DEALING WITH DIFFICULT COLLEAGUES
A look at what can make colleagues difficult to work with, and techniques to overcome that difficulty

THIS ISSUE

How to work in... Obstetrics and Gynaecology
Dr Janine Potgieter explains what it’s really like to be an obstetrician and gynaecologist.

Top 5 medicolegal hazards for junior doctors
The top hazards and how to survive them.

Surviving on calls
A collection of advice on how to get through those dreaded on calls.
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We welcome contributions to Junior Doctor. Please contact the Editor, Sam McCaffrey at sam.mccaffrey@medicalprotection.org
Welcome to the latest edition of Medical Protection’s Junior Doctor. This issue comes to you just as you embark on your medical career, beginning your first rotation as a doctor. It is an exciting time but can also make you feel anxious and intimidated.

Medical Protection is about more than just defence – we aim to be a genuine partner in your career. This issue is packed full of advice and guidance to help you transition from medical student to doctor, and hopefully calm those nerves and make you feel more comfortable with your new responsibilities.

On page 6 we round up the top five medico-legal hazards you might face as a junior doctor, and provide survival tips on how to avoid them. Then, on page 11 we have a further 15 tips of how to survive those dreaded on calls.

We also recognise that one of the most difficult challenges you might face could be in dealing with your colleagues and seniors, so on page 8 Dr Suzy Jordache, Senior Medical Educator at Medical Protection, provides advice and strategies on how to deal with difficult colleagues.

Even at this early stage in your career it’s important to start thinking about the future, so we continue our popular ‘How to work in...’ series with Dr Janine Potgieter providing an insight into what a career in obstetrics and gynaecology is really like.

As always Junior Graham is on hand to walk you through the medico-legal maze, this time dealing with the J88 form, and from the case files Professor Marius Coetzee explains why honesty is always the best policy.

Please do let us know your feedback on this issue – we welcome all comments and suggestions. If you’d like to write for us, or have a feature idea, please get in touch.

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Medical Protection is committed to using the service when necessary to alert members when a new Medical Protection publication is available, to provide updates on events that can help you develop your skills, and pick up on the latest medico-legal news that you should be aware of. There’s never been an easier way to access all the latest Medical Protection news and updates.

Using smartphones in practice

The evolution of the cell phone is remarkable with smartphones now able to perform any number of tasks. There truly seems to be an app for everything. We want to know if and how you use your smartphone in your practice – is there an app that helps in diagnosis or treatment? Do you use it as a note-taking device? Does it help in some other way?

Tell us all about it! Send your stories about how you use your smartphone to sam.mccaffrey@medicalprotection.org and we’ll publish the best and most innovative submissions in the next issue.

Your chance to write for Medical Protection!

We are always looking for contributors for features and articles in Medical Protection 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!

If there is anything 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, please email Sam McCaffrey, Junior Doctor Editor, at sam.mccaffrey@medicalprotection.org

Any published contributions may be eligible for up to R1,000 payment in vouchers, depending on length and quality, but just getting published will stand you in good stead.
Junior Graham is asked to complete a J88 form about a patient he treated the previous week.

Junior Graham is told that the J88 form is a police examination report form and as such is a legal document that may be critical to an investigation. It may be included in the court docket.

Junior Graham is the only doctor who can complete the form as he is the doctor who examined the patient.

It is imperative that Junior Graham document all the injuries sustained by the victim that he noticed when he completed a thorough physical examination.

When completing the J88 form Junior Graham needs to write and draw clearly as the form is likely to form part of the written and pictorial evidence.

If the matter goes to trial Junior Graham may be subpoenaed to provide oral testimony in court. It is advisable to try and obtain a copy of the completed J88 form prior to the court date.

The more detailed the completion of the J88 form the less likely it is Junior Graham will be called to appear in court.

If you are asked to complete a J88 form and need advice do not hesitate to request assistance from Medical Protection.

For more information on the J88 form read ‘The J88: Not just another medical form’ in Vol 5, Iss 2 of Junior Doctor. Or access it online by searching for ‘J88 Form’ on the Medical Protection website.
CONSENT
Junior doctors should not feel pressurised to do anything beyond their knowledge, experience and competence, this includes obtaining consent for a procedure that they are not familiar with.

Failure to take consent properly can lead to medicolegal problems including complaints, claims and disciplinary proceedings.

Consent is a process, rather than a form-filling exercise. For more information see the Medical Protection Factsheet ‘Consent – the basics’ on our website.

SURVIVAL TIPS
• Always act in your patient’s best interests.
• Record in the notes what a patient has been told.
• Use your common sense – consent is patient-specific and depends on the individual’s circumstances, including age, lifestyle, occupation, sporting interests, expectations, etc. It may well be that you are not in a position to advise fully, eg, professional sportspersons.
• Patients are presumed competent to consent unless proved otherwise.
• Any competent adult can refuse treatment.
• The law concerning adults who lack capacity, and are unable to give valid consent, is more complicated. If you are in doubt consult senior colleagues.
• Remember there are circumstances where a child can give consent without reference to a parent – if in doubt consult a senior colleague.
• Discussion with senior colleagues should be documented in the clinical file.

PREscribing
Prescribing is fraught with complications – from over-prescribing, transferring incorrectly to new charts and prescribing for the wrong patient, to forged prescriptions and overdoses, incorrect dosages, interactions and allergies.

It is imperative that you have a good knowledge of the pharmacology and the legislation surrounding drugs, and the hospital protocols and controlled drug routines – if unsure, ask.

SURVIVAL TIPS
• Prescriptions should be legible, clearly identify the patient, the drug, the dose, frequency and start/finish dates, be written or typed and be signed by the prescriber.
• Be aware of a patient’s drug allergies.
• Good handovers require good leadership and communication.
• Refer to the SAMF.
• Verbal prescriptions are only acceptable in emergency situations and should be written up at the first available opportunity. Particular care should be taken that the correct drug is used.
• When giving verbal prescriptions it is good practice to repeat the order to a second nurse, or nursing sister, to make sure that both have heard and understood the same instruction to ensure it is correct.
CONFIDENTIALITY
Confidentiality is central to maintaining trust between patients and doctors. As a doctor, you have access to sensitive personal information about patients and you have a legal and ethical duty to keep this information confidential, unless the patient consents to the disclosure, disclosure is required by law or is necessary in the public interest. For more information see our series of Confidentiality Factsheets on the Medical Protection website.

SURVIVAL TIPS
• Before breaching confidentiality, always consider obtaining consent.
• Take advice from senior colleagues. Discussion with senior colleagues should be documented in the clinical file.
• Remember that confidential information includes the patient’s name.
• Competent children have the same rights to confidentiality as adults.
• Doctors can breach confidentiality only when their duty to society overrides their duty to individual patients and it is deemed to be in the public interest.
• Doctors are required to report to various authorities a range of issues, including notifiable diseases, births, illegal abortions and suspected child or sexual abuse.
• The courts can also require doctors to disclose information, although it would be a good idea to contact Medical Protection if you find yourself presented with a court order.
• High-risk areas where breaches can occur are lifts, canteens, computers, printers, wards, emergency departments, clubs and restaurants.
• Be careful not to leave memory sticks or handover sheets lying around.

RECORD KEEPING
Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. The notes will also form the basis of the hospital’s defence should there be any future litigation against your hospital. Notes are a reflection of the quality of care given so get into the habit of writing comprehensive and contemporaneous notes.

SURVIVAL TIPS
• Always date and sign your notes, whether written or on computer. Don’t change them. If you realise later that they are factually inaccurate, add an amendment.
• Any correction must be clearly shown as an alteration, complete with the date the amendment was made, and your name.
• Making good notes should become habitual.
• Document decisions made, any discussions, information given, relevant history, clinical findings, patient progress, investigations, results, consent and referrals.
• Medical records can contain a wide range of material, such as handwritten notes, computerised records, correspondence between health professionals, lab reports, imaging records, photographs, video and other recordings and printouts from monitoring equipment.
• Do not write offensive or gratuitous comments – eg, racist, sexist or ageist remarks. Only include things that are relevant to the health record.

PROBITY
The HPCSA advises doctors that they must be honest and trustworthy when signing forms, reports and other documents. It also requires doctors to make sure that any documents they write or sign are not false or misleading.

SURVIVAL TIPS
• If you are uncertain double check your work with a senior. Discussion with senior colleagues should be documented in the clinical file.
• Take steps to verify what you are saying. Never sign a form unless you have read it and you are absolutely sure that what you are saying is true.
• Probity means being honest and trustworthy and acting with integrity.
• Be honest about your experiences, qualifications and position.
• Be honest in all your written and spoken statements, whether you are giving evidence or acting as a witness in litigation.
• You must be open and honest with any financial arrangements with patients and employers, insurers and other organisations or individuals.
• Assume that all records will be seen by the patient and/or others, eg, HPCSA, court.

For more guidance on these topics see the factsheets on our website medicalprotection.org/southafrica/casebook-and-resources/factsheets
Dealing with Difficult Colleagues

Interactions with colleagues can be one of the most challenging aspects of medicine. The people you work with have a profound effect on how you practice – colleague interactions can lighten the burden, or make it infinitely heavier.

The experience of Medical Protection is that poor communications between two or more doctors, providing care to patients, lies at the basis or the heart of many complaints, claims and disciplinary actions.

It is inevitable at some point throughout your career as a doctor that you will come across at least one colleague who you have issues working with, it is therefore important to be aware of different strategies and techniques you can use to deal with the situation.

Clashes between colleagues often centre on attitudes, behaviours and skills in a colleague that challenge or are different to your own.

Some examples of common problems include illegible handwriting, another doctor interfering in your patient management plan, poor communication during handover, and colleagues who are slow to return calls or emails.

So what can you do to reduce the risk around difficult colleague interactions?

1. PICK YOUR BATTLES

Use your energy wisely, you might have several issues with colleagues but some will generate more risk to patients and yourself than others. It is wise to concentrate your efforts and energy on high risk areas with the patients' best interests at the centre of discussions.

It is important to balance the amount of respect you show for your colleague along with your concern for your patient in order to get an effective response, as table 1 shows.

2. CATCH AND STOP RISKY ASSUMPTIONS

Assumptions are a common, human error that we all make. They are especially prevalent when dealing with colleagues we dislike or find challenging. We can be more likely to make an assumption rather than check with that colleague. This generates a variety of risks that can lead to catastrophic outcomes.

The use of well-designed and mandated checklists or models to ensure completeness of communication can reduce this type of risk. Other effective methods to manage difficult colleagues include:
- Ensure referral, investigation and follow-up tracking systems are in place
- Utilise IT systems to automate information transfer
- Recruit the patient into a checking role around the communication between you and your colleague
- Take action if communication received is inadequate.

3. HANDOVER

A standardised handover checklist, such as SBAR or SHIFT, which is trained, expected and policed, can cut through personalities. If colleagues don't get along it doesn't matter, an SBAR or a SHIFT is given and a patient is handed over safely.

Medical Protection recommends the SHIFT method:
- Status of the patient
- History to this point
- Investigations pending
- Fears of what may unfold
- Treatment planned until care handed back.

A useful addition to this is to check that the message has been received by asking the other doctor to repeat or read back what you have said. This can help with colleagues who struggle with attentive listening, or repeatedly fail to do what has been asked of them at handover. The ‘repeat back’ improves listening skills and checks that the message sent has been received and understood.

Unfortunately, the table mentioned in the document is not included here. It would typically show the different responses expected from colleagues and the corresponding consequences.
4. ACTIVELY MANAGE DISAGREEMENTS

Frequently a ‘hint and hope’ approach fails to work. It can be much more effective to actively manage disagreements, however it is important to have the skills to do this the right way. When addressing an issue with a colleague it is important to go in with respect and suggestions, otherwise they may feel backed into a corner. Any colleague who feels trapped is unlikely to behave well or engage in problem solving.

A good example of how to address an issue with a colleague is: “Jane, I’m really concerned that the quality of communication between us is placing not just our patients but you and me at significant risk. Do you think we could allocate more time in the morning for clinical handover or perhaps use a checklist to help reduce our risk? I really believe we need to improve the way we communicate to help reduce the risk to us all. I am committed to doing this.”

5. ESCALATE & DOCUMENT

If you have a colleague who routinely puts you at risk you should consider:
• Raising your concerns directly with your colleague
• Suggesting options for how improvement could occur
• Framing the conversations in terms of the risks to all
• Highlight that you are committed to taking action
• Documenting your concerns and action taken
• Escalate to a senior/call Medical Protection
  if no resolution is possible.

Make sure to record the steps you have taken to try and resolve the situation. It is important to have an evidence trail in these situations as they can end up in catastrophic outcomes for patients and doctors, including claims and referrals to the HPCSA.

CASE STUDY WE DON’T TALK ANYMORE

Mr Y, a 35-year-old marine engineer, was undergoing surgery in the posterior compartment of the thigh to treat a congenital vascular lesion. Dr O, consultant vascular surgeon, was carrying out the procedure. The lesion was closely related to the sciatic nerve and some of its branches, and Dr O was hoping to avoid damaging the sciatic bundle, if possible.

The anaesthetic was given by Dr A, consultant anaesthetist. During the induction phase Mr Y had suffered repeated generalised muscular spasms, so Dr A had given a muscle relaxant, to prevent intraoperative movement of the surgical field.

During the course of surgery, Dr O used tactile stimulation to attempt to determine whether a nerve which was likely to be compromised by his surgical approach was the sciatic nerve or a branch of the peroneal nerve. Reassured by a lack of contraction of relevant muscle groups, he continued to operate under the impression that the structure about which he was concerned was not the sciatic nerve.

Unfortunately, in the context of neuromuscular blockade there was no rationale for this approach. It transpired that Mr Y suffered severe foot drop as a result of extensive damage to the sciatic nerve. Mr Y sued Dr O as a result of his injuries.

The case hinged on whether Dr O had taken sufficient care in establishing the relevant anatomy during surgery. Dr A had documented in the anaesthetic record that he had given the muscle relaxant, and was adamant that he had told Dr O this fact. Dr O was insistent that Dr A had not informed him about the administration of the drug and thus had left him open to the error that he made.

During an investigation of events surrounding the case it became clear that there was a history of animosity between the two clinicians. There were unresolved investigations into allegations of bullying and harassment between Dr O and Dr A. In the context of how Mr Y suffered his injury, and the clinicians’ apparent failure to communicate, it was impossible to defend the case, which was settled for a moderate sum with liability shared equally between the two doctors.

Medical Protection advice:
Effective communication between healthcare professionals is essential for safe patient care. In the context of an operating theatre, where there are anaesthetic factors that may have an impact on the surgical outcome (and vice versa), it is vital that this information is imparted.

Unresolved personal or professional disagreements between healthcare professionals who share responsibility for patients are potentially prejudicial to patient care. It is the responsibility of all who work in the clinical team, and those who manage them, to make sure that patients are protected from any adverse outcome that results from doctors not working properly together. The wellbeing of patients must always significantly outweigh the personal problems of doctors.

Independent, external professional assistance with conflict resolution may sometimes be necessary and can be extremely effective.
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SURVIVING ON CALLS

Medical Protection has compiled 15 tips to help you survive those dreaded on calls.

1. Don’t rush – work steadily and prioritise appropriately. You’ll get faster.

2. List the tasks that you were given – mark them off when they have been completed. Including times is helpful.

3. Stand your ground – don’t be afraid to negotiate to get a CT or an x-ray if it’s needed.

4. Show gratitude – it’s better to have the nurses onside than against you.

5. Keep calm and carry on – this will help you tackle any challenge that comes your way, even when the bleep goes off incessantly.

6. Smile – if you’re happy to be there so will your team be.

7. Ask questions – don’t be afraid to ask ASK!

8. Take breaks – remove yourself for short bursts and you’ll become more efficient and perhaps less grumpy?!

9. Eat – Make sure you’ve got hidden supplies for those moments when it dawns on you that all the shops/cafeterias are closed.

10. Create an on-call bag – with your Oxford handbook, a jacket, snacks, syringes, cannulas for your walks around the ward.

11. Ensure safe and comprehensive handover arrangements.

12. Write clear and contemporaneous clinical notes.

13. Deal with one clinical issue at a time. Only when it is completed move on to the next one.

14. Ensure that you and your possessions remain safe.

15. Make sure that you have appropriate indemnity arrangements in place.
HOW TO WORK IN...

OBSTETRICS AND GYNAECOLOGY

Practising in obstetrics and gynaecology is full of risks, writes Dr Janine Potgieter, but it is also full of rewards. She explains what working in the specialty is really like.
How do you work in obstetrics and gynaecology? The short answer to this difficult question is: with great caution! However, the true and sincere answer deserves an in depth explanation. Before one can answer the all important HOW question, one needs to answer the WHY question first.

**WHY BECOME AN OBSTETRICIAN AND GYNAECOLOGIST?**
Why would anyone choose a profession that deals with PMS and a steady stream of babies arriving (usually in the small hours of the night), requiring a pair of safe hands at the other end of the tunnel? Why take up a specialty with one of the highest degrees of medicolegal risk?

**THE REASONS WHY I CHOSE THIS ARE NUMEROUS**

Firstly, obstetrics and gynaecology has essentially a healthy patient population, requiring medical care through normal stages of a woman's life: puberty, pregnancy, menopause and beyond. Preventative healthcare, as the old adage states, is still better than cure, and this entails a number of gynaecological consultations, for example Pap smears and contraception. Should these patients become really ill, they respond well and rapidly to correct and active management.

Secondly, an obstetrician and gynaecologist is guaranteed never to do a prostate exam ever again! I prefer female patients and feel comfortable dealing with them. Females are generally a very compliant population, especially during pregnancy, which makes one's task easy, productive and rewarding.

Obstetrics and gynaecology is thirdly a specialty that requires a lot of follow up consultations. That is what I find most rewarding. It is possible to see a woman for primary dysmenorrhea as a teenager, for a contraceptive as a bride-to-be, throughout her pregnancies and deliveries, through menopause, and beyond. Inevitably one gets to know the patient very well and share in her life. Compare this for instance with an anaesthetist, who mostly deals with one off patient contact consultations.

In the fourth place, there is a good balance between medical and surgical management for almost all conditions seen by the gynaecologist. The doctor is required to have a keen diagnostic mind and sound knowledge of available pharmacotherapies to manage a medical condition successfully, as well as sharp surgical skills and mastery of a finite number of prescribed operations. Compare this to the physician writing arm-length scripts for cardiac failure and the orthopaedic surgeon spending the best years of his life in the twilight zone of theatre. A good balance is key.

**“”

**Medicine in its essence is a life and death profession. Obstetrics and gynaecology is the one specialty that appreciates just how fine this balance is.**

The fifth reason for choosing obstetrics and gynaecology is the special investigations one faces every day. A cardiologist’s ears perk up at the mere mention of a diastolic rumble and the orthopaedic surgeon cannot walk past an x-ray posted on a light box. I, on the other hand, cannot resist a fetal ultrasound. I love it all - the beautiful first heart beat at eight weeks, the perfectly-formed 6cm human complete with 20 digits and a four-chambered heart at 12 weeks, right up to the 37-week almost-neonate stubbornly sucking his thumb in breech position. These images never lose their appeal nor do I lose the desire to execute an ultrasound with flair.

Medicine in its essence is a life and death profession. Obstetrics and gynaecology is the one specialty that appreciates just how fine this balance is. Fortunately, the vast majority of cases tip the scales to the life side of the coin. Great joy always accompanies the birth of a baby and the birth of babies happens round the clock. The doctor inevitably shares this joy with patients. What other profession can put that in its pipe to smoke?

**WHAT IS REQUIRED TO PRACTISE OBSTETRICS AND GYNAECOLOGY?**

After completion of a medicine degree, and compulsory internshp and community service, one may apply to train as an obstetrician and gynaecologist. The selection process differs depending on universities, but good references and some time spent during the above-mentioned years working in this specialty, will count in one’s favour. A diploma in obstetrics if at all possible is invaluable, especially in those very first months as a green registrar. Evidence of completing a course in advanced life support is also deemed positive. As with everything in life, a little bit of luck to acquire a training post is needed.

Training as a specialist obstetrician and gynaecologist is, to say the very least, like chewing rocks. The hours are long and the patient load very high. The pressure for service delivery is relentless, often with marked resource limitations. Twenty-four hour on calls are very tough and nights are mostly sleepless. This becomes the pattern of your life with startling regularity, between six to eight times per month. Everything done and all decisions made during these shifts comes under scrutiny in the cold light of day in the following morning’s meeting. A registrar must always be able to defend actions and decisions within the principles of evidence-based medicine. Team work is essential for a successful call. As a registrar leading an intern and medical students, it is expected of you to teach them important principles, answer their questions and demonstrate the necessary skills.

A normal work day would consist of ward rounds, seeing patients in a clinic, or working through elective theatre lists. After hours is spent studying for the compulsory examinations, preparing case presentations or an article for academic meetings, or working on the all-important research project on which to write a thesis. The requirements for completion of the degree are four years of training on an apprenticeship basis (i.e. “doing time”), doing relevant research and writing a thesis for the masters. Furthermore a logbook with cases, procedures and operations is to be completed before writing and passing the two-part examination of the Colleges of Medicine of South Africa. Some, but not all universities, require an intermediary examination on pathology.

Apart from having the necessary boxes ticked on one’s CV, it is important to possess a keen analytical mind, an extremely positive disposition, a hardworking, loyal and reliable work ethic, a well-developed sense of integrity and responsibility, a trust-inspiring and compassionate attitude and a healthy dose of common sense. These attributes will ensure long term survival as well as work satisfaction in this field of medicine. A sense of humour will also go a long way to keep one’s wits intact!

Obstetrics and gynaecology is not for you if you dislike drama and emergencies; if you tend to shy away from intimate and emotionally-charged subjects; if you find families and entourages intimidating; if you prefer routine work; office hours and predictability.

Dr Janine Potgieter is an obstetrician and gynaecologist working in private practice in Pretoria.
TOP TIPS FOR JUNIOR DOCTORS

1. Always ensure that you have appropriate professional protection arrangements in place.

2. Never work beyond or without your HPCSA registration – i.e., do not locum while an intern or CoSMO (or locum for a specialist while you are a registrar).

3. Do not delegate work to anybody unless you are sure that they are appropriately qualified and registered.

4. Know the limits of your knowledge, training and expertise and seek assistance from a more qualified or experienced colleague when necessary.

5. Never ignore or prevaricate about a complaint – contact Medical Protection immediately.

6. Ensure that you make good, contemporaneous medical notes. Litigation revolves around what can be shown to have happened (or not have happened), rather than around what actually happened. If for some reason the notes you make are not contemporaneous make absolutely sure that it is clear when the note is made and why information has been added after the event. Under no circumstances try and add information after the event, to pass it off as contemporaneous.

7. Never forget that clinical medicine revolves around patients and that patients are autonomous individuals who are entitled to make informed choices – even if their choices do not comply with your advice. Always document your informed consent discussion clearly.

8. Avoid all perverse incentives and kickbacks.

9. Perform intimate examinations in the presence of a chaperone where possible. If a patient refuses the offer of having a chaperone present explain to the patient that you would prefer to have one, however if they still refuse you must honour their decision and still provide treatment.

10. Avoid any romantic involvement with patients.

11. Record in clinical notes all phone calls, referrals and handover information.

12. Learn while you work; ask questions and look up relevant information in textbooks.

13. Keep patient and clinical information confidential. Do not overshare with family or friends and do not leave clinical notes lying around.
Dr S was a House Officer in a satellite obstetric unit of a teaching hospital in South Africa, where junior doctors worked on a rotation of 36 hours on, 12 hours off. The policy at the hospital was that the House Officer must administer the epidural and manage it while also attending to the delivery. Dr S was the only doctor on duty that night, with the registrar being on call at home. It was a busy night, with around ten patients in active labour. Dr S administered an epidural to a woman, Ms C, in the second stage, but needed to go to the toilet soon after. Dr S asked the senior medical students to monitor the saline drip and blood pressure while he was away.

When Dr S returned a short while later, the students had gone to tea and Ms C was shocked and could not be resuscitated. As an anaesthetic death, the case was referred for to the Forensic Pathology Service.

Dr S wrote up the notes accurately. The registrar Dr D had been called in and advised Dr S against writing the truth. Following this advice Dr S changed the blood pressure readings.

Dr S immediately regretted this decision and the same night went to the Government Mortuary to report his dishonesty. A senior police officer questioned him and filled out a report on his actions. Dr S then contacted Medical Protection and was advised to write an extensive report explaining events. The consultant, nurses, and other doctors all wrote statements accusing Dr S of negligence. The students were not accountable.

At the inquest Medical Protection represented Dr S. The Magistrate concluded that the death was caused by a combination of unfortunate circumstances and that there was no negligence. No anaesthesiologist would agree to testify at the hearing as none would support the policy of monitoring an epidural while simultaneously attending to a delivery.

**Learning points**

- Honesty is the best policy
- Do not be lured into covering up evidence
- Only delegate to appropriately qualified staff
- Cases against doctors often point to faulty systems and policies
- When writing a report about an incident please stick to the facts and do not accuse colleagues
- Manage your risks by applying evidence-based policies
- Sleep deprivation impairs clinical judgment
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