ASSOCIATION OF MEDICAL STUDENTS OF SOUTH AFRICA*

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When I received the kind invitation from the President of the Witwatersrand Students Medical Council to open the first Conference of the Association of Medical Students of South Africa, I felt most appreciative of the privilege conferred on me. It reminded me of the occasion many years ago when I attended the first conference of an important student organization. This was in 1921 when I was a medical student at Manchester University in England, and was one of 10 delegates representing the British Universities at the first International Conference of National Student Organizations. The Conference was held in Prague, and M. Maseryk, President of the newly created democracy of Czechoslovakia, entertained us to a state banquet and gave an inspiring address.

When I received the invitation to attend your Conference, a brief memorandum on the history of the movement towards the establishment of a National medical students' association was included. It is now 10 years since the first 'Medical Schools Interfaculty Conference' was held in Johannesburg.

The start was not very auspicious and the original Conference was abortive. However, since then the idea has never really been dropped and, after one or two further false starts and following further experiments, the present Association of Medical Students came into being last year with 4 member faculties. A Constitution was adopted and the first Conference with all the faculties of medicine in South Africa represented, either by delegates or observers is now being held. I feel that you are to be congratulated on your achievement.

Medical History

It might interest you to know that in the 1880s a medical South African Students' Union existed. At that time it was exceptional for a South African student of medicine to enrol elsewhere in Europe than at Edinburgh University. This steady flow of South African students, who were mostly medical, prompted some enterprising students in 1892 to form a South African Students' Union. A club house was purchased and the circular about this read in part:

'Students should mix with others, but also keep in close contact with those of their own country as the best protection against temptations; it minimizes the risk of the inexperienced, coming over from South Africa, from being led astray . . . or practically wasting an academic career.'

Although not restricted, the members of this Union were mostly medical students. According to its original trust deed, if its membership fell below 10, the trustees would wind up the Union and transfer any money to the University of Cape Town. This occurred in 1935.

Medical societies and even journals had existed in Cape Town during the 19th century, notably one in 1830, which engineered a revision of fees. However, the South African Medical Association was first founded in Cape Town in 1883. Following this, medical societies sprang up in the Eastern Province, Kimberley, Natal, Pretoria and Johannesburg, but most of them remained independent, some becoming branches of the British Medical Association.

The first joint Medical Congress was held in 1892 in Kimberley and this was followed by further congresses at intervals. Also a medical journal came into existence after 1903. Despite these unifying influences, it took 40 years to achieve unity and only in 1926 did the Medical Association of South Africa, existing symbiotically with the parent organization, the BMA, achieve unity and stability. In due course the Medical Association of South Africa separated completely from the BMA as an independent Association.

I believe that medical history should hold a real place in the curriculum of a medical school. Sir William Osler, perhaps the greatest medical teacher of all time, Professor of Medicine first at the Johns Hopkins Hospital and then at McGill University and at Oxford University, always stressed the part medical history should play in the training of students.

The medical profession is deeply steeped in ancient tradition. The recent election of Pope John reminds me of the by-laws of the Royal College of Physicians of London. For the election of its President each year, the Fellows assemble on the day after Palm Sunday. There is no formal proposal or nomination. Each Fellow writes down and places in a large silver urn the name of one of the Fellows for whom he votes. In order to ensure that the President shall be 'as required by the Charter of Henry VIII, a prudent person and one skilled in the science and practice of Physic' only Fellows of at least 10 years standing are eligible. If one of the Fellows receives two-thirds of the votes, he is elected; otherwise the names of the two Fellows receiving the highest number of votes are put to the ballot. Except for this last provision, the procedure conforms to the Papal Election. We may question the method or procedure, but it has produced Presidents of becoming dignity and also wise in counsel.

* Address at the opening of the First Conference of the AMSSA, Johannesburg, 10 July 1959.

The Medical Association of South Africa

The Medical Association of South Africa has a truly democratic Constitution and is governed by a Federal Council whose members are elected by the 14 branches every 3 years. The basis of representation is 1 representative for the first 50 members or less in a Branch, and then 1 additional representative for each 100 members or part thereof beyond the first 50. The Chairman is elected by the Council for 3 years and I am only the fifth Chairman to be elected in the 33 years of the existence of Federal Council.

Membership of our Association is the right of any legally qualified medical practitioner normally resident in the area of any Branch of the Association which covers all the Union of South Africa and South West Africa.

The Medical Association of South Africa is a foundation member of the World Medical Association. This body recognizes only those medical associations which can reasonably claim to be the national medical association of their country. There are 55 such national medical associations representing almost all countries other than those behind the 'iron curtain'. The 'Declaration of Geneva' was adopted by the General Assembly of WMA in 1948 and also by the Medical Association of South Africa. It reads as follows:

'*At the Time of being Admitted as Member of the Medical Profession*

'I solemnly pledge myself to consecrate my life to the service of humanity;

'I will give to my teachers the respect and gratitude which is their due;

'I will practise my profession with conscience and dignity;

'The health of my patient will be my first consideration;

'I will respect the secrets which are confided in me;

'I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;

'My colleagues will be my brothers;

'I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

'I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity;

'I make these promises solemnly, freely and upon my honour.'

Agenda of this Conference

In looking through the Agenda of this Conference, I notice that there are some interesting items and I should like to refer to one or two of them.

Firstly, there is the question of affiliation to the Medical Association of South Africa. I would say to you that we are very happy to know that you have arrived so far in the development of an association of medical students. We should like to give you every help and encouragement, and I feel sure the Medical Association would welcome some formal affiliation.

Another item on your agenda is the Transvaal Hospital Ordinance. Free hospitalization has had a chequered career in the Transvaal and I shall try to show you quite simply what has been the medical profession's point of view.

It all began with terminology. In the ordinance of 1946 hospitalization was defined as accommodation, food and nursing care and also medical treatment. As the ordinance introduced free hospitalization and made this available to everybody in the Province, it meant the Province intended to provide hospital accommodation, food, nursing care and medical treatment free to all who wished it.

Our terminology was different. We said hospitalization meant accommodation, food and nursing care, and this we were agreed could be free. Medical services we defined separately and we said the Provincial authority had no right to provide these services free to all unless they employed the whole profession to provide such services. When the National Health Service was introduced into England, every doctor who wished could be employed by that Service on application.

The Province, however, had no intention of employing the profession as a whole, and so we insisted that patients who were able to pay for their medical services should do so. This principle was finally accepted when a mediator was appointed by the Government, and the Interim Suspension Ordinance of 1948 suspended free medical treatment for all.

In 1958 a new ordinance was introduced which abolished 'free hospitalization' in accordance with our definition and introduced a means test. The Medical Association stated that they considered that the introduction of free hospitalization had been a real social advance, and to withdraw it would be a retrograde step. However, the reason given for its withdrawal was the very high cost.

It is interesting to note that in Canada free hospitalization, according to our definition and excluding medical care, has been introduced in some Canadian States and is spreading. It represents the Government's contribution to higher medical costs.

The question of medical education is the statutory obligation of the South African Medical and Dental Council. The Medical Association has had a standing Committee on Medical Education for some years—a year ago it presented a memorandum to the Medical Council setting forth its views on the question of training in anaesthesia for undergraduates and interns. It is a matter which frequently engages our attention.

Medicine—a lifelong study, will be the theme of the Second World Conference on Medical Education organized and sponsored by the WMA in collaboration with WHO and the International Association of Universities. This conference is to be held in Chicago in September this year and we hope to have a representative there.

Another matter I should like to discuss is the emoluments of interns. The Medical Association has fought for equal payment to all interns irrespective of race or colour. Numerous approaches have been made, interviews sought and letters written and, although we have not yet been successful, the matter has not been finalized. At its last meeting the Medical Council considered the whole question of medical salaries in relation to race and colour and made an approach to the Government. We have since then been cooperating with Medical Council in this matter with a view to further action.

Another matter which has engaged the attention of the Medical Association of South Africa has been medical health and sickness insurance. For the past 12 years we have given every encouragement to medical aid societies; latterly we have welcomed the introduction of medical insurance schemes by insurance companies and we have sponsored a medical insurance plan in the Johannesburg area to give comprehensive insurance. The basic principles which we have laid down as our ideal for all these schemes have been: (1) Free choice of doctor for the patient, and free choice of patient for the doctor; and (2) payment on a 'per service' basis and not on a *per capita* basis.

These principles reflect the relationship in private practice between doctor and patient which we consider to be the desirable pattern and, particularly in the face of the widening field and scope of medical services in addition to rising costs, insurance is the way to achieve this object.

Then there is the problem of 'specialism'. This is a matter which has engaged the attention of the Medical Association quite frequently in recent years, South Africa being one of the few countries having a 'specialist register'. Recently we made a survey and discovered, amongst other things, that in 1939 some 15% of the medical men on the register were specialists. In 1959 we found the number to be 18%, and between these dates it had fluctuated between these two figures.

In view of this finding there should be no conflict between general practitioners and specialists—they each have their own particular tasks, neither can replace the other. There happens to be a wide sphere of activity common to both, but both are essential. In this connection I should like you to consider a medical movement known in Western Europe as 'the medicine of the person'. Two of the leading advocates of this movement are Dr. von Weizsacker, of Germany, and Dr. Tournier, of Switzerland. This new movement in medicine seeks, not to consider the patient only as a 'case' but also as a 'person'; it seeks to understand and treat disease in terms of the patient's life as a 'whole man'. Perhaps it represents a reaction by doctors themselves against the present dangers of over-specialization. This emphasis in medicine of the 'person' is an attempt by doctors to recover the ideal of Hippocrates that medicine should be practised as a healing art rather than as an engineering technique. This movement may therefore be described as a movement to recover a sense of vocation and purpose for a profession that has been in danger of losing its integrity to a false ideal.

The new movement in medicine has developed from the appreciation that patients have a mental and emotional, as well as

a purely physical aspect. It is the recognition of this fact and the recognition of the power of the psyche which led to the pronouncement of Dr. Hans Selye that stress and tension are responsible for about 70% of modern illnesses, and the statement of Dr. Swaim: 'It is becoming increasingly evident that physical health is closely associated with, and often dependent on, spiritual health'.

Specialism has been one of the features of the development of medical practice during the last 50 years. This has resulted in a great increase in our knowledge of the cause and nature of disease and the means of its control and treatment. Specialism has, however, also led to the reversal of the famous dictum that the whole is greater than the sum of the parts. Specialism implies that the sum of the parts is equal to the whole.

The specialist, in fact, does not practise comprehensive medicine He exercises his skills in some subdivision of the larger framework of medicine. But in the 'medicine of the person' movement, Dr. Paul Tournier considers that the doctor who wishes to treat the patient as a whole must make a personal commitment, and the quality of his personal life and his honesty with himself and his patients, are factors which will greatly influence his success.

I think that I can say that in the medical profession we are very individualistic and independent but that we are also well organized in an Association which will always fight to preserve that independence. Those who are on the threshold of their careers and are training to enter our ranks will have our interested assistance whenever it is desired. To organize an Association and to become affiliated with the professional body can only do good.