. Our new Vice Chancellor has already been threatened ... and not by a "pale skin" voice. However she has the presence and personality to handle this in a meaningful way.

Interesting was an anomaly at a workshop on decolonising the curriculum held at UCT attended by the very influential Mellon Foundation, who give a number of fellowships. The first session involved "thoughtful deliberation" on curriculum reform and its importance while the second session covered reflection on student experiences of the Mellon Foundation Fellowships. Here we have a fascinating example of duplicity.

While the students were enthusiastic in demanding curriculum decolonisation, they saw no problem in the incongruity of first protesting the demand of curriculum decolonisation and secondly then pleading the Mellon Foundation provide even more fellowships to universities such as Oxford, Cambridge and Harvard, each bastions of the colonial structure of higher education. There is comment the Mellon Foundation are tiring of the incessant student demands and conditions, and may review their commitment, making them hesitant in continuing the same level of sponsorship to Higher Education and Diversity in South Africa, with everything that implies. One could regard this as the opposite of an "unintended consequence."

While Habib challenged this dichotomy there's no mention of a UCT comment.

Also understand that in similar cases there is often an inquest at which the surrounding circumstances are fully assessed and here one would question why it was that when Bongani and his wife requested they both be involved in the consultations this was declined. Psychiatrists I've spoken to regard this as inappropriate. Similarly UCT's Vice Chancellor's office will need give exceeding convincing reasons as to how they justified declining his resignation request.

Read Habib's book, "Rebels & Rage." It's excellent, direct and important. You might well come to the same conclusion as many in feeling that if Habib had been UCT Vice Chancellor not only would the Faculty of Health Science, but the wider world, still have the privilege of Bongani Mayosi as colleague, Dean, and likely future Vice Chancellor but his wife a husband, and children a father.

I end quoting Catullus - "Ave atque Vale Bongani".

We then publish an overview on the conclusion of what Alastair Millar correctly calls the "Tim Noakes saga." His comments amongst other matters allude to the "academic mobbing" to which Noakes was subjected, and who finally, after nearly four and a half years and the cost of over R10 million to the HPCSA, has been completely exonerated. However, no one should underestimate the enormous personal emotional pressure and stress he suffered during this period and were it not for the significant support he received there could well have been a different ending, with tragic results. What also saddened me while attending his trial was not once did one see any member of the Health Science Faculty attending as part of "Audi alteram partem" nor was there any attendance from the Sport's Science facility which he was seminal in founding and which has been superbly positive in the lives of many. Just as Nonhlanhla Khumalo, Bongani's wife says, "yes we did fail Bongani Mayosi", the same applies to Tim Noakes. And the poem with which she ends her article remains exceeding relevant.

It's sad Prof Salim Jusuf, an international colleague much respected by Prof Bongani, might have been able to be a useful interlocutor regards the conflicting diet discussion. In some ways he might have been supportive in that Nina Teicholz, a Salim confidant, said he was going to discuss the fact that the low fat diet was inappropriate and high carbohydrate diets unhealthy. He had offered to be a go between.

The fact that UCT is closing its Nutrition and Dietetics teaching programme is of interest and without putting too much emphasis on it, this could be a positive factor from the trial.

The final twist in the tail might be that Ames Dhai, having allowed the trial to go ahead despite it being inappropriate, inadvertently raised the profile to an essentially international LCHF level which may, in the fullness of time, be recognised as a landmark moment in Nutritional Science. Without Dhai allowing this to take place, one might not have had that outcome.

As Noakes comments, he can't in all honesty be absolutely dismissive of her in that in the end, though what she did was wrong, there were benefits from her decision that could not have been achieved without her actions.

UCT should be ashamed of itself as should the HPCSA. ■

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TRIBUTE

Musings on Mayosi as Dean

JP van Niekerk

The people wept. At the remarkable tribute to Bongani Mayosi's life on Saturday 4 August 2018, lasting five and a half hours and attended by more than two thousand people, there was sadness, celebration of his achievements, and much introspection. How could this modest, though highly influential, intellectual and popular leader inspire us to carry the baton of his vision now that he was no longer here?

His rise to national and international fame and influence is a matter of record, and he would have received recognition for his many achievements in any event. However, the massive national reaction to his loss to the nation through suicide, and consideration of the events preceding this, sparked a flurry of introspection and comment.

One of the many questions asked about his appointment as Dean of the Faculty of Health Sciences (FHS) at the University of Cape Town (UCT) was whether he had the capacity for the job. The answer is clear – he had this in abundance as evidenced by his stellar role as head of the Department of Medicine, as leader of a large research team and projects, and in many other influential leadership positions, nationally and internationally. Asked about my view regarding his appointment as Dean at the time, I opined that he was unlikely to stay long as he was destined for greater office. He was undoubtedly a great leader and manager.

However, shortly after he took office as Dean, the #FeesMustFall movement ripped through the country and UCT, and hit him particularly hard. Despite his being a passionate supporter of students and empathetic to their cause, the protesting students invaded his office and occupied it for a long period during which time he was subjected to vitriolic vilification. Compounding this was criticism from his senior colleagues about his perceived inability to manage what was an unmanageable situation. The rejection and vilification by the two main components of his domain, the students and the staff, must have been devastating to this strong but sensitive man, for whom it must have been an awful new experience. Many at the funeral spoke about his capacity to make friends and influence staff and students to achieve greater heights.

The #FeesMustFall campaign left much devastation of physical property and, due to the intimidation and insults, also left many academic staff members suffering from post-traumatic stress. Black staff members were particularly targeted and labelled coconuts and sell-outs. This experience resulted in a number of academic leaders at other academic campuses in the country stepping down.

Bongani Mayosi

But the experience broke Bongani. Depressed, he twice turned to the University with the request to resign. The University itself was grappling with major crises, including the fallout from #FeesMustFall. Acting in good faith and in recognition of his unique talents, the University declined his resignation, but then set about establishing a senior post for him to lead research in the university. Alas this was not to be.

A natural human response is to examine what went wrong and how to prevent similar future events. Guilt and blame are part of this process. A #FeesMustFall activist has sought to scapegoat the University, blaming it for not supporting Bongani, but the activists themselves have come under fire for their role.

Bongani's death has also sparked a further national conversation about the devastating effects that depression has on many people and about the lack of sympathy and the stigma that often accompany this affliction. When someone takes their life, we are also likely to feel guilty about our inability to fully understand the significance of the condition, and about whether we might have been able to be of greater assistance.

The post of Dean in the FHS is unlike others in the university.When, as in Bongani's case, the Dean is appointed from within the academic ranks, the vacated post of the appointee is filled by another permanent appointment. There is therefore no going back if and when the Dean's tenure is terminated, which is a major impediment for someone who may wish to return to teaching and research. I have some personal experience in this regard. When I was appointed Dean of the FHS some years ago, I was aware of this situation and was willing to take the risk as a 'career dean' as opposed to a shorter-term model. However, shortly after my appointment to a second term, the newly appointed vice-chancellor pressed for my removal as she did not want to go into this century with white deans. Not to leave me in limbo, the post of 'Dean Emeritus' was invented to accommodate me. Despite new opportunities in the post of Dean, for Bongani the more immediate reality of taking distance from his greatest passions – teaching and research – must also have weighed heavily when he was appointed.

There have been calls for an investigation around Bongani's death. However, that is unlikely to provide further useful insight, as we have no access to what must have been his troubled mind. He had been caught up in the vortex of a perfect storm – alienation of students and academic colleagues who challenged his core values; the destruction caused by #FeesMustFall; and the perceived lack of support from his university. It has been said that the closest we can get to immortality is to have influenced others to the good. Bongani achieved this handsomely. It would be more fitting now for us all to reflect on how to promote his vision for improving health for all, and especially for the poor. ■

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TRIBUTE

Yes, we did fail you Bongani Mayosi

Nonhlanla Khumalo

Nonhlanhla Khumalo, wife of Bongani Mayosi, paid this tribute to him at his funeral.

The Harvard Business School offers a prestigious Advanced Management Program. This Program aims to 'empower senior executives with the analytical skills and cross-function- al perspective to drive performance across domains, industries, and borders'. Bongani attended the Program (which he called 'an MBA on steroids') during his sabbatical leave from the University of Cape Town (UCT) in 2016. He was part of a class of over 150 chief executive officers and other top executives from more than 20 countries. When I heard that this distinguished class had chosen Bongani to be the one to give the graduation speech, I said to him 'Hayi Rhadebe it is clear, the whole world agrees that you are exceptionally smart.' He smiled and with that twinkle in his eyes said 'Bonanje mfazi these are all clever business people, the only reason they chose me was because I was brave enough to ask stupid questions.'

Such was the humility of Bongani Mayosi, who I first met when I sat next to him in a bus on the first Friday of orientation at the then University of Natal Medical School in January 1983. At the time he was only 16 years old, having achieved the highest marks in the matric examinations of the Independent Transkei at the tender age of 15. Indeed, our conversation started on that tour bus and ended 35 years later on that catastrophic day of 27 July 2018.

When I met Bongani, I was an idealistic, conservative 17-year-old girl who believed that having a boyfriend at university could put my academic success at risk. But in spite of my resolve, I found Bongani's charm, humour and intelligence irresistible. Our daughters once asked me how he had proposed to me. No doubt they were thinking of a romantic setting, flowers, and ring held out with him on bended knee! They laughed when I told them that I don't even remember where we were: he simply asked what the lobola process was in my family. In fact, he asked about lobola (the process of asking a family for a bride's hand in marriage) not once but twice. First when he was 18 and I 19 years old; at that time my mother expressed displeasure, adding that '…' you went to university to get a degree, get the degree first then talk about getting married'. The second time was when we were more mature, aged 22 and 23 years, with our graduation a few weeks away – and our parents could no longer refuse.

I have had the privilege of watching very closely Bongani's unique handling of various situations. He was delighted at becoming a father for the first time. But when I suggested a second child, he asked why anyone would choose to write the same examination twice – implying that the pregnancy and birth were like an exam! In spite of this, he did agree to a second child, who became the apple of his eye. He also relished the opportunity to adopt a teenage girl when so many would shy away from such a prospect. With no unfulfilled desire for a son, he demonstrated selfless love to his daughters and inspired self-confidence in them and in the many girls who called him Uncle Bongani and spent countless weekends at our home.

Every beggar who approached Bongani would be spoken to with respect. However, how much money they got depended on what they said: they got just a few coins if their request was nonspecific. I can't tell how many times I anxiously watched Bongani open his wallet, exposing all his money, to give away the exact ten or twenty Rands he was asked for. Interestingly, not once did anyone grab the wallet and run. I think the beggars were so surprised by his kind response to them on these occasions that stealing from him was not an option.

I have watched his excitement at the discovery of potential in a student and his search for funding to develop it. When so many of his comrades in the 1990s personally gained company shares from 'black economic empowerment' initiatives and became wealthy, Bongani was instrumental in motivating that these shares should rather be used to establish various funding streams for clinicians to do PhDs. He talked often about the need for a critical mass of the brightest African clinician scientists to solve Africa's health problems.

Much has been spoken and written about Bongani's achievements. One little-known fact is that when we were in Oxford as a young family, he and I entered the inter-college Cuppers Competition for dance sport as part of the Wolfson College team. We danced the 'quick step' and, yes, we were the only couple that had children in the audience. Our daughters were screaming our number '119' at the tops of their little lungs. The Wolfson College dance team made history that day by winning the Cuppers for the first time ever. I suspect that the screams of innocent children won the day for us. Bongani would update his CV with the entry of this win that night and refuse to go to further dance classes. When I protested, he simply asked whether there was any chance that we could achieve a higher accolade in ballroom dance. When I said no, he smiled and gave me a hug before moving on to something else.

In recent months some have spoken about Bongani's inability to cope with administration. Let's not forget that in order to fulfil his many national and international roles, to achieve the meteoric rise in the number of publications, the amount of funding and staff compliments during his 10-year tenure as Head of the Department of Medicine, Bongani had to be a pretty good administrator. He was not satisfied with his excellent achievements in medicine.

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TRIBUTE

We did fail you, Bongani continued from p5

He returned from Harvard refreshed and enthusiastic with a vision for the faculty. Bongani, you could not have been ready for what awaited you. Before you could develop a relationship with your team, within the first week of your deanship your office was occupied by protesting students. They sent lists of demands and messages to your private cell phone at all hours of the day and night. I watched you increasingly lose sleep and become edgy. It was not so much what they called you but how they made you feel. Children you cared for deeply treated you as an enemy. 'Staff for social justice' alienated you in a popularity contest you never signed up for, as if your entire being was not for justice. Senior academics criticised and blamed you, as if your very heart did not beat for academic excellence. Something in you shifted. The university neglected you, and when you tried to leave used your high sense of duty, encouraging you to stay. Maybe if your request for sabbatical leave had been processed in time things would have been different. I remember that when you started counselling, you asked that I should come in and we were advised that only the patient was counselled. A case should be made for the next of kin to be present in counselling sessions (as long as the patient consents). Inclusion might have helped me get a better sense of how severe the depression was. I know now that you hid most of your pain from me. I am so sorry – I too failed you Bongani, so busy and excited with my own projects. And on that last day I hurried off without lingering when I kissed your soft lips or looking into your eyes …

I can't remember the sad occasion, but Bongani once told me a story that as children he and his brother Sipho were once sent to fetch milk that they both carried in a large container. He said he did not remember how the milk got spilt, but they helplessly watched it sink into the soil. They were horrified, and afraid of the consequences. He then ended by saying 'Don't cry over spilt milk, Nhlanhla, instead learn from the experience to make sure it does not happen again.' He would mention the spilt milk analogy over the years as a useful tool to move one from the paralysis of regret.

When he was born he was called Bongani Mawethu. Bongani means 'give thanks' and Mawethu means 'our community'. When he became a man he was called Jongilizwe, one who looks after the nation or the world. Bongani fulfilled the prophesies of his names. He had a genuine interest in people, all people – just look at his research group and the many who love him the world over. Bongani was a 'servant leader' who lived out his love for us. If we really want to perpetuate his legacy, we will find ways to fund the production of a critical mass of highly skilled African clinician scientists to solve Africa's health problems. We will find 'our community spirit', 'the Mawethu Spirit', in us. This is the spirit that says 'I see you, I acknowledge you and even when I disagree with you I will not insult or humiliate you.' While there may be many academic lessons, the 'Mawethu Spirit' is to me the core human lesson from Bongani Mayosi's kind, positive, enthusiastic and generous life.

Bongani did not have a mean bone in his body. He was not vindictive or judgmental, and forgiveness came spontaneously to him.

Yes, we did fail Bongani Mayosi. Let's emulate his example as a tribute. Let's embrace 'the Mawethu Spirit'.

As we leave this place:

Let us calmly reflect and learn

Let us forgive each other and ourselves

Let us commit to fight injustice and division

Let us lift as we rise so that we can soar the heights of excellence – as UCT, South Africa, Africa and the world.

Let us embrace the Mawethu Spirit:

I see you, I hear
you even when I
disagree
I will not insult or humiliate you, all humans, even the brightest have fragile spirits that thrive when respected
I will respect your humanity
I will lift even when I want to rise.

Lala ngoxolo eNkosini sithandwa sami
Rest in the Lord's peace my love

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Bongani Mawethu Mayosi

28 January 1967 - 27 July 2018

Mark Sonderup

Look not mournfully into the past, it comes not back again. Wisely improve the present, it is thine." Henry Longfellow

Much has been said and written about the extremely untimely death of our highly regarded, valued and respected colleague, friend and mentor, Bongani, who so tragically left us in July 2018.

Bongani was a true son of the Eastern Cape having been born and schooled there. His undergraduate training was at UKZN but he returned to the Eastern Cape and completed his Internship at Livingstone Hospital in Port Elizabeth. From here he ventured to Cape Town to do a SHO job and later became a medical registrar at Groote Schuur and UCT. My first recollection of Bongani was as an

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Bongani Mawethu Mayosi

Bongani Mayosi continued from p6

undergraduate student encountering him as a medical registrar. As a medical student I distinctly remember him for his acuity if not also for the fact that he always wore a tie and the crispest of white coats!

Bongani became HOD of Medicine at UCT/GSH in 2006 after Ralph Kirsch retired and here I would meet Bongani again. Bongani appointed me to my job when I re-joined the Department at GSH in early 2007 and had the privilege of being in his Department until he moved to the Deanship in 2016.

My perspective on Bongani was of a man that truly led by example. Being HOD is never easy as there are many conflicting demands and interests. However I saw him navigate these effortlessly given a central tenet of his personality and approach viz. The "what is the solution?" approach to issues. When we would meet to discuss issues about the General Medicine Division, he would ask me for my advice or solutions to problems. After discussion we would arrive at them. Given his solution-focussed approach, I always suspected that he already had the solution but would engage in such a manner that you felt like it was your idea that solved the issue!

In keeping with his personality trait, his research focus was equally solution oriented. His research gravitas has been well documented in other writings. What needs mentioning is that it predominantly centred on issues that affect the poor and vulnerable in society, notably in Africa and specifically South Africa. His roots in the Eastern Cape pointedly drove him to raise the many cardiovascular diseases plaguing the developing world. His work answered many question – hitherto unanswered – ranging from rheumatic fever and valvular heart disease to his seminal work on TB pericarditis and idiopathic cardiomyopathies. This work has fundamentally changed medical practice both in Africa and the world. He fervently believed in the capability of Africa in driving its own development in research and its research agenda in pursuit of answers and solutions to its problems. He figuratively put his money where his mouth is in terms of supporting research endeavours as well as setting up research groups in other countries where none such existed. He wanted South Africa and the continent to take its rightful position in the world with respect to high quality research output that centred on African problems. It was a matter of thinking, functioning and developing locally and acting globally.

We had the pleasure of him as our SAMA Branch President (Cape Western branch) in 2014. His presence at branch meetings was welcomed and his valedictory branch presidential function was legendary for the vast number of people who attended and its location in Blouberg.

Personally, I'll miss our informal discussions in the passage and his confirming presence at Departmental events such as Research Day. Here at the centre of clinical and basic science research in our Department he seemed at his most content and delighted in the enthusiasm of the day. I'll miss just shouting "Mhlekazi, kunjani" down the passage when I saw him. His seemingly always-confident demeanour and happy exterior, of late, was shielding us from his inner conflicts. The events of late 2016 at our and many other Universities, was an exceedingly difficult time for many. However few appreciated the toil it took on him. Several tried to speak out and support, but were stifled by the fiend of identitarianism and identity politics. The events of 2016 took their toll and many who claim triumph are blissfully unaware of the Pyrrhic victory that it actually was. Like Bongani, many were already in the corner of those fighting for the cause, but were wistfully and abruptly labelled an adversary. Perhaps some will learn that vehement actions have consequences.

In 2017, at the memorial for the late Professor Denise White at the Health Sciences Faculty, Bongani sat in the front row as I read a piece from John Gillespie Magee Jnr's poem High Flight. Afterwards he asked me about it as he thought it poignant and "hit the right note" as he put it. It seemingly did and does once again, I'll leave it here.

Oh! I have slipped the surly bonds of Earth
And danced the skies on laughter-silvered wings;
Sunward I've climbed, and joined the tumbling mirth
Of sun-split clouds, — and done a hundred things
You have not dreamed of — wheeled and soared and swung
High in the sunlit silence. Hov'ring there,
I've chased the shouting wind along, and flung
my eager craft through footless halls of air ...

Up, up the long, delirious burning blue
I've topped the wind-swept heights with easy grace
Where never lark, or ever eagle flew —
And, while with silent, lifting mind I've trod
The high untrespassed sanctity of space,
Put out my hand, and touched the face of God.

Lala ngoxolo Rhadebe. Sizodibana kwakhona kwixesha elizayo.

HISTORY

The first black doctors and their influence in South Africa

Bongani Mayosi

Prof. Bongani Mayosi was Head of the Department of Medicine at Groote Schuur Hospital and the Faculty of Health Sciences, University of Cape Town, South Africa. He qualified in medicine from the University of KwaZulu-Natal in Durban, trained in internal medicine and cardiology in Cape Town, and graduated with a DPhil in genetics from Oxford University. His research interests included the genetics of cardiovascular traits, treatment of tuberculous pericarditis and prevention of rheumatic fever.
Corresponding author: B M Mayosi

The early black doctors who qualified from foreign medical schools between 1883 and 1940 were pioneers in the history of South Africa. They made seminal contributions to the struggle against colonialism and apartheid, established the principle of fighting against racism in healthcare through the courts, and were trailblazers in academic medicine. They have bequeathed a remarkable legacy to the new South Africa.

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Before 1940, there were no opportunities for training in medicine in South Africa (SA) for people who were not white. The University of the Witwatersrand (Wits) took the first black medical students in 1941, and was followed shortly by the University of Cape Town (UCT). Before 1940, training was possible overseas either through funding from the church for many black Africans or from family resources for coloured and Indian South Africans.

Early black medical doctors

William Anderson Soga was the first black medical doctor in SA. He was the son of Tiyo Soga from Tamarha near Butterworth in Transkei, who was ordained as the first black SA minister of religion in the United Presbyterian Church of Scotland on 10 December 1856. Soga qualified in medicine from Glasgow in 1883 – about 30 years before the creation of the medical school in Cape Town, and 60 years before UCT and Wits considered black people fit for admission to their hallowed halls. Let us not forget that UCT practised a pernicious form of racism in which local black African students were not admitted to study medicine until about 100 years after Soga's graduation from Glasgow.

Like his father, Dr Soga was ordained as a minister (in 1885). He was licensed to practise in the Cape from 1890, and worked as a medical missionary at the Miller Mission in Eliotdale, Bomvanaland. He started private practice in the same area in 1904 and worked there until his death in 1912.

Soga's example was followed by John Mavuma Nembula, who graduated with the degree Doctor of Medicine from Chicago in 1887, and Abdullah Abdurahman, who earned the Scottish Triple in 1893.

Nembula was born in Amanzimtoti, Natal, and educated at Adams Mission Station before he was taken to the USA by American missionaries to translate the Bible into Zulu. He commenced practice as a district surgeon at Umsinga in 1889 and ran a multiracial practice in nearby Pomeroy. He died of tuberculosis in 1897 at the age of 36.

Abdurahman practised in Cape Town between 1895 and 1929. During this time, he fought for better living conditions for black people as a Cape Town city councillor. His daughter Cissie married Abdul Hamid Gool, who qualified as a doctor from London in 1910, and his brother Ismail Abdurahman qualified as a doctor from Glasgow in 1915. Another daughter, Waradea Abdurahman, became the first black woman to qualify as a doctor in SA (Glasgow, 1927).

The dynastic tendency of the first generation of black doctors was also evident among the Sogas. Alexander R B Soga, son of William Anderson, became the seventh black doctor in SA (Glasgow, 1912). Alexander Soga started his practice in Eliotdale, where his father had worked, and subsequently established a private practice in Idutywa in the Transkei.

The next generation

Whereas only three black doctors had qualified in the final 20 years of the 19th century, there were 29 who qualified from UK and US medical schools between 1900 and 1940, including luminaries such as James Moroka (Edinburgh, 1918), Silas Modira Molema (Glasgow, 1919), Alfred Bitini Xuma, with dual American (1920) and Scottish (1926) qualifications, Monty Naicker and Yusuf Dadoo (both Edinburgh, 1934). Moroka and Xuma became successive presidents of the African National Congress (ANC) in the 1940s and have suburbs in Gauteng named after them – Kwa Xuma in Springs and Moroka in Soweto. Naicker revived the Natal Indian Congress (NIC), and Dadoo was initially the president of the Transvaal Indian Congress (TIC) before he became a leader of the South African Communist Party.

Political contributions

The first generation of black doctors made seminal and lasting contributions in at least three areas. The first was their political contribution to the non-racial struggle against apartheid. The famous 'Three Doctors' Pact' bears testimony to their foundational role in the new SA. A 'Joint Declaration of Cooperation' was signed by Xuma, President of the ANC, Naicker, President of the NIC, and Dadoo, President of the TIC, on 9 March 1947. The Doctors' Pact was significant: it provided the basis for unity among Africans and Indians and the principle of non-racialism that was to define the anti-apartheid struggle from the 1950s onwards, and the call for 'a vigorous campaign to be launched immediately' inspired the Defiance Campaign of the early 1950s that signalled the change in the tempo of the anti-apartheid struggle from a series of deputations to the Queen pleading for mercy to direct political action against unjust laws. The irony of the change and radicalisation of the anti-apartheid struggle is that Moroka and Xuma were faced with a stark choice between political activism carrying the risk of imprisonment, and the continuation of their lucrative medical careers. Indeed, during the Defiance Campaign, Moroka was to testify against his comrades in the ANC and escape prison. Nelson Mandela said that Moroka 'was unwilling to jeopardise his medical career and fortune for his political beliefs'.

Xuma also fell on his sword. He opposed the 1949 Programme of Action of the ANC Youth League, which envisaged a campaign of mass mobilisation, and resigned from the ANC, continuing to practise in Sophiatown. Mandela commented that 'his medical practice took precedence ... he made it clear that he was a doctor with a wide and prosperous practice that he would not jeopardise by going to prison'.

There was, however, a new generation of black doctors who had qualified from Wits in the 1940s and 1950s, such as Wilson Conco, Dilizintaba Mji, Ntatho Motlana and James Njongwe, who joined Mandela in the Defiance Campaign and pursued the new radical agenda of the ANC, thus taking over the baton of political leadership from the first generation of ANC doctors.

Molema's story represents the second major contribution of the early black doctors to our history. He commenced practice in Mafikeng in 1922, and ran a subsidiary practice in Johannesburg. He had a multiracial practice and observed the custom of the time that provided for separate entrances for white and black patients. Molema's practice of liberally prescribing medicine (much liked by his black patients) also found favour among Afrikaner patients, who referred to him as 'die dokter van die groot bottel' (the doctor of the large bottle).

In 1927, an incident occurred that I believe was the trailblazer for the health-for-all campaign in SA. White nurses resigned after Molema admitted some of his white private patients to Victoria Hospital in Mafikeng. He did not take this affront to

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The Tim Noakes Saga

Marika Sboros & Alastair Millar

By one definition, a saga is "a long story of heroic achievement". This may be a most apt description of what Tim Noakes and his family have been through over the last four years.

The appeal by the Health Professions Council of South Africa's team in the trial of Prof Noakes on a charge of unprofessional conduct for a single tweet has been finally quashed.

"The argument of the Appellant (HPCSA) that the Respondent (Prof Noakes) provided unconventional advice of breast feeding babies is not persuasive and is rejected. Wherefore, it is the unanimous decision of the members of the appeal committee that the appeal be dismissed".

So reads the judgment, issued on Friday June 9, 2018, of the HPCSA's Appeal Committee.

In August 2017, in the Cape Doctor, Prof JP van Niekerk superbly summarized the events leading up to the trial and some of the consequences of the outcome. With the failure of the appeal, finally after nearly four and a half years, this sorry saga seems to have ended.

However, should it indeed end here?

There are so many threads to this rather dark tale of what can truly be called intrigue. There are all the usual suspects of relationship loyalties, stretching back decades in some instances, professional jealousies and of course money, in the form of big pharma and the sugar industry and in the case of the latter, one cannot but wonder whether some of the main players accusing Prof Noakes, were indeed "captured" to serve their benefactors?

Thus, one should question the motivation for senior members of the Faculty of Health Sciences (FHS) to write the letter to the Cape Times (see more below), which was not formally endorsed by anyone else in the FHS but only by the 4 signatories, the Dean, the Professor of Medicine, a retired but prominent cardiologist and the head of dietetics and nutrition. The letter purported to be prompted by concern for the health and wellbeing of patients but seemed really aimed at undermining Prof Noakes' academic credentials and reputation.

What prompted the formal complaint on the tweet that only reiterated dietary guidelines supported by the person who made the complaint to the HPCSA and the very same organization she represented?

Why was the complaint of unprofessional conduct supported by past senior FHS members for the HPCSA to proceed and charge Prof Noakes?

Lurking in the shadows behind all this were Big Pharma and those with vested interests in the sugar and cereal food industries. The precipitating event seems to have been when Prof Noakes was invited to speak to Parliament's Wellness Group. He spoke about the benefits of low-carbohydrate, high-fat (LCHF) eating as one way of combating South Africa's obesity and type 2 diabetes epidemics.

One should emphasize that this "campaign" against Prof Noakes which amounted to academic mobbing, was tacitly supported by the UCT hierarchy. The letter to the Cape Times must have been seen and endorsed by the UCT Vice Chancellor at the time, for it to have gone forward to publication.

What is disgraceful is that the University chose to publicly disown one of its most prominent, productive and indeed renowned NRF, A rated scientists with an h index of 71 and more than 16,000 citations, who over his many years at the UCT had contributed hugely to the financial and material benefit of the institution. Prof Noakes, in taking a strong position on the LCHF diet had indeed challenged the FHS to scientifically test the efficacy of a dietary intervention, which could have an enormous potential for health benefit. The FHS chose not to take up this challenge. Was he now considered a liability?

Prof Noakes' promotion of the LCHF diet plan has had a hugely beneficial effect on the health of a great many of those in need of help, who have enthusiastically adopted it. There is no doubt that the ketogenic LCHF diet has a very significant role to play in addressing not only specific disease states, such as insulin resistant diabetes, epilepsy and potentially many other conditions from infertility to depression but also on a much greater scale against the so-called "syndemic" of malnutrition and obesity, which are devastating the people of this continent of Africa.

Prof Noakes, having been totally vindicated in the trial on all counts, has yet to receive any public acknowledgement from the UCT FHS of this vindication or any private or public apology.

One of the extraordinary aspects of the vitriolic antagonism to some of Prof Noakes' statements on the effects of the LCHF diet and his opinion on the lack of benefit from statins and the lack of evidence of the cholesterol causation of atherosclerosis and heart disease, is how rarely have individuals confronted him in private or public debate.

The Health Science Faculty has been in turmoil since even before the tragic death of its Dean, Bongani Mayosi, one of its brightest stars, and the resignation, retirement or absence on sick leave of some key leaders within the Faculty, as well as important supporting staff in the Deanery and has rightly asked for an in-depth review with a view to possible restructuring. There is the expectation that much good will come of this.

However, the role of the major players within South African academia, the HPCSA and in the organizations related to dietetics in hounding Prof Noakes has still to be fully explored.

Marika Sboros, an investigative journalist and co-author of Noakes' book, Lore of Nutrition, Challenging Conventional Dietary Beliefs, gives a startling exposé on the-behind-the-scenes intrigue that tried to malign and discredit one our most remarkable and esteemed colleagues.

Alastair J W Millar
FRCS FRACS (Paediatric Surg) FCS(SA) DCH
Emeritus Professor of Paediatric Surgery

Written in my private capacity by invitation of the editor and as a supporter of the huge need for dietary improvement of South Africa's predominantly young population.

Now that the medico-legal dust has settled on the curious case of the Health Professions Council of South Africa's hearing against Prof Tim Noakes it leaves many lessons in its wake for medical doctors.

The case ended in a complete vindication for Noakes, first after the HPCSA's own Professional Conduct Committee ruled him not guilty in April 2017, on all 10 aspects of a charge of unprofessional conduct – that arose from a single tweet Noakes made in 2014. He was vindicated again after the HPCSA's appeal committee confirmed the not-guilty verdict in full in June 2018.

Perhaps the most disturbing of lessons still to be learned is that the dark art of academic bullying is alive and well in South Africa. Also known as academic mobbing, the HPCSA hearing showed that it reaches deep into the heart of all of this country's top universities – and at the highest levels.

The University of Cape Town tops the list with the most academic bullies or **Continued on p10**

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"mobsters" with Stellenbosch University a close second and the University of the Witwatersrand and North-West University not far behind.

Just as disturbing is the deafening silence from all the universities involved that continues to this day.

Noakes has called it an omertà – the oath of secrecy that Mafia members swear not to reveal details of their criminal activities or to co-operate with the police. The comparison with organised crime is not inappropriate or even hyperbolic in this case.

The evidence for an omertà and the mobbing is on public record in the hearing transcripts and documents. It is also documented in in Lore of Nutrition, Challenging Conventional Dietary Beliefs, published by Penguin 2017 (of which I am privileged to be co-author with Prof Noakes).

Among distinguishing features of the mobbing of Noakes is how organised it was; how many medical doctors and dietitians were involved; how many professors of one medical discipline or another participated; that deans of medical schools and even vice chancellors were involved;

All because they disagreed with his scientific opinions on diet and nutrition. Actually, not just on diet and nutrition but also food as medicine, as an alternative to drugs to treat and prevent obesity, type 2 diabetes and heart disease. Even that's not all. One of the biggest triggers for mobbing Noakes has proved to be his opinion on statin drugs and the diet-heart hypothesis that saturated fat causes heart disease, on which the blockbuster, billion-dollar drugs rest. Noakes shares the evidence-based opinion with many cardiologists and cardiovascular researchers worldwide that the diet-heart hypothesis is not evidence-based. That's a message that infuriates cardiologists who support conventional "wisdom" on cholesterol and the drug industry that continues to profit massively from it.

Of course, cardiologists and others have the right to hold and express opinions differing from Prof Noakes. Just not to try to mob, discredit and destroy him for holding those opinions.

The grim reality of academic mobbing is it is not restricted to South African universities. It is a global phenomenon of academic "hit jobs". The consequences can be fatal, as the tragic case of Canadian neurology and neurosurgery professor Justine Sergent at McGill University showed. Sergent's colleagues started mobbing her in 1992. In 1994, she and her husband were found seated next to each other in their car in a suicide pact, dead from carbon monoxide poisoning.

Last year, former poet laureate of Canada Brad Cran wrote an article on academic mobbing in (an influential website offering a “platform for free thought”), headlined The Academic Mob and Its Fatal Toll. It's a riveting, disturbing read that includes the work of Canadian Kenneth Westhues, an internationally recognised authority on

Tim Noakes

academic mobbing and an emeritus professor of sociology at the University of Waterloo professor emeritus of sociology.

Westhues : “[A]n impassioned, collective campaign by co-workers (or academic colleagues in this case), to exclude, punish, and humiliate a targeted worker. Initiated most often by a person in a position of power or influence, mobbing is a desperate urge to crush and eliminate the target.

“The urge travels through the (academic institution) like a virus, infecting one person after another. The target comes to be viewed as absolutely abhorrent, with no redeeming qualities, outside the circle of acceptance and respectability, deserving only of contempt.

“As the campaign proceeds, a steadily larger range of hostile ploys and communications comes to be seen as legitimate.”

He could have been writing about the mobbing of Noakes.

Noakes never came close to contemplating suicide – but that's more by luck than good judgment on the part of the academic mobsters. The many distinguishing features and extent of the mobbing of Noakes gives it the dubious distinction as one of the most egregious examples of the ugly phenomenon globally, to date.

Noakes has written and spoken eloquently of his despair and distress at the treatment colleagues and peers meted out to him. He describes it as "unfathomable cruelty" that took him to "some very dark places". He has felt particularly betrayed by UCT, his alma mater, a university he served with distinction for decades. Were it not for the love and support of his family, particularly his wife, Marilyn, friends and the few brave medical doctors who did speak up for him, Noakes might not have survived the mobbing relatively unscathed as he was able to do.

So, it is disturbing – or should be – for doctors to know just how many of their colleagues ganged up on Noakes. And that leaders of their voluntary association, the South African Medical Association (SAMA) were also involved. After all, the medical profession, by definition, is supposed to be a caring one. There was nothing caring about how so many prominent medical doctors went after Noakes in organised gangs, attacking him.

Dr Max Price, VC of UCT at the time, has dismissed the mobbing throughout as "robust scientific debate" to which UCT was committed. It's hard to see anything robust or close to scientific "debate" in attempts by so many academics to eviscerate Noakes' distinguished career and scientific legacy built up over decades.

Among the many distinguishing features of the mobbing is how many lay at its heart (pun intended). They made it open season on Noakes with their "open letter" published in the Cape Times in 2012. In it they accuse him of going against the Hippocratic oath, of being a cholesterol "denialist" and a "danger to the public" – all without providing any evidence.

The authors were Patrick Commerford, at the time professor of cardiology and head of the cardiac clinic at UCT and Groote Schuur Hospital, Mpiko Ntsekhe, of the cardiac clinic at UCT and Groote Schuur, Dirk Blom, of the lipid clinic at UCT and Groote Schuur, David Marais (of chemical pathology and clinical laboratory services at UCT's Health Science Faculty), and UCT-trained Cape Town cardiologists Elwyn Lloyd and Adrian Horak.

They accused Noakes of going against the Hippocratic Oath, and being a cholesterol "denialist" and a "danger to the public". Johannesburg cardiologist Dr Anthony Dalby is also on public record calling Noakes' views on statins and cholesterol "criminal".

One would think that, given their elevated status and knowledge base, at least one of these experts would know that before it is possible to claim that cholesterol causes heart disease, there must be evidence for a clear and consistent relationship between cholesterol and heart disease. Noakes joins many other reliable scientific voices across the globe who say that if there is such a relationship, the evidence actually shows that it is inverse: in other words, "high cholesterol is associated with lower heart disease and vice versa".

Two years later, more UCT academics followed suit in another open letter to the media. The authors of the now infamous 2014 "" were: Prof Wim de Villiers, dean of UCT Faculty of Health Sciences, now rector and vice-chancellor of Stellenbosch University, Prof Bongani Mayosi, (now deceased) head of UCT Department of Medicine and later dean of the Medical School, Prof Lionel Opie, emeritus UCT cardiology professor, and Dr Marjanne Senekal, associate professor and head of UCT Division of Human Nutrition. Mayosi died by suicide last year after battling depression but also after relentless mobbing by UCT students that may very well have contributed to his premature death.

In that letter, the authors claim that Noakes was making "outrageous, unproven claims about disease prevention" – without providing any evidence to support their claims. An email chain of correspondence shows that one of the main drivers of the letter along with Senekal was UCT Health Science Faculty's communications and marketing manager Linda Rhoda, wife of UCT Council member advocate Norman Arendse.

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Senekal's conduct is another distinguishing feature that makes the mobbing so egregious: Despite being Noakes' colleague in UCT's Health Sciences Faculty, later became a consultant to the HPCSA against him in November 2015. That was once it became clear that terminal wounds were opening up in the case against him. UCT has stayed mum on the ethics or appropriateness of that.

Senekal was also a co-author of a controversial study published in the PLoS One journal in 2014 known as the Naudé Review, after lead author, Dr Celeste Naudé, nutrition academic at Stellenbosch University. Another co-author is Stellenbosch Dean of the School of Medicine and Faculty Health Sciences Prof Jimmy Volmink, a UCT graduate.

Noakes and British public health researcher Dr Zoë Harcombe published their own analysis of the Naudé Review in the SAMJ in December 2016. They found it to be so riddled with errors and design flaws as to undermine the conclusions. Noakes and Harcombe stopped short of accusing the Naudé Review authors of "scientific fraud". Instead, they asked whether so many eminent researchers committed many honest mistakes or "mischief"?

That question and calls for retraction of the study remain unanswered.

Volmink's involvement in the mobbing is also significant and mirrors that of another of his friends, UCT graduate Prof Jacques Rossouw, now with the National Institute of Health (NIH) in the US. Both are staunch critics of Noakes and took part in the so-called UCT Centenary "Debate" in December 2012. It turned out to be not so much a debate as a mobbing exercise, a kangaroo court aimed at humiliating Noakes and discrediting his views in public on diet and statins.

Rossouw came close to giving expert witness against Prof Noakes at the very last minute in the HPCSA's case but failed to turn up on the day of the penultimate hearing in February 2016. Rossouw declined to answer emails on why he made the dramatic turn-around. All the NIH would say is that it "could not give him permission in time" to be a witness. Yet Rossouw was in Cape Town visiting friends in late January 2016, among them UCT professor of medicine Krisela Steyn whose research involves highlighting the increasing burden of chronic diseases and their risk factors in developing countries.

Steyn's friend is UCT clinical endocrinologist and diabetologist Prof Naomi "Dinky" Levitt, who heads the Division of Diabetic Medicine and Endocrinology at Groote Schuur Hospital. Levitt has been integrally involved in the development of guidelines for patients with diabetes nationally, regionally and internationally over the past decade. Her antipathy towards Prof Noakes is no real surprise, since his research and evidence-based opinions on best treatment options for diabetics are diametrically opposed to hers.

Both Steyn and Levitt are on public record attacking Noakes and his scientific opinions.

Another distinguishing feature of the mobbing of Noakes is that in the case of Rossouw, it is very much a family affair. His son, Jacques Rousseau (sic), a junior lecturer in UCT's Commerce faculty, has to date written more than 30 vicious blogs attacking Noakes and accusing him of practising "pseudoscience" – despite not being a scientist or having any qualification in nutrition. (Spelling his last name differently from his father helped hide his connection with his father for a few years.)

And while it's hard to single out the most shocking of the many disturbing distinguishing features of the mobbing, it's hard not to see the conduct of Wits University head of medical bioethics Prof Amaboo "Ames" Dhai, of all people, as especially disturbing.

It is common cause by now that the HPCSA charged Noakes with unprofessional conduct for a single tweet saying that good first foods for infants are LCHF (low-carb, high-fat). And that his tweet so "horrified" Johannesburg dietitian, Claire Julsing Strydom, that she reported him to the HPCSA within hours.

Anyone who knows anything at all about LCHF for infants knows that it means meat fish, eggs, chicken and dairy. That opinion also aligns perfectly with South Africa's paediatric guidelines as well as international paediatric guidelines, as Strydom and the HPCSA's own expert witnesses conceded under cross-examination. Strydom also conceded that she dishes up the same advice to clients these days. So does the Association for Dietetics in South Africa (ADSA), of which she was president when she first reported Noakes to the HPCSA.

Dhai chaired the HPCSA's Fourth Preliminary Committee of Inquiry – its first port of call when considering complaints against medical practitioners. (Fourth denotes the HPCSA's committee comprising medical doctors.) On the committee with her were UCT surgery professor John Terblanche and psychiatry professor Denise White (now deceased) – all were or had been SAMA office bearers.

The task of the committee was simple enough: consider Strydom's complaint, give Noakes an opportunity to respond and then decide whether the HPCSA should charge him and if so, with what. Thereafter, the committee members were functus officio – the legal term for "their job was done". In other words, they should have taken off their HPCSA hats and gone back to their day jobs as medical academics. Instead, Dhai and Terblanche put on their thinking caps to indulge in what Prof Noakes' legal team has called "highly irregular conduct". That's a euphemism for highly unethical conduct, according to the HPCSA's own rules as laid down by the Health Professions Act.

Dhai did give Noakes an opportunity to respond but appeared not to like his response. However, she had no evidence whatsoever on which to base a decision to charge him at that stage. Therefore, instead of concluding that there was no case against him, Dhai went looking for evidence. That was her right, of course, if she genuinely believed that he was a danger to the public as Strydom was claiming. Dhai commissioned a report from the one academic she must have known was likely to write something highly critical of Prof Noakes, NorthWest University nutrition academic Prof Hester "Este" Vorster, a friend of Strydom's.

Vorster's antipathy to LCHF is well-known as are her links to the sugar industry. Vorster is also author of South Africa's high-carb, low-fat guidelines – the ones from which processed food, soft drink and drug industries continue to benefit massively. The guidelines that robust research has shown were without any scientific evidence to back them up when the US first launched them onto an unsuspecting public in 1977, and the rest of the English-language world followed suit shortly thereafter. That scientific status quo remains.

Vorster also wrote a key recommendation in the guidelines that persists to this day: that we should all "make starchy foods the basis of all meals". Vorster and her university have declined all emailed requests for scientific justification for that recommendation. Or for why she decided to become an expert witness against Noakes.

And while the hearing was supposed to be all about a tweet about infant nutrition, it quickly became clear what the real target was - apart from Noakes himself. It was LCHF for people of all ages because it represents a clear and present danger to the reputations of doctors and dietitians who have preached and continue to preach the benefits of low-fat, high-carb diets to treat and prevent chronic disease – and, of course, to the profit margins of processed food, soft drinks and drug industries that feed off conventional dietary "wisdom". It's probably no coincidence that among the ties that bind many of those involved in mobbing Noakes, including Vorster and Senekal are long-term links with a shadowy organisation called, **ILSI (International Life Sciences institute)** a front first for Coca Cola, then Kellogg's.

It is reasonable, therefore, to think that Dhai should have known that Vorster was heavily conflicted and thus not a reliable source of evidence against Noakes. Which makes Dhai's conduct thereafter more surprising – for a professor of ethics.

After she procured Vorster's report, Dhai did the unthinkable: she kept the report secret from Noakes before using it to base her committee's decision that the HPCSA should charge him with unprofessional conduct. By doing that, Dhai breached the HPCSA's own rules, Noakes' constitutional rights and the common law principle; audi alteram partem (let the other side be heard). In other words, the principle that all accused persons have the right to see all evidence against them and respond to it before being charged.

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The evidence for Dhai's conduct showed up in an incriminating series of emails that fell into the hands of Prof Noakes' eagle-eyed defence team quite by chance during the November 2015 hearing. The emails are on public record and documented in Lore of Nutrition. In one email, Dhai tells the HPCSA legal team to bring in outside lawyers because she doesn't believe they are up to the task of prosecuting him successfully (not in so many words, but that's the gist). In another email, Terblanche goes beyond his remit as a committee member to helpfully offer to secure the services of "expert" witnesses against him, including De Villiers. As it turned out, De Villiers did not give evidence against Noakes. He has declined to say whether Terblanche ever asked him and he declined - and if so, why.

With that, Dhai set off the HPCSA's hearing against Noakes and the HPCSA quickly became a vehicle for spreading even more mobbing of Noakes. The public quickly dubbed the hearing the "Nutrition Trial of the 21st Century". Others called it an "inquisition", a farce and "Kafkaesque" for the many twists and turns - and how long it took. After all, HPCSA hearings are not supposed to be adversarial. They are supposed to be "dispassionate inquiries into the truth of the matter". Legal experts have noted that there was nothing dispassionate about the HPCSA's hearing. It was adversarial from the start and became even more so once the HPCSA took on an expensive team of outside lawyers after it became clear its case had developed gaping and terminal holes. The HPCSA prosecution team was bumped up to include Cape Town medical doctor-turned advocate Ajay Bhoopchand and Johannesburg instructing attorney Katlego Mmuoe, of KK Mmuoe Attorneys.

The HPCSA appeared to have taken a leaf straight out of the book of Noakes' A-team of lawyers. On his team were instructing attorney Adam Pike, of Pike Law was Johannesburg advocate Michael van der Nest (SC) included Pietermaritzburg medical doctor-turned advocate Ravin "Rocky" Ramdass, a physician with more than 23 years' experience in family medicine.

Co-opting outside lawyers and stretching the hearing out over more than four years sent the HPCSA's costs into the stratosphere – conservatively estimated at more than R10-milliion. Noakes' legal costs would have been similarly high had Van der Nest and Ramdass not offered their services pro bono from the start – so certain were they that he was the victim of a set-up and that the case against him had no merit from the outset.

Dhai has refused all requests for comment on and justification for her conduct as committee chair, apart from to say, through Wits VC Prof Adam Habib, that she was involved in "no wrongdoing". Similarly, all the universities involved and the HPCSA refused to comment before, during and after the hearing.

The list of mobster protagonists in this strange saga is lengthy but certainly not exhaustive. In the closing chapter of Lore of Nutrition, the authors say that it is tempting to think that it is surely not possible for so many medical doctors, academics and dietitians to be out of step except Noakes. They give all the evidence to show that it is not just possible, as anything is, it is also highly probable.

The authors also speculate whether the HPCSA hearing could have happened at all were it not for the "incestuous web of UCT academics" that spread rapidly to other universities.

They are not saying that all those who mobbed Noakes are mad or bad. Some may very well be mad or bad – there are rogues in all professions. But many, if not most, probably acted out of ignorance (one would like to give them the benefit of the doubt), in thrall of their beliefs unfettered by scientific evidence – and fear for their reputations, careers and funding.

The Upton Sinclair quote is apt here: "It's difficult to get a man to understand something when his salary depends on him not understanding it."

That leads to an important last lesson for medical doctors: the unedifying reality that so few were brave enough to raise their heads above the parapet and speak up publicly for Prof Noakes. Which brings to mind a variation of Pastor Niemoller's famous poem about the cowardice of German intellectuals following the Nazi's rise to power and the purging of chosen targets, one by one:

"First, they came for the cardiologists and I did not speak out because I was not a cardiologist ... ".

Among those brave enough to speak up was UCT emeritus professor of paediatrics Max Klein (now deceased). In 2014, Klein sent a lengthy, impassioned email to De Villiers, then Dean of UCT Medical School, under the subject heading: Bias and distasteful vilification of Noakes.

Klein protested "in the strongest terms" firstly about what he saw as " the biased presentation of 'facts' on (the) web page which is the guise of informing debate is aimed at discrediting Noakes". Klein was referring to a page on UCT's website titled The Big Fat Debate that Senekal and Rousseau junior are said to have put together (neither is confirming that on the record). The web page is anything but a debate since it promotes only one side of one of the most contentious issues in nutrition science: establishment, conventional low-fat, high-carb dietary advice. Noakes' opinions and published responses to the criticisms presented on the website are still not included.

Thus, it ends up as just more proof that under De Villiers, UCT's Faculty of Health Science had indeed turned its back on open debate and freedom of academic speech, at least for some. Instead, it appeared that only information favourable to vested industry interests would be allowed on the UCT medical campus. (In Lore of Nutrition, Prof Noakes and I have drawn attention to the long-standing dependence De Villiers' career has had on the largesse of the pharmaceutical industry.)

Klein also took aim at the UCT Academics Letter in 2014. "I find the letter distasteful," he wrote. "It diminishes the Faculty's stature and credibility. That latter was ostensibly sent on behalf of the Faculty but in fact it merely expresses the personal views of the authors." To De Villiers, Klein said bluntly: "Your signature gives it a deceptive cloak of authority."

Klein ascribed the attacks on Noakes as the result of egos that had been "badly bruised" by his "temerity" as an A-graded sports scientist "nogal" (as Klein put it) to "seize the initiative in a field others see as their private reserve".

Klein went on to say that an important lesson from the history of science is that advances often come from people "in parallel fields" rather than "experts" in a particular field: "Experts have their status on the basis of past knowledge and achievement and are often too set in their ways of thinking about a problem to be able to see it in a different light."

Klein has more to say, and his email is well worth a read – especially for cardiologists. (You can find it in full on pages 105 to 108 of Lore of Nutrition.) He received no reply to his email from De Villiers. De Villiers declined to say why.

Another who braved the wrath of colleagues was GP Dr Rosalind Arland. In response to the UCT Academics' letter, she wrote a letter to the media: "As a graduate of UCT medical school myself, I owe Professor Noakes an inordinate debt of gratitude for opening my eyes to an alternative explanation for obesity which I was not taught at medical school."

Most people who criticise the Banting (LCHF) diet "don't know much about it and have not read any of the books" Noakes recommends, Arland said. She challenged all doctors to read Why We Get Fat (And What To Do About It) by Gary Taubes.

"At worst, you'll understand some of the theory and evidence behind the (LCHF) diet even if you disagree with it. At best you may, like me, also reap benefits for yourself and/or your patients."

Just as brave was UCT emeritus professor and former Dean of UCT's Health Faculty JP van Niekerk, who wrote the foreword to Lore of Nutrition. Van Niekerk made his opinion of the trial clear: It was not the "appropriate mechanism" to resolve major and complex academic debates.

He likened the HPCSA trial of Noakes to "religious persecution". He wrote: "Changing beliefs is incredibly hard, as they are fixed firmly in our limbic system and are not readily amenable to our thinking brain. Confirmation bias protects our belief from any opposing and uncomfortable facts. But a fundamental characteristic of science is to constantly challenge beliefs."

Which is what Noakes did and in response doctors and dietitians tried to destroy him.

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Tim Noakes Saga continued from p12

In the interim, many medical doctors have expressed shock at the full extent of the bullying and have apologised to Noakes in private for not supporting him.

Some have wondered why Noakes did not make the hearing go away simply by deregistering from the HPCSA as a medical doctor. After all, he had not practised clinical medicine for more than 15 years when the HPCSA charged him. The HPCSA would have had no jurisdiction over him. The HPCSA could have held a disciplinary hearing against him anyway and found him guilty. Given its behaviour throughout the hearing, and the many delaying tactics and changing of the goal posts in which it indulged, it's likely that the HPCSA would have gone that route.

But Noakes has said evading the charge was never an option. For the sake of his professional and personal integrity but also to ensure that no doctor would ever again have to face what he faced, he felt he had to face his accusers.

Still, many questions lie unanswered in just why the HPCSA so speedily took up cudgels against Noakes on Strydom's whim. And why all the universities involved have so resolutely refused to offer any apology.

There are signs that universities are slowly waking up to the dangers of academic bullying or mobbing.

Dr Fleur Howells, a senior lecturer in psychiatry at UCT, has reviewed the issue of and given a broader description of academic bullying. In a manuscript submitted for publication in 2017 (F Howells and L Ronnie, Academic gullying, Shadows across the Ivory Tower), Howells writes that there are three forms of academic bullying. The third, "social bullying", also known as relational aggression, is "the deliberate or active exclusion or damage to the social standing of the victim through, for example, publicly undermining a junior academic's viewpoint".

She identifies four key components of bullying: intent to harm, experience of harm, exploitation of power and aggression. (The conduct of the academics against Noakes neatly fulfil all diagnostic criteria for bullying.)

Australian academic Dr Jacqui Hoepner has studied the use of bullying tactics to suppress or silence dissenting scientific opinions. In a discussion with Daryl Ilbury, author of Tim Noakes: The Quiet Maverick, Hoepner disclosed her original assumption: that most cases of academic suppression or silencing arise from outside academic circles. To her surprise, she discovered the opposite: "The bulk of suppression or silencing came from within academia, from colleagues and competitors," she told Ilbury. "This suggests that the assumed model of respect and disagreement between academics is inaccurate."

Hoepner was astonished to uncover 43 different "silencing behaviours" that fly in the face of the concept of academic freedom: "Every policy and university guideline I looked at suggested that academic freedom was absolutely central to what academics do and their place in society[But] there's a real disconnect between what academics think they are guaranteed under academic freedom and what the reality is for the life of an academic."

She also discovered that the nature of these silencing attacks was "more of a personal gut response: that someone has crossed a boundary and we need to punish them. The exact motivation differed from case to case but it seemed very much a visceral response."

Typically as in the case of academic bullying of Noakes, attacks are ad hominem, with allegations such as "You're doing real harm," "You're causing confusion," and "you're undermining the public's faith in science."

Perhaps with direct relevance to Noakes experience, Hoepner said of academic bullying: "If a scientist discovers evidence that contradicts decades of public health messaging and says that data doesn't support the messaging, and that person is attacked, and publicly ... that's insane!" ■

History of Black Doctors continued from p8

decent healthcare for his patients lying down – he took legal action, and won the case for access of his patients to appropriate care unencumbered by racism.

Academic achievements

Finally, the first generation of black doctors were not devoid of academic ability. Dr William Anderson Soga was not only the first black doctor in SA, but he also wrote a Doctor of Medicine thesis after 10 years of practice in Bomvanaland. The thesis has remarkable aspects. First, it emphasised the role of climate, nutrition and housing in the genesis of ill-health among the Bomvana people – Soga foresaw the role of climate change in health and disease that has become a major subject of study and controversy in our time. Second, he wrote about the epidemiology of local diseases, including the persisting problems of rheumatic fever, tuberculosis and leprosy. Finally, he provided a mixed assessment of the effectiveness of traditional medicine, praising the methods used to treat fracture but lambasting the wily and deceptive ways of traditional diviners.

Wilson Zamindlela Conco was a promising successor to William Anderson Soga as the second black academic physician in SA. He was a brilliant medical student who qualified from Wits at the top of his class in 1948. His appointment as demonstrator in histology at Wits provoked a protest among National Party MPs that led to his demotion to demonstrator to black students only. The acquiescence of Wits to academic racism was a harbinger of the Archie Mafeje affair at UCT in 1969, and closed the doors to aspirant black scholars in our university system for decades.

A remarkable legacy

The first generation of black doctors have bequeathed to us a great example that is as relevant to the new SA as it was during their time. Rudolf Ludwig Carl Virchow, the German pathologist and politician, said that medicine is a social science, and politics is nothing other than medicine on a large scale. Our generation of medical doctors accepts the responsibility to play a public role, which may require direct political action from time to time. This we have done, for example when our politicians attempted to cut beds at Groote Schuur Hospital – such public action has ensured that tertiary medicine is recognised as a legitimate component of an effective national health system.

The courts that were used effectively by Silas Modiri have been a powerful weapon in ensuring that the government of Thabo Mbeki provided antiretroviral therapy against its own wishes, and that drug companies are forced to provide lifesaving medication at a cost that poor people can afford.

Finally, we are building on the remarkable Doctor of Medicine degree of William Anderson Soga by raising a new generation of scholars in medicine on a large scale. We have started a multitude of schemes to provide opportunities for health professionals to become researchers and scholars as good as any in the world. One ambitious project is to produce 1 000 PhDs in medicine over the next ten years. This and other plans are beginning to bear fruit, and promise to usher SA on to the high road of research and innovation in healthcare and help to overcome the formidable health problems of the people of Africa. ■

HISTORY

The History of Infertility in South Africa

Paul Dalmeyer

On the 25 July 1978 Louise Joy Brown was born, the first human to have been born after conception by in vitro fertilisation at the Bournhall Clinic in the United Kingdom.

At that time infertility and Artificial Reproductive Technology (ART) research was well advanced worldwide. In South Africa research goes back to 1978 under the enthusiasm of Prof Jan van der Merwe from The University of Pretoria and the andrologist "Old Doc van Zyl" as he was affectionately known. It was under these two academics that brought about the split of male and female infertility. Furthermore the Bournhall's success of Louis Brown, infertility research programs really got off the ground worldwide including SA.

It was due to a better academic future that "Old Doc van Zyl" moved to University of Stellenbosch and that he and Prof Willie Van Niekerk started the infertility work in South Africa in all seriousness.

The main research drive came from the Universities of University of Stellenbosch and Cape Town.

It should be noted that the first successful pregnancy worldwide was under the stewardship of Prof's Ian Johnson of the University of Melbourne. Unfortunately this was short lived for it turned out as a first trimester miscarriage.

The first IVF success by Prof's Steptoe and Edwards put further impetus to all researchers worldwide, and a very active collaboration between the two medical schools in the Western Cape was initiated in 1983, This brought success with the first South African birth of Falcon de Vos on 29 April 1984 by Prof Thinus Kruger, at the Tygerberg Hospital of the University of Stellenbosch. Further successes followed shortly by a number infertility laboratories both in the private and public sector, all as developing different fertilization techniques such as ICSI, IMSI, IVM together with gamete and embryo freezing, including gamete and embryo donation programs, which were in keeping with the best of the world.

The private sector as referred to did not lag behind, with the first successful private clinics established in Port Elizabeth and Cape Town under the Institute of Reproductive Medicine. This brought about enthusiasm throughout the country and clinics started in both the private sector as well as more in the public sector. Contrary to the rest of the world ART in South Africa was relatively well controlled and we did not see the trend that developed in the USA where over 200 clinics mushroomed and only 10% of the clinics were responsible of 90% of pregnancies. A regulatory environment was established immediately to prevent exploitation of this new medical technology.

Initially, self-inspection by those involved, earmarked the need to self-regulate before statutory regulation would be put in place. An Infertility Society was found, now known as the South African Society of Reproductive Endocrinology (SASREG) that laid down guidelines and codes of good practice. This society has become a well organised entity, affiliated with the International Federation of Fertility Societies (IFFS), on which South Africa (SASREG) has had representation for many years. SASREG has staged the 2007 Durban IFFS conference, under the chairman ship of Dr Paul Dalmeyer, with over 2000. Over the years this society has presented many international workshops and conferences in all of the aspects of our subspecialty. Furthermore it has played a pivotal role, to bring together the public, private, academic and authority sectors. We have also been able to attract international pharmaceutical firms associated with our discipline to have their annual meetings in Cape Town. Furthermore South Africa is the only country outside Europe that was earmarked to run the Winners endoscopy training course by Prof. Igno Siebert, an examination which is part of Reproductive Medicine curriculum discipline and that has become a pre-requisite for the Colleges of Medicine Certification of Reproductive Medicine.

Needless to say Reproductive Medicine needed to follow the rest of the world and become a full sub-speciality of Obstetrics and Gynaecology. The first step was to "peer" accredit a number of clinicians involved in the discipline under the grand-father clause, with a moratorium that ended in 2005. In that window period a curriculum was developed by Prof Thinus Kruger and revised by Prof Zeph V d Spuy.

With reference to the HPCSA as the regulator of Reproductive Medicine (as well as the other sub-specialties subspecialty) register was promulgated on 13 December 2004. Our qualification has still not been promulgated although submitted on 23 June 2003, resubmitted on 25 February 2016, resubmitted on 26 October 2016 and resubmitted on 12 October 2017. The CMSA has again requested promulgation of the qualification "Certification Reproductive Medicine (SA)", as per the regulations. The present situation however is that the register has been promulgated but not the qualification. We were recently advised that the HPCSA Board has approved perpetual grand-fathering and that practitioners should have 5 years of experience prior the promulgation of the speciality.

It is evident that a major part of our discipline is laboratory driven, and that the expertise that is needed to bring about success is the intense training of the embryologist. Historically the laboratory work was done by general lab technicians from general pathology labs and the handling of gametes and embryos became a specialised science. Embryology has developed to the extent that it is now an entirely academic orientated course of education, and is currently from a basic bachelor's degree up to the level PhD. This education may be read from three of the traditional medical schools.

The self-regulatory drive from our society and the regulatory promulgation of the register over the years has driven the regulators to take our discipline in their confidence and has led us to be able to review Chapter 8 of the of the National Health Act. This was done under the Chairman of Prof. Michael Pepper of the University of Pretoria, with Chapters 8 regulation of our discipline done by our Society under the chairmanship of Dr Paul Dalmeyer.

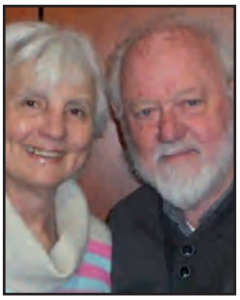
Furthermore the responsibility of data collection for ART for both South Africa (SARA-South African Registry for Artificial Technology) and Africa (ANARA-Africa Network for Artificial Reproductive Technology) has been developed by Prof. Silke Dyer of the University of Cape Town under the auspices IFFS. A function that is mandatory for the maintaining of standards of excellence on an international basis that allows these regions to measure ourselves to the rest of the world.

South Africa is recognized internationally as a country of excellence in the field of Reproductive Medicine from both clinical outcomes and research. This with a favorable exchange rate to first world currencies, a diverse sort after genetic pool makes South Africa an attractive destination for infertile couples seeking help from the rest of the world. This practical phenomena is well represented in the number of foreigners that seek help at the clinics throughout South Africa.

We can only look to a bright future of the sub-specialty in South Africa, for it does not only serve infertile couples with families as the technology improves but the development of the human genome interlinking greatly with future diagnostic and treatment technics and ART. ■

A GP in George in the 70's and 80's

Rory Dower



I qualified at UCT in 1963, did 18 months internship, O&G under Cecil Craig, Medicine under Helen Brown and Paediatrics at Red X under Pat Smythe who, with Helen Brown, had the greatest influence on any success I may have achieved in Medicine as a career.

In 1964, having got the necessary permission from Prof James Louw, having had to convince him that I did not have to get married, and that I would not sleep "at home" when on call, I married Renee Barns after a 6 year relationship, and we remain together today enjoying the 60th year of our "friendship", with three children, the eldest, my son, an Orthopod at Vincent Pallotti, and our two daughters, also both very successful in their own way, and 8 grandchildren between 20 and 9

After my stint at Red X, I started in a MO post at Uitenhague Provincial which unexpectedly had a significant influence on the direction my practice of medicine would take. We were three MO's who, together, were responsible for all the minor surgery, rotating through the responsibility of operating, assisting or giving anaesthetics. As I was blessed with ten thumbs through not having done an internship in general surgery, I was excluded from assisting or operating which started my career as a GP anaesthetist, under the guidance of Steve Meihuizen, a local GP who had specialised in anaesthetics and then went into general practice. The competence gained in anaesthetics meant that a considerable amount of my time in my first 20 years of practice was devoted to giving anaesthetics.

After three months at Uitenhague we discovered that there had been a slip between the "cup and the lip" and our son had been conceived – due during my stint at Uitenhague and with apologies to Uitenhague, we decided that our firstborn would not have to carry the stigma of Uitenhague as place of birth on his ID, and a move was necessary.

Piet Du Toit of Oudtshoorn fame's mother provided an advertising service for practices in the Western Cape. And noted in her own handwriting on the list that Piet Steyn in George was looking for an assistant "with a view" to partnership. While I was at Red X, on Saturday nights in February there was a "crazy" GP doing a scholarship at PMH who spent Saturday nights helping in the drip room and I remembered that he was from George – it was Piet Steyn! Needless to say I made contact, visited him and then joined the practice of Steyn and Vosloo on the 1st December, 1964 and my son has George as the place of birth on his ID.

In order to extend his practice, Piet had bought the GP practice of Drs Vermaak and Louw, who had gone to specialise. Our first home was their old consulting rooms. They had also been responsible for the medical care at the SANTA hospital which became my responsibility

Joining Piet and Vossie was originally seen as a temporary move but thoughts of further moves and possible specialisation were soon forgotten.

Medical Services

George had an interesting spectrum of medical services for the small town it was then. There were 10 GP's, Piet, Vossie and myself, Marthinus Stander and, Hendrik Du Toit , Michael Gardiner, Norman Gerber and Francois Le Roux in active practice, Harry Mann was semi-retired and saw patients from his house, We frequently got phone calls from him like "Hey, Broer, which is the best antibiotic for bronchitis ?" In the 60's there was not much of a choice!

Another "GP", Dr Koos Lamprecht, who had retired – was a real character who had both medical and dental degrees from Edinburgh. He had stopped practicing and devoted his time to his responsibilities as the Mayor of George. Stories about him were legend. He lived in a house on a property on which the Lamprecht Clinic was later built. His house was in effect the first "private hospital" in George – he did confinements in a bedroom in the house, and surgical and dental procedures in his kitchen. Story has it that he not only repossessed dentures that he had made (sometimes removing them from the patient in the street) but also babies, when the payment of his fee was overdue. Rumour had it that the Medical Council played a part in his no longer practising and he was doing a very good job as Mayor of George.

Among the Specialists, there was Surgeon, Jan Smalberger, a Physician, John Foster, a Gynaecologist, Sarel Smal and Ophthalmologist, Piet Van Soelen .

A Radiologist, Harry Navid, offered a sort of Radiology Service using a portable x ray machine in his house. However most x Rays were done at the hospital and we had to be competent in their interpretation. Later Hannes Nel filled the role of specialist Radiologist at the George Hospital and later in private practice in the Geneva Clinic premises when Geneva relocated

The Specialist group were joined by a semi-retired Urologist from Pretoria, Thos MacDonald, and an Orthopaedic Surgeon, also from Pretoria, Naaz Zaaijman, who when he was not fusing spines and replacing hips, built violins as a hobby. Sarel Smal was joined by Johan Zaaijman to expand the Gynae service, and PW Botha's son in law, Jan Maritz joined Johannes Smalberger with Johan van Zyl.

Jack Trengrove Jones joined the hospital staff as a full time Surgeon, with a limited private practice, left under somewhat of a cloud and was replaced by Tewie Wessels. Soon after Tewie arrived I had done a home visit on an elderly gentleman with a ruptured abdominal aortic aneurysm. I got him to George Hospital, started an IV, ordered blood, phoned Tewie and he was taken straight to theatre. Both Blaar and Koos were unavailable and I had to do the GA with telephone assistance via the standard telephone service in the Sister's office. That and other things helped me to believe there is a God,

One of the nursing personnel worth mentioning is Sr Willa Le Roux who worked at George Hospital as senior theatre sister when I arrived and only left when she was persuaded to help us get Geneva Clinic started.

Two stories about Sr Willa are worth repeating. She had never done a urology list and Thos MacDonald had booked a penis amputation for an unfortunate African man with a fungating tumour on his penis. When they uncovered the instrument trolley, the most prominent surgical instrument was an orthopaedic bone cutter!

Later at Geneva Clinic when we asked her to order a more expensive sweetener than saccharin we were told that it was not on the stock list!

Another is Staff Nurse Charlotte Stevens who was often my " right hand" when giving anaesthetics. She married a Barnard and has been forever known as "Stevie" Barnard. I met Stevie first as a 13 year old schoolgirl when she had fallen off her bicycle and presented in Trauma with grazed knees. She trained as a nurse at George Hospital and became a very competent anaesthetic nurse and we persuaded her to join Sr Willla at Geneva Clinic where she worked part time in theatre and the rest of the day assisted us at our consulting rooms, With sale of Geneva she worked at our rooms full time. When I reached 65 I started my own practice and she became my receptionist cum nurse and remains such to this day – an association for more than 40 years.

The GP's had the full responsibility of medical services at the George Hospital. The 3 solo practices refused the Honorary MO posts at the Provincial Hospital, so these were shared by the two partnerships.

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PROFILE

A GP in George continued from p15

The Honorarium was worth the princely sum of R50 per month!

A weekend on call was mostly spent in the NE casualty attending to stab wounds, incomplete abortions and the occasional ectopic pregnancy – all this with the help of the Sister in charge, Sr Van Zyl, a large blonde lady, who, with a sailor's vocabulary, kept both staff and doctors under control. There was also an E Casualty where we were allowed to attend to our "private" patients who were then exempt from the hospital out -patient fee.

As I also had anaesthetic sessions, I was, in rotation, responsible for all hospital case anaesthetics, which could be a heavy load with a General Surgeon who insisted on doing a laparotomy on every abdominal stab wound. He did not believe in peritoneal lavage as a diagnostic tool. One memorable casualty/anaesthetic experience for me was when I was giving the anaesthetic for my partner to do a ruptured ectopic, with the scrub Sister assisting, we received a call from Sister in Casualty that the ambulance had brought a very shocked young lady who almost certainly had a ruptured ectopic. I had to leave my anaesthetised patient in the hands of a very skilled anaesthetic nurse, run down to Casualty where the patient was already on a drip, do a colposcopy under local anaesthetic to confirm the ectopic, went back to theatre, woke the first patient up and proceeded with the GA on the second. Both patients and the anaesthetist survived.

Communication

Communication was done through the services of the local telephone exchange. If we went out anywhere we would inform the exchange of our whereabouts and he would redirect calls accordingly. He would also know who had called for the middle of the night home call and it was not necessary to wake our wives and tell them where we were going – the exchange would know!

On one occasion when I was not on call, an elderly Greek patient was arrested for driving under the influence, and the family insisted that he be examined by me. Exchange tracked me down and after a cup of strong black coffee, I headed off to the charge office, where I managed to convince the arresting officer, in the company of the entire Greek population, that my patient had had a series of heart attacks (true) and that he would not survive a night in a cell. The George charge office was entered up a long flight of stairs with a sharp right turn at the top – I triumphantly walked out of the office and forgot to make the turn, falling heavily to the ground amid loud cheers and clapping from the Greek audience The bottle of whiskey I received as a thank you did little to appease my embarrassment!

Another interesting callout was to what is now the George Museum but was previously a popular hotel bar. A very large gentleman in the bar had collapsed while eating biltong and drinking beer. He was picked up and laid out on a billiard table. When I got there he was obviously dead and I told the onlookers that I would arrange for the removal of the body – the response was "please be quick Doc – we want to finish our game!"

Anaesthetics

George's principal anaesthetist was a semi-retired lady from Sedgefield whose anaesthetic qualifications were from the UK. Relaxation was achieved with a Pentothal and flaxedil drip and spontaneous breathing through an anaesthetic machine that consisted of two flow meters only! This suited the Eye surgeon because the patient did not cough for days. To the best of my knowledge she never had an anaesthetic misfortune.

Dr Elizabeth Barret, who was married to a Surgeon practicing in Oudtshoorn, had a diploma in anaesthetics and used to come across to George to do Surgery and Gynae lists. As she and her husband were very involved in mission work in Thailand, she was frequently away.

Dr Blaar Carstens was appointed as Specialist Anaesthetist at the hospital, and Dr Koos Badenhorst started as a Private Anaesthetist. Koos and I shared the emergency hospital lists with Blaar

I did the Urology and Ophthalmology lists which was very challenging – Urology starting with infants' anti-reflux ops and ending with Prostatectomies in the 80 – 90 groups. Eyes starting with squint corrections and ended with cataracts - all under GA – spinals were not the thing in the 1960 – 70's.

Being experienced with small children anaesthetics, I was involved in a lot of tonsillectomies which reminds me of an article written by Francois Le Roux in the SAMJ, responding to a claim that GP's did too many tonsillectomies, in which he claimed that most children were "happier" after tonsil removal – an early appreciation of what was later referred to as "sleep deprivation syndrome" in articles from Red X.

In the early years it was common practice to give anaesthetics in the Dentists rooms. The practice was barbaric to say the least and the fact that we had no unfavourable incidents was obviously in the hands of a higher control. I would arrive at the Dentist's rooms and there would as many as 5 moms and small children sitting in the waiting room assuring me that they were indeed "nil per os". The mother would bring the child and hand the child to the dental nurse who would hold the child while I administered either ether or ethyl chloride (rag and bottle technique) until the child stopped wriggling (one dentist used the "hair pull test" - he would constantly pull the child's hair until it stopped reacting) – the mother would leave, the child would be held in the chair, teeth extracted, hopefully before the child was fully awake, the child then held upside down and taken back to the waiting room, and the next child brought in, while the child's mother was the recovery nurse.

With the advent of halothane I acquired a Fluotec, which administered halothane using 100% oxygen via a mask! It was less traumatic for both the child and the anaesthetist.

Possibly the most daunting "anaesthetic" I gave was to a horse – a prize pregnant mare that had been spooked by a low flying aeroplane and tried to jump out of her enclosure and ripped her abdominal skin on a barbed wire fence. There was no Vet available and the owner indicated where I could inject into a neck vein. I gave as much IV Valium as I estimated I would need and the horse dropped as if pole-axed. Fortunately the wounds were superficial and were easily sutured and the horse recovered.

Two more private anaesthetists settled in George and when I was told by one of them that I had no formal training in anaesthesia and that, if I ever got into trouble I was not to look to him for help. I then stopped giving anaesthetics

CME and Private Hospitals

I think Piet Steyn must have been the original instigator of CME – to the point that just attending what preceded formal CME's and were called "refresher" courses, was not enough and he was one of the first M Dom Med graduates from Pretoria.

In Pretoria he met a GP who had a registered "Day Clinic" attached to his practice. We had been doing our minor GA procedures in what had been a Vincent Pallotti hospital in George but as the Theatre Sister was in her eighties and the "Matron" close to ninety, the hospital was used as a retirement centre and they eventually asked us to stop doing procedures there. We started looking for suitable premises, found a vacant shop site in a block of flats in Victoria St in George and with partitioning were able to establish a six bed ward and theatre. Our Landlord's company was called Geneva Investments and hence the name Geneva Clinic.

There was no model on which to base a tariff and our original fee for a procedure was R12.50. It proved so popular for minor GA procedures, that we rented the adjacent ground floor flat increasing the bed capacity to 12 beds with a decent sized waiting room.

The waiting room became the venue for monthly "refresher" meetings which were addressed by local and visiting Specialists and which were always well attended. When we were not able to get a Drug Company to sponsor the meeting, we provided the refreshments.

Geneva Clinic was a member of the Day Hospital association and I represented Geneva on the board of the National Hospital Network. There I met a number of other doctors and Dentists with Day Hospitals and the idea of a larger Geneva Clinic with more doctors involved became reality

We formed a new company with 20 doctors as shareholders , planned and built a 20 bed day hospital with 2 theatres. The financing was interesting – a local attorney, Felix Harris, put a proposition to NBS that they loan each shareholder in his individual capacity R100 000 with

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William Ruben (Bill) Turner

Bruce Dietrich

What a man. Very Knowledgeable, Kind, Helpful, Hardworking and ECCENTRIC.

Bill was born in Cape Town on the 8 October 1934. His Father was Prof Polly Turner professor of Forensic Pathology and author of the well know Forensic Pathology textbook. Bill started his schooling at Rondebosch Boys school in 1940 and matriculated there in 1952. He played first team rugby as a front rank, lock and even once as flank. His cricket skills were less successful but he continued playing until he left school. Even as a junior school boy he would enjoy walking and climbing Table Mountain with various friends.

He started medicine at UCT in 1953 and graduated in 1959. During the last 4 years of his studies he lived in Medical Residence. He owned a powerful scooter while at university. He also suffered from severe Narcolepsy and one evening while transporting his girlfriend on this scooter he fell asleep only to wake up when he hit the curb. He also used to fall asleep during lectures if the lights were turned off even for a brief moment. He did his internship in Medicine under Dr Helen Brown and carried on to Orthopaedics as his aim was to become an Orthopaedic Surgeon.

He maintained a very strong interest in climbing. One night he and a friend climbed up the crane on the building site of the new Gynaecology building, at that time this was the tallest crane in South Africa. Bill crawled along the crane arm intending to tie a human dummy to the end of the arm, however the task proved more difficult than anticipated which resulted in a flow of strong language, upsetting the nurses in the adjacent building who had no idea where the commotion was coming from.

After his internship he worked as a medical officer at the City Hospital and also did locums for various GPs. In 1961 he married Di who he had met on the beach at the Wilderness. It was love at first sight; they had 5 children who are now scattered around the world and 7 grandchildren. His eldest son died a few years ago from a brain tumour.

In order to save money for a trip to Europe he went to, the then, Southern Rhodesia. Here he worked as a medical officer and later did locums for local GPs. Being very active he took part in rowing and white-water rafting. His wife, Di, joined him and excelled in these sports. They then left for Europe for 6 months of touring.

Bill Turner

In 1968, after 6 months in Europe, they returned to Cape Town where Bill took a Registrar's post in Pathology in order to complete an MMed degree in Clinical Pathology. He qualified in December 1972. He worked as the Pathology Consultant at Red Cross Hospital for 6 months before joining Mulligan and Beyers in 1973.

While living in Hout Bay, Di presented him with 2 peafowl: Anthony and Cleopatra. Despite being kept in a hokkie for some months, on release Anthony immediately absconded back to his previous home in Constantia.

Bill couldn't find a replacement for him, however the Rhodes Zoo had a surfeit of peafowl so he recced the zoo one afternoon, soon discovering all peafowl roosted at the top of the stone pines, which only a native of the cocoa nut islands would be able to climb. He explored the place carefully and discovered a large bird who was roosting low down in a bush near the lions' den, hopefully a peacock.

One should explain he was swatting for M.Med finals, and the cabinet ministers were in residence with police patrolling the area close to the zoo,

Around midnight one night, feeling fed up with studying he grabbed a large grain bag, hopped onto his Lambretta and headed off to the zoo. Parking some distance away, he crossed under De Waal Drive via a storm water drain then up over the low stone wall and on to the vicinity of the lions' den. You may remember this consisted of a large sunken amphitheatre with the dens at the rear.

The large bird roosting low was indeed a peacock. Grabbed by the leg, it immediately shouted "Helllp" whereupon scores of other peafowl in the stone pines answered. And the lions began to roar.

Shutting the peacock's beak with his fingers, shoving it into the grain bag the fowl shut up, however the rest of the cacophony continued and various other animals joined in. With bag over shoulder he clambered back over the wall, scuttled through the storm water drain, leapt onto the Lambretta and hurried home to Hout Bay.

Had he been caught, the consequences would have been severe as a medical doctor with several years' experience. Could he have been struck off the register, who knows?

Anthony II and Cleopatra accompanied Bill and Di to their small farm outside George where they soon multiplied. Every evening they could be heard crying, "helllp" as they climbed to roost in the Willow trees around the reservoir. The plan for a peacock braai never materialized as, eventually the numbers were depleted by predators until finally there were none left.

Another example of his eccentricity. One night, while at Mulligan and Beyer, he burnt the front of his jersey. For several days after that he wore this jersey to work until the practice sister told him that this really didn't look very professional, he politely took the jersey off and put it on back to front.

One day while at work he was overheard talking to his wife on the phone ..... "I forgot to give you my salary cheque last night, if you drive to Rondebosch Common, find the second street light pole, walk 2 paces from it towards Muizenberg, then turn 90 degrees right, walk 2 paces, you will find the cheque under the stone there."

After 9 months, at Mulligan and Beyer, he accepted a Senior Pathology Consultancy post at the George State Hospital. As the state refused to fund improvements to the Laboratory he left and started a private practice in George. The practice thrived and in 1984 he was joined by Dr Brian Mather from Kimberley.

One evening Bill and Di were invited to a hobo party. On their return home they discovered that their house had burnt down. They then lived in their potting shed for a few years while their son rebuilt their home. As they had lost everything except the Hobo clothes they were wearing, Bill had to go to work as he was the following day and for many days after that.

As he was a smoker and his desk always cluttered with papers it was not surprising that he set his desk and overhanging book shelves alight. The lab was a converted old house and weeds grew up between the floor boards. The parking area, an old lawn, was several inches high in grass and weeds.

Bill was very generous and kind. One day

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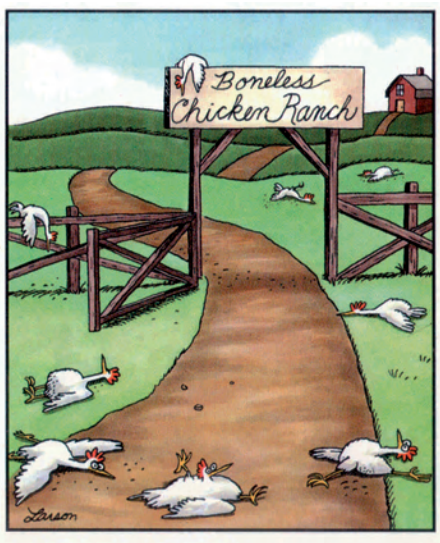
TRIBUTE

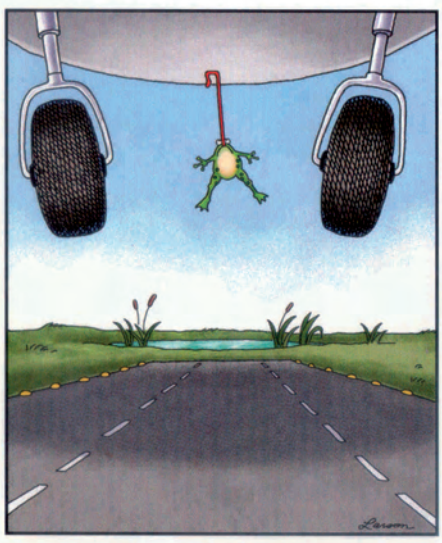
Bill Turner continued from p17

at the Hermanus Yacht Club, during the Sonnet National Sailing Regatta, he arrived in an old army truck with 2 Sonnet dinghies, the back of the truck was full of young orphan children whom he had brought to sail and have a holiday, he then helped the kids erect their tents, he and Di cooked supper for them in the evening and he would read to them before they fell asleep. The next day he helped them rig their boats and sent them off. Only after he knew they were all organised did he rig his boat and with one of the children as crew set sail.

One morning Bill arrived at my cabin smoking a cigarette, he said he was not feeling well, I felt his pulse which was very irregular, and from my very limited knowledge of Cardiology I diagnosed atrial fibrillation. I phoned City Park and arranged for him to see a cardiologist. He was advised not to drive so I arranged for, Di, his wife to drive him to Cape Town. That evening I was relaxing at my cabin with a glass of wine when Bill returned, smoking and asked for a glass of wine. I enquired how his day had been and he said fine. The doctors had shocked him with paddles and reset his heart's sinus rhythm. They had told him not to smoke or drink any alcohol, both of which he was doing. The next day he was off sailing again.

In 1991 his practice joined PathCare. He retired in 1998 having reached 64 years of age, the compulsory retirement age at PathCare. He has continued horse riding, Laser sailing, parasailing and mountain climbing to this day, at the age of 85!





A GP in George continued from p16

which they could purchase their share in the company which gave us the initial capital to build and equip the clinic. There was a serious potential hiccough when someone at NBS decided that we had sidestepped a corporate loan and proceeded to cancel all the private loans. It took a threat from Felix Harris, whose firm did all NBS's legal work in George, to cancel their contract with NBS to rescue the situation.

Geneva filled the need for day surgery but soon became apparent that an overnight facility was needed and Geneva added a floor with 20 more beds, including a 4 bed ICU and a lecture room for refresher meetings for both doctors and nurses. 10 more doctors were invited to become shareholders.

At the same time a private hospital developer from Johannesburg had bought Koos Lamprecht's house, and the considerable ground around it, to build what he called the Lamprecht Clinic. It had 3 floors with wards on the east side of the building and doctors suites, which they purchased, on the west side. The 4th floor had consulting rooms for a surgical practice and for the physicians. The 5th floor was a flat for rental.

A block of flats adjacent to the Lamprecht Clinic was taken over by the Pathology practice started by Bill Turner, later joined by Brian Mather and is now PathCare.

The history of Pathology services in George is also interesting. Brian Johnson Barker was a technician in the State Lab in George and started a part time lab service for our practice in our rooms – doing cultures, haematology and limited biochemistry. Bill Turner was appointed as Pathologist to the State Lab and he and Brian started what has become George PathCare.

Back to the hospital situation. Lamprecht Clinic was very poorly run and the owner resorted to rewarding the surgeons financially for doing lists there. He was prepared to sell the hospital at a ridiculous price. I was negotiating for Geneva Clinic to be bought by Netcare – we had a large piece of vacant land on which they would be able to extend the hospital. The Geneva shareholders would have earned about R250 000 per share, 50% paid in Netcare shares, which were then valued at 51c per share – current value R38! Netcare were prepared to pay Lamprecht Clinic's price, and would have converted it into a Step Down cum Frail Care facility. The Specialists were at the same time negotiating with Mediclinic to buy Lamprecht Clinic in which many of them had consulting rooms. Mediclinic indicated their interest but only on condition that they got Geneva Clinic at a considerably discounted price. It was put to the vote at a shareholders meeting and Mediclinic won by 1 vote. Geneva Clinic was sold to Mediclinic for R5m less than the Auditors valuation.

Current situation

At an evening gathering of doctors, some years ago. Vossie was asked by a Rep how many doctors there were in George – his immediate reply "at 4 o clock there were 34, I don't know how many there are now!"

George has expanded tremendously, stretching from the Airport to almost the Kaaiman's River, and with it the medical practitioners. Specialists – General Surgeons 4, Orthopods 4, Ophth 5, Plastic 2, Gynaes 4, Neurosurgeons 2, Urologists 2 resident and 2 part time from Mossel Bay, Physicians 4, Neurologist 1, Paeds 4, Anaesthetists 4, Radiologists 4, Ampath and PathCare with an uncertain number of resident Pathologists, General Practitioners 20 in various established practices and the "Walk In Doctor" with an unknown number of part time General Practitioners.

The hospital situation remains much the same with Mediclinic and Geneva unchanged, creating an almost untenable bed shortage. Mediclinic's attempts to build a new hospital on the outskirts of George have been thwarted by zoning and sewerage management problems.

What has been added is a state of the art Eye and Plastics hospital. When officially opened by the Bloemfontein Prof of Ophthalmology, of International renown, he described it as the "Best Planned and Best Equipped Eye Hospital" he had ever seen.

Groote Schuur Hospital Trauma Centre - serving the injured Cape Town Community

Andrew Nicol, Sorin Edu, Pradeep Navsaria, Deidre McPherson

The function of a major Trauma Centre is to provide super-specialized trauma surgical care. The American College of Surgeons demonstrated an up 40% reduction in trauma deaths by establishing these region specific, highly specialized Trauma Centres. The creation of Major Trauma Centres in England in 2012, has similarly seen a 19% increase in survival for major injuries and an estimated additional 1600 lives saved during this time.

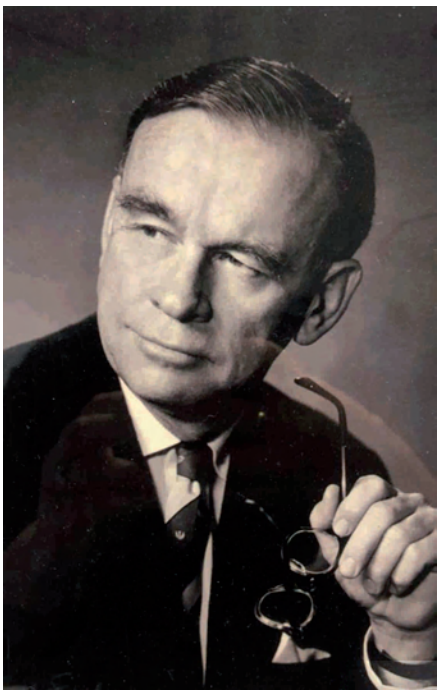
The first Trauma Centre in the world was the Birmingham Accident Hospital, opened in Birmingham, England in 1941, after a series of studies found that the treatment of injured persons within the British Isles was inadequate. The hospital operated on three basic principles:

1. Segregation of the ill from the injured with only trauma victims treated at the Accident Hospital

2. Continuity of care and unity of control with the same consultant surgeon responsible for the patient throughout their hospital stay and throughout recovery and rehabilitation.

3. Rehabilitation seen as an integral part of management.

Groote Schuur Hospital Trauma Centre (GSHTC) is one of the world's first and leading Trauma Centres. The background to the Centre dates back to 1960, when the Multiple Injury Unit was established for the handling of mass casualties, following experience gained in the admission of 70 patients injured during the Langa Riots and Ndabeni train accident. In 1965 the Unit was seeing 10 severely injured patients a week under the leadership of Dr Toddy Schrire. There was, however, a steady escalation in medical emergency and trauma attendances to the combined Casualty department from 30 000 in 1959 to more than 60 000 in 1973. The realization dawned that it simply was not possible to manage trauma within the confines of the severely overcrowded Casualty. Dr Johan van der Spuy commented on the situation in an interview with the Cape Times; " At Groote Schuur, we had the two together and it did not work. We lost patients that we should have- and could have - saved. You can't deal with massive serious trauma in among dealing with ordinary medical emergency cases. That's why we set up a separate Trauma Unit." The years long



Bags Baigrie

planning of the Trauma Unit finally came to fruition on the 1st February 1973 when the Casualty department was formally divided into the Emergency and Accident/Trauma Units. "Bags" Baigrie, father of surgeon Professor Bob Baigrie, was appointed as head in the new trauma section constructed in the old Groote Schuur Hospital. "Bags" went on to establish the first private ambulance in Cape Town that was aptly named the "Bagsmobile". Dr Johan van der Spuy was to succeed "Bags" in 1978 and go on to

Johan van der Spuy

become one of the doyens of trauma surgery in South Africa.

A parallel movement in the evolution of acute injuries was evolving in Johannesburg. It was becoming increasingly difficult to manage all emergencies in the general Casualty Department as the large number of trauma patient's required timeous access to treatment. A decision was made to set up a dedicated area for the trauma patient. In 1962 the Head of the Department of Surgery, Professor DJ du Plessis, at the Johannesburg General Hospital (now the

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TRIBUTE

The Gift of the Givers

Imtiaz Sooliman

Gift of the Givers is the largest disaster response NGO of African origin on the African continent. Having been established on the instruction of a Sufi Sheik, Muhammed Saffer Effendi al Jerrahi (a spiritual teacher) in Istanbul, Turkey, on a Thursday evening 6 August 1992, Gift of the Givers has delivered life-saving aid in the form of search and rescue teams, medical personnel, medical equipment, medical supplies, medicines, vaccines, anti-malarial medication, high energy and protein supplements, food and water to millions of people in 43 countries, South Africa included.

Commencing as a disaster response agency the organisation now has 21 categories of projects which include bursaries, agricultural self-sustainability, water provision, counselling and life skills services, entrepreneurship and job creation, establishment of primary health care clinics and medical support to hospitals, winter warmth and supply of new clothing and shoes, sports development, feeding schemes and food parcel distribution, supply of household and personal hygiene packs, educational support and toy distribution, provision of housing, care of the physically and mentally challenged, orphans and the elderly as some of our diverse activities. Innovating the world's first and only containerised mobile hospital comprising 28 units, innovating the world's first containerised primary health care unit, innovating the world's first groundnut-soya high energy and protein supplement in the use of severe malnutrition, HIV/AIDS, TB, cancer and other debilitating conditions, and establishing Africa's largest Open Source Computer Laboratory has earned us 125 individual and organisational accolades and awards including 4 Presidential awards.

Thus far we have disbursed R2.1 billion in aid to needy individuals and communities in our 25 year history. Our motto is simple. "Best among people are those who benefit mankind" and accordingly we serve ALL people irrespective of race, religion, culture, colour, political affiliation or geographical location, unconditionally.

Mohammed Kagee gave this closing address after a talk on Gift of the Givers:

Gift of the Givers are acclaimed worldwide for humanitarian work in disaster stricken areas, in some of the most dangerous areas of the world.

There was a time we were a proud rainbow nation looked to for statesmanship, peace building and reconciliation with icons like Nelson Mandela and Archbishop Tutu.

Now, thanks to founder Dr Imtiaz Sooliman's initiative, mission and vision we proudly say, this is a remarkable organization, capturing world admiration and support

For this he has received numerous awards, honorary doctorates and wide acclaim.

It has even put SA back on the map with some degree of internal respect.

The tenets:

1. Compassion in action:
Underlying their amazing work is the God given intrinsic human capacity for compassion, a central theme of all religions. Important is practical compassion

2. Compassion for others:
More important is to express compassion for others as it's easy to express compassion for one's own. Responding to distress of others, and selfless concern for welfare of others is a true test of ones humanity. Pain, despair, suffering loss of life and tears have no boundaries and are universal.

3. Solidarity with humanity at large:
It's only when you identify and show solidarity with pain, suffering and distress for others that you can expect others to identify with your pain and suffering. It's when you display loyalty to only one portion of humanity, a state, a nation, or faith group, not recognising dignity of others that leads to hostility to the other, expressed as racism, xenophobia, Islamophobia and anti-Semitism, and turn a blind eye to human rights violations inflicted on others.

Let's not forget the role played by Gift of the Givers in securing the release of Cyril Karabus detained in UAE in 2013 for 9 months while travelling home from Canada.

We draw powerful ethical concepts from each other's faith instead of politicising each group's self-interest, such as the Torah speaks of Tikkun Olam, where each has personal responsibility to make a difference to all humanity and help heal our fractured world. Sukkot where you are required to leave the comfort of your home to live in shacks, translate this to identify with homeless refugees.

Muslim traditions:

As Racham/Rachim in the Tohrah compassion or Rahma which is the theme in the Qur'an, as is Tzedeka/Sadaka in Jewish and Islamic scriptures, meaning charitable actions. Simhah, Hebrew for sharing, when coming to conflict over land and resources. Or Hessed, another Hebrew word, translated as kindness in action.

There is a saying in Islamic tradition saying "jis dil me muhabbat hay, us dil me khuda he". In whose heart is compassion, you will find God. ■

Is Wheat / Gluten sensitivity over diagnosed? Is Gluten the Root of all Evil?

John Wright

The perceived dangers associated with gluten ingestion have united many health care professionals in a feeding frenzy to purify our natural environment and rid us of ingested toxins. How did we get to this position where gluten containing wheat which we have eaten since prehistoric times has become an important cause of ill-health both mental and physical? Is it simply the latest in a long line of bogey men that have captured the human imagination?

Three aspects of gluten associated disease need to be addressed:

Coeliac Disease (CD)

The problem is that we have a scientifically proven condition, being coeliac disease (CD). This is caused by cereals that contain gluten. Wheat, spelt, barley, rye and oats. CD produces a variety of symptoms which blur imperceptibly into the everyday experience of many people. Symptoms such as subtle change in bowel habit, increased flatus and vague abdominal unhappiness could well be the harbingers of CD or the result of an anxiety state. Another aspect to be addressed is simple allergy to wheat, but more of this later.

The prevalence of CD depends on your heritage, where you live, and the criteria used to make the diagnosis. Europeans in Europe (1) have prevalence of 1 in 184 and in North America (2) of 1 in 141. In Europe the risk is thought to be higher in the north than in the south. Similarly, it was thought that the incidence in the southern hemisphere is even lower. This might be a fallacy as estimates from Australia have put the prevalence of 1 in 80 to 1 in 250. The reported prevalence largely depends on whether symptoms, blood tests or histology are used to make the diagnosis.

So, what is the hard data associated with the incidence of CD?

Firstly, the genetics. Coeliac Disease is strongly associated with specific HLA class II genes known as *HLA-DQ2* and *HLA-DQ8*. About 95% of patients with coeliac disease express HLA-DQ2 but so do 30% of Caucasians. The addition of HLA-DQ8 improves the accuracy but is estimated that the risk of developing coeliac disease in this population is only 36 to 53% (3).

Secondly, there are a variety of blood tests which show the body's response to gluten. The most reliable are the tissue transglutimase IgA (TTG) and endomysium IgA (ENS). In a recent meta-analysis, positive tests (10x raised) were found to occur in 75% of CD patients with a specificity of 38%, a positive predictive value of 87% and a negative predictive value of only 29% (4). There are also tests on stool samples which are not acceptable evidence to most experts

Thirdly, the gold standard has always been a positive histology of villous atrophy in mucosal biopsies of the duodenum, but the interpretation of histology is also subject to some observer variation. A further problem is that a gastroscopy is required to take the biopsy. Understandably the reluctance to perform endoscopy has prompted diagnosis based on symptoms and blood tests alone. As shown above the variability of genetic markers and blood tests complicates the diagnosis of CD. The soft option of non-histological diagnosis is probably the root cause of the over diagnosis of gluten related disease.

Is the firm diagnosis of CD really that important?

This question has a philosophical aspect related to the perceived trauma of gastroscopy compared to the lifelong difficulties, costs and implications of a gluten free diet. This blurs into our second topic.

Non-coeliac wheat/gluten sensitivity

For the believers, symptoms include abdominal pain, bloating, diarrhoea, constipation, headaches, bone or joint pain, chronic fatigue, brain-fog, depression. ADHD-like behaviour and even ataxia. All have been shown to improve when gluten is avoided.

So, what is the hard data?

Grain allergy is a well-documented condition with immunologic responses to grain proteins which can be immunoglobulin E (IgE) mediated. Wheat is the commonest allergen but other cereal grains such as rye, barley, oat, rice, corn, and millet, as well as non-cereal grains, quinoa and sorghum can be responsible. It usually begins in childhood and is outgrown by adolescence. Children often have allergic like upper respiratory tract symptoms. Diagnosis can be made with blood and skin tests. Fortunately, treatment beyond avoidance is seldom needed but antihistamines may be useful.

Coeliac Lite is a nebulous syndrome popularised by the Gluten Warriors. It is impossible to diagnose firmly or disprove conclusively. Whilst there can be no doubt that some sufferers have a gluten related condition, for many it is a religion.

A meta-analysis of placebo-controlled studies of the exacerbation of symptoms in these patients with wheat gluten sensitivity was published in 2017. Eighty percent of these patients given gluten experienced a deterioration of symptoms whereas 40% given placebo deteriorated as well (5).

As many of these patients respond to a diet excluding fermentable sugars (FODMAPs). An overlap with irritable bowel is suspected (see below) (6).

The non-gastrointestinal symptoms listed above are difficult to understand. Nevertheless, some of these have been investigated and there is no doubt that wheat/gluten may be responsible for some. The problem is, how often this is the case. The suspicion is that many patients complaining of these symptoms have other explanations. Time will usually tell.

Disturbed bowel physiology

In clinical gastroenterology this is the most common condition that patients associate with gluten/wheat sensitivity.

For our colons to work normally, two factors are needed.

Firstly, enough non-absorbable carbohydrate, i.e. fibre, to feed the bacteria in the colon. This is needed as faeces consist mainly of bacteria. Without bacteria little faeces are made and constipation becomes inevitable. A major problem of the popular high protein/fat diet for weight control.

Secondly, hard pieces, at least 6 mm in size, stimulate peristalsis and the production of a stool.

Based on the above, a low fibre, smooth diet produces constipation and aggravates the symptoms of irritable bowel syndrome. This is characterised by hard stools, excessive gas, abdominal bloating, and cramps. All symptoms commonly associated with wheat/gluten sensitivity. Ironically it may be the lack of wheat fibre that exacerbates the condition.

So, is wheat the villain of the modern diet?

Continued on p22

ISSUE

Is Gluten the Root of all Evil? continued from p21

So, is wheat the villain of the modern diet?

Hard to know. Wheat was first grown in the Middle East in about 9600 BC. Prior to this it appears that grains such as rice, corn, millet and sorghum were consumed for over 100 000 years. So, in the big picture, wheat is a recent addition to our diet.

Suffice it to say that the jury is still out on the generalised toxicity of wheat/gluten. Meanwhile, blaming wheat for all manner of ills may be seriously overdone and avoids the making of a proper scientific diagnosis by the profession. Into this diagnostic void, alternative practitioners and chat show hosts are driving public opinion into uncharted seas.

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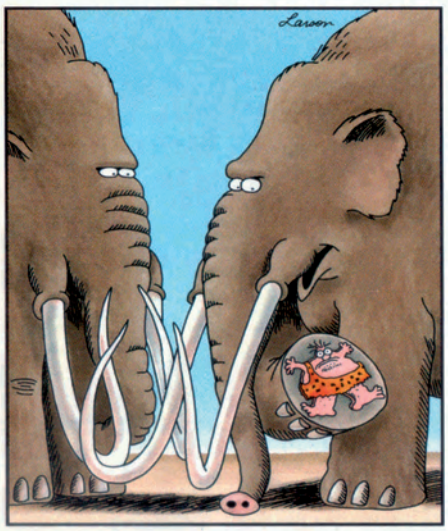
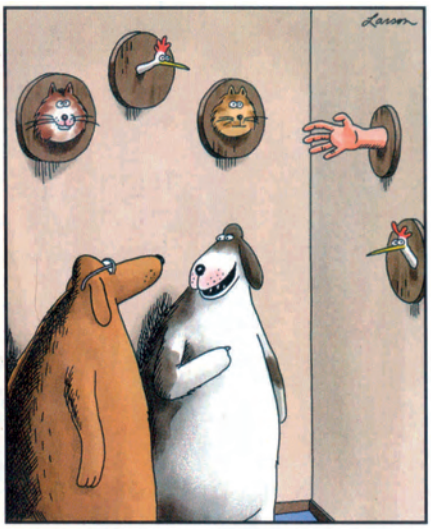


"Well, what the? ... I *thought* I smelled something."



"And that's the hand that fed me."

Groote Schuur Trauma Centre Continued from p19

Charlotte Maxeke Johannesburg Academic Hospital) established the Trauma Unit under the leadership of Professor AE Wilkinson. This trauma unit was; "..... seen as an answer to the problems of overcrowding and difficulty in access to trauma care."

The development of stand-alone Trauma Units has revolutionized trauma management in South Africa. Dr Richard Spence completed his PhD on quality assurance in surgery and revealed that the survival of injured patients admitted to the GSHTC is on a par with that of a major Level 1 Trauma Centre in the United States. This is a remarkable achievement given these results are being achieved with approximately 30% less staffing in the South African context compared to the USA.

High profile cases who have been managed in the GSHTC include Nelson Mandela for an injured foot requiring heel surgery in 1979, the St James Massacre (1993), the Heidelberg Tavern massacre (1993), Debbie Addington (2001) who was the sole survivor of one of the most gruesome family murders ever to happen in South Africa, the Sizzler Massage parlour massacre with four gunshot wounds to the head arriving (2003), the Kloofnek school bus accident (2005) involving learners from the Dennegeur Avenue Primary school on an outing to Table Mountain when the brakes failed with 4 killed and more than 40 injured,and the Garden's Centre gas explosion (2018).

The experience gained in the St James Church and Heidelberg Tavern in 1993 prompted the Trauma Unit to introduce comprehensive surgery namely "trauma to completion" in that trauma surgery patients remain under the care of specialist trauma surgeons until discharge. The presence of subspecialist trauma surgeons is the reason case mortality rate in the unit has not risen above 2% between 1973 and 2018 despite the increasing severity of cases seen from 1990 with respect to the higher proportion of gunshot wounds. Currently the GSHTC is managing 1100 patients per month with 60% of admissions due to interpersonal violence (including 80 gunshot patients per month), 30% motor vehicle accidents and the remaining 10% due to falls and sport injuries. The trauma surgeons are responsible for neck explorations, acute cardiothoracic trauma, abdominal surgery and the vascular trauma surgery. We manage a total of 50 beds including a 10 bed high care unit and perform the relook surgery on patients in the critical care unit. There are currently only 3 full time trauma surgeons at Groote Schuur Hospital including Professor Navsaria, Dr Sorin Edu and myself. Dr Deidre McPherson is undertaking the trauma surgery fellowship which is a 2-year subspecialty comprising 15 - month's trauma surgery and 9 months of critical care. Trauma surgery subspecialty is recognized by the College of Medicine of South Africa as a subspecialty and one can be accepted into the program after completing the general surgery exams.

In South Africa, the following hospitals now have stand-alone trauma units; Groote Schuur Hospital, Chris Hani Baragwaneth, Charlotte Maxeke, Inkosi Albert Luthuli, Tygerberg Hospital, Pelonomi Hospital, East London (planned), and Netcare Milpark Hospital. In 2012, the name Trauma Unit at Groote Schuur Hospital was changed to Trauma Centre so as to reflect the current international nomenclature.

The Trauma Society of South Africa firmly endorses the establishment of Trauma Centres and has established strict criteria in order to standardize and allow for accreditation of hospitals fulfilling the specific and very rigorous criteria of a Major Trauma Centre. These Trauma Centres are seen as a vital component in the management of the severely injured patient in combatting the current trauma epidemic we are experiencing in South Africa.

A patient wrote of their experience at the GSHTC; "I believe with your attitude you can only fly. I will talk about the Groote Schuur trauma section wherever I'll go."■

Southern Winds of Change

Jake Krige

Compared with other colonial countries, South Africa has a young history of medical education. The Health Sciences Faculty of the University of Cape Town was founded in 1912 and initially offered only pre-clinical subjects. The Department of Surgery was established in 1920 with Charles FM Saint, as the founding professor of surgery. Saint, from Durham University and Newcastle-upon-Tyne and an illustrious protégé of James Rutherford Morison, set a high standard for South African surgery during a celebrated 26 year tenure. He was followed in 1948 by Marcus Cole Rous and in short succession thereafter by 'Francie' van Zijl (acting head) in 1949 and JFP Erasmus in 1950. Three distinguished surgeons with long tenures followed, Jannie Louw in 1955, John Terblanche in 1981 and Del Kahn in 2000 until 2016. The Department of Surgery at Stellenbosch came into being later in 1956 with 'Francie' van Zijl as the first head and dean of the medical faculty. He was followed by equally eminent surgeons, his younger brother JJW (Kobus) in 1968, Boet van Rensburg in 1982, Johan van Wyk in 1992 and Brian Warren in 2002 until 2016.

However, the old order changeth, yielding place to new. The prescient "Wind of Change" speech was a historically significant address by the then British Prime Minister, Harold Macmillan, to the South African Parliament on 3 February 1960 in Cape Town . The speech acquired its name from a now-famous quotation embedded in it. Macmillan said: "The wind of change is blowing through this continent. Whether we like it or not, this growth of national consciousness is a political fact". To paraphrase this prophetic oration, southern winds of change are again blowing, in particular the so'easter, our "Cape Doctor". Two acclaimed surgeons, Professor Elmin Steyn and Professor Elmi Muller, have been appointed to the prestigious Chairs of Surgery at the Universities of Stellenbosch and Cape Town, replacing the incumbents in bastions of previous traditionally male dominated Chairs. And it was yet another British prime Minister, not a vacillating Theresa May, but the original and formidable Iron Lady, Margaret Thatcher, daughter of a Grantham grocer, who, unfettered and undeterred by establishment constraints, shattered the double-paned English glass ceiling of gender and class. Memorably, she, as Tory leader in the Commons, while forcefully and emphatically thumping Putin's dispatch box, and without a hint or trace of irony, thundered, "if you want something **said**, ask a man, if you want something **done**, ask a woman!"

And it thus came to pass that across the Liesbeek Professor Elmin Steyn was appointed Head of the Department of Surgery at the University of Stellenbosch and Tygerberg Hospital in March 2016. She was one of the first women to qualify as a general surgeon in South Africa and is a registered subspecialist trauma surgeon who is also passionate about transplantation. She was Head of Tygerberg trauma unit before entering private practice at Christian Barnard Memorial Hospital in Cape Town, heading the CBMH Trauma Emergency Centre and establishing the first private renal transplant program in Cape Town, as well as the Trauma Centre at Vincent Pallotti hospital. Elmin served as Chair of the Organ Donor Foundation and later as President of both the South African Transplantation Society and the Trauma Society. Under her leadership the Trauma Society focused on injury and violence prevention advocacy and launched the accreditation programme for Trauma Centres in South Africa.

She currently is President-Elect of the International Association of Trauma Surgery and Intensive Care (IATSIC), which is part of the International Surgical Society. As an international instructor for advanced trauma surgery training courses (DSTC™'aa), she has trained surgeons worldwide, both in countries with a high injury burden such as Sri Lanka and India, Hong Kong, Greece, Thailand, but also countries with low levels of interpersonal violence and few road traffic injuries such as Japan, Australia, New Zealand, Scandinavia, Singapore and the UK.

Elmin has presented papers and delivered keynote presentations at Trauma conferences worldwide. She is co-editor with Andy Nicol of three editions of the Oxford Handbook of Trauma and has contributed chapters to several textbooks of Trauma Surgery. She served on the Board of the Western Province Blood Transfusion Service, is a current board member of the HPCSA and is the recipient of numerous awards. Elmin collects art, loves travelling and is passionate about flying helicopters.

Further west in the foothills of Devil's peak and in the shadow of Table Mountain Professor Elmi Muller was appointed Head of the Division of General Surgery at the University of Cape Town and Groote Schuur Hospital in January 2017. Elmi has been active in renal and liver transplantation since 2005. She is committed to promoting organ donation and transplantation and was The

Elmi Muller

Elmin Steyn

Transplantation Society (TTS) councillor for the Middle East and Africa between 2010 and 2014 and served on the TTS Executive until 2018. Elmi has been involved in various transplant-related outreach and educational programmes in South Africa and Africa. Through the ISN Educational Ambassador's programme she trained surgeons in Zambia and Nigeria to do vascular access. In 2013 she organized a workshop for African clinicians who started transplantation programmes in their own countries, which was attended by 31 delegates from 11 countries.

Elmi was the programme committee chair for developing countries at the 26th International Congress of The Transplantation Society in August 2016 in Hong Kong. She also co-chairs the Declaration of Istanbul for Organ Donation Custodian Group (DICG) and was co-chair of the 10th year anniversary meeting of this document in 2018.

In 2008 Elmi initiated a transplant programme for HIV positive patients utilizing HIV positive donors at Groote Schuur Hospital. For this work she was featured in The Lancet in 2012 and in a number of journals in 2015. She is the principal investigator of a NIH-funded study based at the University of Cape Town which drives a research project on the virological and immunological impact of the second viral strain after receiving a kidney from a HIV positive donor. The interest created by this work has impacted on the humanities-centred debates about ethics and human dignity, as demonstrated by her work with Professor Susanne Lundin, with whom she co-edited the book "Global Bodies in Grey Zones: Health, Hope, Bio economy", published in August 2016.

For years women in science have encountered implicit bias in the workplace, bias which supposedly is neither conscious nor deliberate. The "Matilda effect", coined by Professor Margaret Rossiter, is named after the 19th century author and activist, Matilda Joslyn Gage, who experienced the phenomenon herself. Some famous historical examples of the Matilda effect at work include Rosalind Franklin's often-overlooked role in discovering the structure of DNA for which her male colleagues,

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OBITUARY

David Beatty

Marian Jacobs

David Beatty, Emeritus Professor of Paediatrics and Child Health at the University of Cape Town, passed away on 14th August 2018. In the days following this unexpected and sad event, all the comments about David from colleagues and friends, here and abroad, reinforced the privilege of having known him and worked with him. Colleagues used words to describe him like approachable, trustworthy, and especially having the ability to encourage and support, and Emeritus Professor Solly Benatar, a former classmate, noted that he had "*a calm and gracious temperament that endeared him to all who knew him*" *and* that he would *"long remember him with a deep sense of admiration and affection*."

Above all, David Beatty was a UCT man, and it was an honour for the institution to have hosted him from his entry as a medical student in 1960, to his official retirement as a revered professor of paediatrics and child health in 2006, and way beyond that in his emeritus role.

Following the award of his specialist qualification as a paediatrician by the Colleges of Medicine of South Africa, he completed a MD in immunology under the supervision of Professor Eugene Dowdle. After having undertaken a fellowship in immunology in the USA, David returned to the Red Cross Children's Hospital and the Department of Paediatrics and Child Health where he was later appointed as UCT Professor of Paediatrics and Child Health in 1991. Here he excelled as an academic leader of distinction, sustaining and advancing the department's national and global reputation of excellence in research, teaching and clinical service, while also playing an active, hands-on role in each of the domains of this academic clinical triad.

Beyond being an astute clinician, a compassionate doctor, and an excellent teacher, he was a passionate advocate for research. He not only established the Department's first research laboratory in the Institute of Child Health, but also ensured that it was not simply a physical facility, but a home for nurturing many clinical and basic scientists, and for generating cutting edge research. In his own field, he led the development of research in paediatric immunology and

David Beatty

infectious diseases, established extensive international collaborations, and more broadly, continued to supervise and mentor many masters and PhD students, as well as colleagues and emerging academic leaders, way beyond his retirement.

David's academic contribution and leadership prowess was widely recognised and respected, leading to his having generously accepted the University's request for him to serve as interim dean of the Faculty of Medicine at a difficult time in its history. Again, his leadership in this position was characterised by his strength of character, his deep wisdom, and his having the humility to seek advice, to listen, and take the opinions of others seriously – all of which earned him wide admiration and affection.

In his written engagement with the Faculty, he avoided electronic communication, and hard copies of documents would be annotated in his beautiful highly legible handwriting. He was a voracious reader, with a wide range of literary interests, and fellow pedants appreciated his use of the English language, and never having been offended by a split infinitive!

At UCT, as in the public service, retirement policy is founded on an unsubstantiated criterion that at 65 years of age, your value to your academic career ceases, and you are put out to pasture. David disproved this myth over and over, as in that very pasture, he continued to express his commitment to the health of children through delivering clinical services in paediatric nephrology, teaching, reviewing research proposals, and more. But he also continued to serve children in other ways, especially through his deep involvement with the Children's Hospital Trust, of which he was both a birth parent and an ardent, highly effective advocate and fund-raiser. He played leadership roles in the governance and management of several institutions, such as the Sarah Fox Home, and served the Harry Crossley Foundation and its beneficiaries with distinction as an insightful advisor. In their public tribute to him, they acknowledged him as "*a giant of a man, who was kind, humble, wise and loyal. His integrity, sense of humour and his sage advice made him a wonderful Trustee and a friend*."

He showed a keen interest in people, beyond their academic or professional lives, remembering our families, their academic and social achievements - such as a PhD or a hole in one - and could even ask after our dogs by name. But David was also a renaissance man whose passion for academic pursuits matched his other interests.

He was equally at ease on his bicycle or the golf course; framing the beautiful artworks produced by himself and his wife, Sue; and walking their beloved dogs with her every day.

He loved children, and dedicated his career to serving them through his service at the Red Cross Children's Hospital, the University and his many philanthropic engagements. But his greatest love was for Sue; his children John, James, Sandy and their spouses Lisa, Mechi and Ingrid; and his most adored grandchildren, Keira, Francisca and Camila.

His generosity, kindness and magnanimity of spirit will be deeply missed, but his legacy will live on in his family, and in the many people that he trained, supported and mentored over many decades. Many more are thankful that he crossed our paths, and we will remember him as a strong leader, an accomplished academic, a compassionate paediatrician, a caring mentor and a special friend.

Today, 18 November, is David's birthday – he would have been 77 – and I feel so sad, as every year I would send him a message on his birthday, and that would always be followed up with a call, mostly asking about my family, my dogs and me.

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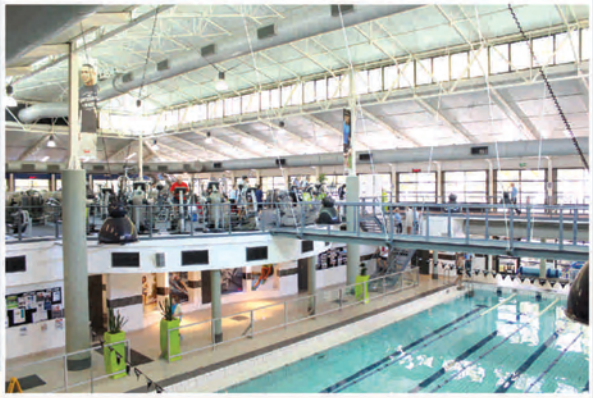

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TRIBUTE

Heather Zar - Recipient of the 2017 Alan Pifer Award

Nadia Krige

Professor Heather Zar, was recipient of the 2017 Alan Pifer Award - a prestigious prize presented annually by UCT's Vice-Chancellor in recognition of outstanding socially responsive research.

Zar, a paediatrician and scientist, has gained a reputation for rising above the challenges posed by a lack of resources to create new strategies to address key childhood illnesses. Over the past 20 years, she has helped improve and save the lives of thousands of children through research and innovation in child health.

It is therefore fitting that she has been recognised with this award, which underpins the UCT's commitment to producing a body of work that contributes to the advancement of South Africa's disadvantaged people.

"It's a wonderful acknowledgement of the work being done by my teams and with many collaborators," says Zar, who is chair of the Department of Paediatrics & Child Health at the Red Cross War Memorial Children's Hospital and director of the South African Medical Research Council's Child and Adolescent Lung Health Unit.

"One of the contributions one wants to make as an academic is helping to improve the lives of people who need it most."

The 2017 Alan Pifer Award also comes hot on the heels of two other prestigious honours for Zar: being named the 2018 L'Oréal-UNESCO Women in Science Laureate for Africa and the Arab States and receiving the World Lung Health Award from the American Thoracic Society.

Innovation – where it's needed most

As a paediatric pulmonologist working in South Africa, Zar has focused on the key illnesses that cause death among children – pneumonia, tuberculosis (TB) and asthma. Although these diseases are treatable, lack of knowledge, under diagnosis and insufficient medical resources pose a challenge throughout Africa.

Childhood pneumonia causes around one million deaths each year, according to global estimates. This burden is disproportionately high in sub-Saharan Africa where pneumonia is the commonest cause of illness, hospitalisation and mortality in children.

The rate of TB infection on the African continent is among the highest in the world. In South Africa, childhood TB makes up about 20% of all cases. Recent estimates of TB prevalence in Cape Town show that 511 of 100 000 cases are children under the age of five years.

Asthma affects between 10 and 20% of children, and studies by Zar and her team show that one in five adolescents in Cape Town is affected.

Heather Zar, paediatrician and scientist, recipient of the 2017 Alan Pifer Award in recognition of her work in child health, has helped improve and save lives of thousands of children.

A practical and cost-effective approach

The challenges of childhood respiratory conditions in low-income communities in South Africa may seem insurmountable, but Zar is combatting them with cutting-edge science. She has been at the helm of developing accessible and cost-effective innovations by applying high-level science to these conditions common in resource-limited settings.

These include developing better strategies to diagnose TB and pneumonia in children from spit, mucus and nasal swabs, and applying sophisticated molecular tests for accurate diagnosis. This work has changed the approach to diagnosing childhood TB globally and has been integrated into World Health Organization guidelines. She has also demonstrated that preventative use of a common antibiotic for treating TB reduced by 50% mortality in HIV-infected children who were not on antiretroviral medication.

In the area of childhood pneumonia, her studies have included defining factors that influence the burden and risk of infection, and improving diagnosis. These have contributed to better preventive and treatment options.

Where the treatment of asthma is concerned, Zar is known for developing and rolling out an easy-to-use spacer made from a plastic bottle to help deliver medication. Zar and her team showed that this homemade device is an excellent alternative to more expensive, commercial devices.

"This has had a large impact on improving care of children with asthma in resource-constrained settings," writes Dean of the Faculty of Health Sciences Prof Bongani Mayosi in his motivation letter for Zar's Alan Pifer nomination. "It provides a way to deliver inhaled therapy to children anywhere."

Drakenstein Child Health Study

One of Zar's recent projects is the Drakenstein Child Health Study, which will follow the lives of 1 000 mother–child pairs living in low-income communities on the outskirts of Paarl. Through this study, Zar and her team aim to investigate the early life determinants of child health and causes of illness. They will focus on risk factors in seven areas that may influence child health and development: environmental, infectious, nutritional, genetic, psychosocial, maternal and immunological.

Mothers are enrolled while they are pregnant and are followed through pregnancy and childbirth. Once the child is born, the study follows the pair for at least five years.

The study has already yielded important new information on the causes of childhood illness and offered opportunities for prevention and treatment strategies.

Fostering leaders in child health

Underpinning Zar's research and innovation, is a strong commitment to capacity building and developing the next generation of African leaders in child health. She has trained several clinical scientists from a range of backgrounds and mentored many postgraduate students and other healthcare professionals from South Africa, Kenya, Uganda, Nigeria, Ghana and Malawi. As president of the Pan African Thoracic Society, she has been able to lead global advocacy efforts to improve lung health for all.

Inherent to this capacity development has been the growth of clinical research sites and infrastructure. In addition to the Drakenstein Child Health Study, Zar has established research sites in Khayelitsha and the Eastern Cape, as well as the Research Centre for Adolescent and Child Health and the Medical Research Council Unit on Child and Adolescent Health at Red Cross Children's Hospital.

When asked what her advice would be to young researchers looking to follow in her footsteps, Zar says, "Find something that you're passionate about and pursue it. Work in a team – collaboration is key – and find a good mentor.

"Finally, believe in yourself and strive hard for those goals that may not seem so easy to attain."

Mark Sonderup - Our Man from Denmark

Norman Mabasa & John Steer

One's always wanted to do a story on Mark, but he's been evasive implying one only writes on colleagues toward the end of their career...that he's certainly not. So Mark brace yourself and wince if you must accept it's a good story, and ... remember you and I met many years ago at a SAMA meeting when you were looking for "money" for junior doctors and I surprisingly was, if I recall, able to arrange this.

I had the temerity to ask Bongani Mayosi about our intent, which he supported and said to contact Norman Mabasa with whom you've had long association. I, using editorial privilege had some input. Respectful of course, but with a touch of fear as to what your reaction might be ... I expect onslaught, but am prepared.

As Norman said this was the most difficult task he'd ever been asked to carry out, not only to write the story of a man, of not only physical but academic prowess as well as taking significant leadership roles in the health profession.

Norman met Mark in early 2000 when he was representing registrars on SAMA. He was eloquent and persuasive, and recalls Mark as witty, forthright and unintimidated during debates with not insignificant presence. There was no hint of introversion. He then mentioned a story a journalist wrote of a well-known "freelance entertainer" practicing his craft in Johannesburg ... wait for it ... a tap dancer, saying whoever did not know Mad Joe did not know Johannesburg illustrating how Joe was synonymous with the City of Gold.

Similarly in medicine whoever doesn't know Mark, is newly arrived, since if you stay a few days one will likely hear him not only on radio, but see him on television or read his statements in the press.

Norman served SAMA with Mark in a wonderfully close relationship when he was Chair and Mark deputy. On leaving SAMA in 2012 Mark took the Chair and became Vice Chair when Makusi Grootboom was elected. He has, to this day, held that position during this time seeing both best and worst of medical politics. Anyone who has ever been in a leadership position in any Organisation understands the confrontations and complexities with this territory.

Mark has been involved in shaping our Health Politics being a cornucopia of information. Ask about the Certificate of Need, Occupation Specific Dispensation for doctor's remuneration, or National Health Insurance and he will clarify both the anatomy and physiology of such debates. And, as you realise from his Danish genotype, he's taken part in Doctor's protests leading from the front in fullest sense. One needs recall in early days he was first a pharmacist and now Hepatologist, mentored by the likes of Ralph Kirsch, working under the elegant wing of Wendy Spearman.

One hasn't noticed evidence of academic introversion and there's an impressive list of memberships. American Association for the Study of Liver Disease, International Association for the Study of the Liver and WHO Strategic Advisory Committee on Viral hepatitis while locally the South African Gastroenterological Society

No stranger to world stage he's council member of the World Medical Association, and board member of South African Rugby Medical Advisory Committee while also Non-Executive Director of PPS Holdings Trust Board, to say the least.

Let's accept that's an impressive list and appropriate for a man who received his pharmacy Bachelorship 'cum laude' as well MB ChB with first class honours in 1995. Don't forget Fellowship of the College of Physicians of South Africa nor Masters in Medicine UCT.

With this plethora of academic achievements he's published locally and internationally while the list of his publications is appropriately impressive. He's given talks and presentations both at home and abroad.

Mark is in addition, not only husband but father. It takes men of Danish fibre to navigate this terrain and one can safely say Mark disproves men "cannot multitask".

Norman Mabasa has told of Mark the Medic and it behoves us to examine his genotype. I attest his stature having seen him in the flesh at Sport's Science, sporting elegant beard adorning a chin which in debate is likely thrust forward. So let's examine his origin.

The Danish age began with the Vikings around 800ad where they were notorious for plundering churches and monasteries, not to mention other well-known actions of this masculine group. They struck fear into firstly North England which by 1878 they'd conquered, then Eastern England. By 11th century King Canute ruled the vast territory of Denmark, England, Norway, Southern Sweden and part of Finland.

So understand where Mark, who led that massive medical protest to parliament some years back, hales from. Then forget not Danes have significant artistic culture and I can well imagine Mark part of the cast of that remarkable film, "Babette's Feast".

I asked Wendy Spearman with whom he works whether she would have further comments and she, doubtless for subtle reasons, declined, the like of which we shall never know.

Personally, I would tremble as a Registrar on his ward rounds although I'm sure he would assure of his enormous tolerance and empathy. For all we know Mark might be an introvert... or something like that.

Mark Sonderup is a colleague who contributes enormously at local and International level who deserves not only our thanks, but enormous respect for his involvement and contribution to our profession in the widest sense. ■

PROFILE

Colin Cook

James Rice

Professor Colin Cook retired from the Morris Mauerberger Chair of Ophthalmology at the end of 2018, following 11 years as head of the division. He leaves the Division of Ophthalmology not only as a centre of excellence, but also with a legacy akin to his particular passion in ophthalmology, namely the Community Eye Health Institute and the Surgical Training Unit for cataract and glaucoma surgery.

Colin was born in 1953 in Southern Rhodesia, a country which ceased to exist in 1963, and his schooling was as a boarder in Salisbury (Southern Rhodesia). He describes his move from high school to the University of Cape Town in 1972 as 'freedom beyond imagining!' and the path he freely chose eventually led him to the Chair in Ophthalmology at UCT in 2007.

He did first year BSc in 1972 and entered second year MBChB in 1973. He admits to 'wanting to specialise in almost every subject' (except obstetrics) during his medical training. He returned to Rhodesia to complete his internship at Mpilo Hospital in Bulawayo in 1978 followed by national service as a regimental medical officer for the Rhodesian Special Air Services. While it is topical to equate training a pilot and a surgeon on simulators, Colin is keen for trainee surgeons to understand that rupturing a capsule during cataract surgery (a significant complication) is similar to jumping out of a military aircraft on a static line parachute for the first time (blind panic). He explains that appreciation of how the complication occurred only comes with training and practice. Fortunately, all Colin's parachute jumps were uncomplicated, and he survived the period of conflict in Rhodesia at that time.

As he describes it, there was 'one happy consequence of his national service', namely the meeting of a 'charming and beautiful nurse' in casualty who was later to become his wife. Colin and Myrna were married in 1980 in Harare.

Colin returned to ophthalmology as a senior house officer in Harare in 1981 where he learned to operate without gloves nor a microscope, performing large corneal incision cataract extractions. He wrote the general surgery primary examination in Edinburgh, Scotland, before returning to take up a registrar post in ophthalmology in Cape Town in 1983. Their son, Stephen, was born in 1984 and daughter, Teresa, in 1987.

Colin has had a passion for community ophthalmology since early in his registrar years. The much-neglected ophthalmology service at Edendale hospital in Pietermaritzburg was to benefit tremendously from his leadership and management skills. Between 1987 and 2003 he transformed the unit from a single room behind the casualty department to "Vulamehlo" (Open eyes) Clinic with new eye wards, new clinic facilities and eye surgeries being performed 5 days per week. During this time, he trained and mentored 45 medical officers as well as setting up a one-year ophthalmic nurse training course which trained 10 ophthalmic nurses. He also recruited medical officers from surrounding districts to train as cataract surgeons and thereby serve the surrounding districts.

His career was particularly influenced by a young, energetic ophthalmology consultant, Dr Peter Steven, who convinced the 5th year medical student to pursue ophthalmology as a career; Professor Anthony Murray, who always modelled meticulousness and professionalism; and Dr Allan Foster, from Christian Blind Mission (CBM), who encouraged his passion for community ophthalmology.

He began work for CBM while still at Edendale in 1996 and was appointed the CBM eye medical advisor for Southern Africa. He developed community eye health training programmes and Vision2020 planning workshops in Southern Africa and taught at workshops as far afield as Latin America and Eastern Europe. He is still actively involved with CBM internationally.

Colin's final move to Cape Town was as a CBM employed ophthalmologist assisting and supporting the cataract surgery programme at Groote Schuur Hospital in 2004. He describes the following two years as ones of 'formation and preparation' as he felt directed to apply for the Chair in 2006, at the time of Professor Anthony Murray's retirement. He took up the Chair in 2007.

Together with Deon Minnies, Colin founded the Community Eye Health Institute at UCT in 2008. The Institute offers certificate courses and a postgraduate diploma in community eye health as well as a Master of Public Health (Community Eye Health Track). It also supports community eye health programme development and research. In addition, together with Will Dean, a surgery simulation unit for training in cataract and glaucoma surgery has been set up at UCT and these two initiatives continue to facilitate the fight against common causes of blindness.

If you are looking for Colin during his retirement, you're likely to find him walking the Camino (the Way of Saint James) in northern Spain. I leave with you some of the ways in which he will be remembered, as described by his colleagues: A strong, empowering leader of utmost humility and dignity; a giant in nobility, leadership, wisdom and patience; calm, consistent and practical; empathetic and kind. He will be missed in the department, but his legacy will continue. Indeed, his trainees span the globe. ■

Colin and Myrna Cook

PROFILE

Syd Cullis

Bob Baigrie

Syd Cullis has long been an institution in Southern Suburbs and GSH surgery. In 1941, our Dads (his was Robin, mine Bags) were both members of the legendary Chain Gang, the South African Medical Corps which did their square-bashing training at Robert's Heights later Voortrekkerhoogte), after many had answered the call by Jan Smuts to return home from overseas and support the troops heading north. Both Robin and Bags served in North Africa. So Syd was born in Pretoria in 1942, but grew up after the war in Bergvliet and boarded at Bishops. Robin took up General Practice and was a generous supporter of surgeon Bags. So from the time I was in short pants I heard about the promising young Sydney Cullis – and he didn't let that reputation down! Colours for rugby, cricket, boxing and athletics, school prefect, head of choir, a host of prizes and a scholarship to send him with some funds to UCT medical school.

A favourite Bob Dylan refrain tells us "You're gonna have to serve somebody" and Syd's life had embodied this from the start, and he is not finished yet! At UCT he won the Frank Forman prize for Service to the Medical School and was the director of the Retreat SHAWCO Clinic (later named The Bruce Baigrie Clinic in memory of my brother Bruce who was killed in his 3rd year). Bruce and Syd played in the UCT hockey club together- an endearing family link.

Always a great traveller and explorer, Syd set off after internship for the old Rhodesia, and worked in the Harari (sic) Central Hospital in Salisbury. Thence locums in London for a year, Durban's King Edward VII for two more, and back to GSH for three years as a registrar. Here he struck up a lifelong friendship and career bond with Peter Jeffery, sealed by Peter marrying his sister Marjorie (little Miss Muffet or Muffy), while Syd stole young Catherine Hathorn's heart in Durban. The story of their ill-starred European backpacking honeymoon is one of Syd's most entertaining and rueful yarns. He still visibly winces as he describes his travelling mishaps which he says represented the first test of Catherine's lifelong saintly tolerance.

Having cracked the local and Edinburgh Fellowships, the happy couple set off in 1976, with their new-born James, for a year of registrar training in Hereford, UK, and on their return Syd joined Peter in persuading John Gasson to take them on as partners. Syd and Catherine celebrated the hope of financial security with the birth of Robyn. After a bit of a rocky start, Peter's brilliant management skills combined with John's great reputation, Syd's commitment and then the arrival of Garron Caine, combined to create a homogenous and balanced practice. These fine men established their unique brand of collegial ethos and loyalty which continues in the partnership 41 years and fourteen partners later.

Always loyal to his alma mater, Syd continued sessions at GSH, pioneering surgical gastroscopy with Peter Jeffery under the tutelage of Solly Marks. Never lacking surgical bravado, they then bought Solly's old scope from him and started the first private surgical endoscopy service in the Cape. This is a great story of pioneering endoscopy and it began in the Wynberg consulting rooms' small kitchenette, with Colleen the secretary acting as the nurse and a foot pump suction device. As confidence grew, and armed with a new scope, Syd and Peter travelled across the city and Peninsula private clinics, even providing emergency services to Somerset, Victoria, Woodstock, Conradie and Fish Hoek Hospitals. For many years in the 1980's Syd drove to Swellendam once a month for a scope list. It is a great history recorded on a display in our Kingsbury rooms.

Solly Mark's Scope

Philip Bornman arrived at GSH in the '80's and Syd helped him establish the ERCP service in those days of rudimentary fibre optic scopes. But their partnership was to go stellar after they travelled to Paris and Dundee together, returning to perform the first laparoscopic cholecystectomy in Africa in 1990. Syd was deservedly awarded subspecialty status as a Surgical Gastroenterologist and was on the inaugural committee (treasurer) of SASES, our still very successful national laparoscopic society. He finally retired from the GIT Clinic at GSH in 2015, a formidable 42 years after he began there.

But "all work and no play makes Jack a dull boy", so Syd made sure he avoided the monster we all know: an all-consuming surgical life. At UCT he had earned a hockey blue, and represented SAU and Western Province, and once in the grind of practice, having reluctantly conceded 1st XI club cricket to work and family life, he turned to marathons and club hockey, achieving national Masters colours in 1993 and became a venerable Springbok Grandmaster in 2014. He has ridden 24 Argus cycle tours and finished 25 Medical-10 races to date. When the Medical-10 stuttered fifteen years ago after the sponsors withdrew, he resuscitated it with new sponsors, a new venue and a remarkable photographic race history exhibition each year. It remains a popular annual affair for colleagues of all ages, and it's all thanks to Syd's prime virtues: tenacity and enthusiasm. We all still miss the witty race commentary of this journal's editor.

Syd loves choral singing and remarkably made the time to keep it up after school. His credits include The Messiah with The London Welsh Choir at The Festival Hall in London, The Three Choirs Festival in Hereford in 1976, the Durban Symphony Choir and many years with the Cape Town Melodic, Philharmonic and Symphony Choirs. Whenever there is an opportunity at some function for a sing along at a piano with some Maurice Kibel type humorous verse, Syd will rope in a group of us to practice and perform.

Twenty years ago, this ever inquisitive surgeon was inspired by his son's school project on Antarctic history, to read further. From this he has evolved into arguably the world's greatest expert on the historical links between South Africa and Antarctica.

Catherine and Sydney at Neko Harbour

His knowledge is encyclopaedic and his much-in-demand lectures are always engrossing. He has travelled to remote parts of our country and elsewhere in search of authenticity and verification, for example the dusty gully where Captain Oates was shot at the start of the Anglo-Boer war, and the columbarium - the vault under the Braamfontein cemetery's chapel - where Frank Wild's lost ashes were eventually discovered. Wild was

Continued on p30

PROFILE

Syd Cullis Continued from p29

Shackleton's right hand man. Catherine and their regular traveling companions know that the itinerary of any cycling or touring holiday needs to allow a few extra days for these historical diversions to remote locations. My favourite sleuthing expedition of Syd's was his trip to Guernsey to find a chess set belonging to Captain Scott's surgeon, Reginald Koettlitz, who had come to South Africa to make his fortune farming ostriches, went broke and died in 1916 within a few hours of his wife, both of typhus. Syd had tracked the chess set, upon which Koettlitz played with Scott, to the loft of a vague relative of the ill-fated doctor, who lived in Guernsey.

During years together at the operating table, he shared these stories with us, and when, inspired by Syd, I set off a few years ago to be an Antarctica guide and tall-ship's surgeon, he generously lent me all his books and his talk material for my own on-board lectures. These stories and slides were hugely popular with the international clients on the Bark Europa voyages, who also loved my description of this colourful surgeon historian.

Syd has entertained countless historical groups in South Africa, lectured at the UCT Summer School and recently organized an exhibition of Antarctic ship paintings by

Peter Bilas at the Iziko Maritime Museum at the V&A. It's a fine legacy of spreading the fame and swelling the name of South Africa in Antarctica.

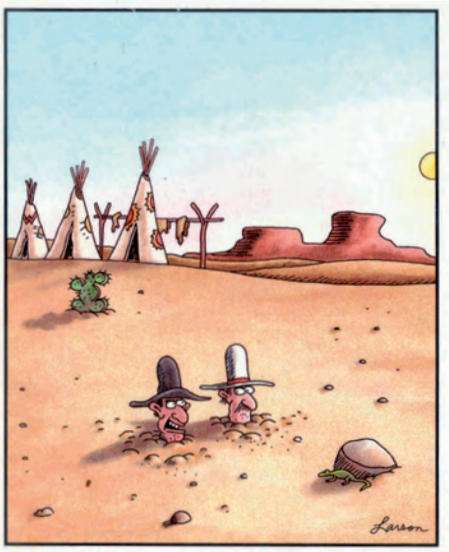
Nothing has demonstrated so well Syd's commitment to his colleagues as his administration of the "Friday morning meeting". He started these at Wynberg Surgical Clinic in 1989 and transferred them to the Kingsbury when the practice moved to this new hospital. Ever since, Syd has organised an annual program of talks on every Friday at 7.30am, school holidays excluded. When I arrived from the Nuffield Dept of Surgery in Oxford (Sean Cunningham's old turf) in 1996, I was invited to introduce myself with a presentation on some area of my interest.

This traditional welcome is one Syd has bestowed on every new colleague who has come to join the hospital. Finally, 10 years after he officially retired from practice, Syd has handed over the baton. Hopefully his occasional "general interest" midweek evening meetings will continue. A lovely memory recalls when Sister Corrie Collins was with us at the Kingsbury, and the two of them provided an unmissable Friday morning double act. Her merciless lampooning of us all at her annual Awards Meeting was the highlight of the year, and was always packed to the rafters.

What of Syd the surgeon in 2019 and the future? This fine friend and colleague continues as an invaluable and ever available assistant to the practice. He will drop anything, anytime and speed over in his red mini Cooper (which Catherine so loathes and he just loves) to help a partner with an emergency operation. They are both fit and travel hungry; daughter Robyn and family have moved in down the road, requiring grandparental duties; the Medical 10 runs again this November; The Philharmonic still requires his fine tenor voice; and there is always a surgeon in the practice in need of a skilled assistant and historian who, as the operative drama recedes, can lighten the mood with a historical vignette.

Thanks Syd ■

"You guys are both witnesses ... He laughed when my marshmallow caught on fire."



"Hey, Frank ... nice and cool here in the shade ... yesiree ... niiiiiice and cool."

"Well, the sloth nailed him ... Y'know, ol' Frank never was exactly a 'quick draw'."

Southern Winds of Change continued from p23

Watson and Crick, received Nobel prizes, and Lise Meitner, who was not awarded the 1944 Nobel prize for chemistry along with her male colleague for their foundational work in nuclear fission. Nettie Stevens, a pioneering geneticist, discovered the chromosomal determinants of an organism's sex, but the Nobel Prize was awarded to a man who described the same concepts later and Marthe Gautier, who discovered the chromosomal source of Down's syndrome, but for which a male colleague was given sole credit for years. Unfortunately the Matilda effect survives but in a more subtle version than in the past.

The excellence of academic medicine in this country has enjoyed international recognition and is a precious national treasure, to be jealously guarded, nurtured and developed. Now, more than ever, these academic departments, which constitute the intellectual backbone of the country and are repositories of our surgical DNA, face critical constraints and challenges. In confronting and overcoming these obstacles, academic surgery will need to adapt and respond creatively to new realities and responsibilities without abandoning their intrinsic and core missions of patient care, education and research. Auspiciously, both Professor Steyn and Muller have broken existing moulds and represent exceptional role-models and leaders for future generations of doctors. On behalf of the medical community we congratulate both surgeons on their outstanding academic achievements and distinguished careers and wish both well with their future endeavours as custodians of our surgical heritage. ■

Jake Krige - The Joys of Academic Surgery

Irvine Eidelman

December 3rd 1967, when Professor Christiaan Neethling Barnard performed the world's first heart transplant, was an indelible date in the history of the Department of Surgery, the University of Cape Town Medical School and Groote Schuur Hospital. Buoyed by this historic event, eight aspirant and eager medical students, clustered around the cadaver on their dissection table in the Department of Anatomy befriended each other at the beginning of the academic year the following year. Little did I know that I would have the pleasure of writing this profile about one of those medical students after a special friendship lasting more than half a century. At the outset I am reminded of the Irish proverb: "a good friend is like a four-leaf clover; hard to find and lucky to have."

In retrospect it was inevitable that Jake and his brother Luke would do medicine. Their father Lou was an energetic general practitioner in Upington, then a frontier town far from major medical centres and near the red dunes of the Kalahari. In the 60's, country GPs were experienced and capable general factotums and it was not unusual for their morning operating lists to range from Caesarian sections to cholecystectomies to thyroidectomies. Life was exciting then and Jake had his first view of surgical procedures at the age of 7 years - wearing a surgical gown and standing on an apple box beside the anaesthetist. Even more thrilling were the Flying Doctor experiences with his father instead of attending school, retrieving bleeding patients deep in the Kalahari and especially when the ex WW II fighter pilot was at the controls, landing on makeshift airstrips and flying at low level, skimming dunes and kameeldoring tree tops.

Jake's first inspiring encounter with a specialist surgeon was at the age of 10. The then United Party senator's 22 year old UCT student son had been kicked in the abdomen by a horse and a pancreatic and splenic injury was suspected. Bill Wilkie, a prominent surgeon in Cape Town was consulted. Six hours later a Ventura bomber (courtesy of the Air Force) landed in Upington delivering Wilkie with his bag of surgical tools and retractors. Krige senior administered the anaesthetic and Bill Wilkie performed a splenectomy and distal pancreatectomy. Bill stayed for dinner and flew back to Cape Town the next morning in the bomber. Ten is an impressionable age and Jake was left with the perception that this was what grown men did and it was a natural and perhaps preordained career progression from there. Many years later, members of the department of surgery at Groote Schuur Hospital including John Terblanche, Raoul de Villiers, Flip Borman and Jake volunteered to assist the army in Namibia. Jake flew by Hercules military aircraft to do his two week surgical tour of duty to operate at Ondongwa Air Force base and Oshikati Hospital south of the Angolan border. He vividly recalls that the first surgical procedure he performed there was a distal pancreatectomy and splenectomy in a young man kicked by a horse. Undoubtly this evoked a 25 year old feeling of deja vu and prescience that he had been programmed and destined to do surgery.

The Krige family subsequently left Upington, his father to do radiology, his mother to achieve heights in clinical psychology, the sons to do medicine and their sister, Alice, to excel in the arts and gain fame on the stage in Stratford and London and in films including "Chariots of Fire" and "Star Trek". The secrets of successful families invariably include the ability to demonstrate and instill specific qualities and moralities in their offspring, virtues and traits which include charity, kindness, tolerance, altruism, empathy, compassion and a commitment to academic excellence. These attributes are amply exhibited in the lives of the Krige siblings.

After preparatory school in Upington with influential seniors including Christo Wiese and JP Landman, Jake left for the bright lights of Cape Town and schooling at SACS where he excelled academically and at rugby and athletics. His leadership qualities were recognised at an early age as House and School prefect by Robin Whiteford, John Ince, Ernie Spencer-Smith, "Doodles" de Kock and Doug Brown. His appreciation and gratitude for the benefits of a SACS education he received in those formative years were repaid later when he had the privilege of delivering the keynote address at the 175th anniversary school celebrations in the JH Hofmeyr Hall and was inducted as the eighth SACS Spectemur Agendo ("let us be judged by our deeds") awardee, joining luminaries such as Justice Albie Sachs and The Lord Hoffman of Chedworth on the Honours Board.

Entry into Medical School at UCT gave Jake a clear sense of purpose as he understood where his ultimate goal was and how he could make a difference. University was also a time of fun and frivolity. Dashing and debonair on campus

Jake and Marj Krige

in his red Porsche convertible, he caused many a UCT freshette's heart to flutter and was a popular dancing partner at the Varsity Spring Balls and University Residence formal dances and required little encouragement to squire Rag princesses and Intervarsity Champagne queens to Intervarsity functions. It was also noted that this same red Porsche was spotted patrolling the road between Camps Bay and Clifton on Sunday afternoons, the driver and his medical student companions wearing deerstalkers of the style normally reserved for the landed gentry and British nobility.

It however was an event as captain of the Saints Rugby team that led to his most harrowing Medical School experience. Chris Barnard was the Honorary President of the Saints Rugby team when an ill-directed water bomb from above splashed the team (and Chris Barnard) during the team photograph in the Med Res quad. Jake thought his nascent medical career had come to an inglorious and sudden end. Fortunately for him he can relate this now hilarious story of how Chris Barnard graciously dismissed the incident with only a stern professorial admonition.

Armed with one of the only three distinctions in surgery in the final year exams he did his surgical internship at Red Cross Hospital with Professor Sidney Cywes, Mike Davies, Heinz Rode, Peter Jeffery and Irvine Modlin and a visiting surgeon from Bloemfontein, Flip Bornman, and then at GSH in Professor Jannie Louw's Surgical Firm with Dr Walter Birkenstock and Dr David Dent in charge and John Robbs, Hans van Leenhoff, Phil Cohen and Mike Smith as registrars. The second six months were in Professor Lennox Eales' Medical Firm with Bernie Gersh, Willem Lubbe and Paul Getaz.

Surgery beckoned and without losing sight of his goal he spent the next year as a Pathology registrar with Professor CJ Uys, Len Anstey, Alan Rose and Andy Tiltman.

Continued on p32

PROFILE

Jake Krige continued from p31

Then the next 4 months as an anatomy demonstrator to second year medical and physiotherapy students before nailing the surgical primary exam and immediately thereafter starting in the Trauma Unit as a registrar with "Bags" Baigrie and Johan van der Spuy.

Charisma and chutzpah were hallmarks of his early career. His ability to charm the night matron on duty and flip pancakes for the night staff between operations was legendary. His life changed dramatically however after 6 months as a registrar in the Louw Firm when he was selected by Jannie Louw to join the Department of Surgery at UCLA in Los Angeles as a surgical resident for exposure to American HPB Surgery with the great William P Longmire, Ron Bussutil, John Jones, Don Schiller and Jim Johnson, an event that changed the trajectory of his career and his life. He returned to Groote Schuur Hospital, completed his registrarship, wrote the Surgical Fellowship and was awarded the Douglas Gold Medal as the outstanding surgical candidate of his year. This was followed in rapid succession by the American and Royal College of Surgeons Fellowships.

Two years as a Junior Consultant for David Dent and Raoul de Villiers followed and then the most desired job of all - a consultant post with John Terblanche and Flip Bornman in HPB surgery. The Department of Surgery at GSH in the 1980's comprised a dynamic and competitive group of surgeons. These were exciting and invigorating times for Jake as John Terblanche was making international waves with original and ground-breaking trials in the endoscopic treatment of oesophageal varices and developing a liver resection and transplant programme while Flip Bornman established a first rate ERCP and laparoscopy service. Together, John and Flip provided superb training for surgeons specialising in HPB surgery, many of whom have made their mark around the world. Under their leadership the Department of Surgery became the Mecca for HPB surgery in the southern hemisphere and disciples from England, USA, Australia, New Zealand, Japan and Europe made the pilgrimage to either visit or complete a fellowship and return home to spread the gospel according to Terblanche and Bornman.

During the rites of passage in surgery one develops friendships and bonds that form the foundations of a career and an anchor in life. Those who have toiled long and hard in the vineyards of empirical data understand the commitment and sacrifice required to succeed. Jake earned his stripes and the privilege as a neophyte surgeon of joining a department of internationally acclaimed researchers who were the ideal role models for a young surgeon seeking to emulate and advance surgery. As he climbed the surgical ladder he in turn was able to inspire younger colleagues and develop the next generation of future leaders. On John Terblanche's departure as HOD, Jake took over the liver surgery programme and then the Headship of Surgical Gastroenterology, HPB Surgery and the GI Clinic when Flip retired.

One of Jake's strengths has been to be intellectually nimble and academically agile in an ever changing and evolving surgical landscape, recognizing that original data are the new currency for success and novel information the rocket fuel necessary for achievement and international travel. At an early stage of his surgical career he identified neglected surgical areas that required analysis in order to compete on the world stage. One such subject limited by a lacuna of global knowledge was the optimal surgical treatment of complex injuries of the pancreas. He pinpointed this deficiency and by the time he had completed his PhD on the subject, he had operated on more patients and written more papers than any author ever on the subject and had traversed the globe as a passionate pancreatic evangelist to appreciative surgical audiences.

Colleagues consider him a surgeon's surgeon, gifted with operative skills, gimlet-eyed concentration, sage judgement and the rare surgical ability of rock-steady composure and equanimity in the eye of even the fiercest storm. But HPB surgery's greatest gift was the entre it gave him to the international surgical fraternity. Endowed with skill and ability and a pioneering spirit dedicated to the practice of surgery, he has been an invited speaker at surgical symposia on every continent and in countries as diverse as England, USA, Australia, France, Egypt, Greece, Israel, Japan, China, Sweden, India, Serbia, Czech Republic and Argentina and given a raft of eponymous lectures. The extensive HPB database he created is today a treasure trove of surgical data which surgical fellows are able to mine and pick the easily accessible low-hanging fruit for publication. Although his CV shows over 200 peer reviewed papers in international surgical journals and 56 invited book chapters, it is the more than 100 papers he has co-authored with registrars and fellows as first authors that gives him the most pleasure and gratification.

Several other areas have also given him great satisfaction. As editor of the South African Journal of Surgery he established a dedicated team of equally committed deputy and associate editors to fulfill the journal mandate as the voice of South African surgery. As President of SAGES he wrote a new constitution for the society, implemented an up to date operational plan to promote academic performance and enhance the quality of research and initiated a major drive to source funding for overseas travel for bright young gastroenterologists. As a founding member and trustee of the SA Gastroenterology Foundation he has been actively involved in postgraduate education of GI Fellows nationally. In 2002 he received the prestigious University of Cape Town Distinguished Teacher Award for recognition as an innovative and inspiring undergraduate teacher and a skilled practical postgraduate instructor of complex operative hepatopancreatobiliary surgery. He has also been passionate about student research support and is proud of the four UCT medical students he mentored who over the years have won the coveted Aesculapius trophy for the best student presentation at the annual SRS national congress.

Jake is palpably concerned with the development of the surgical fellows and registrars, which by its very nature is other-centric and he maintains that South Africa remains a land of great opportunity because of a core of intelligent, resilient, considerate and responsible people. We all know and have learnt that career achievements and success in surgery do not occur or exist in a vacuum and that ambitious juniors need constant support at all levels of development be it departmental, collegial or domestic. He constantly urged his team to remember that success requires innovation, hard work, dedication and determination and that we are placed here with certain talents and capabilities and that it is up to each of us to use those gifts and abilities as best we can.

Jake firmly believes that the blueprint for growing academic champions is self-evident and the formula is simple. All the ingredients for the recipe exist in the department, a robust team with wings to fly, support and access to knowledge and resources and a wise and canny mentor who is a global expert and who is willing and able to consult. These elements are priceless. All truly great surgeons show resilience in the face of adversity and carry scars on their backs to show for their efforts. It is the transmission of years of experience that successful operators are able to transfer to the next generation. Jake's consistent mantra to the surgical fellows has been that the starting point of all achievement is the will and the desire to succeed. His exhorting refrain is that each is the master of their own destiny to make your life what you want it to be. His chorus is that one does not wait for things to happen and wait for someone else to make it happen. His lesson for life is to go and make things happen. He is justifiably full of admiration for the new generation of skilled HPB surgeons, Ed Jonas, Sean Burmeister and Marc Bernon who will fly the UCT flag with distinction.

Jake appreciates that medicine is about the connections we make, the deep connections with a patient in the ward, surgical fellows in the departmental fellowship program, colleagues and staff in the unit, or students at the bedside. This is why he does surgery and why he reminds the registrars of the privilege and the responsibility of being a surgeon. He says his patients have taught him much about strength, confidence, and resilience in the face of risk. It is a privilege to go with each patient on their journey. Who else in the world gets to do that?

Jake acknowledges that any success he has had has been due entirely to the devoted support and encouragement in his career and in life by his charming and talented wife, Marj and his family. Jake is most comfortable and at ease in the garden with a beer or a red-blend in hand and braai tongs instead of an endoscope at the ready, with Marj ever the gracious

Continued on p33

Gerald Maarman

Elbie Els - Matieland Voices

"Respect people, irrespective of who they are and what they can do for you. Nothing in life (that is worthwhile) will fall into your lap; you have to work hard for it."

With poor Grade 12 results and a challenging life in Eerste River where gangsterism, alcohol and drug abuse were part of everyday life, Gerald Maarman did not have much hope for the future. His dream to become a doctor seemed impossible when his first application at Stellenbosch University (SU) was unsuccessful. Fortunately, things changed for the better and the SciMathUS post-matric programme at SU gave Gerald a second chance. With their excellent support, he gained access to the University.

In 2004, he started with his BSc in Human Life Sciences and thereafter, BSc Honours and MSc degrees in medical physiology at the Tygerberg campus. Thereafter, he obtained a PhD in cardiovascular physiology at the University of Cape Town. This was followed by a two-year postdoctoral fellowship, research fellowships in Europe, multiple awards and approximately 35 publications (published and manuscripts in preparation).

"The South African Rooibos Council was the first funder to see my potential as a junior researcher, and funded me to investigate the underlying mechanisms of Rooibos-induced cardio protection. They have been instrumental in my success and I am thankful for their support," he says. He is currently in the process of establishing himself as a researcher in the niche of cardiopulmonary disease, and is a Research Manager at the Desmond Tutu TB Centre, Department of Paediatrics and Child Health, Faculty of Medicine and Health Sciences at SU.

Gerald Maarman

Other funders that have helped him to establish his career include the South African Medical Research Council (MRC SIR Grant) and SU's Faculty of Medicine and Health Sciences with its funding support for early career researchers. "Another highlight is a clinical study of which I am a collaborator, a study that will investigate the pathogenesis of pulmonary arterial hypertension in patients who previously had tuberculosis and moderate/severe lung damage." Gerald dreams of becoming an internationally renowned researcher who contributes significantly to the field of medicine, conducting scientific research that has clinical impact.

He has been working with SU and other institutions for more than 10 years as a motivational speaker, and is a mentor to health professionals and postgraduate students. He also is a Gospel singer and songwriter, started performing at the age of eight, and recently featured on an album of a Grammy award nominee and Dove Award winning artist.

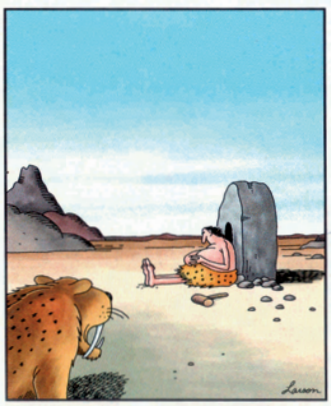
"I want to touch lives wherever I go whether it is through my practical Christian faith, my voice, music or the ways in which I treat those around me. When I die, I must have left my mark in this world, people's lives must be better just because God graced me to step in."

Gerald is a firm believer that respect and hard work go a long way. "Respect people, irrespective of who they are and what they can do for you. Nothing in life (that is worthwhile) will fall into your lap; you have to work hard for it."

He plans to release a book about his life challenges as a means to motivate young people to achieve success in spite of adversity. He believes that *"to have a vision is crucial, because if you don't have a vision you will drift around aimlessly and be easily swayed by everything that comes your way. Your history or past mistakes do not define who you are, neither who you will become nor your destiny."* ■

"Let go, Morty! Let go, Morty! You're pulling me in! ... Let go, Morty! You're pulling me in!"

"And what is *this*, Nurse Wilkens? I distinctly asked for the *big* scalpel! Big scalpel! Big scalpel!"



Thag Anderson becomes the first fatality as a result of falling asleep at the wheel.

Jake Krige continued from p32

hostess, and with family and friends around, Jake explaining the intricacies and skills necessary to be an expert braaimeister or pontificating on the topic of the day or regaling all with deliciously delectable and invariably self-deprecating spekskietery and skinderstories. For him and for those around him surgery continues to be the ultimately gratifying and fulfilling journey in life. As he enthusiastically encourages the surgical registrars, "life is full of surprises, nothing is inevitable, nothing is preordained, and it is incumbent on each of us to set our own goals and chart our own course, which is what makes life so infinitely rich with promise and possibility". The essence of Jake's leitmotif can be distilled as *Live! Live the wonderful life that is you! Let nothing be lost upon on you. Be always searching for new sensation. Be afraid of nothing* – Oscar Wilde. ■

ISSUE

Blue Pill-Pushers - Why is Viagra being marketed to young men?

Lara Prendergast

In September last year, official figures showed a startling rise in the number of young British men turning up at A&E with painfully persistent erections. The number of admissions for priapism, to use the medical term, has increased by 51 per cent on the previous decade. Medical experts suggested that the cause was young men taking Viagra in combination with other illegal drugs.

This may come as a surprise to anyone who assumed that taking Viagra was the preserve of older men who want to keep their sex life going for as long as possible. But now, 20 years after the famous blue pills were first approved, they are a lifestyle drug for young people. A reasonable question to ask is why younger men, in the prime of life, should need Viagra — or want to take it. Aren't they virile enough already?

Marketing plays a big part in the story. In 2014, the branding agency Pearlfisher was hired to rebrand Viagra for the Russian market. The brief was to adapt Pfizer's drug for a 'changing consumer profile'. The 'A' at the end of the word was enlarged, to make it look more tumescent. The box was redesigned so it resembled a packet of chewing gum — to have a 'snap, crack, pop' feel. Viagra was repositioned as an aspirational drug, with 'premium credentials', to be offered to 'powerful and dynamic' men. The advertising babble sounds ludicrous, but the plan seems to have worked. Young Russian men now feel comfortable taking Viagra at the end of an evening — and discarded packets have become a common sight among the usual detritus that litters the streets.

The drug has not yet had the same rebrand in the UK. Still, a proliferation of adverts on the London Underground suggests a similar drive is under way. Viagra seems to be being pitched at British men of all ages; a jolly elixir to perk up one's sex life. 'Order online, deliver in bed,' says one poster. 'Firm up your plans for Valentine's Day,' reads another. For bargain hunters, Poundland sells 'Nooky': a 'natural' knock-off version of Viagra. Later this year, pharmacies will start selling 'Viagra Connect', an over-the-counter version of the drug that doesn't require a prescription. Picking up a packet of Viagra will soon be as easy as buying a bottle of Night Nurse.

This will make Britain the first country in the world where Viagra can be bought without prescription. The aim, according to Pfizer, is to help men get hold of the drug more easily, without the embarrassment of having to go to the doctor to ask for it. Male embarrassment may explain the enormous black market for the drug in Britain. In the past five years, £349.4 million worth of counterfeit Viagra has been seized. Impotence drugs now account for 90 per cent of all captured counterfeit pills. A comparable story is playing out across the Atlantic. In a single week in 2016, Canadian police seized $2.5 million worth of counterfeit pharmaceuticals at the border, 98 per cent of which were for sexual enhancement.

In December, the first generic version of the drug appeared in the US, and Silicon Valley types sniffed an opportunity to profit. Zachariah Reitano, a 26-year-old entrepreneur, recently launched 'Roman', a men's health 'cloud pharmacy'. The app aims to provide a 'seamless and affordable way' for men to get hold of Viagra or cheaper, legal versions. Roman's target customers are 25- to 45-year-old men. Which brings us back to the question:

why are young men taking Viagra, or feeling under pressure to do so? The simple explanation would be that they are taking it recreationally, in order to perpetuate their hedonistic lifestyles. Viagra means that men can be intoxicated with all sorts of other substances, legal and illegal, and still perform sexually. But the paradox is that younger men are known to be more abstemious than their predecessors, more addicted to their smartphones than to hard drugs.

What is more likely is that smartphones are part of the problem. A generation of men have grown up with easy access to pornography. Compared with the exotic appeal of the internet, normal sex seems vanilla. '-Pornography addiction' is a modern malady and there is plenty of evidence to suggest that men are seeking treatment because of it. One US study published last year showed that men who regularly watched porn were more likely to suffer from impotence. In 2011, an Italian study came up with the term 'sexual anorexia' to describe the divorce of sexual desire from real life.

The ease of access to pornography comes against a backdrop of girl power and female emancipation. Men and women find themselves pitched against each other in an increasingly vicious gender war. The #MeToo movement continues to topple prominent male figures who have misbehaved by the day; the battle cry is that women should no longer feel under pressure from men to behave in a certain way, especially when it comes to sex.

But this expectation culture cuts both ways. The rise in the number of young men taking Viagra — and Pfizer's interest in pushing it towards them — hints at the fact that many feel they must also perform in a certain way. Our era is hypersexualised and hyperprudish: men are told to be macho, yet soft. It's no wonder there is confusion. Jordan Peterson, the psychologist, has recently become a cult figure in large part because he addresses the subject of emasculation. 'The West has lost faith in the idea of masculinity,' he says. I suspect men feel this loss more keenly than women. Viagra just offers a temporary escape from impotence.

The Spectator 3 March 2018

Adrian Lombard - Falconer

John Steer

There are very few South African medics who head international associations but we have one in Adrian Lombard, who was for many years, President of the International Association for Falconry. www.iaf.org

Understandably because of the fact, that historically it is in many ways part of an ancient tradition, and you find countries of the such as Turkey, Tunisia, Pakistan and in fact the entire Middle East and beyond as members. It was first developed in Syria some 3000 years BC and Adrian has some wonderful photos of himself and the Middle Eastern falconers replete with classic garb and their superb falcons.

One needs little imagination to picture the complexity of the politics involved. Behind what would seem to be a quiet exterior, there can be no doubt Adrian must have formidable political skills in resolving what must inevitably be international sensitivities and territory, making him a skilled "international negotiator"

Born in Zimbabwe Adrian was schooled at the well-known Falcon College where he first began his association and subsequent love of falconry, by working with a vet in a wildlife operation called Noah. In addition he met Peter Steyn, one of South Africa's most distinguished bird photographers who was one of his school masters. It was at college he began flying falcons which became his passion.

Qualifying in Harare he then became a medical officer in the famed Selous Scouts where he saw significant action and remained until in 1980 they closed shop.

He moved South to Fish Hoek and took over from the charismatic Nick Lee, previous editor of the SAMJ, then in association with Steve Rushworth and Mike Smit. In many ways, he and Malcolm Henry, who have been together some 20 years, established the Fish Hoek MediCross.

In addition to medical practice, he and his wife Sylvia, established a bed and breakfast. They produced three children, Francis, Rowena and Alexa, who in turn produced four grandchildren. One notes daughter Alexa having been World surf ski champion, was also third in the World Canoe masters.

Falconry is a demanding hobby with some 150 members in Southern Africa of whom 60 are in the Cape. But of interest is that he's the only medic involved amongst the many professionals in the club.

Adrian Lombard (Photo: Mark Williams)

The falcons are kept in mews and trained on farms with Guinea fowl frequently the target. They need three flights a week as minimum exercise and preparation takes some three weeks to get a Falcon hunting trained.

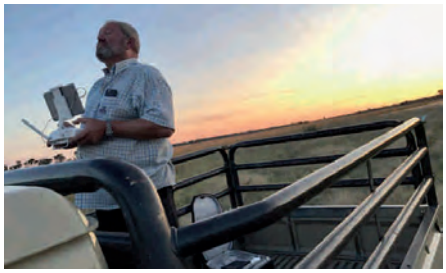
Goshawks are most favoured being the easiest to handle, but the best are the Peregrine falcon, or Black Sparrow Hawk which can live some 15 years. Of interest is their use in controlling problem birds for example, at golf courses where Egyptian geese are a particular nuisance.

Most falcons are taken from the wild of which there are essentially 10 species. There is of course an illegal trade in falcons, the most notorious of which came from Holland.

The secret of falconry is its internationalism which is the only reason why there are 110 members of the association from 80 different nations. Sheikh Zayed bin Sultan Al Nahyan of the United Arab Emirates was sensitive to discord between falconers and conservationists and brought these groups together. This is a remarkable hobby and it's hard to believe that Adrian is the only local member. I'd be surprised if on reading this tribute, more doctors don't contact him for info on how to join.

To have had a South African as the International President is an enormous compliment to Adrian which fits in with firstly his innate courtesy and ability to communicate but also a compliment on managing the politics which must inevitably come with such a wide spectrum of global members.

Adrian's address "A word from the President" can be found on https://www.iaf.org/download/AWordfromthePresident.pdf or read up on "Falconry in Southern Africa" on https://www.ewt.org.za



Frans Duminy at the controls

In Cape Town we have two uniquely positioned medics. Firstly Adrian as the International Chair of the Falconry Association and secondly Frans Duminy the only commercially registered drone trained medic which opens up all kinds of potential challenges and opportunities. But then recall in the past he was once a camel owner which in many ways links him with the Bedouin falconry. ■

PROFILE

Tamryn Green - Miss South Africa and runner-up to Miss Universe 2018

Margi Halkett

Born in Worcester, Tamaryn Green moved with her parents and siblings to Paarl at age 9. She attended William Lloyd primary and New Orleans secondary schools. She is the middle of three children, her older sister, a qualified physiotherapist and younger brother studying BA Humanities. She believes the holder of the title Ms SA should be humble, but confident, kind and compassionate, true to herself and her beliefs, with good communications skills and an ability to relate easily to people. She should be confident, hardworking and passionate about representing South Africa to the world.

Her parents, both in the field of education, Mum as a teacher of Grade R and Dad an adviser of curriculums in Life Sciences are her role models and she cites them as being her inspiration to succeed in whatever she does.

One of Tamaryn's favourite things is her love of spending time at home with her family and friends, and she lives her motto, "healthy body, healthy mind" with regular attendance at the gym. A keen lover of nature she can often be found swimming in dams, pools or ocean, and hiking ... another of her passions which ticks the therapeutic boxes for physical and mental health as well as all round fitness.

No stranger to the world of pageants, the 23 year old Miss South Africa is Tamaryn's eighth competition of which she's previously won the titles of Miss Immanuel, Miss New Orleans, Miss Rochester and Paarl's Miss Funky Buddha. Her favourite Miss SA, Rolene Strauss, achieved the goals Tamaryn set herself as a little girl, in that she went on to take the Miss World crown, qualify as a Doctor and marry and start a family.

As a UCT 6th year medical student, whose studies will more than likely be put on hold for the year of her reign, and a survivor of TB, Tamaryn was perfectly poised to take her personal *#breakthestigma* campaign, using the Miss South Africa title as a platform when she addressed the UN General Assembly

In her own words *"The world is on the cusp of a global push to deal with this killer disease. I am very grateful to have the power of Miss South Africa platform – which is so much bigger than I could ever have imagined – and to be in a position to make my voice heard. Because of my title, I have an opportunity to help as many people as I can."*

She aims to inspire, educate and motivate South African women to overcome their challenges! ■

Spike Erasmus

Spike Erasmus

I started my life on a remote farm in the district of Somerset East in the Eastern Cape. By road, we were three hours away from Somerset East, our main town, having to cross eleven drifts and thirteen gates on the way there.

At the age of five I left home to go to school in Somerset East at Gill College, one of the oldest schools in South Africa.

Always being the smallest, thinnest and youngest in my class, I got the nickname "Spyker", which somewhere along the line changed to "Spike".

After my stint in the army I came to Stellenbosch. I was unsuccessful in being accepted into medicine as my matric marks were not good enough. In those days, however, the first year medical course and the standard BSc first year, accepted that an E and English Lower Grade didn't have anything to do with understanding a scientific subject, so I got good enough marks in my first year to join the medical group in my second year.

We were lucky to be able to spend two years at Stellenbosch and then moved to Karl Bremmer hospital with a residence in the bush, in what in those days was called Tier Vlei. We were only 60 medical students and being such a small group was wonderful. We all knew everybody's vices and virtues that made that year very special.

In my third year I had a bit of a crisis, we had introductory internal medicine lectures out of a book called "Symptoms and Signs", written by Chamberlain – a black book with orange stripes printed by Oxford Press. The book was, to me, totally uninspiring. It had some strange pictures of sick people, and a strange smell. Our lecturer was, in a way, similar to this book. At this point I decided that medicine was not for me. I contemplated stopping medicine and changing to engineering, but knowing the attitude of my father, I knew that would create a huge problem. Luckily a week or two later we had an introductory lecture on orthopaedic surgery and there and then I decided this was my way out.

After graduating I spent one year in a hospital in Malawi. There were 25 doctors registered with their medical counsel serving a population of 3 million people! This situation forced one to be very innovative and learn fast. In 1980, after finishing Orthopaedics at Stellenbosch, I went on a trip to America. I spent two weeks with John Insall in New York, at that time, the guru of knee surgeons. It was the first time that I saw security guards and bottled water. I thought it would never come to South Africa! From New York I went to Los Angeles to Norman Sprague, who had just started doing orthopaedic knee surgery, and from there to a course he organised on arthroscopic knee surgery, and we all attended this course. From a financial point of view, I really had to scrape the bottom of the barrel to do this, amongst other things, staying in an underground cellar in New York, getting fat from eating doughnuts, and living on coffee that was freely available in hospitals. This visit, however, was probably the most important thing I did in my career as it opened my vision and allowed me to build a network in the field of knee surgery.

In my career I had very special colleagues. The first I'd like to mention is a very special physician Ottie Bock, in who's firm I started my career as houseman. One of my orthopaedic mentors was Ken Pretorius, a hand surgeon – he taught me to be innovative and always look for ways to improve things, never to fall into a groove, swim upstream and never float downstream he would say.

When I started my professional career, the Liesbeeck was a big divide between UCT and Stellenbosch and I was lucky to meet and befriend Dave Pollock, a lifelong friend and colleague. There was an immediate symbiosis between us, allowing ideas to be thrown around, and look objectively at new innovations. I always had an abundance of ideas and Dave was more critical and objective. From a sport medicine side I was lucky to meet and become friends with Augie Cohen, who for years, was the doctor of the Western Province Rugby Team, as well as Francois Malan who was looking after the rugby players in Stellenbosch.

I think one of the most positive things in my life was the ability to cross the Liesbeeck and get acquainted with the best of both worlds.

I was lucky to start orthopaedic surgery at a point when arthroscopic surgery had just started to emerge, and this had a huge influence on our field, especially with sport injuries. At that time there was a perception amongst older colleagues that it was impossible to operate through a hole as one needed proper exposure, but this has been proven time and again to not be the case. We now stand at the beginning of a new era, consisting of 3D printing of patient specific prosthesis, and the use of robotic arms to be more accurate in our surgical procedures. This is, once again, an exciting era, one which I believe, will have a profound effect on how we operate and treat our patients. We as older colleagues should not be too critical of our younger colleagues for following these new trends, as long as they recognise that there must be scientific proof that there is indeed a benefit from these procedure, and that it is cost-effective.

Looking back at my career I am thankful for all the opportunities that came my way, for wonderful colleagues, orthopaedic surgeons, anaesthetists and nursing staff, the latter who I believe are not appreciated enough.

I do not have any regrets concerning my life and career although I could perhaps have spent more time with my family. I was however lucky in having my wife, Louise, who really cares about the family and the children, with the result we are still one big happy family, consisting of three sons, a daughter and five grandchildren.

I asked my wife Louise what she would say and this was her comment: "Sometimes it felt as if we were in a desert for 40 years, working, rearing children and attending congresses. The desert life experience was living with this man to whom time for rest and relaxation meant little. We did hike together, we cycled together and we wind-surfed together. I never ran like him and he never played tennis like me, but as different from one another we are, there was always the complementary aspects of our lives that brought us nearer to the promised land of blissful happiness. Through sickness and health we have been blessed to run this race side by side for 44 years. ■

PROFILE

Sandie's Journey

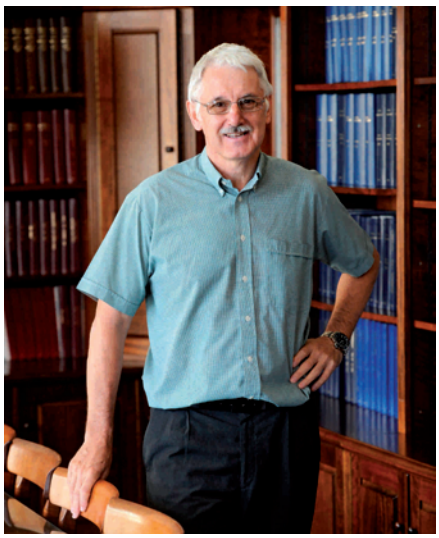
Jake Krige

Now that Sandie has handed over the Headship of the GI Clinic at Groote Schuur Hospital and winds down, he can reflect with pride and satisfaction on a remarkable career. The key element in life, as in a career, is not the ultimate destination, but the journey. As many will know, Sandie's embryonic journey started in Lossiemouth, a fishing village in north-east Scotland. Steeped in Celtic and Scottish Gaelic tradition and exposed from birth to the exploits of William Wallace, Rob Roy and Bonnie Prince Charlie, Sandie and his three older siblings were always destined for success, encoded with robust highland DNA from Horace and Mabel, his supportive and achieving parents. He excelled at Lossiemouth Junior and subsequently at High School in the cathedral city of Elgin and finished with a distinguished scholastic career at the Aberdeen Academy.

Although St Andrew's is the oldest University in Scotland, it was Aberdeen, the oldest medical school in the English speaking world that beckoned. His greatest sporting success at medical school was his selection as captain of the Aberdeen University golf team to compete in the Scottish Universities championship. While at university and not on the links he wooed and won the hand of a fair maiden from dough school, Margaret Blease. Such was his love and abiding passion for aforesaid maiden, that he forsook all inclination and desire to attend his own medical graduation, and married said fair maiden at Netherbeholm Kirk on graduation day, clad in the Thomson clan tartan kilt and resplendent in full Highland garb with matching sporran and dirk.

After completing his internship in Aberdeen at the Sick Children's Hospital Sandie set his mind on becoming a surgeon. By serendipity he had joined the Royal Air Force for the last 2 years at medical school and accepted a short service commission as a pilot officer. By this time Spitfires and Hurricanes were no longer airworthy and he cut his aviation teeth flying Chipmunks, the Royal Air Force standard training aircraft. Secondment to the Birmingham Accident Hospital was followed by appointments at RAF Cosford, Knockton Hall and Ealy before an overseas posting to RAF Akrotiri in Cypress as Squadron Leader. The heady Boys Own stuff came to a close when Sandie returned to earth and Aberdeen to do a mundane rotation in paediatric and cardiothoracic surgery.

But Sandie was clearly destined for greater



Sandie Thompson

things. He set off for Boston and completed a ChM in surgery on indirect calorimetry measuring energy expenditure by oxygen consumption and carbon dioxide production in postoperative patients. He returned to Aberdeen, a decision which ultimately had a significant influence on his subsequent career. Hugh Dudley had been in Aberdeen before going down under to Monash in Australia and had been a mentor to Lynn Baker who became Head of Surgery in Durban. Lynn was invited to return to Aberdeen to do Grand Rounds and give a lecture. Lynn Baker met and immediately recognized the ability and the surgical potential of the young bearded Thomson and offered him a senior registrar job in Durban where Sandie duly arrived in 1986.

Those were halcyon days in Durban with Lynn Baker at the helm of the department, aided and abetted by a strong team which included John Robbs, Arif Haffejee, William Huizinga, Edoo Barker and Fred Luvuno. This appointment led to a lifelong friendship with Lynn and the privilege of close contact with a master surgical technician. Impressed by Sandie's abilities and performance Lynn appointed Sandie as a consultant after a year in Durban. Here he developed and honed his all-round skills in surgical gastroenterology and especially in liver, pancreatic and biliary surgery.

Sandie's skills and talents were evident and did not pass unnoticed. He was head hunted to fill the vacant headship of medical gastroenterology at Groote Schuur Hospital, a remarkable but not unexpected achievement for those who know him well. After his migration south and arrival in Cape Town Sandie achieved much as a leader, teacher, researcher and mentor while at the helm and added value and brought lustre to the GI clinic, to the

Sandie and Jake

department, to the Faculty, and to the University. Sandie's versatility and dexterity in particular were admired. His talents ranged from endoscopic wizardry to penmanship and naturally to golf. I believe there is an untested hypothesis which states that endoscopic ability and in particular, ERCP skills, are directly related to golf handicap, which probably explains why Sandie is so good at both.

In terms of penmanship Sandie was an able deputy-editor of the South African Journal of Surgery during my editorial tenure and has subsequently taken over the editorial reins. Those who have read and are familiar with his work will know that he writes persuasively and convincingly with flair, panache, style and confidence, as of course, did many of the great doctor authors of the past. We think of Arthur Conan Doyle, John Keats, Somerset Maugham, Anton Chekhov and others. In fact, it was Chekhov who said "Medicine is my lawful wife and writing is my mistress, when I get fed up with one, I spend the night with the other" So I can truthfully reassure Margaret that when Sandie was not at home of an evening, he was with me at work, both of us attending to a mistress!

Success in surgery and gastroenterology at the highest level is never the result of spontaneous combustion and requires passion and persistence to ignite the spark and to fan the embers and sustain the fire within. In recognition of his leadership abilities, Sandie at various times has been President of the Surgical Research Society of Southern Africa, President of the South African Gastroenterology Society, President of the South African Society of Endoscopic Surgeons and President of the Association of Surgeons of South Africa.

It was a testament to his talents and tenacity as a surgeon and gastro-enterologist and his accomplishments

Continued on p40

Barking Mad or Finest Kind? The Peter Berning Story

Martin Young

There is a gravel road that turns off the N2 opposite the township of Kwanokhutula outside Plettenberg Bay, heading away from the sea in the direction of the distant Outeniqua and Tsitsikamma hills. The view is stunning, and one that relatively few visitors or even residents in that area see – of wide-open farmlands, hills, green belts and natural vegetation in the valleys. On a clear day one can see all the way to Natures Valley and the Crags. It is a sight just as beautiful as the better-known ones in the area.

The road to my destination, the home of Plett GP and adventurer Dr Peter Berning and his wife Joan had two prominent signs that one could not miss. One said 'Barking Mad' and the other 'Finest Kind'. They pointed in the same direction.

Only a lot further down towards the end of the road did the signs separate and lead to two clearly different but neighbouring properties. I turned right to Finest Kind, the address I had been given. But the other sign had been a provocation, perhaps one that could apply to a small-town doctor who has on occasion been seen trudging along the Plett beaches tugging large tires through the sand via a harness for no apparent reason. Was Peter Berning indeed barking mad?

I was asked to find out.

We met cordially, then sat to talk comfortably on the farmhouse veranda, overlooking the same view that had caught my attention as I arrived. Peter had, typically, been busy making a video on how to treat and prevent blisters, and the props were all over the table in front of us.

Where did you grow up?

My Dad was in the 'mega' class of medical graduates in 1950 at UCT and I was born on his birthday in 1951 at Frere Hospital while he was doing his housemanship at the same place. In early 1952 he bought a practice in the Transkei, which is where I grew up. He was a district surgeon there until 1972. I went to school in Queenstown – Queens College – matriculated there in 1967 and went straight to UCT, Smuts Hall in 1968 and went on from there …

After you qualified?

I did my housemanship at Victoria Hospital in Wynberg, a fantastic training hospital for GPs, then early in 1975 I went to do locums, army in 1975, 76. I married Joan in 1975, worked at day hospitals in Cape Town for a while – Heideveld, Langa, Gugulethu, KTC – and then we travelled overseas.

Do you speak isiXhosa?

Martin Young and Peter Berning

Yes I do, but I needed to polish it up. I saw a patient today and did the whole consultation in isiXhosa. It makes a huge difference.

How did Plettenberg Bay come to be your home?

After travelling overseas, I realized I needed anaesthetic skills at some stage, and I managed to get an anaesthetic job in Anton Ferreira's department at Groote Schuur Hospital, and I spent two years there, but I knew I was not going to be an anaesthetist. I left straight for there in 1981 to come to Plett where a GP job had become available. I replaced one of the two doctors here at the time, and very soon afterwards a third doctor arrived.

How big was Plett at that time?

2000 black people, 5-6000 coloured people and I'm not sure how many whites

That makes you the longest practicing in GP in Plett?

Yes. John Donald came in the late 1980's, and Peter Honeywill came at about the same time. Peter still works for me – he's 83 and still going strong!

Now there must be 7 or 8 GP's in Plett?

I counted eleven!

I know you have the postal address P O Box 1 – that's usually the domain of mayors and very rich people. How did you ever manage that?

I inherited it from Glennie van Hoogstraaten, the GP I replaced. She started her practice at 1 Kloof Street, which was erf no. 1 in Plett, part of a block owned by Helmar Thesen of Knysna fame, and the box number went along with the practice.

So that puts you here for nearly 40 years?

37 years now, yes

What were the early days of your practice like?

My anaesthetic experience and diploma proved very valuable, and in the early days, for example, the other GP Dr Willie Strauss would have a tonsillectomy and other minor procedure list in Knysna. He would pick me up and we would go through and do the list there before coming back around 10.00am to start our day in Plett.

So all hospital work had to take place in Knysna?

Exactly. There was just one small municipal clinic in Plett. That was all. I used to do runs monthly to outlying areas like Buffels Nek, but when those clinics became established with nursing sisters that was no longer necessary.

So you had a mixture of state and private practice?

The state work was all district surgeon work, including the forensic work, the post mortems etc. that my colleague did not want to do. It is messy work, but as a young starting GP I had solid support from both the police and my colleagues. I gave it up in 2003.

How has your practice changed in those years and have those changes been good or bad?

I think the changes have all been good. The much-needed influx of specialists started in the 80's and 90's. The nature of our daily work changed.

And this wasn't a bad thing for you? The limitations over what you could do and not do?

Not at all. I feel it was a huge advantage. To have someone I can pick up the phone and send all my problematic cases to, and to have the support in treating minor disorders in their fields on my own was invaluable.

What are the biggest highs and lows of small town general practice?

You can't do your shopping without being interrupted at least two or three times because you will always meet people who want to discuss their problems in the aisles, but I don't see that as a low. Very few lows – I've always really enjoyed the work.

Has the advent of managed care, turning GP's into gatekeepers been a negative in your eyes?

It hasn't really affected me until now. One case in point - Discovery Health has now nominated a designated doctor to manage diabetes, and who happens to be in another town, and Discovery expects my diabetic patients who are Discovery members to go there if they want Discovery to cover the bills. This may not only be an illegal expectation, but is unethical, implies supersession, etc. But that's about the worst of it for me.

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PROFILE

Peter Berning continued from p39

You are well known as an adventurer. Where did that begin, and where has it taken you?

I was a conventional sportsman at school and university – cricket and rugby. Nicky Behr was the initiator of this road for me. He was once married to Glennie van Hoogstraaten, and ironically it was their divorce that brought me to Plett to take over her practice. Nicky and I became friends. We would walk and talk a lot together. He said one day that he would like to take me with him to Verbier, where he went every year, if I would take him walking along the Transkei. As a result, we walked in stages the whole of the Transkei coast, something which has now become very popular today as assisted walks. On one of those walks we woke up to see the Oceanos liner sinking right in front of us, and slightly further down the coast the captain who had infamously been the first to abandon ship on the beach being interviewed.

This association with Nicky morphed into an invitation by his Verbier and Geneva friends to go on a three-week hike in Nepal, along the direction west towards Pakistan, not the common routes. We went over three mountain passes, and very high. I found I could do that kind of thing quite easily.

The aftermath of this trip was another invitation to do Aconcagua – one of the seven summits, and the highest outside the Himalayas - in 1989 / 1995 and I went along as group doctor on Nicky's recommendation

Did you summit?

Yes, we did. These invitations kept coming at me, and if you don't say no they happen.

I then got an invitation to go to the arctic from my old rugby captain. To cut a long story short in 2005 we entered a South African team to race across the Artic to the North Pole. We worked out it was probably about 700kms, unsupported, pulling sleds, and got it done in three weeks. It was fantastic.

From that invitation followed two sponsored trips down to the Antarctic– one to the South Pole and another to climb Mt Vinson. These were sponsored trips and done for charities.

What do you still have left on your bucket list? Mt Everest?

Not at all! It's too dangerous, too expensive, one in five die, why would you? Sean Wisedale, who came to the South Pole with us, was there with the big avalanche. We've seen the movies about it. It's not on my bucket list.

Are you still flying?

No. I gave it up. It was becoming too expensive, too selfish, and too difficult to keep up the medicals etc, etc. I walked away after 25 years without regrets.

I recently visited the highest volcano in the world in Chile with Sean Wisedale, and got mountain sickness there. I probably wasn't fit enough and might have been sick as well. You can drive to 5000m there and it seemed like just another 1000m to go. I'll go back again if they want me to.

But I really don't have that list. Look where we live. I'm more than happy to do things around here.

How do you occupy yourself locally?

Joan has done 7-8 of these Eden to Addo hike in 20 days over three weeks. I've done one of those, and that was very very nice. I will help her in the future with providing the back up.

I'm not working nights or weekends any more …

We've got a bit of wilderness land outside Calitzdorp which we keep as a corridor, and we visit regularly – just tents, and a kitchen under the trees. Keeping that running keeps us busy.

Do you farm anything here at Finest Kind?

No. We used to. We had goats, and a cheese-making business from them. Now we're down to two chickens, two horses and two dogs . . . We're very much into our permaculture veggie patch and eating naturally.

You've been married 43 years?

43 in December.

You can't really talk of Joan as your 'current' wife then?

I'd soon be 'ex-husband' if I did Clyde – 3 kids and Rhiaan – 2 kids.

Are you still feeling fulfilled within medicine as a career?

Yes – especially Monday to Friday. I have the unstoppable Pete Honeywill doing Friday afternoons for me. It is very fulfilling.

What would you want to say to youngsters wanting to study medicine today?

If they want to be financially comfortable the rest of their life, look outside medicine. We're slipping towards NHI in one form or another and new doctors are going to be trampled on, utilized and abused to no end. If they are prepared to do that and work through a sense of altruism. But they're going to battle to do things like send their kids to university, that kind of thing …

I get a sense from you that medicine as a career can be a means to an end and not an end in itself – is that true for you?

Agreed.

What does the future hold for Dr Peter Berning? No signs of giving up practice or retiring?

No. I had a young guy from Saudi say to me this morning – Please don't stop. We need that kind of moral boost at times. I'm in for medicine until 75 at least. Pete Honeywill is 83. As long as I am not making mistakes and am keeping up with current trends in medicine, I'll keep going.

.....

I left the interview, even more impressed with the man I had met nearly twenty years earlier when I arrived as a new specialist to the area, and whom I had come to respect.

As for the question I had on arriving … it struck me that one must be just a little bit barking mad to achieve as much as Peter Berning has, to take calculated risks and to do exceptional things, and I am sure that he will continue to do so. But the second sign, the one that names the place that has been their home for 40 years is more appropriate.

Peter Berning is, as so many of his patients will tell you, the 'finest kind' indeed. ■

Sandie's Journey continued fromp38

and acuity as a scholar that led to international recognition. Honours and awards followed naturally for Sandie and included honorary membership of The Royal College of Physicians and Surgeons of Edinburgh and the Mary Weston Achiever of the Year at the University of KZN and most recently, the distinct honour of being inducted as a Master of the World Gastroenterology Organisation. Sandie has also delivered a raft of high profile and important eponymous lectures including the DJ du Plessis Lecture in 2010, the SASES Roche Lecture in 2013, and the Solly Marks Lecture in 2014.

Sandie has led an active life outside medicine, including reigniting his passion for golf. Many golfers maintain that playing golf is a metaphor for life. You need to be disciplined, organized, and courteous and have integrity. Others say that golf is a game where you yell fore, score six, and write down five. Fridays and Sundays are sacrosanct golf days at the de Zalze and Rondebosch golf courses regardless of the weather and Sandie, Flip, Joe Grobbelaar, Adie Horak, Andy Girdwood and Del Kahn have lost more balls in the water, out of bounds and in the rough, than can be counted.

Sandie combines disarming conversational charm with intellectual rigor. It may be impossible to measure the positive impact he has made to surgical life, not only in academic terms, but in terms of the kindness, patience and respect he displays to colleagues, staff and patients. He has a wide circle of friends and he is a true to each as confidant, mentor, and colleague. His warmth and charm which he has in unfair abundance is combined with fearless integrity and wisdom. All this has been achieved with the unwavering support of Margaret and his family and together on week-ends

During Sandie's journey he has played a pivotal role in surgery and gastroenterology in South Africa. Sandie can take great satisfaction from his efforts and will be gratified to know that the younger doctors he fostered have grown in their careers

Continued on p44

The Whip Hand - Why do powerful men love to be spanked?

George McCoy

Britain's S&M business is going strong — and it can no longer be explained by public-school beatings

Spanking is back in the news. Le vice anglais was meant to be a dying art — a vestige of a time when men were more repressed, but it's recently become clear that British men enjoy a thrashing just as much as they ever did.

In the past few weeks a London barrister, Robert Jones, has claimed he was unfairly dismissed after a consensual spanking session with a junior worker, while up north a 'dungeon master' called Shaun O'Driscoll, who has thrashed diplomats and a duke, gave evidence at Bolton Crown Court. Then there's the big one: the claims by the erotic actress Stormy Daniels that she spanked Donald Trump with a rolled-up copy of Time magazine that had his face on the cover.

Why do powerful men like to be spanked? It is a question I have often asked myself during the many years that I have spent researching Britain's escort agencies and massage parlours (I edit a guide to what's known as 'adult services'). Received wisdom once had it that public schools were to blame. Because a generation of men were beaten during their formative years, so the theory went, they yearned to be spanked as adults. But long after the last boy was legally caned, and ten years after Max Mosley's famous tryst with 'Mistress Abi' was revealed in the tabloids, Britain's S&M business is still going strong.

I've asked around and discovered that far from feeling ashamed of their jobs, sex workers in so-called 'corrective services' consider themselves a cut above their less assertive colleagues. They dominate not just their clients, but the industry. Such is the demand for spanking that many parlours have their own house dungeons.

In fact, dungeons operate all over Britain, in our sleepiest and most respectable towns. Sometimes it's just one lady working alone from a room in her own house, but there are grander examples, places with complicated equipment such as the Palace of Kink, a sizeable converted pub in Rotherham run by the very experienced dominatrix Mistress Tanya. There's also Oubliette, in a detached house in Bedfordshire, which is a family business.

Here, Mistress Paris and her daughter Mistress Serena are available to attend to gentlemen who want to be beaten or even put in a 'leather body bag'. In the 'Luxury Bedroom', a suspended cage hangs beside a picture of Paris. 'Why not cage your submissive for the night?' asks the Oubliette website, 'leaving them suspended with a view over the Eiffel Tower while you enjoy the luxury of the opulent gold and red fin de siècle kingsize bed?' Why not.

There are equally successful spanking businesses in Manchester, Birmingham and Leeds. And those who like to imagine this as a particularly English peccadillo will be surprised to learn that the very grandest establishment still going strong is in Scotland. The Glasgow Dungeon occupies a suite of former offices in Sauchiehall Street.

The adult industry, like others, was affected by the 2008 crunch, but in the early 2000s there were several more enormous dungeons, the most magnificent being Victorian Dover, which operated out of a house near Dover Castle, and Mistress Hellena's Hotel BDSM, a four-storey converted vicarage in Dewsbury. At Hotel BDSM, one room contained an imaginative wheel, mounted on the wall, to which one could be secured and beaten up from different angles.

So what, in our enlightened era, is the appeal? We're not repressed or puritanical, nor were we beaten at school. What's going on? I think it's about giving back control — a reverse Brexit kink, if you will. Many middle-class men like me were brought up to believe that success is everything. We constantly strive hard to be on top of our game at work and so it's a relief to cede power temporarily. I'm told by sex workers that the old cliché is true: it's the high-flyers — men who go unchallenged and dominate others in their daily work lives — who are most likely to visit a dungeon. The men who make rules are often the keenest to submit to another's authority. Judges in dungeons are a given, but some stories I've been told about certain MPs would leave you wide-eyed.

There is a return to childhood in the appeal of spanking but it's not as obvious as a Freudian association with a nanny's smack. The conclusion I've come to is that men like to look back to a time when they were free of the responsibilities of adulthood. The enduring appeal of spanking is not so much about sex as about being comforted.

The Spectator / 19 May 2018 / www.spectator.co.uk

Note

"This article might interest you should your Prof be one who goes unchallenged and dominates others in their daily work lives ... because they are most likely to visit a dungeon". So when they're off to yet another 20 congress in the UK, or elsewhere, it might be useful to view their quest for academic knowledge with a querulous "nod nod, wink wink".*

Editor

SPORT

Medical 10 2018 - The 40th Staging of the Event

Syd Cullis

The 40th iteration of the Medical 10 fun run/walk took place on Sunday 25th November at the Western Province Cricket Club Sports Complex off Campground Road, Newlands - in ideal weather as opposed to the strong wind of the previous year.

There were 384 entries, including 40 on the morning of the race, with 287 finishers - 210 runners (104 male and 106 female) and 77 walkers (16 male and 61 female). The 3rd largest number of finishers thus far.

The winners on handicap were Colin George (a physiotherapist from Wynberg) and Sue Mackinnon (a nurse from Kingsbury Hospital) and on actual time Colin George -37 minutes 16 seconds - and Catherine Antel (Haematologist from Constantiaberg) - 42 minutes six seconds. As in previous years the trophy for the fastest runner was, with the exception of Kim Laxton in 2008, only won by a male athlete, it was decided to award a separate trophy for the fastest female runner.

The new trophy was designed and turned by Lynette du Plessis (ex-theatre sister at Kingsbury Hospital), the new logo designed by Danie Theunissen (surgeon at Constantiaberg) and it was sponsored by PathCare.

The leading walkers were Ian Couper (family physician from Stellenbosch) and Yolanda Collins (radiographer from Kingsbury Radiology)

As it was the 40th staging of the event, those who took part in the first race in 1978 were encouraged to turn out again. There were 10 runners (Spike Erasmus, John Eloff, Kerry Allerton, Keith Scott, Syd Cullis, Athol Kent, Des Heron, Tim Noakes, Joe Smith, Basil Sacks) and 4 walkers (Clare Stannard, Hannes Loots, Robin Black, and Otti Bock). After the prize giving a sit-down breakfast, sponsored by PathCare, was enjoyed by the 1978-ers and John Steer, who had for many years provided a very amusing commentary at the event. Those at the breakfast also received a substantial "goodie bag" from Discovery Health.

One of the runners was Roleen Joubert-Coetzee, a physiotherapist from Stellenbosch, who is the daughter of Andre Joubert. He took part in the first race in 1978 - but tragically died on his way home to Laingsburg, where he was a GP, when his aircraft crashed in bad weather. It made the 40th celebration of the event very special to also welcome Andre's widow, Yvonne, as a spectator.

The proceeds of the event (hopefully in excess of 40,000 Rand) will be donated to the paediatric department of Victoria Hospital to help them acquire extra sats monitors for their sick children.

This year's Medical 10 will be on Sunday 24th November and entry forms should be available at Life Healthcare Hospitals in September.

The photo of the start of the first Medical 10 in 1978 shows: *#73 Dave van Breda Smith – now a GP in Canada #64 Peter Krige – GP in Sydney #53 Jerome Sedgwick – retired orthopod in Overberg #45 Cedric Nainkin – GP from Fresnaye #62 Andre Joubert – GP from Laingsburg #51 Gerry van Aswegen – Physician from Constantiaberg #82 Hendrik Coetzer – Anaesthetist from Northern Suburbs #76 Ricky Raine - - Physician from GSH #83(obscured) – David Nathan – retired Physician in France #88 Kerry Allerton – retired orthopod at Miller's Point #43 Dick Barnes – Urologist at GSH*

Colin George - winner on handicap and actual time

Des Herron - oldest runner, aged 80.


Family Affair


Happy families

Gill Shermbruker, Head of Paediatrics at Victoria Hospital, our charity.

Medical 10 participant

Participants of Medical 10

John Steer and Tim Noakes

Post run refreshments

Ronelle and Yvonne Joubert

APPEAL

A note from the ancient Editor

I forget how many years I've been editing Cape Doctor but it all came about when, in the mists of time, I said to JP van Niekerk “one ought to make it a touch controversial.” “Well why don't you take it over,” said he. Which in complete obliviousness I did... ignorance being my style. I specialise in this, and lack of insight and subtlety which are perhaps good attributes for a potentially provocative editor.

“Cape Doc” strangely, seems fairly popular taking on various, sometimes sensitive topics, but that has been our aim.

What has given the most joy is being able to acknowledge the excellence of colleagues, often on the point of retiring when they then slip silently beneath the surface soon to be forgotten, despite their significant contribution to our profession.

One's also tried to make it as user friendly and relevant as possible. A sort of “Private Eye.

But now as I teeter on the edge of an 8th decade, the time has surely come to talk of succession. One of the sadnesses is, that probably due to my inefficiency and tendency to sloth, we've not been able to produce articles to cover say the Northern suburbs and Countryside as one would have wished. This should really be the newsletter of both Cape Western and Tygerberg SAMA branches.

So what I'd like to ask, if there are amongst you.... a group of brave souls, irreverent, combative, and not hide bound by bureaucracy, any who would consider being involved in Cape Doctor in taking it into the future.

Think about it, or if you know those who feel they might be appropriate let us know. Margi who helps enormously and creatively to put it together, and I, while ageing gracefully, are not made of indestructible material ... Emily and Chenienne are our “office” support team.

This is a labour of love, if that’s the right word, and carries no benefits apart from being held as a target for abuse and on strange rare occasions getting a pat on the “journalistic back”. One needs be a “Daily Maverick” addict and being “Woke” will not be an advantage nor being politically correct... They could, in fact, be distinctly inappropriate attributes.

John Steer

John and Margi

Sandie’s Journey continued from p40

as a result of his influence and example. In particular, my close collaboration with Sandie through the years has always been filled with intellectual stimulation, good fellowship, humour and fun. Sandie has demonstrated that an academic life can be satisfying and richly rewarding and that he has led a life that can be described in superlatives – as a person, gastroenterologist, surgeon, researcher and mentor.

As a final note, we all know that Sandie uses every opportunity to go regimental and don the Thomson tartan kilt. Many have wondered if Sandie follows the true Scottish highland tradition of romance and mystique when wearing his kilt or whether the old practice has become outdated. Jamie McGregor - whose bill to the Scottish Parliament unanimously established 'The Scottish Register of Tartans' – has commented: "The mystery of what a true Scotsman wears under his kilt is as much part of Scottish culture as the Loch Ness Monster. So what is the current situation? Probably, in general, it's a case that some kilt wearers do and some don’t. But, in the individual case, the curious enquirer of the vital query may have to be content with the ambiguous reply from he who is enquired upon: "That's for me to know and you to ponder!" However, there is nothing mysterious about what is worn below a clansmen's shirt. "You cannae tak the breeks aff a Hielanman!", runs the old saw, signifying the futility of attempting the impossible! ■

PathCare "Pathology that **Adds Value**"

THE PATHCARE NEWS

RAPID IDENTIFICATION OF BLOOD CULTURES

Pathcare Reference Laboratory has recently instituted a rapid blood culture ID technique where organisms from positive blood cultures can now be identified after about 4 hours from the time when the blood culture system flags the blood culture bottle as positive.

The technique was validated for commonly isolated Gram negative and Gram positive isolates, but not for yeasts, infrequently isolated bacteria or fastidious bacteria that are slow-growing.

The rapid ID will add value to clinical decisions as it can inform antimicrobial choice to some extent.

If the blood culture Gram stain reveals a Gram positive coccus, the rapid identification will make a distinction between streptococci and staphylococci. Streptococci can mostly be treated with a penicillin whilst staphylococci can be treated with cloxacillin (if the infection is community acquired) or daptomycin / linezolid / vancomycin / ceftaroline, if the infection is hospital acquired.

If the blood culture Gram stain reveals a Gram negative bacillus, the rapid identification will distinguish fermentative bacteria (e.g. *E. coli, Klebsiella, Enterobacter* etc) from non-fermentative bacteria (e.g. *Pseudomonas and Acinetobacter*), which will further guide empiric antimicrobial choice.

Rapid blood culture ID results will generally be communicated to the requesting clinician by phone or SMS.

Dr Marthinus Senekal

(Clinical microbiologist: PathCare)

The private pathology groups in South Africa recently reported on blood culture results from a select group of bacteria causing healthcare-associated infections, known by the acronym, ESKAPE (*Enterococcus faecium, Enterococcus faecalis, Staphylococcus aureus, Klebsiella pneumoniae, Acinetobacter baumannii, Pseudomonas aeruginosa, Enterobacter cloacae and Escherichia coli*) together with their antimicrobial susceptibility testing (AST) patterns (1). AST performed on ESKAPE organisms isolated from 9029 blood cultures during 2016 were analysed.

Of the 9029 blood cultures analysed, 58% (5247) were Enterobacteriaceae, 28% (n=2564) were Gram-positive bacteria and 14% (n=1218) were non-fermentative Gram-negative bacteria.

Of the seven ESKAPE organisms, *Escherichia coli* (30,8%), *Klebsiella pneumoniae* (27,3%), *Staphylococcus aureus* (16,7%) and *Pseudomonas* (10,1%) were the organisms most commonly isolated from blood cultures.

Of the *Escherichia coli* cultured, eighteen percent were ESBL producers. Less than one percent of isolates were non-susceptible to the carbapenems, but thirty-one percent of isolates were non-susceptible to ciprofloxacin.

Of the *Klebsiella pneumoniae* cultured fifty six percent were ESBL producers. Just less than 10% of isolates were non-susceptible to the carbapenems: imipenem, meropenem and doripenem, and fifteen percent were non-susceptible to ertapenem. Forty-one percent of isolates were non-susceptible to ciprofloxacin.

Twenty-six percent of S. *aureus* isolates were non-susceptible to cloxacillin (MRSA).

Less than 30% of *P. aeruginosa* isolates were non-susceptible to the third-generation cephalosporin, ceftazidime, and the fourth-generation cephalosporin, cefepime. Non-susceptibility to the carbapenems, meropenem and imipenem, was 36% and 38%, while non-susceptibility to doripenem was observed in 32% of the isolates. Thirty-six per cent of isolates were non-susceptible to piperacillin/tazobactam.

Reference:

1. Perovic O, Ismael H, Van Schalkwyk E et al. Antimicrobial resistance surveillance in the South African private sector report for 2016. South African Journal of Infectious Diseases 2018;33(4):114-117.

ISSUE

Daddy Issues - The Fatherhood Revolution has Failed

Cosmo Landesman

When I was growing up in the late 1960s, boys like me craved the admiration and approval of our dads; we wanted nothing more than to impress them. And now that we are dads, we crave the admiration and approval of our children; we want nothing more than to impress them. But the curious thing is, they don't care about impressing us. In fact, our teenage children are just like our dads were — distant figures who are busy getting on with their own lives.

Today we demonise dads of the recent past for being cold and uncaring. For failing to change nappies, read stories at bedtime, provide the unconditional love and praise children need to grow into happy, well-adjusted adults. Despite the fact that historians have shown that fathers of the past — both in Victorian times and the 1950s —were much more involved with their children than the popular stereotypes allow, they provide modern dads with the perfect example of how not to be a dad.

But as an anxious dad who is always desperate to impress his 15-year-old son, I envy the dads of old. God knows they had plenty of faults, but Dad Anxiety was not one of them. They didn't worry about being a Good Dad or a Bad Dad, the way we modern dads do. They didn't read books with titles like How To Be a Good Dad: What Every Father Must Know To Be a Good Dad and Raise Great Kids (John McQuilkin) or George Zelina's The Loving Dad's Handbook: Raise Them Like Your Life Depends on It. Dads were just … dads.

And they didn't worry about boring their children, either. They'd drag them off for long, tedious Sunday car trips that ended in places of 'historical interest' that nobody found interesting but dad. And did they care if their kids were asphyxiated with boredom? Not a bit. Children had not yet discovered that being bored was a violation of their human rights.

Dads were expected to provide food, shelter and security. We modern dads are expected to provide the same and protect them from boredom. We're so anxious that our kids might have to suffer the torture of silence and the torment of doing nothing, we dish out digital pacifiers; smartphones are shoved in the little hands of toddlers while older kids are inoculated with iPads and laptops.

Some of us even try to entertain our children ourselves, just like our dads did. We tell our 'funny' stories over dinner and do bits of comic improvisation — and usually die the death. You think your anecdote about what happened at work or some 'hilarious' incident when Dad first met Mum is going to entertain your kids? Get real. No dad can compete with the endless outpouring of funny and entertaining things your kids can find on their smartphones and YouTube 24/7.

We assumed that we were going to be better dads than our dads because we were enlightened men who knew fathers had an important role to play in the lives of their children. And unlike our dads we knew how to express love and show our feelings and so we'd be closer to our kids and they'd be closer and more loving to us.

But talking to other dads, I sense that while parenthood has been — overall — the most enriching and rewarding experience of their lives, there's a small sense of disappointment. As one put it: 'I did everything I could not to be like my dad. I was more loving and encouraging — and I don't think it's made much of a difference. Most of the time my kids think I'm a crap dad.'

What happened? Put simply: the Dad Revolution has failed. By that I mean the dream that we could be better men, better dads creating better children. It was a form of parental utopianism that had its roots in the 1980s. It was then that fatherhood was repackaged and promoted as a progressive alternative to the macho go-getting materialism of Thatcherism.

It was the time when lefty-minded men who'd fallen under the spell of feminism were questioning conventional gender ideas of what it meant to be a man. There was much talk of the New Man — remember him? That caring, sharing figure in touch with his feelings. David Beckham was the New Man poster boy.

Leftist champions of the New Man movement who were aiming to deconstruct toxic masculinity saw in fatherhood a new kind of role model for all men, even those without children. Writing in the *New Statesman* in 1997 Jack O'Sullivan in 'A Manifesto for Men' argued that 'the "father" concept is a way we can generally modernise ourselves'.

And so we self-aware, anti-macho new men went off to antenatal classes and attended the births of our sons and daughters. We were happy to change nappies and do early morning bottle feeds. (At least some of us.) Instead of the *laissez-faire* approach to our children's lives, we followed the new child expert advice for a more hands-on style.

But if the dad of old was too distant, today's dad is too close, as can be seen in the phenomenon of helicopter parents. Where is the dad who dares tells the children to piss off, leave him alone and go out and explore on their own? Instead of strong, self-confident and robust kids we produced the 'snowflake' generation.

Most dads in the past did their best with mixed results — but we arrogantly assumed we could do so much better. And yes, having more attentive and caring dads does provide for a better start in life. But it would be hard to argue — given the growing rates of mental health problems, drug abuse, depression etc. — that today's teenagers and twentysomethings have emerged happier and better equipped for adult life than the generation raised by distant dads.

Anna Machin is an evolutionary anthropologist and author of *The Life of Dad: The Making of a Modern Father*. She has long been a champion for the role of dads in their children's lives, but even she admits that there is 'no formula' for successful parenting. And yet young modern dads buy books and read blogs that promise to show them the 'secrets' to being 'super dads', 'awesome dads' producing 'amazing', 'happy' and 'successful children'. Good luck with that, chaps, but I suspect that such unrealistic aspirations are doomed to disappointment.

The Spectator 15 June 2019

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