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A great way to learn about MPS. A great chance to reflect on some case studies where we were entered the golden age of psychiatry

Opinions expressed herein are those of the authors. Please contact the Editor, Sarah Whitehouse at sarah.whitehouse@mps.org.uk.

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

Get the most from your membership...
As a doctor, you should be honest, decent, fair, trustworthy, law-abiding and of good character. You should behave professionally and with probity. What does this mean in practice?

“Probity requires that the doctor’s conduct at all times justifies patients’ trust and the public’s trust in the profession.”

Probity (from the Latin probitas) is the quality of having strong moral principles: honesty and decency. You could be the most brilliant medical student or junior doctor, but your hard work could be in vain if your conduct raises concerns about your fitness to practise. Your actions should be ethical and you should uphold the reputation of the medical profession, helping to maintain public confidence in it.

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Do not make any claim or statement that is not capable of being substantiated or justified.

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Being a professional

Your duty to be honest and open covers all aspects of your professional practice. This includes:

- Preparing medical reports
- Record-keeping — medical records should be contemporaneous and not retrospectively altered in the event of a complaint or claim
- Any other documents or forms you are asked to sign or complete must be comprehensive and include all relevant information
- Giving evidence or acting as a witness — as well as being truthful when giving a spoken or written statement, you must be honest about the limitations of your knowledge and competence
- Co-operating fully with any complaint or investigation related to your treatment of patients, including disclosing any relevant information with appropriate consent
- Assisting with inquests or inquiries into a patient’s death

Your CV and job applications

Even a single episode of plagiarism or dishonesty, for example in CVs and applications, could harm your chances of obtaining HPCSA registration, and your future career as a result. When applying for jobs, tell the truth. Healthcare organisations may consider dishonesty on an application form as a disciplinary matter, which may ultimately lead to termination of your contract of employment.

You must be honest about your experience and qualifications when applying for posts.

Do not make any claim or statement that is not capable of being substantiated or justified.

Own up to your mistakes – it’s your responsibility to inform the HPCSA of any criminal convictions or cautions, even if they occurred before you started medical school.

Dishonesty

Dishonesty arises when statements are made which a doctor knows (or should know) to be untrue, inaccurate, or likely to be misleading. An instance of this is providing incomplete information, or biased information, especially if this involves a conscious, deliberate decision to withhold information or to present it in a way which will alter how the information is received, understood and interpreted.

Whether such acts are committed in one’s professional, business, or social life, they all have the capacity to undermine the credibility and integrity of the doctor concerned.

Another example of dishonesty is cheating in professional examinations.

Writing reports and academic papers

There have also been instances where research has been misrepresented, or research findings manipulated, and situations where doctors have been found to have plagiarised the research or publications of others, presenting it as their own work.

Passing off the work of others as your own is clearly wrong, but many medics have been tempted to take ‘short cuts’ when under the pressure of large workloads, high competition, and tight deadlines.

However pressured you feel, remember that plagiarism is completely unacceptable and could lead to you being subject to disciplinary action. Make sure you include references for any quotes or information gained from other publications or authors. Be especially careful when using material sourced online – although the information you include may appear to be freely available, you must reference everything that is not your own work.

REFERENCES

Segen’s Medical Dictionary

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2014 Ethics Essay Prizewinner

Congratulations to Notonwabo Moyalke for her winning entry in the 2014 Ethics Alive MPS Undergraduate Bioethics Essay Competition for medical students at the University of the Witwatersrand.

The winning essay, entitled “Exploring the right to quality healthcare in South Africa”, looks at the moves towards a nationalised healthcare system and calls for health equality for all, regardless of economic background.

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.

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Top five medicolegal hazards for junior doctors

1. CONSENT

- Inexperienced doctors should not feel pressured to do anything beyond their knowledge, experience and competence. This includes obtaining consent for a procedure that they are not familiar with.
- Consent is a process, rather than a form-filling exercise. The HPCSA makes it clear that interns should not usually be asked to obtain consent unless the procedure is a minor one that they are familiar with.
- Failure to take consent properly can lead to medicolegal problems including complaints, claims and disciplinary proceedings.

**Survival tips**
- Always act in your patient’s best interests.
- If you take consent, record in the notes what consent has been taken.
- 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, a professional athlete.
- Adult patients are presumed competent to consent unless proved otherwise.
- Any competent adult can refuse treatment.
- Where an adult patient is deemed to lack capacity to make decisions, reasonable steps should be taken to find out whether any other person has legal authority to make decisions on their behalf. If so, the team should seek that person’s consent to the decision.
- If no other person has this authority, your senior colleagues will have to decide what action to take, in the patient’s best interests.
- A judgment that a patient lacks the capacity to make a particular decision does not imply that they are unable to make other decisions in the future.

2. PRESCRIBING

Prescribing is fraught with potential pitfalls – from transcription errors and inadvertent dosage mistakes to overlooked drug interactions, allergies and side effects.

**Survival tips**
- Prescriptions should clearly identify the patient, the drug, the dose, frequency and start/finish dates. They must be legible, dated and signed.
- Be aware of a patient’s drug allergies.
- Good handovers require good leadership and communication.
- Refer to the SAWA.
- Verbal prescriptions are only acceptable in emergency situations and should be written up at the first available opportunity. If a telephone prescription is necessary, you should make a note of the call in the patient’s notes and records and send a written prescription to the pharmacist without delay. Particular care should be taken that the correct drug is used.

3. 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.

**Survival tips**
- Remember that confidential information includes a patient’s name and address.
- Before breaching confidentiality, always consider obtaining consent. Take advice from senior colleagues.
- 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.
- Disclosure of patient information may be required by law, for example to comply with infectious disease regulations.
- The courts can also require doctors to disclose information, although it would be a good idea to contact MPS if you find yourself presented with a court order.
- High-risk areas where breaches can occur are lifts, canteens, computers, printers, wards, emergency departments, pubs and restaurants.
- Be careful not to leave memory sticks or handover sheets lying around.
- Patient information should be held securely and in compliance with data protection legislation.

4. 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. Only include things that are relevant to the health record.
- Patients have a right to access their own medical records under the Promotion of Access to Information Act 2000.

5. PROBITY

Doctors must be honest and trustworthy when signing forms, reports and other documents. You should make sure that any documents you write or sign are not false or misleading. This means that you must take reasonable steps to verify the information in the documents, and must not deliberately leave out anything relevant.

**Survival tips**
- 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.
- Never sign a form unless you have read it and you are absolutely sure that what you are saying is true.
- If you are uncertain double check your work with a senior.
- Assume that all records will be seen by the patient and/or others, eg, the HPCSA or a court.

**REFERENCES**
- Reference 1: Setting Out Policy. Written Consultation. The Ethics Committee (May 2008) www.hpcsa.co.za

Good doctors apply clinical knowledge in a way that is legally and ethically correct – but all doctors can slip up. Here are survival tips for the top five medicolegal risks for junior doctors, writes Charlotte Hudson.

**Find out more**

Read the full version of this article in Avoiding easy mistakes: Five medicolegal hazards for interns and Community Service Medical Officers. This booklet is available free of charge when you join MPS.

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Challenging times

Being a junior doctor can intensify the level of stress in what is already an extremely stressful job. We sometimes deal with the most challenging of patients, often at the most challenging of times, says Dr Lynelle Govender.

Patients, as we are so often taught at medical school, are more than simply a vessel for pathology. They are living human beings, and human beings do not always display the most harmonious behaviour.

Challenging patients come in a variety of shapes and sizes: aggressive, flirtatious, demanding, drug-dependent. You will see it all: patients who will stretch you to the limits of your kindness and compassion. As with all pathology, however, having an approach to dealing with the different types of challenging patient, prior to seeing one, often makes the difference between a successful consultation and a near-disaster.

Factors contributing to a challenging interaction are two-fold: patient factors and doctor factors. Whereas patient factors are easy to understand, it is often a bitter pill to swallow when realising that some of the blame has to be pointed to ourselves.

Patient factors include:
- High expectations
- Personality traits
- Feeling misunderstood, or otherwise dissatisfied with treatment
- Cultural differences
- Substance abuse.

Doctor factors:
- Junior doctors are in fact more likely to become involved with challenging interactions than senior doctors. This is a by-product of inexperience, poor communication skills, and an inability to prioritize. Our clinical judgements may be clouded by the multitude of cases we have to see in a single day. We often ask more and more of you, and you feel perpetually dissatisfied.
- Junior doctors are a product of our current medical training system. Their level of stress in what is already an extremely stressful job.

We sometimes deal with the most challenging of patients, often at the most challenging of times, says Dr Lynelle Govender.

Strategies for dealing with challenging interactions

Demanding and needy patients will often ask more and more of you, and seem perpetually dissatisfied. The key here is setting boundaries and realistic goals. It is perfectly acceptable to ask a patient at the outset what their expectations are from the consultation and thereafter keep the consultation short and focused on trying to meet those expectations.

Simply put: drug-seekers can be manipulative. They have done this before and know all the tricks to getting a prescription of their favourite fix. Red flags include “doctor shopping”, requesting specific addictive medication on the premise of being allergic to others, and classically aggressive behaviour from the patient when you fail to provide the requested script. As a junior doctor, the key is to recognize the signs of drug-seeking behaviour, do a proper history taking and examination, make good notes, and if you are suspicious, alert your senior.

Most patients become angry and aggressive for a reason (with personality disorders and intoxication being the obvious exceptions). In dealing with this type of behaviour, your greatest ally is to find the cause. Address the reason for a patient’s irritation and you are more likely to resolve the situation. It is important to remember, however, that doctors are not invincible. Aggression can progress to violence and it is important to keep yourself safe.

Always sit closest to the door and call for help and exit immediately if you feel threatened in any way.

Crossing boundaries happens; no-one ever really expects it from a patient, but it happens nonetheless. Patients use their relationships with doctors to feel powerful and in control, and you may feel uncomfortable in your own work space. In these situations, emphasis that this is a professional relationship, request a chaperone to watch over your consultations, and if necessary, alert your senior.

Non-compliance with treatment can be intensely frustrating to deal with. Patients will seek help, with apparent desperation, but not comply when such help is provided. You will do no-one any good by getting angry. Try, if possible, to educate the patient about their condition and the dangers of non-compliance and then make clear notes. Beyond that, the situation is out of your control and it is easier to accept that reality than try to force treatment on a patient.

Ultimately, realise that the key to dealing with a challenging patient interaction is good communication. Cultivate good rapport with patients and success is likely to follow. Furthermore, as with all consultations, detailed note-taking is your ally. Whatever the situation may be, be sure to document it extensively. If nothing else, a challenging interaction is a learning experience which will only serve to improve your skills in future.

Dr Lynelle Govender is a Medical Officer based at ER Consulting Inc., Nelspruit MediRic.

Case Study: Dr F’s approach to the intoxicated patient

Dr F is a young intern working in a busy Emergency Centre. On call, it is the responsibility of the intern to suture all lacerations. On weekend evenings, there are often so many patients to suture that a queue forms outside the procedure room door whilst the supply of sterile suture packs starts to dwindle.

It’s reached that point in the morning when Dr F’s energy levels are at rock-bottom. She wants a shower, a meal, and then bed. But when the nurses call to say there is another laceration to be seen, she must respond. Such is the nature of this job.

By the time she gets there Mr H has already jumped down from the bed and is stumbling, shouting at the nurses in a string of slurred sentences. He’s clearly drunk.

Non-compliance with treatment can be intensely frustrating to deal with. Patients will seek help, with apparent desperation, but not comply when such help is provided. You will do no-one any good by getting angry. Try, if possible, to educate the patient about their condition and the dangers of non-compliance and then make clear notes. Beyond that, the situation is out of your control and it is easier to accept that reality than try to force treatment on a patient.

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How to work in...psychiatry

Historically, psychiatric patients and their families, as well as psychiatrists, were stigmatised. Fortunately, this is rapidly changing as psychiatry becomes more embedded in medicine, says Dr Volker Hitzeroth.

(Paragraph 1: Remember mental health problems can affect anyone.)

Registrar training is usually divided into two important examinations: Part I and II examinations. Part I comprises anatomy and physiology (both with a neuroscience emphasis), as well as psychiatry. Part II entails a written examination, OSCE and an oral examination. Throughout the registrarship a candidate is also expected to complete a number of therapy cases with the help of a supervisor. Each candidate has their own in-house annual academic training programme that a candidate will be expected to attend and participate in (eg, case or journal presentations).

Upon successful completion of the Part I examination from the CMSA, and the confirmed fourth-year training a candidate will qualify with a degree of FC Psych (CMSA). This will allow the individual to work in the public or private sector, as well as some international territories. In order to receive the MMed (Psych) degree, a candidate will have to complete a research project to the specific departmental or university specifications (eg, publication in a peer-reviewed journal). South African psychiatrists are commonly sought after and well-accepted in the international community.

The average day

As a registrar, your working hours are pre-determined. You will be expected to work daily from 08:00 to 17:00 during the week. On calls usually occur after-hours, over weekends, and public holidays. On call work can be very demanding, whilst other times may be quiet with sufficient spare time to study or prepare your research project and read prescribed articles. On call may also entail travel between a number of mental health facilities.

A consultant is usually available by telephone to assist in problem situations. Once you are a qualified psychiatrist, your working hours are determined by your working environment. Within the public sector, there is no real flexibility and you may be expected to complete a log sheet of your working week. In the private sector, you remain your own boss. Those choosing to establish a full-time private practice can expect to work very long hours (Lesson 6). You will have to be very disciplined to manage your working hours.

In the public sector, your focus is the establishment and delivery of psychiatric services to the local population. Many such posts are popular as they provide a good income with clear working hours in some of the more beautiful locations within our country.

Establishing a private practice

If you have decided to open a private practice you can expect to take a number of years to become established (Lesson 6). Your success depends on your availability, personal style and location. Managing a private practice has become a specialist field of its own and will require clear business plan and support services (Lesson 7). It is best to get advice and professionals to assist you and to ensure your practices are run efficiently.

Some urban regions seem to be saturated, eg, Cape Town, Pretoria East and Northern Jo’burg. The demand for psychiatrists is expected to work harder and longer to be successful unless you link up with a clinic, willing and established private practitioner who is prepared to show you the ropes and share his overview with you (Lesson 8). Be polite to your private practice colleagues, as you may want to join them after your training. If your heart was more academically inclined you would have to apply for the occasional academic post at the tertiary facility or mental health hospital of your choice (Lesson 9). Be a hard-working registrar who is diligent and realistic, as an academically oriented registrar and get along with your colleagues, as you may want to apply for a job after training.

Like most specialties, psychiatry has a professional organisation called the South African Society of Psychiatry (SASOP), which looks after the standards of living for you and your family.

SASOP has a specific interest group called the “Young Psychiatrist Special Interest Group” (YPSIG) which runs an advocacy psychiatrists for young psychiatrists in order to protect the young and mentor newly-qualified colleagues (Lesson 11: It is useful to make helpful contacts during your registrarship).

Remuneration

Within the public and academic sector, psychiatrists earn the standard prescribed government salary depending on their post and experience. Within the private sector, the remuneration is calculated per time unit, eg, half or full hour. Whilst this is generally a good income, it is limited by the hours you are able to work, ie, after 9 to 10 hours of daily consultations one is generally exhausted and risks burnout (Lesson 12). You and your time are the product that you sell – both are limited resources. Overall, however, the remuneration for a qualified psychiatrist is good and can ensure a high standard of living for you and your family.

Core features of working in psychiatry:

■ If you think you can work with severely ill people, emotionally stressful situations, and manage conflict successfully, you are honest, and have very high levels of empathy, then psychiatry is for you.

■ You have to have exceptional interpersonal skills and be able to get along with people from all walks of life (Lesson 13). The doctor-patient relationship is critical to any successful consultation, even more so in psychiatry.

■ You have to be comfortable with severely disturbed individuals, distressed families and threatening situations (Lesson 14).

Psychiatrists are exposed to daily situations that their medical and surgical colleagues have never even dreamt of.

■ You have to be able to manage ruthless honesty, complete vulnerability, and intense fear (Lesson 15). Psychiatry is the specialty that serves as an escape for scarred souls, and traumatised minds.

National and international subspecialties within psychiatry:

■ Child and adolescent psychiatry

■ Geriatric psychiatry

■ Forensic psychiatry

■ Addiction psychiatry

■ Neuropsychiatry

■ Consultation – liaison psychiatry.

Dr Volker Hitzeroth is a psychiatrist in private practice in Bellville, Cape Town. He is also a part-time Senior Lecturer at the Department of Psychiatry, University of Stellenbosch, as well as Western Cape Chair of SASOP.
Consent in children and young people

Wandile Ganya, a medical student at the University of Stellenbosch and winner of last year’s MPS Ethics Essay Competition, explains why valid consent is just as important when treating children and young people as it is with adults.

“Children have the right to express [their] views freely in all matters affecting [them],...the views of the child being given due weight in accordance with the age and maturity of the child.” UN Convention on the Rights of the Child (1989).

The South African Constitution makes provision for children’s rights, and in particular, the rights of children with a disability. Under the Children’s Act 38 of 2005, as amended by the Children’s Amendment Act 41 of 2007 (the Act), children are defined as individuals, not merely the property of their parents or a passive object.

Informed consent

The concept of informed consent holds that patients should be allowed to make the final decision concerning treatment, providing that the following necessary elements are fulfilled:

1. Competence
2. Disclosure of information
3. Understanding and appreciation of information disclosed
4. Voluntariness in decision-making
5. Ability to express a choice.

Competence refers to the ability to perform a task, and, by reference for application form(s) to be completed.

In emergencies situations where the hospital superintendent is unavailable, a doctor may perform life-saving treatment on a child in the absence of consent. The treatment should be limited to what is immediately necessary, and consent should be obtained as soon as possible thereafter.

Consent to surgical operations

A child may consent to a surgical operation granted that they are over the age of 12 years and of sufficient maturity and decisional capacity to understand the benefits, risks, social and other implications of the surgical intervention; and they are duly assisted by their parent or guardian. Written informed consent is required (see reference for application form(s) to be completed).

For children who lack decisional capacity and/or are under 12 years of age, consent for medical treatment is obtained from the parent, guardian, or caregiver. A care-giver can also be a child head of a household.” Where surgical operations are concerned, only a parent or guardian may provide consent.

When consent cannot be obtained in the usual way, and the treatment or operation is necessary to preserve the life of the child, or to save the child from serious or lasting physical injury or disability, the hospital superintendent may act as a proxy in providing consent for the child, only in emergency circumstances.

The Minister for Social Development may give consent if the parent or guardian unreasonably refuses to give consent (or to assist the child in giving consent), is incapable of giving consent (or assisting the child in giving consent), cannot readily be traced, or is deceased. The Minister may also consent when the child unreasonably refuses to give consent. The High Court or Children’s Court may be approached to give consent in all instances where another personal that may give consent refuses, or is unable to give such consent (see reference for application form(s) to be completed).

In emergency situations where the hospital superintendent is unavailable, a doctor may perform life-saving treatment on a child in the absence of consent. The treatment should be limited to what is immediately necessary, and consent should be obtained as soon as possible thereafter.

Consent to termination of pregnancy

Although dealt with in a different Act, consent regarding termination of pregnancy is worth a mention. The Choice on Termination of Pregnancy Act provides that a female, regardless of her age, may consent to a termination of pregnancy without the assistance of her parent, guardian or care-giver.

Decision-making

If a child makes a final decision which appears to be irrational or incompatible with the doctor’s opinion, it does not necessarily mean that the child is incompetent to make an informed decision. In such circumstances, you should ensure that the child understands the implications of his/her decision. Informed consent should be sought for all medical and/or surgical interventions involving the child by a treating healthcare practitioner.

It is a legal obligation for healthcare practitioners to disclose relevant information to their patients regarding:

1. The patient’s health condition (except when disclosure of information would be contrary to the patient’s best interest)
2. Available diagnostic and treatment options
3. Risks, benefits, costs and consequences attached with each option
4. The option of non-treatment, that is, informed refusal and its implications.

You might wonder: “How much information should I disclose to safely declare a patient ‘informed’ enough to consent?” The ‘reasonable’ patient standard is often employed which dictates: disclose as much relevant information, that a reasonable person would be placed in the patient’s position and informed of all pertinent information, including material risks, which would find significant to in order to decide.

The process of consent should also be conducted in a language that the patient understands and in a manner that considers the patient’s level of literacy. This is especially so with children.

Avoid or clearly explain medical jargon. For informed consent to be valid, the child must not be influenced by other individuals either by coercion, persuasion, or manipulation.

Lastly, the child’s final decision may be expressed orally, in writing or may be implied – termed tacit or implied consent. However, it is advisable that you get written informed consent, and always make contemporaneous notes on what was discussed. Caution is placed against tacit consent as a child’s submission to treatment may not necessarily imply informed consent.

Perplexing circumstances

South Africa is a culturally diverse country. It is only sensible for any healthcare practitioner to be aware of the value systems held in the community where they practise. In the African context, for example, individual autonomy is of smaller status than the pursuit of the communal good. A child in such context often has no say in decision-making on matters concerning them and thus may often defer decision-making to his/her parents, elders, or extended family.

Further, the parents (or the child) may disagree with performing indicated medical or surgical treatment based on cultural, social or religious reasons, for example, parents belonging to the Jehovah’s Witness faith refusing transfusion of their critically ill child.

It must be emphasised here that all decisions must have the child’s best interests at heart. In emergency cases, even if the parents or child disapprove of the intervention, their wishes need not be accorded to in cases when they appear not to be in the child’s best interest. The Children’s Act states that a parent, guardian, or care-giver may not refuse to assist a child or withhold consent by reason only of religious or other beliefs, unless that parent or guardian can show that there is a medically accepted alternative choice to the medical treatment or surgical operation concerned.

For more information see MPS’s factsheet, Consent: Children and Young People.

REFERENCES

7. National Health Act 61 of 2003
8. National Health Act 61 of 2003
11. This is especially so with children.
12. The process of consent should also be conducted in a language that the patient understands and in a manner that considers the patient’s level of literacy. This is especially so with children.
13. Avoid or clearly explain medical jargon. For informed consent to be valid, the child must not be influenced by other individuals either by coercion, persuasion, or manipulation.
14. Lastly, the child’s final decision may be expressed orally, in writing or may be implied – termed tacit or implied consent. However, it is advisable that you get written informed consent, and always make contemporaneous notes on what was discussed. Caution is placed against tacit consent as a child’s submission to treatment may not necessarily imply informed consent.
So you want to work as a locum?

Working as a locum can provide you with a variety of clinical experience, but with this work comes specific risks.

First things first – you need to make sure you have the appropriate indemnity in place. Either provided by your employer or arranged by you through MPS. Working as a locum can be extremely rewarding. You may wish to gain further experience in a particular clinical setting, or you may wish to supplement your income after many years of being a student. There are benefits for healthcare organisations too. With the ability to cover shifts at the last minute or provide assistance when permanent staff are absent, locums are an essential resource, particularly in an Emergency Centre setting or PCTs providing primary care. Some recruitment agencies are contracted to fill open shifts with locums.

Knowledge is highly flexible nature of the job, as a locum, which usually involves working in an unfamiliar environment and with different people each day, can present you with a number of challenges. So what are the common risks, locums face and how can you reduce them?

A lack of information

Any member of staff is likely to perform below standard if they are unfamiliar with their surroundings, so as a locum getting as much information as possible before the shift starts is highly advisable. Not all healthcare settings maintain records which are up to date, so you should familiarise yourself and try to agree your terms and conditions ahead of your shift.

Different IT systems

Different practices and hospitals work with different medical computer packages, so as a locum you could find yourself suited up to three different computer programmes in a single week. This can be hairy if it introduces the likelihood of making mistakes. For example, if you are giving a prescription to a patient and then entering the details onto someone else’s electronic patient record you may have a double order. Familiarise yourself with the technology and procedures before you start.

Are you covered?

In the event of disputes, independent contractors are not entitled to undertake locum sessions as they are not appropriately registered and have no work under approved supervision. If you are a fully qualified junior doctor wanting to carry out locum work you should check that you have valid indemnity insurance and are registered with the GMC. If you are in any doubt contact MPS before embarking on any locum work.

Accurate and detailed handovers

Meticulous record keeping is essential for a safe and effective transfer of information. After all, the next doctor the patient sees will most likely be someone else. Where there is a lot to be communicated, it is critical that handover notes are accurate and detailed. For this reason, it is helpful to consult carefully and efficiently with new patients and document detailed clinical notes. When it comes to handing over computerised notes, these records will help guide how well the complaint is processed and managed.

Training and development

If you do not have a professional post elsewhere, you should be mindful of ensuring you are up-to-date with the latest training opportunities. You are also at risk of professional isolation, as you spend a lot of time working on your own. Peer groups can provide support for locums and assist in providing education for the locum. In addition, many organisations provide training and development opportunities. You are also at risk of professional isolation, as you spend a lot of time working on your own. Peer groups can provide support for locums and assist in providing education for the locum. In addition, many organisations provide training and development opportunities.

Learning points

Do not be overly reassured by a colleague’s previous diagnosis. In the context of an acute illness, symptoms and signs may evolve rapidly, and one should always seek to confirm the same or similar findings to a previous examination before formulating your own opinion.

Dr A’s advice to seek further medical help if the symptoms had not settled, and his documentation of this fact, was good medical practice and made his actions defensible.

When dealing with an acute illness in an otherwise well patient, take care to be thorough and conduct and record an adequate history and physical examination to reassure yourself that you are not missing an important diagnosis. The following points, which discuss potential pitfalls that may lead to a failure to diagnose appendicitis in the primary care setting, might be relevant to those working in primary care.

MPS is a 23-year-old patient who worked in this local Emergency Centre (EC) one evening with a six-hour history of vomiting and abdominal discomfort. The symptoms had come on shortly after eating a takeaway meal. He was seen by Dr A, a community services doctor working on the emergency medicine rotation. Dr A documented a detailed abdominal examination which showed no evidence of an acute abdomen. Dr A diagnosed acute gastritis or early gastroenteritis and advised Mr U to go home, rest, and see his GP the next day if things had not improved.

By lunchtime the next day, Mr U felt increasingly unwell and had been feverish, so he returned to the EC. The resident Dr W were somewhat bystr and did not record an abdominal examination. Mr U later claimed that Dr W had not examined his abdomen during this consultation and had been dismissive, telling Mr U that he was reassured that the patient had an EC with no other signs of infection.

Dr W had noted that urine analysis showed a trace of blood. Dr W diagnosed a urinary tract infection and treated Mr U with a course of antibiotics.

Twenty-four hours later, Mr U was in severe pain and attended the EC again. Mr U was referred for urgent abdominal assessment and an ultrasound, which confirmed the diagnosis of acute appendicitis. Mr U underwent an emergency appendectomy. Drs A and B alleging negligence causing a delay in diagnosis, leading to unnecessarily suffering.

Expert opinion

This was largely supportive of Dr A’s record and considered the failure to follow up the early positive signs of appendicitis, which appeared too early in the evolution of the illness. Dr W’s failure to record an abdominal examination meant that Mr U’s assertion that he had not done so could not be refuted, and it was felt that Dr W had been negligent.

In the following weeks, Dr A underwent a detailed clinical examination which showed how making detailed records of an examination in an emergency setting can help if a claim is later made - and how you should not be overly reassured by a colleague’s diagnosis.

The following case scenario shows how making detailed records of an examination in an emergency setting can help if a claim is later made - and how you should not be overly reassured by a colleague’s diagnosis.

A takeaway lesson

Work as a locum can provide you with a variety of clinical experience, but with this work comes specific risks.
New e-learning hub
Free to all members

Learn at a time and place to suit you

- Over 40 hours of education available
- Track your learning progress
- Interactive content produced for doctors by doctors
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