DISCLOSURE OF A POSITIVE HIV DIAGNOSIS TO A SEXUAL PARTNER

A look at the guidelines for junior doctors

THIS ISSUE

The dangers of digital communication
Social media pitfalls that doctors should consider

Consent success
Tips for obtaining a patient’s valid consent to a procedure

How to... train and survive as a neurosurgeon
Dr Ncedile Mankahla explains what it is like to work in neurosurgery
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The Medical Protection Society Limited (“MPS”) is the world’s leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members around the world. Membership provides access to expert advice and support as well as the right to request indemnity for any complaints or claims arising from professional practice. Highly qualified advisers are on hand to talk through a question or concern at any time.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, e-learning, clinical risk assessments, publications, conferences, lectures and presentations.

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We welcome contributions to Junior Doctor. Please contact the Editor Kirsty Plowman, at kirsty.plowman@medicalprotection.org

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Welcome

Welcome to the latest edition of Medical Protection’s Junior Doctor.

Every day we help members deal with difficult issues arising from their clinical practice, while also using our expertise to address the current dilemmas and challenges facing the healthcare profession.

When compared to any other country worldwide, South Africa has the largest manifestation of HIV and AIDS and it is therefore extremely likely that as a healthcare practitioner, you will attend to HIV positive patients during your career. On page 6 we identify the guidelines which are available to assist you, as junior doctors, on the disclosure of a patient’s positive HIV diagnosis to a sexual partner.

We also recognise how social media, apps and smartphones play a large role in the innovation of healthcare. While junior doctors should be free to take advantage of the many professional benefits that social media can offer, it is important to be aware of the potential risks involved. On page 8 we consider these dangers specifically in regard to file-sharing apps and social media websites.

Whether through a medical negligence claim, a Health Professions Council of South Africa (HPCSA) complaint, or simply by offering professional advice, our medicolegal advisers have experience of helping Medical Protection members on concerns regarding consent. On page 10 we address your responsibilities for consenting patients for a procedure, providing you with useful scenarios and tips to assist you as a clinician.

Once again, Doctor Graham is on hand to accompany you through the medicolegal maze – this time he shows you how to deliver successful telephonic instructions.

I do hope you enjoy this edition of Junior Doctor. As always, we welcome your feedback and comments so please get in touch.

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Dr Graham Howarth
Editor-in-Chief,
Medical Protection
Head of Medical Services (Africa)

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Public or private: Know your service

The differences in the Medical Protection subscription rates paid by state-employed doctors and private practitioners in South Africa have at times led to queries and misconceptions about what their membership provides them with.

In reality, there is only one difference between the membership provision for doctors working in the public sector and those working privately, and that is the handling of claims for clinical negligence. Privately practising members are not, as is commonly believed, somehow ‘subsidising’ the costs relating to some state doctors.

Which means that while privately practising members are entitled to request assistance on all aspects of a claim, including potential legal costs and compensation payments, members working in the public sector have this handled by the state. However, all enjoy access to the diverse range of Medical Protection’s education programmes and publications, including topics such as clinical risk management, and professionalism and ethics.

New workshop launch

Medical Protection is committed to supporting members in their practice, and part of this support is achieved through delivering a series of risk management workshops. These are designed by medical colleagues to provide insights, advice and skills to help you deliver improved patient care and reduce your medicolegal risk.

Members can benefit from our new ‘Achieving Safer and Reliable Practice’ workshop. This workshop provides healthcare professionals with knowledge, essential strategies and practical tools to maximise their delivery of reliable and safer clinical care enabling them to:

- Identify areas of significant risk
- Engage with colleagues to improve reliability
- Examine and redesign processes essential to the delivery of high reliability, high quality care.

For more information, contact Enid Dettmer, Education Operations Consultant to Medical Protection, at educationsa@telkomsa.net

Visit medicalprotection.org/southafrica/workshops to discover our full range of workshops.
A nursing sister phones you to request advice about a patient’s case while you are on-call. In order to avoid misunderstandings and lower medicolegal risks you should adopt the closed loop communication method.

Once you have a comprehensive understanding of the clinical situation, give a clear verbal instruction on the care you want the patient to receive, and then repeat your instructions.

If you are prescribing medication to be administered by the nursing sister, issue distinct and unambiguous instructions – answer fully any queries they may have.

The nursing sister will write the instruction down and recount her notes to you. Afterwards, replicate this process with another nursing sister on the ward.

Immediately document the telephone call to ensure your notes are contemporaneous and demonstrate the facts on which you based your decision.

On your return to the ward, review the patient’s condition and document your telephonic instruction in the patient’s medical records.

For more information on communication and recording essential information read our advice booklet Common Problems: Managing the Risks in Hospital Practice in South Africa which is available on the Medical Protection website.
DISCLOSURE OF A POSITIVE HIV DIAGNOSIS TO A SEXUAL PARTNER

From HIV testing and management of a patient with a positive HIV test result to a disclosure of a positive diagnosis, it is imperative that you are familiar with the legislation and guidelines outlining your duties and obligations, says Medical Protection’s Medicolegal Assistant Ralitsa Sahatchieva.

South Africa has the largest manifestation of HIV/AIDS in comparison with any other country in the world; it is palpable that HIV/AIDS are an immense health concern in the country, and a cause of social stigma. HIV/AIDS has an impact on the larger community and not just on those infected; it is extremely likely that, as a healthcare practitioner, you will regularly attend to HIV positive patients during your career.

The following guidelines are available to assist junior doctors on disclosing a patient’s positive HIV diagnosis to a sexual partner.

CONFIDENTIALITY
Section 14 of the National Health Act (2003) states that all information relating to a patient’s health is confidential and no person may disclose any information unless:

a) they have the patient’s consent in writing,
b) a court order or any law requires disclosure,
c) not disclosing the information will pose a serious threat to public health.

The HPCSA’s General Ethical Guidelines for the Health Care Professions (2008) Booklet 11 ‘Ethical Guidelines for Good Practice with regard to HIV’ provides you with guidelines for the management of patients with HIV/AIDS and is a good starting point as it again impresses upon the fact that an HIV positive diagnosis should be treated with the greatest level of confidentiality.

CONSULTATION
The guidelines further specify that a decision to disclose a positive HIV result should be reached in consultation with the patient. It is apparent that whether the patient consents to the disclosure or not, he or she should nevertheless be informed that their HIV positive status may be disclosed in certain circumstances.

DISCLOSURE TO A SEXUAL PARTNER
In order to facilitate good clinical practice, a healthcare practitioner should encourage patients to disclose their status to their sexual partner.

The experience at Medical Protection indicates that many healthcare practitioners remain uncertain whether they are legally or ethically obliged to disclose a patient’s positive status to their sexual partner if the patient does not provide consent. This decision is left to the discretion of the healthcare practitioner. In reaching a decision, the practitioner should also bear in mind the risks to the patient if a positive diagnosis is disclosed. For example, the risk of violence against the patient and the risk to the sexual partner if the positive diagnosis is not disclosed. It is imperative to contemporaneously document all relevant conversations, thoughts and decisions.

STEPS ON DISCLOSING AN HIV POSITIVE STATUS TO A SEXUAL PARTNER WITHOUT CONSENT
You must take all reasonable steps to obtain consent from the patient to disclose their HIV status:

• Impress upon the patient the importance of disclosing this vital information to their sexual partner and on taking other measures to prevent transmission. Provide appropriate support to the patient.

• Should the patient refuse to disclose their HIV status to their sexual partner, explain to the patient that you are under an ethical obligation to disclose this information.

• You may have to then assess the situation, weigh up the risks and benefits, and decide whether to disclose the patient’s HIV status.

• The patient’s HIV positive status can be disclosed to the patient’s sexual partner following the steps above and, once disclosed, you should assist the sexual partner by offering testing and treatment if necessary.

• It is crucial to follow up with the patient and their partner after the disclosure has been made and assist the patient appropriately.
CASE 1

Complaint lodged at the HPCSA against a practitioner for non-disclosure of an HIV status to the patient’s partner

Mr and Mrs C have been married for 15 years. Mrs C underwent testing for HIV in the practice of Dr L. She was advised to book an appointment to collect her results the following week in Dr L’s practice. The following week, Mr C attends the practice and asks the receptionist to speak to Dr L himself. Dr L agrees to see Mr C, regardless of the fact that he is not a registered patient at the practice. Mr C explains that he is there to collect his wife’s HIV test result. Dr L informs him that he is unable to provide him with the test results as he is not in possession of her express consent to divulge such information to Mr C. Dr L then advises that Mrs C should make an appointment at the practice to collect her results. Mr C is displeased and makes yet another attempt to persuade Dr L to disclose the results. Dr L repeats that due to the doctor-patient confidentiality he is unable to disclose this information.

A few weeks later, Mr C lodges a complaint at the regulator expressing dissatisfaction with the fact that the HIV test results of Mrs C were not disclosed to him and alleging that Dr L has acted unprofessionally. The regulator found no evidence of unprofessional conduct against Dr L and held that Dr L has acted professionally in not disclosing the results and thus maintaining the doctor-patient confidentiality at all times.

If the patient had tested positive for HIV, then Dr L would have to follow the guidance on disclosure to a sexual partner, as outlined above.

CASE 2

A healthcare practitioner seeks advice on disclosing a patient’s HIV status to a sexual partner in error

Mr F attends an appointment with Dr G and requests a full medical check-up, including a request for an HIV test to be performed. Dr G agrees to perform the test on the patient and advises that his results will be sent via SMS. The patient agrees to receive the test results via SMS.

Upon receiving the test results, Dr G’s practice sends an SMS to the patient informing him of his results. The following day, Mr F telephones the practice of Dr G and demands an explanation as to why his test results were disclosed to the patient’s wife – Mrs F. Dr G is surprised to hear that this has happened and investigates the matter further. Dr G finds that the patient had provided his wife’s telephone number and informs Mr F of the same. Mr F advises that this was done in error and he is nevertheless dissatisfied with the fact that a disclosure occurred. Dr G explains to the patient that it is his intention to always protect his patients’ confidential information. Dr G reassures the patient that he has taken measures to ensure such unfortunate situations will not occur in the future.

This case has not escalated into a complaint to the HPCSA yet; however may be considered a breach of confidentiality. If the patient had tested positive for HIV it is important that the healthcare practitioner follows this situation up to ensure no adverse outcome has occurred as a result of the disclosure in error.

The cases mentioned in this article are fictional but based on true clinical scenarios and are used purely for illustrative purposes.
THE DANGERS OF DIGITAL COMMUNICATION

Junior doctors are increasingly using social media websites and apps to communicate with each other and senior colleagues. While this has many advantages there are pitfalls to consider. Kirsty Plowman investigates.

The medical world is transforming because of the technology explosion. Social media, apps and smartphones play a large role in the progress of medical technology and healthcare innovation. One of the most appealing elements of smartphones for medical professionals is the range of functions they perform. However, there is a thin line between what is acceptable and inappropriate and dangers are often only a thumb-swipe away.

It is important that medical professionals are able to engage fully in debates about issues that affect their professional lives and the internet is fast becoming the forum where these discussions can take place.

With many doctors now using smartphones and tablets for professional purposes, it is tempting to make use of file-sharing apps and websites to share clinical photographs with colleagues. While this may appear to be a valuable way to converse about medical conditions with other doctors or to seek another professional opinion, the medicolegal risks could outweigh the benefits.

These are a few of the popular apps and social media websites that you may be using in a professional capacity:

FIGURE 1

Since its launch in South Africa two years ago, Figure 1 – a free e-Health photo-sharing platform for healthcare professionals – has become a popular tool used by doctors. It is a pioneering platform that enables professionals to connect, discuss and share de-identified content. It is recognised as being particularly useful for connecting healthcare professionals in rural areas with city centre colleagues.

WHATSAPP

Healthcare professionals are increasingly using WhatsApp – the free-to-download messenger app that uses the internet to send messages, images, audio or video in a fast, ready-to-use format. Doctors are using it to remain connected through groups enabling quick peer consultation and shared discussion of possible diagnoses, treatment plans and outcomes.

TWITTER

Platforms like Twitter are valuable for healthcare discussions – clinicians are able to easily interact and follow thought leaders in any area of medicine who distribute the latest medical news and information.

FACEBOOK

Facebook, the world’s largest social network, enables registered users to create profiles, upload photos and videos, send messages and keep in touch with friends, family and colleagues. Increasingly, doctors are using it as a tool to generate medical discussions by discussing cases online.

PUBLISHING A PHOTOGRAPH OR OTHER IMAGES

Alongside contemporaneous notes, referral letters, clinical research, laboratory reports, forms and certificates, “Audiovisual records such as photographs, videos and tape-recordings” constitute a health record.

Doctors who wish to publish details about specific medical cases or clinical experiences online, which identify or run the risk of identifying a patient, should ensure they follow the guidelines relating to patient consent and disclosure set out by the HPCSA. These state that a patient’s express consent must be obtained before publishing case reports, photographs or other images in media that the public can access. This rule applies regardless of whether the patient can be identified or not.

Ensure you have documented consent for taking photographs and making recordings. Hospitals will usually have specific consent forms that should be used or medical photography departments who can guide you through the process.

REFERENCES

3. Ibid
**KEEPING PATIENT INFORMATION AND IMAGES**

Patient confidentiality is protected in law – the National Health Act 2003 makes it an offence to disclose patients’ information without their consent, except in certain circumstances.

The HPCSA states that: “Patients have a right to expect that information about them will be held in confidence by health care practitioners. Confidentiality is central to trust between practitioners and patients. Without assurances about confidentiality, patients may be reluctant to give practitioners the information they need in order to provide good care.”

This right to confidentiality means more than simply refraining from divulging information – you are also responsible for ensuring that all records containing patient information are kept securely.

Dangers may arise when sharing images with other colleagues and their devices. For instance, WhatsApp automatically saves photographs on a smartphone and these could transfer to other cloud savers.

**DEFAMATION**

Defamation law can apply to any comments posted online. Defamation is the act of making an unfounded statement about a person or organisation that is considered to harm their reputation. If an individual makes a statement that is alleged to be defamatory, it could result in legal action against them and the HPCSA could launch an enquiry too.

The advantages of using social media to share information with colleagues and patients are obvious; but it is important to be aware of how and when things can go wrong.

Head of Medical Services (Africa) and Editor-in-Chief of Junior Doctor, Dr Graham Howarth, says: “Taking care to avoid these potential pitfalls will help you make the most of social media, which offers exciting new ways to communicate in the ever-changing world of medicine, and has become an integral part of our lives.”

**TEN TIPS FOR DOCTORS USING SOCIAL MEDIA AND APPS**

1. **Maintain and protect patients’ information** by not publishing any information that could identify them on social media without their explicit consent.

2. **Maintain appropriate boundaries in the relationships** you have with colleagues.

3. **Comply with any internet and social media policy** set out by your employer.

4. **As a clinician, you have a responsibility** to behave professionally and responsibly both online and offline.

5. **Your online image can impact on your professional life** and you should not post any information, including photographs and videos that may bring the profession into disrepute. Once you post a comment or photograph online you relinquish control of that information, so think carefully before hitting ‘send’ or ‘upload’.

6. **Anything you post on social media is in the public domain** and can be easily copied and redistributed without your knowledge.

7. **You should presume that everything you share online** will be there permanently.

8. **You should regularly review your privacy settings** to ensure unintended audiences do not access information. Healthcare professionals should be aware that the default settings for Twitter are public – unlike Facebook, where members need to approve social connections, anyone can follow anyone on Twitter.

9. **Even the strictest privacy settings do not guarantee your information will be kept secure.** Both Facebook and Twitter allow various types of content to be shared beyond an individual’s network of friends.

10. **Any information you post could be viewed by anyone** including your patients, colleagues or employer.

If you are unsure about how to tackle a situation online, talk to your employer, supervisor, or contact Medical Protection to discuss the best way forward. Contact a medicolegal adviser at: medical.rsa@medicalprotection.org
As the doctor, you know that you need to obtain a patient’s consent before beginning clinical treatment. But our experience of helping Medical Protection members – whether through a medical negligence claim, a Health Professions Council of South Africa (HPCSA) complaint, or simply by offering professional advice – shows that taking valid consent, with a discussion and documentation of relevant risks, is not always as simple as it might seem.

It is vital that you as a junior doctor should not feel pressurised to do anything beyond your competence, experience and knowledge – this includes obtaining consent for a procedure that you are not familiar with.

The HPCSA states that all doctors must “Acknowledge the limits of their professional knowledge and competence. They should not profess to know everything”.

In regard to consent both the National Health Act (2003) and the HPCSA outline that healthcare practitioners should:

- Give their patients the information they ask for or need about their condition, its treatment and prognosis.
- Give information to their patients in the way they can best understand it. The information must be given in a language that the patient understands and in a manner that takes into account the patient’s level of literacy, understanding, values and belief systems.
- Refrain from withholding from their patients any information, investigation, treatment or procedure the healthcare practitioner knows would be in the patient’s best interest.
- Apply the principle of informed consent as an ongoing process.

Failure to respect a patient’s right to bodily integrity may lead to a complaint to the HPCSA, civil or criminal proceedings for assault, or to a claim.
SCENARIOS

Case 1
Dr T is a newly qualified doctor working in gynaecology. Mrs V is admitted prior to a Uterine Artery Embolisation (UAE) and Dr T is asked to confirm her consent to the procedure, which she gave three weeks earlier in the outpatients’ department. Further questions and some concerns have occurred to Mrs V in the intervening weeks, and she particularly wants to know how the UAE will affect her chances of conceiving and carrying a baby to term. Dr T has only a sketchy, theoretical, understanding of the procedure, which he has never seen performed. He is therefore not competent to obtain Mrs V’s consent and must refer her questions to the radiologist who will be carrying out the procedure.

Case 2
Mrs N is 86 years old and has had a stroke. Her speech is unintelligible and she does much of the time. She suffers a fractured neck of femur in a fall. The staff on the ward explain what has happened and that she needs an operation. Because she is unable to speak, the staff watch her body language intently to gauge her understanding and give her a picture board to help her communicate. Mrs N is able, through these means, to convince the staff that she understands what has happened and that she wants them to carry out the operation.

Case 3
Mr D has been admitted as a day case for colonoscopy for investigation of rectal bleeding. He finds the colonoscopy extremely uncomfortable and insists that the procedure be stopped. This happens just as the surgeon identifies a suspicious-looking lesion in the transverse colon. The surgeon stops the procedure and then explains the situation to Mr D, who agrees to further sedation being administered so the colonoscopy can be continued and the lesion biopsied.

Case 4
Mrs M is 82 and usually very lively and alert. However, she has recently become very confused, probably due to a urinary tract infection. She is admitted to hospital where it is noted that she has an irreducible femoral hernia. The surgeons who are called to see her suggest immediate repair to avoid the risk of infection. She is admitted to hospital where it is noted that she is unable to consent and there is no imminent danger (the hernia is not strangulated), it is decided to wait, in the expectation that she will regain capacity, and then seek consent to surgical repair.

For more information see the Medical Protection Factsheet ‘Consent – the basics’ on our website. Useful information is also available in the HPCSA guidance in booklet 9 Seeking patients’ informed consent: the ethical considerations. Visit hpcsa.co.za/

REFERENCES
2. National Health Act 2003 (p. 2)

TOP TEN TIPS

Advice for junior doctors when consenting a patient for a procedure

1. Never obtain consent for a procedure that you are not familiar with. Junior doctors should not feel pressured by experienced doctors or other staff to do anything beyond their knowledge, experience and competence.

2. Record in the notes what a patient has been told. The presence of a signed consent form does not in itself prove valid consent to treatment – keep contemporaneous notes which record the key points discussed and relevant warnings given to the patient.

3. Use your common sense – consent is patient-specific and depends on the individual’s circumstances, including age, lifestyle, occupation, expectations etc. If you are uncomfortable consenting a particular patient, always discuss with a senior colleague or contact Medical Protection.

4. Ensure you have documented consent for taking photographs and making recordings. Hospitals will usually have specific consent forms that should be used or medical photography departments who can guide you through the process. Do not take photographs on your personal smartphone.

5. Remember, the patient must have decision-making capacity. The starting point in the case of adults is always to presume that the patient has capacity until it is shown otherwise.

6. The law concerning incompetent adults, who are unable to give valid consent, is more complicated. If you are in doubt consult senior colleagues or Medical Protection.

7. Remember there are circumstances where a child can give consent without reference to a parent. If in doubt consult a senior colleague or Medical Protection.

8. Allow the patient to give their consent freely – pressuring patients into consenting to treatment invalidates the consent. Where possible, patients should be given time to consider their options before deciding to proceed with a proposed treatment.

9. Always remember that consent is a process, not a one-off event – it is important to maintain a continuing discussion to reflect the evolving nature of treatment.

10. Ideally consent should be obtained well in advance so that there is time to respond to a patient’s questions and provide adequate information on the procedure that is planned. If you are asked to consent a patient immediately before an intervention and are uncomfortable to do so, you must seek advice from more senior members of the medical team.
A neurosurgeon must master the esoteric while navigating the complex terrains of ego, colleagues, families and tragedy, writes Dr Ncedile Mankahla of Groote Schuur Hospital in Cape Town.
The little known French/Romanian philosopher E.M Cioran is recognised for his view that one of the most uncomfortable things that man can do is “thinking against oneself”, doing what we are all engineered to avoid – scrutinise our actions, motivations and as surgeons, our outcomes. Unfortunately as a neurosurgeon, there is nowhere to hide.

**MOTIVATION**

Ask any practicing neurosurgeon why they pursued this career and they will certainly tell you that what drove them is quite different to what made them stay. The sun having set on the century of the physicist, it has just risen on the century of the neuroscientist. After the Large Hadron Collider at CERN, Europe has now invested €1.3 billion in the Human Brain Project, while the US – in the equivalent BRAIN initiative – has invested $110 million. This has put the brain and neuroscience very much in the spotlight. Media hype and popular television have glamourised neurosurgery and this also has attracted many.

The promise of financial reward, social admiration and – for the very few – the prospect of touching people at their most intimate selves are all motivators. These however tend to change as training progresses and are not what makes one stay. With time, what grows is a sense of appreciation for the privilege and responsibility of working on an organ that makes us who we are.

**DISILLUSIONMENT AND REDEFINITION**

Now that applications are in, interviews scheduled and the dream is becoming reality, what lies ahead?

The requirements for neurosurgical training have evolved with time and are different across all universities. General surgery experience is no longer mandatory but highly recommended and surgical primary exams could be written while already in training. However, I tell this to all our starting colleagues, the process of creating a competent neurosurgeon is enormous, complex and rarely fits into allocated time. This means that neurosurgery is there to teach you “neurosurgery” and assumes you have already acquired basic surgical principles.

The job is gruelling, nights long and days longer. Because neurosurgery is relatively esoteric, clinicians consult for nearly everything – even what is seemingly basic for us. We have to be acutely aware of the medicolegal consequences of brain and spine injuries. This is where self-discovery begins.

While in the midst of learning to work through fatigue and simultaneously assimilating the vast amounts of literature, you have to learn the challenging art of collegiality and professionalism. Few neurosurgical conditions are treated entirely by the surgeon. Multidisciplinary interaction, especially with allied professionals, is part of patient care.

**AN AVERAGE DAY**

The average working day for a neurosurgical registrar has some common patterns across the country. This includes early morning rounds, preparation of patients undergoing surgery or going to the operating room before your consultant to ensure the day runs smoothly. There is also on-call, where one must field consults across the spectrum of neurological conditions.

There is some uniqueness however and I will describe the average day in Cape Town’s Groote Schuur Hospital.

Training is split into rotations (six months junior/six months senior) according to consultant led subspecialties – Neurosurgical Critical Care, Vascular Neurosurgery/Skull Base, Oncology and Endocrine, Spine Surgery and Pediatric Neurosurgery. Each day the trainee will do early ward rounds, attend the post intake meeting, see post-operative patients and prepare new pre-operative cases.

Elective operating occurs twice a week for each unit and registrars are expected to assist. Involvement, including counseling for consent, is graded according to level, knowledge and ability; however, it is part of training to learn how to relay specialised information to non-specialised people. Registrar focused teaching sessions occur twice a week and each senior registrar must prepare cases for focused teaching by consultant faculty. Completion of a research project is also expected of every trainee neurosurgeon.

On-call is busy – for junior registrars there is always a senior on hand to help guide decisions which can be challenging. Emergencies are unforgiving when not recognised appropriately and this process, which frequently requires negotiating with other clinicians who may not have the same insights on the need for urgent action, can lead to friction. One often works throughout the night, performs multiple and sometimes challenging operations while battling fatigue and more consultations. Neurosurgical patients are ill and can deteriorate unexpectedly. This adds an enormous amount of physical and emotional strain. Learning to cope with losing patients, finding time to study and still meet academic expectations from your supervisors as well as dealing with the demands of anxious family members faced with tragedy comes with the job. These are the real challenges of neurosurgery. Operative ability comes with practice, 10,000 hours does the trick – what builds a professional is not taught, but what one encounters at 3am after the fourth craniotomy. The answer here for me is in mentorship.

**HOW TO SUCCEED**

To get through neurosurgery training and be an exemplary professional in one of the most challenging fields of medicine, you should find a mentor.

With that mentor, relinquish yourself so that you can be rebuilt. As surgeons, we are intimate with our egos, and criticism from someone you admire can seem a fatal blow. But the introspection it should induce is vital. This should generate reflection that does not debilitate but rather creates a better you.

This, in my opinion, is the real “how to” become a neurosurgeon. Finding a mentor and nurturing a modesty that allows both the job and mentor to break down with the intention to rebuild. It is important to appreciate that as a community, neurosurgeons are only now beginning to understand the nuances of their job. We are seeing an explosion in knowledge both of the intricacies of the conditions we treat and the effect we have when we intervene. This translates to a lifelong process of learning and demands a constant willingness to evolve with the changes in time. We evolve however, when we are willing to acknowledge to ourselves that what we are doing is no longer the best that we can do. Once this painful art of looking into oneself has been learnt, one can be ready to face the career-long challenges of being a neurosurgeon.

Dr Ncedile Mankahla is the Chief Registrar and Clinical Fellow in Spine and Skull Base Oncology at Groote Schuur Hospital in Cape Town.
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""

The Communication workshops should be compulsory.
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Read ‘Poor communication leads to poor treatment’ on page 15

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FROM THE CASE FILES

How communication problems between colleagues can impact on patient safety

Mrs X gave birth to J, a healthy baby boy. J was discharged, with a note in the records stating he was a “normal healthy infant”; a further note stated that, on examination, there was a bilateral red reflex.

At four weeks, the Baby Clinic’s notes showed that J’s parents were concerned that J’s left eye was smaller than the right, and the Baby Clinic referred the baby to a paediatrician. A couple of weeks later, the Baby Clinic documented the left eye as being more open and the referral was cancelled.

J was then seen by the family’s GP, Dr A, for a six-week check-up; his vision and hearing were recorded as being “satisfactory”. At three months, Dr A referred J to the ophthalmology department after noticing a squint in his left eye; the left pupil was also smaller than the right pupil. Six weeks later – before the ophthalmology consultation took place – J was admitted to hospital as an emergency via Dr A, with coryza, vomiting and poor feeding. J was transferred to the paediatric department, but there was no record from this admission of any examination of J’s eyes.

At six months, J’s ophthalmology appointment took place. He saw a specialist ophthalmologist, Dr H, who noted that she could not detect any visual acuity in the left eye and that the eye was microphthalmic. She also noted a central cataract on the left side. J eventually became blind in his left eye.

His parents made a claim against Dr A and the hospital for the delay in the diagnosis of the congenital cataract.

Expert opinion
Expert GP opinion on breach of duty stated that Dr A had not been diligent when initially examining J’s eyes at the time of the six-week check. By that time the Baby Clinic had listed initial concerns about the size of the eyes, which should have prompted Dr A to be meticulous in his examination of the eyes; had the red reflex been absent, referral to a specialist should have occurred immediately. Prompt and appropriate referral would have led to a 20% chance of restoring J’s visual acuity to a level adequate for driving.

Another expert report, provided by a specialist ophthalmologist, also stated this examination was inadequate, as an abnormal red reflex would almost certainly have been present; this would have allowed for appropriate surgical intervention of the cataract that was later diagnosed.

This report also criticised the hospital paediatric department for failing to communicate the concerns in J’s records about his eye size to the appropriate colleagues. The case was settled for a substantial sum.

Learning points
- Poor communication leads to poor treatment. Here there is poor communication at various stages, between GP and hospital and within the hospital itself.
- Congenital cataract has a finite time period in which surgical intervention is beneficial.
- J was not seen by a specialist ophthalmologist until he was six months old; this delay highlights failings at both ends. Dr A’s referral letter did not make the urgency of the appointment clear but, also, the recognised association of microphthalmia with congenital cataract should have prompted the specialist reading the letter to offer an urgent outpatient appointment.
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