The drugs don’t work

AN MPS MEMBER SPEAKS OUT ABOUT OVERCOMING ADDICTION

PAGE 6

Inside this issue:

How to work in...paediatrics
Dealing with difficult senior colleagues
Handovers: Don’t drop the baton
Helping members in South Africa for more than 50 years

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MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.

Inside this issue of Junior Doctor…

4 Update
Details of your chance to write for Junior Doctor, plus a look at the Risky Business Conference held in Cape Town

6 The drugs don’t work
An MPS member reveals how he has managed to rebuild his medical career and personal life from the rock-bottom of prescription-drug addiction

8 How to work in… paediatrics
Dr Allan Puterman and Dr Despina Demopoulos reveal why paediatrics is much more than just being a “Baby Doctor”

10 Working well together
Sarah Whitehouse and Dr Michelle Pentecost look at dealing with difficult senior colleagues – how do you say no if you are asked to perform a procedure outside your level of competence?

12 Passing the baton
Good handovers provide continuous care and can help to avoid errors, says Sara Williams

14 Dilemma
A case of inappropriate delegation leads to invalid consent for a procedure

Welcome

MPS’s response to the Business Day article of 20 March 2012, Patients ‘need educating on rights, responsibilities’, generated some interest from members. The article reported Dr Kgosi Letlape, the HPCSA’s acting CEO, as saying that a decline in the levels of professionalism among healthcare practitioners and the increasing cost of medical negligence demonstrate the need for greater public awareness.

We agree that there has been an increase in medical litigation and the costs associated with it – we could hardly disagree; our data was quoted. Where our opinions converge are the reasons why. We feel that the public’s awareness of their rights, along with changes in the Road Accident Fund legislation and increasing contingency fee arrangements have increased litigation. The costs have been further escalated by improvements in medical care – meaning severely injured patients live longer – and an increasing sophistication of claimant attorneys.

While we differ on the reasons behind the increasing litigation costs, we have no problems with increasing awareness by patients of their rights – South Africa is a young democracy and this increase is to be welcomed.

Doubtless the advertising campaign will lead to more patients complaining to the HPCSA, many of whom will be treated by the State. Junior doctors are obliged to work for the State for the first couple of years and many stay on longer to gain knowledge and experience. Chances are that they may bear the brunt of the increased complaints.

That makes MPS membership all the more prudent. It is unlikely that your employer would help you with a complaint to the HPCSA – on the contrary, there may be a conflict of interest; indeed it could be them complaining.

Two important messages here then: join MPS, and never ignore a complaint from your registering authority. Treat them and the complaint with the respect deserved.

Opinions expressed herein are those of the authors. Pictures should not be relied upon as accurate representations of clinical situations.

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Declaration signed on mental health

A declaration on mental health was signed on Friday 13 April following a two-day summit attended by NGOs, international experts on mental health, academics, researchers and health MECs. The summit was opened by Minister of Health Dr Aaron Motsoaledi, who expressed concerns around inadequate resources in the mental health sector in SA.

Neuropsychiatric disorders have the third highest disease prevalence in South Africa behind HIV and other infectious diseases. Hurdles facing mental health improvement include a lack of community-based mental health services, inadequate public awareness of mental health, stigmatisation and discrimination.

The summit focused on a range of mental health issues including: prevention of mental disorders; suicide prevention; HIV and AIDS and mental health; and culture and mental illnesses.

All parties present at the summit signed a declaration to improve the delivery of mental health services in the country.

World Down Syndrome Congress

The next World Down Syndrome Congress will be held at the International Convention Centre, Cape Town, on 15-17 August 2012.

Hosted by Down Syndrome International, together with Down Syndrome South Africa, the congress aims to allow delegates to discover the latest developments and up-to-date knowledge and tools to improve the lives of people with Down Syndrome.

For more information and for registration visit www.wdsc2012.org.za

Outdoor gyms help to fight the flab

Soweto’s first outdoor gym has been opened by Johannesburg city council to encourage residents to lose weight, without the need to sign expensive gym contracts.

The machines are designed to withstand outdoor weather conditions and minor wear and tear – and so far have been used by people of all ages.

South Africa is one of the world’s fattest nations – a study by a pharmaceutical company in 2010 revealed that 61% of the country’s 50 million people were obese, a figure only beaten by the United States and Britain. Health authorities blame easy access to unhealthy fast foods, as well as a decline in overall fitness levels.

Tim Hogin, managing director of Green Outdoor Gyms, the company behind the gym equipment, said: “Our aim is to get people moving, fit and healthy. I realised that not everyone could afford paying for a gym membership and that was the biggest excuse for not exercising,” he added.

The company plans to roll-out 1,000 more gyms across the country in two years.

Write for MPS in South Africa!

We are always looking for contributors for features and articles in MPS publications. After all, as a members’ organisation, we want to see your opinions and concerns reflected in your publication. With a readership of more than 3,000 junior doctors in South Africa, make your voice heard!

To kickstart contributions, we would like you to answer the following question: What is the most harrowing medicolegal experience you have encountered as a junior doctor?

If there is anything else you’d like to share, be it a debate, a question, or just an account of what it is like to be a junior doctor in South Africa, please email Sarah Whitehouse, Junior Doctor Editor, at sarah.whitehouse@mps.org.uk.

Any published contributions may be eligible for up to R500 payment in vouchers, depending on length and quality, but just getting published will be worth a lot of credit!
What do a shark attack victim, a mountain rescuer and “babies in boxes” all have in common? These were just some of the amazing stories that were presented at the first Risky Business Conference held in South Africa, hosted in Cape Town on 29 and 30 March.

Risky Business: Learning from Other High-risk Industries first began in November 2006, as a joint initiative between Great Ormond Street Hospital and the Royal College of Surgeons of England. Its aim is to learn from defining moments in high-risk industries and discover which of these can be translated to medicine to improve patient safety.

Over the following years the conference expanded, with eight Risky Business conferences being held around the world (three in London, two in Boston, one in Phoenix, Geneva and Cairns). More than half the speakers on the programme were from South Africa, as well as international speakers from Australia, Malawi, Germany, the Netherlands, USA and the UK.

MPS was a key conference partner, providing a number of speaking slots on the conference programme and hosting a panel discussion. MPS also sponsored one of the keynote speakers, Dr. Gerald Hickson from Vanderbilt University in the USA, who described how to effectively identify medical professionals who are problematic and to develop systems that promote accountability.

Dr. Mark O’Brien, International Programme Director, MPS Educational Services, presented two sessions on “Leading high-performance teams to minimise risks” and “The ‘aftermath’: supporting frontline clinicians and teams to maintain or improve performance after a serious adverse event”, which described how people working directly with patients can recover to full potential following an adverse event.

John Tiernan, MPS Director of Educational Services, together with Enid Dettmer, our Education Consultant to MPS based in South Africa, were on the conference organising committee. Ian Middleton and Alika Maharaj, our Membership and Marketing Agents, had an MPS trade stand at the event providing delegates with copies of MPS publications.

visit the MPS website www.medicalprotection.org/southafrica for the latest information from MPS. Here you will find numerous factsheets, booklets, new online applications to join MPS, news, and access to MPS’s e-learning platform. Our latest factsheet focuses on living wills and advance directives and can be accessed here: www.medicalprotection.org/southafrica/factsheets
The drugs don’t work

An MPS member shares his story of a spiralling drug addiction whilst at medical school

“Perhaps you’ve heard a rumour about a colleague with a drinking problem. Maybe a friend’s colleague has an addiction to pethidine. If you’re anything like me, addiction could never happen to you.

But extraordinary stresses can lead people to do extraordinary things. Addiction is an insidious disease, moving slowly closer like a cat stalking an unsuspecting bird. It’s also the only disease where your mind tells you that you aren’t sick. Looking back, I can see how addiction slowly sucked me in.

Why?

No two people have the same set of circumstances or reasons for becoming addicts. At medical school, I was faced with the usual stresses of student life, together with the added stress of supporting my young family. I felt that I didn’t deserve to be there and I was a fraud. The stress I created in my mind was far greater than reality. I found myself at the age of 30 unable to deal with overwhelming emotions. Initially, I found escape in alcohol. I drank to get out of my own head, so that I didn’t have to think or feel torturous emotions. I didn’t drink often and it was always at home. I didn’t see a problem. In retrospect, this abusive drinking laid the foundation for my addiction.

One evening, I settled in with a bottle of red wine. My wife and mother were at each other’s throats and I couldn’t deal with the tension. I finished half the bottle but could still feel the pain. I can still remember the exact thought: “Morphine works so well for physical pain, I wonder if it works for emotional pain”. I went to the car, opened the drug bag I had as part of my professional responsibilities and injected a 15mg ampoule intravenously.

I am often asked how opiates make you feel. It is hard to describe without sounding like I’m glamourising abuse. Opiates change your basic emotions. That evening, I went from feeling desperately depressed to completely at peace in a matter of seconds. It is easy to imagine how seductive the knowledge of this power can be.

My wife found me in the car, with the needle still in my arm. A big part of me wanted her to find me. I wasn’t coping, but I couldn’t articulate why. Needless to say, my wife completely freaked out. I couldn’t see what the fuss was about.

A creeping dependence

My addiction didn’t develop overnight. Initially, I used once every couple of months, when my coping mechanisms failed. Later, I ignored the fact that the time between these events was getting shorter; my pain threshold for using was becoming lower. At some point, I crossed that nebulous line between abuse and addiction. My stock of morphine had long since dried up. I had a convincing story, along with a list of colleagues who could write prescriptions for me.

About 18 months into my using, I knew that I was an addict. Organising drugs was difficult, which limited my access. I thought this made me “less addicted” than those who used every day. After a weekend binge, I spoke to my wife and admitted that I needed help. I arranged to see a psychologist. After a few sessions, I thought I was cured. I stayed clean, for a while.

Access to drugs

The wheels came off when I entered my fifth year of medical school and began clinical rotations. My first block was anaesthetics. By the end of the first procedure, I took the syringe of leftover morphine and went to the bathroom to inject, with no regard for the diseases I might be exposing myself to.

I began to steal ampoules of opiates that I found lying around. I expected there to be a huge uproar. I was petrified, promising myself that I would never do it again.

MPS COUNSELLING SERVICE

MPS’s counselling service assists members suffering from stress caused by receiving and dealing with complaints, clinical negligence claims, disciplinary matters, and other medicolegal issues.

Provided by Independent Counselling and Advisory Services (ICAS), it is independent and confidential. Simply call 0800 982 766 (toll-free within South Africa) for more details.

For more information see: www.medicalprotection.org/southafrica/counselling-service
Familiarity breeds contempt. When you work with opiates every day it’s easy to lose respect for them, but when you let your guard down they are likely to bite you, like a carelessly-handled snake. By the end of my surgery block, I was completely out of control. I am deeply ashamed of the things I said and did. Addicts often justify their using: “I can’t help myself, I’m sick”. There is no justification, but no amount of willpower could keep me clean.

Every day, I would arrive at the hospital and sit in the parking lot crying, my shaking hands clenching the steering wheel. I would swear that I was not going to use that day. This never lasted longer than an hour. I didn’t bathe or brush my teeth for days on end. I never ate. I just didn’t care.

At one point I was using 12 ampoules a day. I thought that nobody around me had any idea that something was wrong. I later realised that people knew, but had no idea what to do about it. Substance abuse is the medical profession’s “elephant in the room”. Everyone politely pretends that it’s not there.

One evening, I settled in with a bottle of red wine. My wife and mother were at each other’s throats and I couldn’t deal with the tension called my wife and all hell had broken loose. My wife insisted I take a drug test. I broke down and begged for help.

I was at home when the withdrawals began to hit. Opiate withdrawals are every bit as horrific as they are made out to be. The emotional symptoms are worst – I cried for five days solid. It was as if every emotion that I had ever suppressed with drugs had come back to torture me.

I confessed my addiction to the medical school. They were very understanding and agreed to give me the rest of the year off to clean up. My arrogance and pride still kept me from entering a formal rehabilitation programme. I began seeing a psychologist and reluctantly began to attend Narcotics Anonymous meetings.

It was obvious that my drug use had affected my brain. The mere prospect of getting out of bed and having to plan a day at home petrified me. My short-term memory was non-existent.

After three months, I went back to medical school. It was too soon; staying clean was a full-time job and my brain was still recovering. I would walk out of tutorials unable to even remember what the topic was. I knew I had to deregister.

Once again, the medical school was supportive. I soon found work in my old industry, education, and had no access to the drugs. Still, the depression that lingered drew me back to using another two or three times.

A turning point

The final straw came one afternoon when I went to visit my former colleagues. I was caught trying to steal two ampoules of morphine and the company charged me criminally. As I write this, the shame of what I did still makes me cringe. However, it was the wake-up call I finally needed. I knew that it wouldn’t be long before I was in jail or dead.

On the day that the police came to see me, I contacted MPS in a panic. I was a student member while at medical school. I didn’t think that MPS would help me, but I didn’t know where else to turn. I will never forget the kindness they showed me. MPS arranged for an attorney to meet me at the police station in less than an hour, without judging or condemning me. Understandably, MPS could not give me ongoing support; however, they were there for me at the time I needed them most.

The senior public prosecutor asked me about my problem and what I was doing about it. He reminded me that the justice system was not there to punish people, rather to ensure that justice was done. He postponed the case until my rehab programme was complete and after viewing my reports, he withdrew the charge.

The HPCSA ethical rules oblige you to report yourself if you are an impaired practitioner, which I did. I wrote to them asking for help. However, they sent me a cold, generic letter threatening me with suspension if I didn’t report to a nominated psychiatrist for an assessment at my own cost. Five months after that assessment I have yet to hear my fate.

Rebuilding my life

I enrolled in a formal rehabilitation programme. I finally started to grasp what it meant to live a life without drugs. Slowly, my family has learned to trust me again. Amazingly, my wife chose to stay with me. It hasn’t been easy, but I have stayed clean one day at a time. I have resumed clinical practice under supervision and the medical school has agreed to re-admit me.

When colleagues ask me why I left medical school, I tell them. I have chosen not to buy into the conspiracy of silence surrounding addiction in the medical profession. Why, then, have I chosen to write this anonymously? There is still huge stigma attached to addiction. It has helped shape me, but it no longer defines me.

Doctors will always run the risk of falling into the trap of addiction. Those who don’t believe it are probably most at risk. The unique matrix of an incredibly stressful job, knowledge of and access to substances, as well as an environment that does not tolerate perceived weaknesses, means that we need to be vigilant.

Perhaps by sharing my story, just one practitioner under pressure will get the help they need. If this happens, the pain of writing my story will be worth it.”

When you work with opiates every day it’s easy to lose respect for them, but when you let your guard down they are likely to bite you, like a carelessly-handled snake

To read the full account visit: www.medicalprotection.org/southafrica/junior-doctor

© EINA PETERST/ISTOCKPHOTO.COM
Junior doctors considering a career in paediatric medicine should at least start with a good sense of humour and be comfortable with the label “Baby Doctor” – often used by colleagues who do not have the pleasure of working with children on a day-to-day basis.

Paediatrics is not for the faint-hearted; you must be prepared to work long hours and keep up-to-date with new developments. Minute errors in the dose of a medication can have disastrous consequences.

The primary aim of any paediatrician is to be an advocate for child health, which may range from access to housing, education, healthcare and water, to cardiac surgery and neonatal ventilation. The cornerstone of paediatrics is preventative medicine. Promoting appropriate early nutrition, vaccinations and healthy lifestyles goes a long way in decreasing rates of illness and ward admissions.

The most rewarding part of paediatrics is definitely the feedback one gets from one’s patients. This feedback may be in the form of a simple smile, a hug or a hand-drawn pencil and crayon picture.

Training
Training is done at the usual teaching hospitals in South Africa. There are a fair number of training posts and some junior doctors are put off by the long on-call hours. The South African Paediatric Society is working on standardising paediatric training across all teaching units and ensuring reasonable working hours and protected teaching time. Training takes place over four years and the registrar rotates through a number of departments, including the emergency department, intensive care, neonates and the wards. In paediatrics, registrars are expected to have a more “hands on” approach than other specialties, where certain procedures like phlebotomy or lumbar puncture can be left to an intern or medical officer.

After the four-year rotation, college exams and a dissertation, it is possible to spend an additional two years in one of the subspecialty posts.

Working as a paediatrician
Paediatricians can accommodate doctors with a range of different interests. Paediatricians can find satisfaction working at any of the medical schools. This work would entail treating patients from all social strata, dealing with more complex cases and taking on the responsibility of teaching undergraduates and postgraduates. An important part of academic paediatrics is promoting and conducting appropriate research to
There is no escaping the reality of working hours. Patients in private practice are able to do well financially, but should not expect to drive a Masarati and fly their own airplane. A paediatrician in state employment can expect to earn between R600,000 and R1,200,000 per year, depending on seniority, overtime and rural allowances. A paediatrician in private practice will need to bill about R2,000,000 to earn the equivalent of a colleague in state employment. This usually involves a lot of after-hours and emergency work.

Subspecialties
After completing paediatric training, it is possible to specialise further in one of the paediatric subspecialties. Some of these fields are either formal or informal subspecialties and include neurodevelopmental paediatrics, cardiology, pulmonology, neonatology, allergy, critical care, gastroenterology, endocrinology and oncology.

An average day
I wake up at six and take a call from the maternity unit informing me of a newborn baby delivered in the early hours that needs to be assessed. Instinctively, I take a call from an unidentified number and disappointingly find that it is a nervous mom reporting on her disturbed night. I try to be polite and inform her that this is not an appropriate use of the emergency number and she should call the rooms during office hours.

Next, the ward round in the neonatal ICU. The handful of premature babies ranging from a 24-weeker to a 36-weeker are all stable and the staff and parents are happy. Ward round on the well baby side: promote breastfeeding and discuss minor newborn issues.

Ward round in the general paediatric ward: only one patient with RSV bronchiolitis as admission rates are dropping dramatically, with a high vaccine uptake, and treatments are geared for home care.

There are usually about ten patients to be seen in the consulting rooms at half-hour intervals throughout the day. Complaints can range from mild rashes and infections to complex chronic conditions and psychosocial issues. Invariably, I need to leave the rooms to attend an emergency caesarean section.

The final ward round of the day in the NICU and ward takes place between 5.30-6.30pm. On-call for the group through the night, which is usually quiet and undisturbed, although there are sometimes calls for emergency caesareans or admissions via the hospital emergency unit.

Further the understanding and treatment of paediatric diseases. Paediatricians in state employment, working in community hospitals or centres, can make a huge impact on the social wellbeing, health and happiness of the populations in the area that they serve. Community paediatricians are often involved in helping and advising the Department of Health, as they are considered pivotal in translating government policy into action.

In private practice, you can interact on a one-to-one basis with the child and the child’s parents, siblings and grandparents. Identifying a child who is becoming obese, advising the parents on basic dietary intervention and seeing a positive result a few months later can be just as rewarding as admitting a 24-week neonate into the NICU and discharging him three months later in perfect condition.

Private practice is not selfish and isolationist. On a personal level, I am involved in a number of local and international organisations (medical, political and academic) at executive level. Fellow paediatricians and I are also involved in international drug trials and contribute papers to journals and lectures at various conferences.

Working hours
There is no escaping the reality that many babies are born in the early hours of the morning and a lot of children get ill quickly, and at odd hours. This means that a paediatrician must be prepared to work after hours and on weekends. State employment does allow roster work so these duties can be shared. Paediatricians in private practice also arrange shared after-hours duties. With good preventative practice and easy normal hour availability, it is possible to reduce after-hours work. Patients in private practice are increasingly being trained to attend emergency units after hours before contacting their paediatrician.

A career in paediatrics is particularly suitable for part-time work. Many paediatricians who have home commitments will do session work in the state or private sector and provide locum cover for a night or weekend.

Remuneration
Paediatrics is more suitable for a person interested in job satisfaction rather than financial gain. Paediatricians should be able to do well financially, but should not expect to drive a Masarati and fly their own airplane. A paediatrician in state employment can expect to earn between R600,000 and R1,200,000 per year, depending on seniority, overtime and rural allowances. A paediatrician in private practice will need to bill about R2,000,000 to earn the equivalent of a colleague in state employment. This usually involves a lot of after-hours and emergency work.

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Working well together

Learning new procedures and protocols has to be balanced alongside mastering the art of getting along with senior colleagues and dealing with challenging situations, say Sarah Whitehouse and Dr Michelle Pentecost.

No pressure

However, it is important that you do not feel pressured into doing anything beyond your knowledge, experience or competence. Simple things such as writing concise and accurate records, getting valid consent from patients, and knowing when to seek advice can help you practise safely.

The HPCSA makes it clear that consent should only be obtained from a healthcare practitioner who:

- Is suitably educated, trained and qualified
- Has sufficient knowledge of the proposed investigation or treatment and understands the risks involved.

If you are unsure about what is involved in a procedure, however minor, you should get a senior to explain or demonstrate it as part of your training before agreeing to take consent for it from a patient. Consent is a process, rather than a form-filling exercise. When delegating, it is the clinician's responsibility to ensure that their colleague has the correct expertise.

Checking your next steps

If a task has been delegated to you, but you feel concerned about the appropriateness of the treatment, you should raise it with your senior colleagues before proceeding – and document this. Challenging a colleague's diagnosis or treatment plan can be daunting. However, it is imperative to do so if you feel that patient care may be compromised.

Dr Magnus Potgieter, a CSMO says: “Standing up to your seniors is difficult. Senior doctors may very well discuss such incidents with other seniors and you can easily gain a reputation as a trouble maker and rebel. It could also put strain on your future relationship with the senior involved and even those from other rotations. If you are going to challenge a superior, and time permits, make sure you have solid scientific evidence to back your case.”

No matter how daunting, if you believe a diagnosis or treatment plan should be revisited, or you are unsure of how to proceed, it is your professional duty to say so. Dr Potgieter says: “It is important that you do not display an arrogant attitude; rather, try and initiate an academic discussion around the problem concerned.”

Communication is key

Good communication with your seniors is essential in building a successful working relationship; a positive attitude needs to come from both sides. This can make it easier to be more assertive when requesting assistance or a second opinion if you feel out of your depth.

One intern reports: “In one hospital where I worked in surgery for four months, the surgery consultants did not even come out once during a call to help us. The registrars were too scared to call: they didn’t want to be known as the registrar who couldn’t cope on their own, even if it was not in the best interest of the patient.”

Working as a junior doctor can, at times, be a stressful experience. Not least, because you have to chart your way through establishing good professional relationships with seniors, some of whom might live up to the stereotype of a brusque, no-nonsense consultant, who expects the very best and doesn't take any questioning of their decisions lightly. Eager to impress, and fearful of causing problems, you might be tempted to keep your head down and not speak up when something seems amiss, or you feel out of your depth.

Standing up to your seniors is difficult. Senior doctors may very well discuss such incidents with other seniors and you can easily gain a reputation as a trouble maker and rebel. It could also put strain on your future relationship with the senior involved and even those from other rotations. If you are going to challenge a superior, and time permits, make sure you have solid scientific evidence to back your case.”

No matter how daunting, if you believe a diagnosis or treatment plan should be revisited, or you are unsure of how to proceed, it is your professional duty to say so. Dr Potgieter says: “It is important that you do not display an arrogant attitude; rather, try and initiate an academic discussion around the problem concerned.”

Communication is key

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WORKING IN COMMUNITY SERVICE

In a rural area, you may be the only junior doctor on shift and there might not be anyone to ask for help. Dr Michelle Pentecost, who has just completed her community service year, offers the following advice for some challenging scenarios:

- You don’t agree with the diagnosis or treatment plan – In a well-functioning team, every opinion matters, including yours. If you have concerns, voice them with your seniors – they may agree with your insights. Record your queries and your discussion in the medical notes with any adjustments to the treatment plan. For example, “new plan as discussed with Dr X” or “Consultant Y’s decision...”).

- You do not feel competent to perform a procedure – As an intern, you should always have supervision available. If this is not the case at your facility, you should raise it with your seniors, the superintendent or the HPCSA. Start by asking your immediate senior for assistance. If he/she is unavailable, ask if anyone else in the team is able to help. It is better to delay the procedure if it is not immediately necessary, if you do not feel competent. If the procedure is urgent and there is no one to assist you, then you have no choice but to continue. In the interim, ask your nursing staff to call for assistance. Afterwards, be sure to record your actions very clearly, noting whom you contacted, who was not available and the details of the procedure.

- You are the only doctor at a remote rural hospital – Strengthen your clinical skills before community service by taking part in short courses such as ACLS, ATLS, PALS or a surgical skills course. Familiarise yourself with the referral pathway so that you are able to phone for advice. Refer patients who require treatment or interventions that are not within your scope of practice. If the referral hospital’s admitting doctor refuses to accept the patient, note your discussion and the doctor’s name in your records. In an emergency situation, which is the only time where you are permitted to act outside your competency, document the event meticulously.

- You have a medicolegal or ethical dilemma – What is the legal age for consent for surgery? HIV testing? A termination of pregnancy? Acquaint yourself with the law so that you can play by the rules. If you have an ethical concern, raise this with your senior. You can also contact MPS for any medicolegal queries by calling 0800 982 766 or completing the medicolegal contact form on www.mps-group.org.

The right level of competence

It is important, however, that you don’t allow your ignorance of a procedure to become an excuse for not carrying out the task in hand. Dr Potgieter says: “The intern cannot sit and drink tea while the senior medical officer applies traction to all the broken femurs in the ward. You need to be willing to learn and overcome your areas of incompetence. We often use the ‘see one, do one, teach one’ doctrine, which also has its own dangers. What complicates the whole discussion is that doctors have no clear scope of practice, unlike nurses. We all have widely different fields of competence, even with the same qualification.”

Despite this, there are minimum levels of competency expected of a junior doctor and it is simply not practical to have a consultant on hand to check every element of your work. What is most important is working confidently as a team, referring upwards any concerns you have about proposed treatment plans, or any queries you have about your ability to take informed consent for a procedure. Communicating these concerns in a professional and efficient manner will help to ensure that patient care is not compromised.

CASE STUDY 1

Dr S is an intern completing her anaesthetics rotation. She is assigned to an orthopaedic surgery list with consultant Dr C, who is in the latter stages of her pregnancy. Dr C is a good mentor, assisting Dr S to give the anaesthetics and teaching her about accurate note-keeping. However, the afternoon case requires frequent in-theatre x-rays of the surgical field. Having observed Dr S for the morning, Dr C is happy to hand over to Dr S and leave the theatre to avoid the x-ray exposure. She gives Dr S some brief instructions and departs, saying, “I’m sure you’ll be fine.” Whilst Dr S feels very uncomfortable about continuing without supervision, she does not want to upset the consultant and makes no mention of her reservations.

Twenty minutes after the consultant’s departure, the patient’s blood pressure drops precipitously. Dr S panics while trying to correct this with fluids and vasopressors and eventually the surgical assistant, who has some anaesthetic experience, has to intervene and help stabilise the patient.

Learning points:

- The HPCSA stresses that interns should not practise anaesthetics unsupervised; Dr C was incorrect to allow the intern to continue alone.
- Dr S should have voiced her concerns, instead of remaining silent.

CASE STUDY 2

Dr F is an intern completing his paediatrics rotation. He gets a call from his registrar Dr T informing him that a patient has arrived for a CT scan and requires sedation before the procedure. She instructs him to go to radiology urgently to “give some chloral hydrate”. Whilst Dr F has not used this premedication before, he does not ask any questions, nor does his registrar ask if he is comfortable with administering the premedication. He rushes to the CT suite, and gives the chloral hydrate intravenously instead of orally. This caused local irritation to the vein, which usually occurs if chloral hydrate is given intravenously. Fortunately, the adverse reaction was not severe.

Learning points:

- Senior doctors should give clear instructions after ascertaining that the junior doctor is competent and comfortable with the procedure.
- Alert your senior if this is the first time that you will be performing the given task and ask for explicit instructions, repeating what your senior has said for clarification.

Dr Michelle Pentecost is a Medical Officer and Freelance Writer.

REFERENCES

1. HPCSA, Seeking Patients’ Informed Consent: The Ethical Considerations, 5.1 (May 2008)
An Australian doctor in 2005 summed up the state of handovers in his hospital as “unstructured, informal and error prone”
Poor handovers can lead to a “Chinese whispers” effect where information becomes continually degraded or changed. Most handovers are done with the best intentions, but quite informally. People are often distracted, trying to do several things at once, which can affect levels of concentration.

The global patient safety champion Professor Charles Vincent, from Imperial College London, who has spent 20 years studying patient safety, argues that trainees can learn from handover mistakes. “When things go wrong, it’s what I call a window on the system: it exposes areas of vulnerability in the process. If something happens to a patient because information was not handed over, the question to ask is: was this a one-off or are we handing information over badly?”

**Good handovers**

A good handover is a two-way process where information is exchanged and an opportunity is given to ask questions and reaffirm that the information exchange has been successful. It should be structured and focused, with minimal interruptions. Checklists like the one produced by the Royal College of Surgeons in the United Kingdom (see handover checklist) can help with the management of common conditions.

A successful handover requires:
- A senior clinician to lead the handover
- A shared understanding of the plan of action and what is required
- Designated bleep-free time within working hours (30 minutes for larger hospitals)
- Involvement of all health professionals, as more information is needed for high-risk patients
- A clear method of contacting the doctor responsible for a particular patient
- Awareness of potential risks.

**Summary**

What is perhaps most important about improving the quality of care, is to continually examine how we deliver it. Changing an existing process is not easy, but just focusing on one or two things in your handovers might make a lot of difference to you and your patients.

**ROYAL COLLEGE OF SURGEONS (UK) HANDOVER CHECKLIST**

- Begin with a short briefing – “situational awareness”
- Facilitate a structured team discussion
- Establish and develop contingency plans – “what to do if…”
- Encourage questions from the team – there are no “stupid questions”
- As a minimum, ensure the following is imparted:
  - Patient name and age
  - Date of admission
  - Location (ward and bed)
  - Responsible consultant
  - Current diagnosis
  - Results of significant or pending investigations
  - Patient condition
  - Urgency/frequency of review required
  - Management plan, including “what if…”
  - Resuscitation plan (if appropriate)
  - Senior contact detail/availability
  - Operational issues, eg, availability of intensive care unit beds, patients likely to be transferred
  - Outstanding tasks.

**REFERENCES**

6. Ibid 2

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*Sara Williams is a Senior Writer and Editor at MPS*
Mrs R, a 42-year-old amateur opera singer, was admitted for an elective partial thyroidectomy under general surgeon, Dr F. Mrs R was admitted by Dr A, a junior surgical doctor. He recorded that she was having the operation because she had declined radioactive iodine treatment of her hyperthyroidism. Once he finished the history and examination, Dr A informed Mrs R that a more senior doctor would go through the consent form with her at some point during the day.

On this particular day, however, there was a very long and busy surgical list, and Dr F did not get the chance to complete the consent form with Mrs R. Neither did he go through the form on his brief review of Mrs R on the ward round the next morning. When Mrs R arrived in the anaesthetic room, Dr A went through her notes. Realising that the consent form was still missing, Dr A went through to the operating theatre to discuss the matter with Dr F. Dr F was in the middle of another procedure and told Dr A to take Mrs R’s consent for the thyroidectomy and file it in her notes. Feeling a bit intimidated, Dr A agreed and went back into the anaesthetic room. Anxious at Dr A’s hesitancy, Mrs R asked if anything was wrong. Dr A reassured Mrs R and explained that there had been a little confusion because a consent form for the operation had not yet been signed, and he asked if he could go through that process with her. Mrs R agreed and Dr A described what her operation would involve. A written information leaflet was not available but Dr A asked Mrs R if she had any questions about the procedure and Mrs R answered no. Both Mrs R and Dr A then signed the consent form.

After the operation, Mrs R experienced typical post-thyroidectomy side effects, including discomfort on swallowing, hoarseness, neck stiffness, bruising and swelling. The team assured her that this was a usual response and offered her appropriate analgesia. Two days after her operation, Mrs R’s pain and swelling had reduced and she was discharged home after being told that the post-surgical hoarseness should settle in the next few weeks. Four weeks later, Mrs R saw Dr F in his outpatient clinic for routine wound review and thyroid function test. Mrs R commented that although her neck was healing well, the hoarseness had not improved since the operation and, concerned about her singing voice, she asked him how long it could be before this was resolved. Dr F told her that permanent hoarseness is a rare complication of thyroidectomy and arranged to review her again in another four weeks.

At that review, there was still no improvement and Dr F diagnosed permanent damage to the recurrent laryngeal nerve. Mrs R started a claim against both Dr F and Dr A for not warning her that this could happen.

**Expert opinion**

Expert opinion was critical of Dr F’s delegation of the task to Dr A. Although he was not directly accountable for the decisions and actions of Dr A, he was still responsible for the overall management of the patient, and accountable for the decision to delegate. Dr F claimed that he had spoken to Mrs R about the procedure at a previous consultation, but there was no record of this. Dr A should have refused to take consent, on the basis that it was outside his field of competence.

The claim was settled for a moderate amount. *Casebook, Vol 19 No 1, January 2011*

**LEARNING POINTS**

- All doctors have a duty to ensure that they have the necessary understanding of a procedure to take consent. If not, ensure that consent is taken by someone who does.
- It is important not to practise beyond your skills and expertise.
- When delegating care or treatment, you must be satisfied that the person to whom you are delegating has the appropriate experience, qualifications, knowledge and skills to provide the care.
- Written consent is essential for surgical procedures – except emergencies – and patients need to be informed of relevant side effects and complications.
- Record any discussion of possible complications in the notes, even if this discussion takes place outside the formal consenting process.
- A patient information leaflet is a useful adjunct to have but does not replace the discussion about risks and side effects.
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ISSN 2042-2369