First day on the wards

Competence, supervision, handovers – and surviving the paper trail

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Get the most from your membership…

Visit our website for publications, news, events and other information: www.medicalprotection.org

We welcome contributions to Junior Doctor. Please contact the Editor, Sarah Whitehouse at sarah.whitehouse@mps.org.uk.
Welcome to the latest edition of MPS’s Junior Doctor magazine.

Medical school teaches you about pathology and patients, but doesn’t always teach you about the administrative duties required to manage those conditions and treat patients. The first day on the wards, learning about systems and processes, can be a daunting time for junior doctors. Dr Lynelle Govender explains how you can prepare for the challenges ahead by getting to grips with the paper trail, communicating effectively with colleagues, and ensuring you practise with supervision where possible. Turn to page 6 to find out more.

On page 8, we look at another administrative minefield: the J88 form and how to complete it accurately.

Being a member of MPS offers many benefits, not least offering protection where state indemnity leaves off. Find out how you can make the most of your membership on page 14.

As ever, do let us know if you have any feedback on this issue. If you’d like to write for us, or if you have a feature idea, please get in touch.

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Back by popular demand, our Ethics 4 All events will be run in Durban, Midrand (Gauteng) and Cape Town in 2014. MPS is dedicated to keeping you up-to-date with your CME Medical Ethics, Medical Law and Human Rights points. Accreditation for five ethics points have been applied for.

The annual MPS ethics event, free of charge to members, will be held on the following dates:

DURBAN | Sunday 16 November 2014
Southern Sun Elangeni Hotel
Registration from 8.30am for a 9.30am start – 1pm close

MIDRAND, GAUTENG | Monday 17 November 2014
Vodacom World
Registration from 6pm for a 7.30pm start – 10pm close

CAPE TOWN | Wednesday 19 November 2014
Cape Town International Convention Centre, CTICC
Registration from 5.30pm for a 7.30pm start – 10pm close

The programme will include:

■ The ethics of a professional reaction in the face of a complaint – what happens when a professional receives a complaint?
■ The power of the patient voice – making (good and bad) feedback your friend
■ When things go wrong: reflections of a previous Ombudsman
■ Strategies for dealing with disappointment.

For more information and to book your place visit: www.medicalprotection.org/ethics4all

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The heart of the matter

Be wary of being unduly influenced in your medical management by patients who come with a self-diagnosis

Mr G was a 55-year-old art gallery owner, based in a city centre. Over a period of six weeks, he developed a tight, burning sensation in his chest after meals, which cleared when he belched. He took some over-the-counter preparations for heartburn, including antacids. When these failed to alleviate his symptoms, Mr G made an appointment to see Dr V, his GP.

During the consultation with his doctor, Mr G’s blood pressure was recorded as 164/92. Dr V made a note that this was likely to be “white coat hypertension”, and therefore not significant. He advised Mr G to return at his convenience for another BP check-up with the nurse. The medical entry noted the patient as having “heartburn clearing after belching”, with no other details of the nature of the pain, or any exacerbating or relieving factors.

There was no record of whether this was related to exertion. Mr G said himself that he had “probably just some heartburn”. He was told that his wife had asked him to make the appointment when his self-treatment had failed. Mr G said that he had been sweating excessively and that he had been sweating excessively. Dr V told him it was probably due to the stressful environment and that he had likely experienced a panic attack, prescribing him some propranolol.

One week later, Mr G collapsed and died at home. The postmortem examination was reported as showing left ventricular hypertrophy secondary to hypertension and severe coronary artery disease. Mr G’s widow made a claim against Drs V, K and B.

Learning points

- Be wary of being unduly influenced in your medical management by patients who come with a self-diagnosis. This can often be wrong and prompt an incorrect treatment pathway. The terminology used by a patient might not be an accurate representation of pathology and can be misleading.
- Remember that chest pain experienced after a meal, or associated with belching, can also be a sign of angina, rather than a sign of gastro-oesophageal disease.
- Do not be reluctant to challenge the diagnosis of a colleague, regardless of seniority. Symptoms evolve and change and, with careful history-taking, patients can often report different symptoms at subsequent visits, where new diagnostic clues can emerge. Re-examine a patient’s previous history, from the beginning if necessary, if there is a change in symptoms.
- Remember the importance of actively managing chronic diseases and acting on abnormal signs, eg, elevated blood pressure.
- Preventative medicine is a large part of primary care and failure to act can result in adverse outcomes.
Dr S is a newly-qualified doctor. On 29 December, he has orientation at the hospital where he will start internship on 1 January. His first rotation will be obstetrics and gynaecology. Orientation is little more than a series of speeches by various members of the hospital management. The head of department of O&G then fetches his group of interns and takes them to his department. But here, orientation continues as another speech in yet another overcrowded room. The newly-qualified doctors breeze through the wards, but they are not provided with any practical information. As 1 January is a Saturday on this particular year, only two interns will be required to come in. These two interns will do the first call for the rotation. The first call of a rotation is the absolute worst. Not only are you completely inexperienced in clinical aspects of the department, you are also unsure of the practicalities of the system. The head of department expects two interns to volunteer for this madness. Silence. Dr S quickly realises that no-one will volunteer. He raises his hand: he will do it.

1 January rolls around and before he knows it, Dr S is outside the hospital walking in for his first day. In medical school, you imagine this will be a grand affair. It’s your first day working as an actual qualified doctor, after all. It is none of those things. Work starts almost immediately as you push through the labour ward doors. Dr S is expected to start the ward round in the labour ward. The registrar who is supposed to be accompanying him has been called to theatre for an emergency caesarean and has taken his fellow intern with him.

Quite suddenly, Dr S is alone. He tries his best to see the patients, and come up with appropriate management plans, but even the most simple of ward tasks become a challenge because he does not know the system. He doesn’t know which forms to use to order blood tests, or how to order units of blood after hours, or what number to call when he has to book an emergency case in theatre. Thirty hours pass by in a blur of work and stress. Before he knows it the call is over... and it’s already 2 January.
First day on the wards – how to cope

The first day on the wards, learning about systems and processes, can be a daunting time for junior doctors.

The paper trail
Medical school teaches you about pathology and patients, but doesn’t always teach you about the administrative duties required to manage those conditions and treat patients. Every order that your consultant gives on a ward round will inevitably require a form to be filled and sent in the right direction. The doctors’ rooms in the wards are usually piled high with stacks of forms in unlabelled pigeon holes, each a different colour and for a different purpose. Even if you do find the right form, you may make the classic mistake of not filling it out in proper duplicate or triplicate. At the risk of seeming silly, grab your senior medical officer on the first day and ask them the basics about the forms, especially for common things (x-rays, discharge summaries, lab forms). It will save you a wealth of time later, which you will gladly use up on doing actual procedures.

Staff and sticking together
For a brief period, your consultant will have a ward round, your senior may or may not stick around to help with ward duties and for the rest of the day it’s just you on the ward, seemingly alone. The truth is though, you are not alone. You are surrounded by a team of nursing staff. Forming good relationships with nursing staff cannot be stressed enough. Be polite, learn names, and under no circumstances flaunt arrogance or superiority. The nurses have been working in the wards far longer than you have. If you are polite, they will help you with learning the system and doing tasks. If you are rude, they won’t.

If you are fortunate enough to have another intern working on the same ward as you, help each other, even if you are in different “teams” or “firms”. Finish your work and check on your buddy. This is the only other doctor who will be in the ward all day with you. They will need your help, and one day you will certainly need theirs.

Organisation
In a ward, you may be looking after 50 patients or more. Each person with a different name, number and different set of instructions for the day. It adds up, it gets confusing, and then it gets crazy.

All sorts of people become doctors: people who are good at being organised, and people who have a more chaotic approach to tasks. On the wards, though, it doesn’t matter what kind of person you are. It is vital that you have an organised approach to your workload for the day. Whether it is a clipboard or notebook, write your ward work down as you go along in the round with the consultant. After the round, separate things into what needs to be done first, and what things can be done together. The busier your ward becomes the more essential it is that you have a strategy. Time management is, ironically, a skill that is learnt over time. You will become faster and faster at doing procedures and making notes, and you will become cleverer and cleverer at getting things done efficiently.

I had a very strict consultant who once said there was no such thing as too much ward work. It was only the fault of the intern for not being efficient enough. This is a rather harsh approach, and obviously not always true; however it does reflect the level of expectation that your seniors will have on you. The pressure placed on you as an intern on your first day can be insurmountable.

The workload is immense. Some seniors are wonderful; they can help you with your paperwork, procedures and even provide the emotional support structure you need. And some seniors leave much to be desired. Working unsupervised is horrible under any circumstances, but on your first day it can be downright dangerous. If you are unsure how to do a procedure, stop and ask. It is no longer about your pride, or your senior’s attitude, it is quite simply about providing safe treatment for the patient.

Finally, in coping with the first day on the wards, the most important person you need to remember to look after is yourself. It’s not complicated. Eat when you are hungry. Drink water often. And ask for help as often as you need to.

The learning curve is initially very steep, but with surprising speed you will master the wards and learn to cope in situations that were once beyond your strength or expertise.
The J88: Not just another medical form

Even though we loathe the J88 form, it plays a crucial role in the criminal justice system, says Dr Kyle Wilson

It’s 10.30 at night. The smell of alcohol and blood fills the Emergency Department. Orlando Pirates have just lost a soccer match to Kaiser Chiefs and, unfortunately for you, the battle continues into the taverns. There doesn’t seem to be an end to the stream of injured supporters moving through the triage area.

With one hand you are inserting an IV line, whilst passing a nasogastric tube with the other, and over the phone the radiologist wants to know exactly why it is they need to do the CT scan so urgently. And then, from out of the blue, you are presented with a J88; the fungal infection of hospital forms – and just like any good fungal infection, we are all trying our best to avoid them. But once you get one, they don’t go away very easily. For some, they come back to get you at a later stage.

Dr Jessica Meddows-Taylor, Senior Medical Officer at Roodepoort Forensic Laboratory, has more than ten years’ experience in forensic medicine and offers us some practical advice when filling in the J88 form, as well as an important insight into the legal processes that may follow:

The last thing I want to do is fill out a J88. How is it different from any other medical form?
The J88 is a legal document that is completed by a medical doctor or registered nurse, documenting injuries sustained by the victim in any circumstance where a legal investigation is to follow. It may be the only objective information available in a legal case. It may be integral in:
1. The charge itself
2. The validity of the accusation
3. The severity of the injuries sustained
4. The level of punishment to be handed down.

How does the J88 fit into the process of investigating a crime?
The victim, or family, will open a case at the police station in the district where the injuries were sustained. The case will be issued a case number and an investigating officer (IO), who will collect corresponding oral testimony and evidence from the victim, the alleged perpetrator and any witnesses. They will also ask you to fill out the J88 to document the injuries sustained by the victim, and in doing so you will provide written and/or pictorial evidence. This carries substantial clout in any case. The completed document will then be added to the docket.

What are the common mistakes that doctors make when completing the J88?
It is most often found that the doctor asked to complete the J88 is not the same doctor that examined the patient. When we examine the patient in the Emergency Department it is imperative to be descriptive in our notes. Note the site and approximate size of the wounds. Draw them as best to scale in the margins of the notes you make in the patient’s file.

As clinicians, we are most concerned with life-threatening injuries, but it is important to document all injuries. Other, possibly minor, injuries may show intent, type of weapon(s) used and possibly chronic injuries or abuse. Neurological findings are very important, especially in motor vehicle accidents and assault cases. Be thorough in your neurological exam.

Doctors often don’t understand the medical terminology they want to use. If you look at a wound and it has clear margins and no tissue bridges, it is an incision and has been sustained by a sharp object. If it has irregular edges and tissue bridges it is a laceration (a tear in the layers of the skin) and has been sustained from a blunt object. Remember a bullet wound is a lacerated wound. A scrape abrasion shows directionality and irregular surface application to the skin, whilst imprint abrasion indicates direct application of a surface perpendicular to the skin. An imprint abrasion may be patterned, and therefore indicates a weapon or object applied to the skin. Contusions may also be patterned and give an idea of their origin.

What tips do you have for completing the J88?
■ Write legibly, as the court may call you simply to read what you wrote. If you are asked to complete the J88 based on someone else’s notes, write clearly on the form that you were not the examining doctor and then write verbatim what is in the notes. Be careful not to manipulate the information, even with the best intentions in mind. Remember to be honest, even if you have inadequate information on hand. You are
compiling a legal document and are bound by that statute.

- Document the relevant history: any pre-existing illness or medication they may be taking that may have an effect on their clinical state. Always mention any indication of intoxication. Then, as best you can from the victim and/or escorts, get the time and date of injury, who, where, and progression of the events. For example, “an assault on the right temporal area with a brick 3 hours ago by unknown male, after which he became restless and has started to vomit”. Your clinical findings should correlate with the history.

- When describing the wound, try to be as descriptive as possible and understand the forensic jargon that you are using.

- Try to understand the age of the wounds. It would be grossly unfair for someone to be charged for old bruises and injuries sustained prior to the incident in question.

For injuries, as a general guide:

- Initially, the wound has a red inflamed margin and base (6-12hrs).
- Healing begins with granulation tissue and the beginning of a scab is noted (two days later).
- After 3-4 days the scab is now hard and thick.
- By 6 days it is ready to fall off.

Bruises progress through the following colour changes:

- Red/purple: day 0-1
- Blue/brown: day 2
- Green/brown: day 3
- Green: day 4-5
- Yellow: day 7-10
- Fading: days 12-15.

I have been called to testify in court. Why was I called to testify? Am I in trouble?

You are not in trouble. Your J88 may have provided the only untenable, irrefutable evidence in a case. Usually the lawyers, victims and even the judge have a “layperson’s” understanding of medical terminology. So in most cases you are asked simply to interpret your findings for them.

I’ve only ever seen courtroom drama on TV. What can I expect in real life?

You will be served with a subpoena from the investigating officer specifying the date, time and court at which you are to present yourself. It is a good idea to ask for the prosecutor’s details as they may be able to give you a particular time to arrive, and save you having to wait as the court moves through other witnesses. Ask for a copy of the completed J88 so that you may familiarise yourself with your notes.

Make sure you are professionally dressed and your phone is off. Once in the courtroom, you will be shown to the witness box. On entering and leaving the courtroom, bow once as a sign of respect. The court police officer will order everyone to stand as the judge enters from his/her chambers. Stay standing as they sit. You will be asked to take an oath, whilst raising your right hand. Thereafter, the judge may ask if you wish to stand or be seated for your testimony.

The prosecutor will lead the questioning. They will ask

your qualifications, and then ask for you to recite the J88. Then they will ask pertinent questions. When answering questions you are directing your answers to the judge, so refer to them as “your Worship” in regional and district courts and “my Lord or Lady” in high court. When you have given your evidence, the defence lawyer will ask you their questions. Talk slowly – in many cases the accused will have an interpreter, and they will have to interpret exactly what you say. Don’t get verbose, answer succinctly giving only pertinent information. Never feel obligated to say more than you feel comfortable to do so, or feel you must give a particular slant on information in the case. You are impartial in every aspect, and simply provide factual input. Remember, it is not your job to prove, or disprove guilt, only to state the facts contained in the J88 that you completed.

The defence will often try to discredit you if it serves their case, or even just get you flustered enough to make a mistake. Try not to take it personally. The judge will not take kindly to your irritation. If you feel you are being pestered by the defence, ask the judge to intervene. Once the defence has finished their questioning, either the prosecution will re-question you, or the judge will ask questions.

When they have finished questioning you, the judge will excuse you. Stand down from the box, bow once and then leave the court.

Even though we loathe the J88 form, it plays a crucial role in the criminal justice system, as it is an important piece of evidence in the investigation of a crime. Therefore as doctors, it is in our, the patient’s and the public’s best interest to appreciate the importance of such documents and complete them appropriately.

With thanks to Dr Jessica Meddows-Taylor

Dr Kyle Wilson is Community Service Medical Officer in anaesthetics at Helen Joseph and Rahima Moosa Mother and Child Hospitals.

REFERENCES
Junior Graham explains to the patient about the examination he is about to perform and gives an opportunity for the patient to ask questions, before obtaining consent.

Junior Graham offers the patient a chaperone to be present. The patient agrees.

Junior Graham gives the patient privacy to undress behind a curtain.

Junior Graham records the identity of the chaperone in the patient’s notes immediately after the consultation, along with other relevant issues or concerns.

Junior Graham informs the patient of the surgery’s chaperone policy and hands her a leaflet.

In this case, the patient accepted the offer of having a chaperone present; however, this is not always the case. If a patient declines a chaperone and as a doctor you would prefer to have one, explain to the patient that you would prefer to have a chaperone present and, with the patient’s agreement, arrange for a chaperone. Make sure you record in the patient’s notes that they declined a chaperone.
The word “pathology” refers to the study of disease (“pathos” = disease; “logos” = study). It plays a very important role, not only in the diagnosis of diseases, but also in the management of chronic illnesses. The Royal College of Pathologists of Australasia estimates that 70% of the diagnosis of diseases relies on pathology findings.

**An average day**

This depends to a large extent on the type of pathologist. Some, like a chemical pathologist, will spend most of the time in the laboratory interpreting results and consulting with clinicians by telephone. The same applies to a haematologist, although duties are usually distributed amongst the different pathologists in each discipline according to the roster. Although the bulk of the workload will be done during working hours, a pathologist will always remain on call in each discipline to consult on difficult cases.

The day of a forensic pathologist usually begins in the mortuary, or medicolegal laboratory, conducting autopsies. The afternoon is typically spent finalising postmortem reports, performing the histopathology examination of tissue specimens or other specialised tests like neuropahtology examinations. In addition, forensic pathologists will assist the judicial systems by compiling a medicolegal report or assist as an expert witness or assessor at an inquest. Although the working hours may appear very structured from 8am to 5pm, forensic pathologists may sometimes be called out to visit a crime scene or even to inspect an aircraft accident site in the mountains. Most forensic pathologists are employed by the state, and specifically the Department of Health and Forensic Pathology Services.

Although histopathologists also have structured working hours during the week, most histopathology laboratories will have a pathologist on duty on Saturdays to report cases. This individual will also examine and report any urgent histology or cytology cases, or perform frozen sections after hours. The normal working day of a histopathologist usually starts by examining slides and reporting on them. A frozen section may require him to go to a hospital theatre or to do the “cut-up” or dissection of the specimens as they arrive in the laboratory. As clinico-pathological correlations form an integral part in the management of patients, some days may start or end with a multidisciplinary meeting attended by pathologists, radiologists and clinicians. In smaller laboratories the histopathologist may have to work on his or her own, while larger laboratories may have a number of histopathologists at the same site. All laboratories have an internal referral system to allow even the most remote histopathologist access to review and gain input from other colleagues when dealing with a difficult case. The larger laboratories will also be the reference centres for the performance of special techniques like immunohistochemistry or molecular studies.

The professional responsibilities of a pathologist are the same in private practice and the public sector, although the latter may also have academic responsibilities, including teaching, if attached to a medical school. In South Africa, all public sector pathologists are employed by the National Health Laboratory Services (NHLS).

**Training**

Pathology training is a combination of theory, supervised practical training (including the use of multi-header microscopes), and hard work. There are usually very limited opportunities...
The spectrum of pathology

People, including clinicians, often view pathology as one discipline covering all aspects of laboratory medicine. However, pathology consists of a number of disciplines, which include:

**Virology.** Virology is the study of viruses, especially the clinical diagnosis of viral infections and the management of highly contagious viral infections, like Ebola virus, as well as the laboratory diagnosis thereof. The latter usually consists of serology tests or molecular tests.

**Forensic pathology.** Forensic pathology is defined as the branch of pathology that serves to assist or facilitate a legal process or investigation. The main aim of the forensic pathologist is to determine the cause of death in suspicious cases of suspected unnatural death. This is most probably the best known pathology discipline as it is often dramatised in television series like CSI; this has also exposed the lay public to techniques and terminology, eg, DNA fingerprinting.

**Microbiology or, more correctly, medical microbiology.** The primary function of a medical microbiology laboratory is to isolate and identify pathogens from patient specimens, and to perform antimicrobial sensitivity testing. With the increasing drug-resistance amongst micro-organisms, the microbiologist is becoming an important player in antibiotic stewardship to prevent the indiscriminate and sometimes inappropriate use of antibiotics, especially in the hospital and intensive care setting. Microbiologists also report on serology tests and molecular pathology.

**Chemical pathology.** This discipline focuses on the biochemistry of the human body. It involves the understanding of endocrinology, electrolyte disturbances, inherited metabolic disorders and allergy testing to name a few.

**Haematology.** This discipline includes the performance and interpretation of full blood counts, clotting profiles, bone marrow biopsies and the management of an anticoagulation clinic. Working in a blood transfusion centre is also a possible career path.

**Neuropathology.** This super-specialisation focuses on diseases of the central and peripheral nervous system, as well as muscular disorders. As head injuries are such a common cause of unnatural deaths, a strong interface between traumatic neuropathology and forensic pathology exists. The same applies to cases of hypoxic brain damage after a therapeutic mishap.

**Anatomical pathology, also called histo- and cytopathology.** An anatomical pathologist examines tissue samples, including cytology specimens. The possible diagnosis covers not only the full spectrum of medicine, including inflammatory conditions as well as benign and malignant neoplasms, but also all organ systems.

The disciplines other than anatomical pathology and forensic pathology are sometimes grouped together as clinical pathology. Although it is not a recognised pathology discipline on its own in South Africa, molecular science is becoming an important part of the armamentarium of any pathologist, whether a histopathologist, haematologist, microbiologist or forensic pathologist. Molecular pathology cuts across all these fields, as more and more diseases are diagnosed and classified according to molecular techniques. In some fields, like histopathology, individuals may also have a special interest in paediatric pathology.

**Job prospects and remuneration**

There is a shortage of pathologists throughout South Africa. This may be due to the perception that pathology is less glamorous than “life-saving” disciplines, such as surgery. It may also be due to a lack of exposure to the science of pathology amongst undergraduate medical students.

Remuneration in the public sector is according to the published salary scales. Although the reward in the private sector may be greater, the competitive nature of this sector is more demanding.

I would like to thank my colleagues Johan Dempers, Younus Essack, Ilse Louw and Elizabeth Wasserman for their discipline-specific comments.

for a medical doctor to be able to acquaint themselves with pathology by first working as a medical officer in a pathology department. Medical officer posts do exist in forensic pathology, and the candidate will usually enrol for a diploma with the Colleges of Medicine. There is both a pathology and clinical forensic medicine diploma.

In the other disciplines, entry to a department is usually by being appointed as a registrar in a training position. The period to qualify as a pathologist varies between four to five years. A dissertation, portfolio form and log book may form part of this process. Although a MMEd degree or fellowship of the Colleges of Medicine is required for qualification and registration as a specialist pathologist, most South African medical schools now only offer a fellowship.
MPS membership vs state indemnity

Being a member of MPS offers many benefits. Dr Angela Bramley, MPS senior medicolegal adviser on the South Africa team, looks at the key areas where the state leaves off but MPS can pick up.

When it comes to professional protection, most doctors recognise the value of having arrangements in place should something go wrong. However, some of those who are members of MPS in addition to having state indemnity do not use the many resources offered by MPS to help in everyday situations, even before a complaint or a claim is made.

While state indemnity is provided for all doctors who are employed in the public sector and covers them if there is a claim, it does not necessarily extend to assistance for internal disciplinaries or HPCSA investigations. Indeed, in internal disciplinaries or HPCSA complaints it is quite possible that the employer is the complainant and thus they are most unlikely to assist. Whilst the state probably will assist in the case of an inquest, it is usually only on the coat tails of their own defence. If a doctor is vulnerable to individual criticism, or there is a conflict of interest between the state and the doctor, individual representation is preferable. Therefore, those state doctors who do not make alternative arrangements may find themselves vulnerable in any forum other than a claim.
The benefits of membership

As an MPS member, you have access to medicolegal support and assistance that includes:

- Telephone advice 24/7
- Specialist legal advice and representation (for situations not supported by state indemnity)
- Disciplinary processes
- Handling complaints
- Coroner's report writing
- Inquest preparation
- Media and press relations
- Police investigations arising from the provision of clinical care
- HPCSA investigations
- Good Samaritan acts.

RESOURCES

MPS factsheets: www.medicalprotection.org/southafrica/factsheets
MPS medicolegal advice: www.medicalprotection.org/southafrica/contact
MPS risk management workshops: www.medicalprotection.org/southafrica/risk-management-workshops

The following case shows how MPS membership goes beyond the support offered by the state:

Dr K is working in the Emergency Centre of a busy hospital on a particularly demanding Saturday night when a patient, Mr O, arrives in a semi-conscious state. Mr O is well-known to the department; his medical notes reveal a history of alcohol abuse following years of hardship. This was not the first time Mr O had arrived at the Emergency Centre following a binge and he was usually kept in to sleep it off.

It was a busy evening and Dr K was pushed for time. History taking was difficult as Mr O seemed very sleepy and incoherent, but the sweet smell of imbibed alcohol was enough for Dr K to dismiss his symptoms as simply the effects of excessive alcohol consumption.

An examination did nothing to change Dr K's mind. Bloods were taken and sent to the lab and an entry was made in the nursing notes for the results to be followed up later. Dr K then took Mr O to a quiet corner of the ward to sleep it off and continued to attend to other patients.

Unfortunately, the next morning Mr O was found dead. Everyone in the department was shocked to hear of the regular attender's death but worse was to come when his bloods were reviewed and it was noted that his blood glucose had been 33mmol/l with a high potassium level. When Dr K had assumed Mr O was drunk, he was actually in ketoacidosis, meaning his death that night was probably preventable.

What happens next...

Scenario 1: If Dr K had state indemnity only

On realising that he had to justify his actions to the hospital, his seniors and also to Mr O's family, Dr K had no-one to turn to. He spoke to his employer but they couldn't help him. To make matters worse, by the time the hospital's internal review came round six months later, Mr O's medical notes had gone missing. This left Dr K extremely vulnerable, as he had no contemporaneous notes to back up his actions, and there was the fact that the blood results had not been reviewed.

As expected, the patient’s family brought a claim against the hospital and against Dr K. The hospital used its state indemnity to attempt to defend its systems and protocols, but Dr K – without the medical notes – was clearly vulnerable to criticism.

Dr K was then investigated by the HPCSA, following complaints by both the family and concerns raised by the employer.

The story attracted some media interest and once Dr K's local community found out that he was being investigated by the HPCSA, he lost the trust of many of his patients. The damage to his reputation – and subsequently, his livelihood – was difficult to repair.

Scenario 2: If Dr K had been a member of MPS

When Dr K was told that Mr O had died, he immediately phoned MPS’s 24-hour helpline for advice.

A medicolegal adviser advised Dr K to write up a full report of the circumstances leading to the patient’s death, and also suggested that he write to the hospital superintendent requesting that a copy of Mr O’s anonymised medical notes be retained for safe keeping. MPS then investigated the hospital protocol for managing patients in the Emergency Centre and prepared to help with the inquest and hospital investigation.

When the internal review came around, a copy of the notes were available as the hospital superintendent had retained a copy as requested (the originals, however, had gone missing) and the full report written by Dr K immediately after the event was available. During the internal review it was pointed out his attempt to take a history, and the clinical examination: Dr K’s recollection was that he had wanted to do bedside testing for glucose but the necessary sticks were out of stock, so he had been forced to send away blood for testing instead.

The investigation of hospital protocols in the Emergency Centre also revealed there was no set protocol for following up blood results and, although Dr K had recorded that he had taken blood, the nurses had failed to follow up on it, despite a request being made in the notes.

While the hospital used state indemnity to defend its actions when the claim was made, Dr K was able to turn to MPS for assistance in writing his statement. On the basis that he had written a report of his recollection of the event immediately, and could refer back to the nursing notes and the patient’s past medical notes, Dr K was able to show that his management of the patient was not unreasonable.

A complaint to the HPCSA was still made by the family; however, MPS guided Dr K through the process. MPS instructed solicitors to represent Dr K and a meeting was arranged at their offices to go through the case with Dr K. Thereafter, MPS’s solicitors drafted a letter on Dr K’s behalf to the HPCSA. This served to convince the HPCSA’s preliminary proceeding committee there was no prima facie case to answer, and the case was closed with no further action.

The MPS press office was also on hand to help Dr K deal with the media intrusion. A statement was compiled to be issued to the press, which helped Dr K retain his reputation.

On closing the case with Dr K, MPS reminded him of the importance of taking detailed notes in case he had to justify his actions again. Dr K took heed of this advice, and booked a place on one of MPS’s risk management workshops to develop his skills further.

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