Stress and burnout

The intern years

THIS ISSUE...

DECISIONS, DECISIONS:
Choosing a specialty that’s right for you

FAMILY MEDICINE:
Understanding the individual behind the illness

WORKING WITHOUT SUPERVISION:
The risks for doctors and for patients

SAFETY AND SOCIAL MEDIA:
Professionalism and patient confidentiality apply online as well as offline

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We welcome contributions to Junior Doctor. Please contact the editor, Sarah Whitehouse at sarah.whitehouse@mps.org.uk

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A round-up of the news and guidance that matters to you

MPS ethics essay prizewinners

A group of authors has won this year’s MPS Ethics Alive essay competition at the University of the Witwatersrand. Amma Antwi, Tafadzwa Chigumba, Abnel Mutambasere and Ngunja Seyuba took first prize for their essay Healthcare Professionals and Social Conscience. They were presented with the R5,000 prize by Ian Middleton, MPS Membership and Marketing Agent. The winning essay will be published in the South African Journal of Bioethics and Law later this year.

The other prizewinners were: Ashleigh Taylor (2nd place), Thabang Raymond Mokoena (3rd place), and Che Moshesh (4th place).

Dr Lynelle Govender takes an honest look at the average day of the average intern, and suggests some survival tips for avoiding stress and burnout on page 6.

On a brighter note, once the stressful intern years are over, it’s time to consider your options. Following on from our previous edition’s feature, ‘You’re hired’, on how to remain one step ahead of the competition, Professor JP van Niekerk provides some expert advice on how to choose a specialty on page 10. With 30 specialties and 18 subspecialties now recognised by the HPCSA, it pays to start thinking about the different options available to you sooner rather than later. For those of you interested in specialising in family medicine, page 12 offers an illuminating insight from Professor Julia Blitz.

As ever, 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.
Understanding privacy of personal information (POPI)

The universal right to privacy of personal information will soon be made law in South Africa, bringing the country in line with existing data protection laws around the world.

The Protection of Personal Information (POPI) Bill has implications for all medical practitioners. POPI does not replace the HPCSA’s existing guidance on safeguarding confidential patient data – the HPCSA’s Confidentiality: Protecting and Providing Information contains all the key information you need to know about ensuring confidentiality.

POPI does, however, affect all private and public organisations that process information such as names, addresses, email addresses, health information and employment history, and must be complied with if you are outsourcing data to third parties.

Failure to observe and comply with the provisions of POPI can lead to a variety of implications for healthcare practitioners – some of which are potentially very serious. These are:
- A complaint lodged with the Information Regulator
- Receiving a civil claim for payment of any damages
- Criminal prosecution – if convicted there could be a fine up to R10 million or a prison sentence up to ten years, or even both.

POPI places an extra responsibility on practitioners to monitor and self-report their own flow of personal information.

MPS is on hand to provide advice and guidance with these new obligations, particularly if you are preparing to report a possible breach of personal information to the Information Regulator and a patient. If you are unsure of your new obligations, please contact us.

To find out more, read the article ‘Understanding POPI’ on page 6 of the May 2013 edition of MPS Casebook: www.medicalprotection.org/southafrica/casebook

In brief

Traditional Health Practitioners Council established

A new Interim Traditional Health Practitioners Council aims to help the Health Ministry integrate traditional health medicine into the National Health System over the next three years.

Many primary healthcare facilities and hospitals work in collaboration with traditional health practitioners, with the main focus being on training traditional healers in health promotion, public education, and to recognise symptoms for referral to health facilities.

www.doh.gov.za

SAMA Annual Conference

SAMA will be hosting its annual conference and exhibition at the Birchwood Hotel and Conference Centre near Johannesburg’s OR Tambo Airport from 15-17 August. The theme for 2013 is “Changing future of healthcare” and the programme will focus on:
- Clinical updates for practical guidelines
- NHI (Roles of public and private sectors, funding and funders)
- Regulation and regulatory bodies.

For more information visit www.samedical.org/events.html

ICD-10 – Medical records and diagnostic coding

The National Department of Health (NDoH) has published some FAQs in relation to ICD-10 codes. ICD-10 (International Statistical Classification of Disease and Related Health Problems) is a diagnostic coding system developed by the World Health Organisation (WHO) and licensed for use in South Africa through the NDoH.

All healthcare providers who consult with a patient must provide an ICD-10 diagnostic code on a claim.

Codes are used for disease epidemiology, burden of disease profiling, resource allocation and to assist Medical Aid Schemes in the identification and reimbursement of Prescribed Minimum Benefits (PMB), amongst others.

Doctors who fail to provide ICD-10 codes could be charged with unethical conduct at the HPCSA, so it is important to familiarise yourself with these.

For more information visit: www.doh.gov.za

HPCSA amendment to Ethical Rules of Conduct

The Health Professions Council has issued an amendment to the Ethical Rules of Conduct for practitioners registered under the Health Professions Act 1974. The amendment relates to the definition of “canvassing” and “touting” and the information that should be included in a medical practitioner’s letterheads, account forms and electronic stationery.

www.info.gov.za

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!

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 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 stand you in good stead.
I’ve been awake for the last 26 hours. My last meal was a can of cola and a piece of cold pizza – ten hours ago. My registrar tells me I should see the patients in casualty, follow up the blood results, take the “head-injury” to CT scan and meet him in theatre for the next case. My fellow intern is currently standing outside smoking a cigarette, like his life depends on it (excuse the paradox).

We’ve all been there. Where the smell of blood can’t be shaken and the beep of a persistent monitor is the soundtrack to your life as an intern. Somewhere between sleep deprivation and being overworked (or worse, abandoned by your seniors), you start losing hope. You are exhausted, broken and angry. Both the patients and you are suffering the consequences...and you still don’t realise that you’re experiencing burnout.

How do I stress thee? Let me count the ways:

Fatigue – As an intern, you know fatigue best. It’s that potent combination of sleep deprivation, poor eating habits, and an immune system that has taken a battering. No young person should be as tired as you are. Tired right down to the disturbing new creak in your knees.

Expectations – Your patients expect you to keep miracle cures in your back pocket. Your boss expects you to be perfect. And you, following a lifelong of achievement, have only the highest expectations of yourself. The pressure is high and the room for error seemingly non-existent.

Lack of supervision – Internship is already stressful without the added burden of an absent registrar, who feels the urge to sleep while you manage patients alone.

Personal issues – Behind every slave intern, there exists a life, relationships, finances – a whole world. In the hospital, we function as the most lowly of gears in the unit, and it is often forgotten that perhaps we have more on our plate than just pleasing the consultant.

Compassion fatigue – In medical school they taught us compassion fatigue in a vague way. Getting tired of being nice to patients. It didn’t sound so bad. In reality, compassion fatigue is more like a vicious cold anger. Anger at the sheer numbers of patients and frustrated at them for being irresponsible with their health. The bone-deep exhaustion of internship can drain all your passion for medicine and your best efforts at empathy dwindle away with it. Furthermore, an unco-operative patient is usually unceremoniously thrust upon the intern to deal with, while the senior doctors do their affectionate disappearing act.

Poor working conditions – If this were a glamorous TV drama, we would be wearing pristine blue scrubs while working in a pristine hospital. However, in reality, the hospitals are in some level of decay, your clothes are splattered with blood and the call rooms have more bugs than you’d care to mention.

With so many things to deal with, it’s no wonder that burnout is rife amongst the intern community.

So what’s the secret to surviving internship without burning out?

Good grazing – On a call and throughout your busy day, keep healthy snacks on hand and drink water often. Dehydration will only worsen fatigue. Sadly, caffeine and nicotine are not a balanced meal.

Know your rights – be aware of the legislation that is there to protect you:

■ Read your work contract very carefully. Make sure you are not working more overtime than you signed for. Do not allow yourself to be abused. Remember you can alert the HPCSA to any problems you may be experiencing.

■ An intern should have supervised learning. The key word is “supervised”. If you are unsure, ask.

■ Your hospital has an intern curator. Use his/her help when you find yourself struggling.

Mayday – Seek support from your peers, friends and family. When the internship is sinking, there is no shame in sending out an SOS.

Unwind – Spare time is a rare treasure in internship. Fill these hours with the things you enjoy. Shift your focus and you will find that your mood will shift as well. These momentary distractions may seem superficial but will serve as a reminder that you are more than just an intern.

B is for Benzos – Avoid the trap. As medics, we’re surrounded by a variety of happy pills. Don’t make the mistake of confusing a pharmaceutical band-aid with real help.

Peer-perspective – Look around at your peers...the strong ones, the...
smart ones, the ones that seem to ooze confidence when they speak to consultants. Believe me, they have all had days of breakdown, tears and madness. They just know how to fake it a little better.

Keeping up the kindness – In the battle against compassion fatigue, your best weapon is yourself. Look after yourself. Take a minute between difficult patients to take a deep breath; it’s sometimes all it takes to remind yourself that your frustrations are misdirected if poured onto an unsuspecting patient. Don’t attempt to justify poor treatment of patients. Accept that you were at fault with a pinch of humility; it can do wonders to curb the endemic of arrogance in our profession.

Many hands make light work – When tackling a difficult or intoxicated patient, help is imperative. Trying to gain IV access alone will not score you points with the consultant. It will most likely only get you a needlestick injury.

Dodging the decay – It’s easy to feel victimised when working a tough job in a dilapidated building. Remember that the hospital is simply the environment. Your actions and attitude are more important than the setting. That said, a sleeping bag and bug repellent can be lifesavers during a rough call.

Reality-check – Finally, accept the reality. You are an intern; it will be an exhausting two years. But more than that, you are human, and it’s ok for you to make mistakes and ask for help now and then.

The SAMJ has published an interesting article on the working conditions of interns: Erasmus, N, ‘Slaves of the state – medical internship and community service in South Africa’, Vol 102: No 8 (August 2012)

Take a minute between difficult patients to take a deep breath; it’s sometimes all it takes to remind yourself that your frustrations are misdirected if poured onto an unsuspecting patient.
Working without supervision

In a tough economic climate, healthcare and medical expertise have to stretch much further. Working with limited supervision increases the risk for junior doctors and for patients, says Sarah Whitehouse

In an ideal world, you should have a clearly established mentor on hand to assist with any clinical queries that arise throughout your intern journey. The HPCSA recommends that all interns should be supervised by a registered medical practitioner with at least three years of post-internship clinical experience in that specific domain of training. Your hospital should have an intern curator who can help with training. But, as Dr Lynelle Govender highlights on page 6, this is not always the case.

Not only are some interns working unsupervised, they are working unsupervised in hospitals that are severely understaffed, further increasing the risk to patient safety. If you find yourself faced with a clinical situation where you feel out of your depth, remembering that you must work within the limits of your competency is the key to staying safe. Recognise your own limitations and do not practise beyond your skills and expertise, unless in an emergency. The HPCSA states that all doctors must “Acknowledge the limits of their professional knowledge and competence. They should not profess to know everything.”

You must feel thoroughly competent when diagnosing and giving or arranging treatment. All doctors have a duty to ensure that they have the necessary understanding of a procedure to take consent. If you don’t, ensure that consent is taken by someone who does.

Senior colleagues who delegate care or treatment to you must be satisfied that you have the appropriate experience, qualifications, knowledge and skills to provide the care required. In some instances, however, particularly in rural areas, the junior doctor may be the only doctor on shift. There really might be no one else to ask. The Sowetan Live recently reported that some intern doctors working at Cecilia Makiwane Hospital’s surgery unit in Mdantsane fear for patient safety because they are working without adequate supervision. The newspaper reported that only emergency care could be provided because there were simply not enough senior doctors to perform operations. The response to this situation mirrors the HPCSA’s advice, that in an emergency, doctors should “provide healthcare within the limits of their practice, experience and competency. If unable to do so, refer the patient to a colleague or an institution where the required care can be provided”.

If you do find yourself overstretched, you should still take a thorough medical history and an examination if necessary – and document both. Record-keeping standards can easily slip if a ward-round overruns, but it is important to stop and make notes before rushing to see the next patient. Be aware too of “by the way” comments, where symptoms might be mentioned in passing. Make sure you record these conversations.

Stretched healthcare resources can often result in doctors feeling pressurised into working in unfamiliar areas. Dr Graham Howarth, MPS Head of Medical Services (Africa) states: “We have received a number
The HPCSA states that all doctors must:
“Acknowledge the limits of their professional knowledge and competence. They should not profess to know everything.”

of calls from hospital doctors who feel uncomfortable at being asked to provide cover for an area they do not normally specialise in because of staff shortages. If you find that you are so overstretched that the situation is in danger of putting patient safety at risk, or your health begins to suffer, you should raise your concerns within the appropriate channels, for example a senior colleague or your employer.” The HPCSA states that you should “Always regard concern for the interests or wellbeing of your patient as your primary professional responsibility”. Your supervisor, Head of Department and CEO of the hospital must be promptly informed of your concerns in writing.

Dr Howarth adds: “From a medicolegal perspective, you should ensure that the authorities are made aware of the problems facing patient safety. It is prudent to keep a good record of all correspondence which details your concerns.”

Are you competent to take consent?

Dr U is in his first week as an intern at a large rural hospital in the Eastern Cape. A nurse asks him to consent a patient going to theatre; she cannot locate the consent form in the patient’s notes. She says that the consultant will be cross if the patient turns up to theatre without the appropriate documentation, especially as the patient’s operation has already been cancelled once, and it would be terrible if it happened again. Dr U appears unsure, so the nurse adds that Dr U would only have to take consent for a tonsillectomy, which “isn’t difficult”.

Dr U is in a dilemma that many interns will be familiar with. The nurse is asking Dr U to work outside his competence, as he has not taken consent from a patient for a tonsillectomy before. So how should Dr U handle this situation?

- MPS’s advice is that Dr U should seek advice from a senior colleague before obtaining consent (if possible) so that the operation can go ahead as planned.
- Trust, confidence and good communication are fundamental to a successful doctor–patient partnership and providing healthcare involves decisions which should be made with your patient.
- Failure to obtain consent properly can lead to problems including legal or disciplinary action against you.

REFERENCES
3. Sowetan Live, Trainee doctors fear they may kill patients (10 January 2013) www.sowetanlive.co.za/news/2013/01/10/trainee-doctors-fear-they-may-kill-patients
Choosing a medical specialty? It would be great if it could be so easy! When talking to senior colleagues we hear about the influence of their teachers, who by charismatic example often significantly influenced them in their choices. But other stranger reasons for such choices abound.

Career choices in medicine after completing your internship and other commitments are perhaps even more important than the choice of entering medicine itself. And like undergraduate medical training, your choices are beset with doubts and other concerns. Because these choices affect your lifelong professional career, they are as important as choosing a life partner (one may add that both partners need to be supportive and understanding through testing times, as further study and training are demanding of relationships, time and finances at the very time that many have the additional stresses of starting a family).

In today’s world, unlike in the past, it can be quite normal for people to switch jobs from time to time in order to further their careers. Specialisation in medicine does the opposite by locking one into a narrow, albeit demanding and satisfying, field of endeavour.

Background on medical specialties

There have always been divisions in medical practice that determine what today is known as scope of practice, ie, those aspects of practice that practitioners more or less confine themselves to. For example, barber surgeons were distinct from physicians and the title of ‘Mr’ for a surgeon in the UK is recognition of this historical fact of their more humble origins.

Specialties were typically divided into those specialties that offered major interventions, such as the surgical disciplines, whereas the medical specialties generally did not do major interventions in their diagnosis or treatment. However, there are many other criteria for subdivisions: some are organ based, eg, ophthalmology; others are primarily diagnostic or supportive, such as radiology or the pathology disciplines. Age is another marker of specialisation, as illustrated by the number of recognised specialties that relate to children; adult medicine has the bulk of specialties; and geriatrics caters for the elderly. Further specialties deal with communities rather than individuals, such as public health, occupational medicine and medical informatics.

Over time, the number of specialties has increased and this has accelerated with advances in medical knowledge and techniques. Medical regulators, concerned about the cost of medical care that exceeds inflation, try to discourage specialisation in favour of more generalised practitioners. Despite this, further specialties are likely to continue to emerge. Rarely, a specialty may disappear, eg, ‘physical medicine’ has bowed out to orthopaedics and physiotherapy.

A post-qualification career choice can be overwhelming given the vast possibilities. The HPCSA recognises some 30 specialties and 18 subspecialties.
Making the choices
Making a choice about your future career can be extraordinarily difficult, as many factors come into the equation. Influences such as large residual student loans and the needs of your partner, whose job or other requirements may be important, may complicate matters. Some may even decide to leave medicine, perhaps to go into management by pursuing business studies.

You could take the following into consideration:

Personal interests and skills – Personal interests and skills should preferably be matched to the job. However, medical graduates, because of their selection and training, are often multi-talented and could be successful in most medical fields. Nevertheless, if, for example, you lack manual dexterity, it is probably best to avoid a surgical specialisation.

Experience in the speciality – The ideal is to have had some experience in the proposed speciality to ensure you like it before committing to it. This may be easier said than done, as relevant posts may be scarce. However, specialist training departments often give preference to candidates who have already demonstrated an interest and developed further capacity by obtaining an additional qualification in the discipline, eg, a college higher diploma in anaesthetics, before entering the anaesthetics specialist training programme.

Opportunities to practice – Sir William Osler, who has been called the father of modern medicine, first considered becoming an ophthalmologist but decided otherwise because there was already such a specialist in his city, Montreal. It is, of course, extraordinarily difficult to predict where there are needs or perhaps an over-supply of specialists, but nevertheless, this should come into the reckoning.

Availability of training posts – Having come to a considered and clear decision regarding your desired specialty direction, a lack of training posts might frustrate this desire. Surprisingly often, one hears of colleagues who had been faced with such a situation and had temporarily taken a vacant training post in another discipline, only to decide to stay on in the new direction.

Financial benefits – The relative earnings in specialties are obtainable, but they only tell part of the story. For instance, obstetrics and gynaecology and neurosurgery practitioners may appear to earn good incomes, but their professional practice risk premiums are extraordinarily high. One also cannot predict future system reforms that may improve incomes of, for instance, family practitioners, who are currently underpaid, such as happened in the UK.

Final thoughts
It has been said that all jobs are a routine of some kind or another and that what distinguishes one person from another is their interests beyond their work environments.

My personal experience, and that of many other colleagues, is that chance and opportunity play a much larger role in our careers than is usually understood or preached.

Finally, our commitment and healthy emotional and intellectual approach to our careers is essential to our happiness, in whatever direction we find ourselves.
How to work in…

Family medicine

If you’re not a people-orientated person, you should probably stop reading now: family medicine is all about understanding the individual behind the illness, says Professor Julia Blitz.

As Hippocrates (460 – 370 BC) said: “It is more important to know what sort of person has a disease than to know what sort of disease a person has.” While Hippocrates might have put this in a rather extreme form, it is true to say that family physicians place great importance on understanding the person who is ill (though definitely not at the expense of knowing about their disease).

Though not unique to family medicine, the cornerstone of this specialty is a focus on the patient, rather than a focus on a particular set of diseases, age group of patients, or procedural technique.

Family medicine addresses the issues around the patient’s health belief system, their lifestyle choices, their supportive and destructive relationships, and the impact of their economic status on their health choices.

Some of the joys of family medicine come from the continuity of care: building a relationship of trust with the patient (and often members of their family) over extended periods of time.

Some of the joys of family medicine come from the continuity of care: building a relationship of trust with the patient (and often members of their family) over extended periods of time.

Francis Peabody said in 1926: “One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.” Later, in 1972, Ian McWhinney (seen by many as the father of family medicine as a new discipline), said that the integration of behavioural science and clinical medicine would enable the family physician to deal with both the behavioural factors that led to a patient’s healthcare decisions, and the patient’s clinical issues that needed to be managed.

The intellectual challenge of family medicine is dealing with the so-called undifferentiated patient, particularly when patients often present to us in the early stages of the disease process. Unlike in other disciplines, the patient has not yet been through the first stage of sorting into a likely domain of pathology. One does not know if the woman presenting today with lower abdominal pain may have an ectopic pregnancy, appendicitis, or a desperate need to fall pregnant. Does the man who presents with a headache have a brain tumour, a subarachnoid haemorrhage, a tension headache or a desire to be booked off work? Is this set of symptoms self-limiting, whose natural course will be to resolve, or are these symptoms in the early stages of evolving into something more serious?

One of the best ways to keep improving and updating your skills as a family physician is to develop relationships with the specialist colleagues you refer patients to, so that they give you feedback on what management plans they have chosen for the patient and what outcomes they have achieved.

Training

Family physician training in South Africa aims to produce specialists who are able to not only practise competently in district hospitals, but who are also able to work with teams of healthcare professionals to improve healthcare outcomes of the communities they serve.

In order to train, you need to be accepted onto the Masters degree programme by any one of the South African medical schools and to be employed by one of the provincial Departments of Health as a registrar.

Training takes four years, three of which need to be in a registrar post. Many of these posts are no longer attached to tertiary hospitals (as with most other specialist training), but are shifting to be based in district hospitals. If you choose to spend one of the four years not in a registrar post, you still need to be in an appropriate job where you are supervised, but you can use the year as an opportunity to decide if you like family medicine before you start your registrarship, or to pursue something outside the usual curriculum.

The final examination at the culmination of your training is the Fellowship of the College of Family...
Physicians examinations, which comprise clinical exams and examination of the research project that you complete during your degree programme.

**Working as a family physician**

Family physicians work closely with clinical nurse practitioners, particularly when working within primary care at clinics and community health centres. In the public sector they are important members of the district-based clinical specialist team, where they work closely with obstetricians and paediatricians in an attempt to improve South Africa’s chances of decreasing neonatal, child and maternal mortality.

In the private sector, a family physician can work in solo practice or in a group practice, in urban or rural areas, or for non-governmental organisations.

The actual nature of your particular practice is determined less by the scope of the discipline that you have chosen to specialise in, but more by the needs of the community that you work in. In other words, if you practise in a rural town, you may be more likely to take on some of the hospital duties including giving anaesthetics and doing gynaecological and general surgery. If your practice is in an affluent area of a big city, you may be more likely to focus on ambulatory care dealing with non-communicable diseases and psychological problems.

It is really important for you to know the network of other resources that your patients can access, whether these are patient support groups, allied healthcare professionals, counsellors, hospices, for example.

The spectrum of practice which you can choose from is almost limitless and it is easy to find a niche that suits your personality and your interests.

**Working hours**

Working hours can be long, as it is often family physicians who provide both office hours and after-hours services. However, in the private sector more and more use is being made of after-hours emergency units, so that these duties can be shared. In the public sector, the bulk of the after-hours work is often done by the interns, medical officers and registrars, giving some relief to the family physician.

**Remuneration**

In the public sector family physician specialists are paid at the same level as other specialists.

In the private sector, family physicians are not yet recognised as being able to charge specialist rates. Your income can be derived from any combination of consulting, procedures, assisting with surgery, dispensing medication, sessions at the local government clinic or hospital, or clinical trials for pharmaceutical companies.
CHRISTIAN, an intern, was halfway through completing a module in the Emergency Department. He was working one Friday night when a young female patient was brought in by two of her friends, having had a fit in a local bar. Christian took a history from the patient, and realised that she had been a geography student at his university. Christian visited her the following day on the medical ward to follow up on her medical management. They seemed to get on well, so Christian invited her to be a friend on Facebook.

After a while, the relationship soured, and the patient complained to the medical school about Christian’s conduct in contacting her and starting a relationship as a result of meeting her as a patient.

Learning points

■ Always maintain professional boundaries, which social networking can sometimes blur.
■ Do not accept current or former patients as friends or followers.
■ Exercise caution when accepting friend requests from colleagues.
■ Use the most secure privacy settings on social networking sites where available – but remember that not all information can be protected on the web.
■ Certain behaviours might affect your professional reputation, and possibly trigger an investigation by the regulator, for example irresponsible drinking. Certainly don’t publicise such behaviour online.
■ You have a duty to maintain the standards expected of a healthcare professional.

A false sense of anonymity

Anesu, a com serv intern in urology at a large city hospital, is beginning to think about applying for posts after Community Service. She has recently attended a conference, where one of the speakers highlighted the advantages of blogs specifically aimed at medical professionals as a learning resource to share best practice.

Anesu decides to create a blog to showcase her research work to potential employers. She tells some of her friends about the blog, who visit the site and leave messages under one of the opinion pieces. The comments quickly become jokey as the interns reply to one another and some use inappropriate language to recount specific instances of treating difficult patients.

An intern supervisor sees the blog and reports the intern who made the offensive posts to the HPCSA.

Learning points

■ MPS’s advice would be to tread cautiously and consider all the following pitfalls before putting digital pen to paper: breach of patient confidentiality; defamation; breach of employment contract.
■ It is sensible to obtain the permission of your employer or educational supervisor before setting up a blog.
■ Remember that the internet is not a private space. When interacting with medical blogs and social networking sites, or when taking part in forum discussions, remember that anonymity is a myth, even if you use a pseudonym. You should write everything as if you are signing it with your name.
■ Maintaining patient confidentiality applies online too. Don’t post informal or derogatory comments about patients or colleagues on public internet forums, even if they are anonymous. The National Health Act (2003) protects the health information of patients, as well as the fact that they attended a health facility, as confidential.
■ Unguarded comments about patients, your place of work, or other staff members can lead to sanctions by your employer or the HPCSA. Comments of a racist, sexist or bigoted nature, posting inappropriate images, or sharing extreme views are also unacceptable.
■ You could face trouble if you harm someone’s reputation by publishing incorrect or potentially damaging information online.
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