HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA

MEDICAL AND DENTAL PROFESSIONS BOARD

HANDBOOK ON INTERNSHIP TRAINING

GUIDELINES FOR INTERNS, ACCREDITED FACILITIES AND HEALTH AUTHORITIES

PRETORIA
2022 EDITION

PREFACE

On behalf the Medical and Dental Professions Board (MDB), I have the pleasure of making this Handbook available to all Interns, Intern Curators, and Accredited Facilities for Internship Training and Health Authorities who are involved with internship training and who employ interns.

The Board has come to appreciate the need in practice to obtain clear guidelines for internship training. Thus, based on experiences of Board members, Evaluators of Internship Training and inputs of those who went through Internship Training, this *Handbook for Internship Training* has been revised and we trust that it will be relevant as a guideline that will serve the needs of Interns and those responsible for their training.

The Medical and Dental Professions Board looks forward to ongoing improvement in the nature and quality of internship training as part of its role and mission of "Protecting the Public and Guiding the Professions". Part of this improvement is through the feedback and inputs from all our interns during their internship training. As of January 2020, Internship training model has been modified to incorporate six months of training in the primary health platform in the second year. The training will be for 24 months with specific domains to be completed in the first year before proceeding to the domains of second year. This has resulted in the expansion of existing training platform incorporating the district health system. This we consider as transformational in the area of training and service delivery

The Board expresses its gratitude to all who have contributed to this document, and this include the members of Medical Education and training committee, Panel of Evaluators of Internship Training, Secretariat and all those who have worked tirelessly in the revision of this Handbook.

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TABLE OF CONTENTS

INTRODUCTION

It is accepted and practised world-wide that there should be a period of supervised training for newly qualified doctors before they can register as medical practitioners. This training is usually for one year, but in many countries further training is required before registration is possible for independent practice as a general practitioner, as is the requirement also for independent practice in any specialty.

Internship training refers to the period of training in an accredited facility, i.e. a hospital, clinic, health centre or Complex of facilities. The period of internship training is two years after qualifying as a medical graduate.

This document provides guidelines for the training of graduates in a two-year internship training programme. The principles underlying internship remain the same especially if offered in the same complex of facilities.

This *Handbook on Internship Training* consists of the following sections:

Part I which provides broad guidelines applicable to all facilities and domains (disciplines).

Part II which provides the specific criteria and objectives of internship training in each domain.

Part III which deals with ethical and medico-legal aspects of internship training.

It should be appreciated that these guidelines are based on the comments of many individuals and therefore, reflect a consensus of views. It should also be borne in mind that accredited facilities differ widely in their structure and the scope of the patient care services that they offer.

Apart from the above, this document contains a series of **Annexures** which should provide interns and the bodies/persons involved in their training, with some valuable information on the requirements for, as well as the nature and content of internship training, and the facilities which offer such training.

PART I
GUIDELINES PERTAINING TO THE NATURE, STRUCTURE AND DOMAINS OF INTERNSHIP TRAINING

1 AIMS AND PURPOSE OF INTERNSHIP TRAINING

The purpose of internship training is that interns will complete their medical training under supervision and guidance in accredited facilities. They should effect the transition from undergraduate students, with responsibility primarily to themselves, to professional persons with responsibilities to patients, the health team and communities. Internship training should provide opportunities to further develop interns' knowledge, skills, appropriate behaviour patterns and professional thinking, as well as to gain insight, understanding and experience in patient care to equip themselves to function as competent and safe medical practitioners.

Training should be comprehensive and complementary to the health care system being developed for South Africa which places emphasis on the primary health care approach. The training should provide exposure to a spectrum of clinical conditions to provide a wide base of experience as a first step towards further training and study with a view to private practice, specialisation or continued hospital practice. Skills in the management of common emergencies should also be developed.

The importance of cost consciousness, professional behaviour patterns and ethics in professional practice form additional components in this training, both at the informal and semi-formal levels, and by example. Interns should be aware of the *Charter on Patient Rights* (see the document compiled by the Department of Health as contained in Annexure F) as well as the Batho Pele principles (Annexure G). The investigation and management of patients should be in line with those recommendations.

2 FUNCTIONS OF THE MEDICAL AND DENTAL PROFESSIONS BOARD

Internship training should be a constructive, organised and progressive period of training. It therefore forms part of the responsibility of the Medical and Dental Professions Board (hereafter referred to as "the Board"), in co-operation with educational institutions and employing Health Authorities, to ensure that newly qualified practitioners are adequately trained and sufficiently competent when applying to the Board for registration as medical practitioners. As such, it falls within the Board's statutory obligation to act on behalf of the profession by guidance and in the interest of the public. Training will only take place at facilities accredited by the Board, and such status shall be subject to regular accreditation visits (evaluations) and adherence to the prescribed criteria and requirements. It shall be provided by trainers who are medical practitioners with adequate experience (i.e. at least three years post-internship) in that specific domain, and who are accredited by the Board.

3. CRITERIA FOR THE TRAINING OF INTERNS

The following are basic requirements which shall be complied with:

Internship Training shall only be recognised if the intern was registered in terms of the *Health Professions Act, 1974 (Act No. 56 of 1974 as amended by Act No. 29 of 2007),* for the full period of training (see Annexures A, D and E) and if training took place in one or more of the facilities which were accredited by the Board for this purpose (see Annexure K).

CONDITIONS OF INTERNSHIP TRAINING -

Internship training commencing after **1 July 2004** shall be of not less **than twenty-four (24)** months' duration and, where it is broken or interrupted, it shall be completed within a continuous period of **thirty-six (36) months.** Extension beyond 36 months may be considered under the following circumstances

3.1 Late commencement of training after graduation/registration: The Registrar may register the intern administratively so that the intern can complete the internship programme;

However, if the delay in commencement is more than 5 years post-graduation/registration, the Board shall require the intern to pass a competency assessment before commencing internship:

3.2 Interruption of training due to physical or mental illness: The Registrar may grant permission to resume internship on presentation of a valid fitness certificate either from the treating practitioner or the Health Committee on condition that the period of absence from training is less than five years. If the interruption exceeds five years, the Board shall require the intern to pass a competency assessment before resuming internship

3.3 In any other scenario, the matter must be referred to the Board for consideration.

4. CRITERIA PERTAINING TO THE INTERNSHIP TRAINING PROGRAMME

Internship Training shall take place during a **two-year** training period, as follows:

Year 1

Domain	**Duration**
General Medicine	3 months
General surgery	3 months
Paediatrics	3 months
Obstetrics and Gynaecology	3 months

Year 2

Anaesthesiology	2 months
Orthopaedics	2 months
Psychiatry	2 months
Family Medicine/Primary care	6 months

The two years of internship training should preferably be completed in the same facility/complex/cluster/geographical area and **year one domains must be completed before proceeding to year two domains.**

In the case of interns who would be required to complete additional time in the first year domains due to training/skills needs or absence from duty , or any other reason that a facility may determine , such time should be completed before proceeding to training in the second year domains If such extensions are of short duration, arrangements can be made with the hospital management to complete those extensions within the first 12 months during free periods available in the ensuing domains. This will allow the intern to proceed to second year along with the rest of the group.

Extensions in the second year, if feasible can similarly be planned so that the total training can be within the prescribed period of 24 months.

This will not be possible when there are longer extensions. Unfortunately training of such interns will be asynchronous with the rest of the interns as domains with extensions in first year will have to be completed successfully before proceeding to domains for second year.

All domains should be completed in a single, continuous rotation in the event of late starters, such interns may have to wait till the start date of the domain. For example, if an intern is allocated to an institution in March and the start date of the domain is April, then the intern can commence internship only in April. This is to ensure uninterrupted training in that domain and to be synchronous with the rest of the interns. Interns whose continuation of training has been delayed will have to complete all the domains of first year before proceeding to the second-year domains. This will make them asynchronous. The hospital in such instances must plan appropriately to manage the situation.

SPECIALTY TRAINING

The domains of training will remain the same and all logbook requirements of these domains must be met within the stipulated period.

In the case where an intern is given an opportunity for exposure to related specialities and sub specialities by the domain supervisor, the total duration of such exposure must not be more than two weeks in 3 months rotation.

These supervisors must still take overall responsibility for the domain Examples of specialities/sub specialities include ENT, Ophthalmology, Paediatric Surgery, Urology, Neurosurgery, Neurology, Cardiology, Pulmonology, Dermatology, paediatric sub specialities except Neonatology etc. Please ensure that interns are not used purely for administrative work but would benefit from the clinical experience offered by these divisions.

5. LEAVE DURING THE TWO-YEAR INTERNSHIP TRAINING PROGRAMME

The provision for leave benefits forms part of the conditions of service of the Department of Health and is in accordance with the Labour Relations Act, 1995 (Act No 66 of 1995)

NB: Interns should be sensitized that more than 2 months of leave in the 2-year period may result in extension of training in specific domains were additional leave has been availed. Such extension will be implemented in the following circumstances

- **Competencies not achieved and;**
- **The period of absence exceeds 20% of the total training time of the domain.**

The following arrangements regarding leave during the two-year internship training program shall apply as per the Department of Public Service Association guidelines:

5.1 Annual leave of 22 working days/year thus 44 days over a period of 2 years;
5.2 Sick leave of 24 days over the period of 2 years;
5.3 Family responsibility leave of 10 days/year thus 20 days over the period of 2 years;
   a. A maximum of 5 days for death of a direct family member or spouse (per year);
   b. A maximum of 10 days of paternity leave (per year);
   c. A maximum of 5 days for illness of direct family (per year).

Maternity leave may be granted for a period of four (4) months resulting in the intern having to extend the internship training by an additional four months.

Special leave up to **Seven (7) days per year** may be approved for core skills training related to internship planned leave may be granted in the domains as follows:

i. A maximum of Five working days in a two-month domain
ii. A maximum of Seven working days in a Three-month domain
iii. A maximum of Twelve working days in a Six-month domain

However, the planned leave in each year must not exceed Twenty-Two (22) working days.

6. INTERNSHIP REQUIREMENTS FOR PERSONS GOING ABROAD

Applications received from South African citizens, who qualified in South Africa, but completed their internship training abroad, would be dealt with in the following manner:

Applications would be dealt with on an individual, ad hoc basis.

Recognition could be granted for domains of an equivalent, acceptable standard in accordance with the guidelines for internship training in South Africa.

The domains not covered during training abroad, should preferably be completed within a single complex accredited for internship training.

Such practitioners would have to apply to the Department of Health for positions to complete the remainder of the internship training.

Practitioners would be encouraged to complete the requirements for training and registration with specific reference to internship training in South Africa rather than completing internship training overseas which might not be approved.
Practitioners would be expected to submit a satisfactory and current (not older than three (6) months) Certificate of Good Standing prior to registration.

7. OVERTIME REQUIREMENTS DURING INTERNSHIP TRAINING

It is confirmed that interns in medicine should perform overtime duties. It is expected of interns to be on duty for an average of 56 hours per week to a maximum of 60 hours per week and that overtime was part of service delivery and training. Interns are not permitted to refuse to work overtime. However continuous working hours is limited to a maximum of 26 hours. Shorter shifts are preferred.

8. REQUESTS FOR TRANSFERS

The Board, in September 2007, resolved that the recommendation pertaining to the transfer (swopping) of interns be maintained, namely that it was preferable that interns completed their internship training programme within the same facility/complex and that, should exceptional circumstances arise, management of the facility and provincial authorities concerned be mandated to solve the matter.

The following should be noted regarding a request for a transfer from one facility to another

Once the results of the allocation of interns are released, the respective Provincial Co-ordinators could decide whether to allow a transfer or not.

Should an intern request a transfer, the intern should make a written request to the applicable Provincial Co-ordinator. That Province should then release the intern (in writing) with details of domains completed Logbook must also be up to date.
The Province where the intern would want a transfer to, must then accept the intern in writing. All correspondence should then be forwarded to the National Department of Health for endorsement as well as copies thereof to the Board. The Board is not responsible for facilitating transfer of interns between facilities.

Should the province in question refuse to release an intern in medicine, the National Department of Health may not be able to permit such a transfer.

9. ACCREDITED FACILITIES

9.1 APPLICATION FOR ACCREDITATION OF FACILITIES

Facilities, on the recommendation of Provincial Authorities or the South African Military Health Services, may apply to the Board for accreditation as internship training facilities, whether district, regional, tertiary, central or specialised. This may be done singly or as a complex, which could include specialised facilities such as psychiatric or maternity hospitals. A group of accredited facilities may thus share interns to provide wider clinical experience and training. Similarly, community health centres may also participate in training; provided that they are complexed with a base hospital and meet the criteria for accreditation (see Annexure I).

9.2 FACILITIES RELATING TO CLINICAL DOMAINS

An accredited facility shall provide adequate opportunities for the intern to obtain a wide range of clinical experience relating to in-patients, out-patients and emergency services. There shall be sufficient facilities to ensure a proper diagnosis and correct treatment under satisfactory conditions. The Board considers it desirable that the intern be responsible for; not more than twenty-five and not less than fifteen short-term in-patients (which may be reduced to ten patients, should the intern rotate through critical care units in appropriate domains) and that he or she be allocated to not more than two out-patient sessions per week as fixed duty.

9.3 SUPPORT SERVICES

Support services such as diagnostic radiological services, main laboratories (Haematology, Biochemistry, Microbiology, and in the other Pathology disciplines), the pharmacy, the services of other health care professionals, a library and other specialised services should be available. Interns should be encouraged to do their own ECG’s and routine side-room tests.

9.4 ALLOCATION OF INTERNS

The appointment of interns and the number appointed at any accredited facility are the prerogative of the employing Health Authority. Although primarily training posts, it should be obvious that a smaller than recommended number of interns allocated to an accredited facility, will place a greater clinical burden on other categories of personnel.

It is recommended that at least 80 % of the accredited internship training posts be filled at all accredited facilities.

9.5 ACCREDITATION VISITS TO (EVALUATION OF) ACCREDITED FACILITIES

Regular visits/evaluations by the Board to accredited facilities will be arranged to ensure that the accredited facility is adequately fulfilling its training function and, if not, such status may be withdrawn.

Visits/evaluations at accredited facilities are carried out by Evaluators of Internship Training appointed by the Board for this purpose. Criteria for the appointment of Evaluators for Internship Training are contained in Annexure M. Liaison between the Evaluators and Provincial Co-ordinators of Internship Training, appointed by Provincial Health Authorities, will aid the planning, conducting, as well as an appreciation of the importance of such visits/evaluations.

For the purpose of these visits/evaluations, Medical Superintendents/CEO's/Hospital Managers are required to provide the Board with detailed information on the prescribed forms prior to a visit/evaluation taking place. This information must be the result of a self-analysis in terms of the *Criteria of Accreditation of Facilities* (see Annexure I and shall, amongst others, include the views of interns. This information is essential and forms the basis for the assessment of a facility/complex by the Evaluators of Internship Training for accreditation purposes.

10. SUPERVISION OF AND RESPONSIBILITY FOR TRAINING

The primary responsibility for interns firstly rests with the Chief Executive Officer/ /Medical Manager as representative of the Health Authority under which the facility functions. Thus, the CEO/ /Medical Manager plays an important role in ensuring that the requirements of the Board are being met.

The secondary responsibility for the training of interns rests with the senior medical staff. The CEO/Medical Manager is aided by Heads of Domains and other senior personnel who will supervise the training of interns on a daily basis to ensure that the aims and objectives of proper internship training are being met. Apart from their clinical obligation towards patients, it is essential that time be devoted to the training of interns. Furthermore, each relevant clinical department should have a named supervisor to co-ordinate training in that domain.

10.1 DOMAIN SUPERVISORS

Clinical Domains should have a specific supervisor who is responsible for the training of interns in that domain.

The Supervisor is to assist the Intern Curator who is appointed for a whole facility. In large hospitals it is not possible for the Intern Curator to keep in touch with the many interns in the various departments.

Most of the minor complaints of interns relate to "in-house" issues that the Domain Supervisor can resolve. Obviously more serious problems (operational or personal) should be reported to the Intern Curator.

10.2 RESPONSIBILITIES

- Welcome and orientation of interns into the Domain.
- Provide job descriptions.
- Allocation of interns within the Domain.
- Act as liaison between the interns and staff whether nursing or medical.
- Drawing up of the duty roster.
- Supervising leave arrangements including sick leave.
- Co-ordinate the evaluation of interns.
- Ensuring the completion and signing of Logbooks.

Interns should be supervised by a registered medical practitioner with at least three (3) years (post internship training) of clinical experience in that specific domain of training.

The ratio of interns, versus supervisors for the supervision of interns in medicine, be based on a ratio of 4:1.

Specialists, Medical Officers and other practitioners are, by their continual contact with interns, important components in their training and all of them are morally obliged to participate in such training. This applies also to part-time appointees.

Access to supervisors should be available 24 hours per day. Interns should be supported by at least one medical officer or registrar on the hospital premises.

After-hours call rosters should be drafted with an intern on duty, a medical officer on first call and a consultant on second call.
An intern should not work alone in any critical areas such as casualty, labour ward, ICU or theatre. The person supporting him or her must therefore remain on the premises of the health facility (suitable call rooms are imperative). In practice this may be a relatively junior person that can support the intern. Note that the responsibility of supervision and patient care rests with a more senior person whether a medical officer or consultant. He or she should be available at all times and personally assist the intern as required. The senior person on call carries the medico-legal responsibility, since supervision means the acceptance of liability for the acts of another practitioner.

In smaller hospitals, the CEO/Medical Manager may personally perform these supervisory functions. In larger hospitals, the CEO/Medical Manager should, however, appoint an Intern Curator to assist him or her. The functions of the Intern Curator are fully described in 11 hereunder.

11. THE INTERN CURATOR

This person, preferably an experienced member of the medical staff, fulfils a very important role in the training of interns. This is particularly so in large hospitals where the complexity of the structure may not always work to the advantage of the intern who is the most junior member of the medical team.

The responsibilities of the Intern Curator include the following:

Ensuring that the training of interns takes place according to the prescribed guidelines.
Serving as an easy channel of communication between management and interns.
Acting as a spokesperson on behalf of interns.

Especially assisting the CEO/Medical Manager in the following:

a. Organising the orientation programme for new interns at the commencement of the internship training year.
b. Establishing a representative intern committee to meet monthly with the Intern Curator and keeping records of discussions.
c. Ensuring that the different departments provide interns with written job descriptions, specifying duties, as well as the training that will be offered.
d. Ensuring that on-going evaluations of interns per domain are recorded and the evaluation forms, as per the Logbook for Interns, are returned to the CEO/ for his or her assessment and signature.
e. Dealing with any personality problems, impairment or disciplinary issues pertaining to interns.

To be available as a confidant to advise individual interns with serious personal or health problems.

The CEO/Medical Manager and Intern Curators are to involve nursing staff in the orientation of interns at the commencement of the internship training year.

Intern Curators to liaise closely with the various Matrons of accredited facilities regarding internship training.

To recognise the advantages of having internal liaison committees between the various levels of health personnel which could include the CEO/ Medical Manager, Intern Curator, Matron and any other relevant role players where issues pertaining to, for example, scopes of practice, competencies, relationships and clinical skills could be addressed.

The following practical suggestions have been useful in several accredited facilities:

a. Arranging for one or two interns from the previous year to address the new interns.
b. Compiling a small handbook for interns pertaining to local services which effect or relate to the work, community or social environment of interns. The interns know from experience what constitutes key information and such handbook saves valuable time, especially for interns from other medical schools.

NOTE:

Where different facilities form a training complex, one person should be the Senior Intern Curator to whom the other curators/trainers are responsible. This is necessary to achieve a co-ordinated overall training programme, an equitable rotation of interns and comparable duty hours.

c. Intern Curators at accredited facilities could, on submission of appropriate motivation, request at any time that a re-visit/re-evaluation be conducted.
d. It should not be expected of interns to draw up their own on-call rosters.

11.1 GUIDELINES FOR INTERN CURATORS

11.1.1 Introduction

Internship is an important period in the on-going development of junior doctors. Accredited facilities are charged with the responsibility of providing suitable facilities, supervision, guidance and evaluation of interns in medicine. The Board has laid down criteria and requirements for such training. The responsibility for interns' rests with the Chief Executive Officer/Chief Medical Superintendent/Hospital Manager as the representative of the Health Authority under which the training facility operates.

In smaller hospitals, the CEO/ Medical Manager may personally supervise the training of the interns. In larger hospitals this is obviously not possible and he or she will be aided by the hospital staff who have daily contact with interns. The portfolio of an Intern Curator had been established to assist the CEO/Medical Manager in ensuring that internship training fulfils the necessary requirements as specified by the Board.

The Intern Curator should play an important role in the lives of the interns. He or she should look after their interests. The term "Curator" is derived from Latin: *curare* - to care for. Interns are the most junior of the medical staff, are appointed on a temporary basis, and have minimal say in their training and service conditions, hence the need for somebody to act as spokesperson on their behalf.

11.1.2 Appointment of the Intern Curator

This responsibility rests with the Chief Executive Officer/medical Manager.

The Curator should be an experienced member of the medical staff. Where possible, the Curator should not be a Head of Department or part of the administration.
Clinical departments should have a specific supervisor who is responsible for the training of interns in that department. This would involve allocations, duty rosters, job descriptions, leave, etc. This is not the same person as the Intern Curator who is appointed for a whole facility.

There should be provision for the appointment of an Intern Curator for the overall Complex (where two or more facilities had formed a Complex for purposes of internship training).

There should be provision for the appointment of a deputy intern curator per facility (where two or more facilities had formed a Complex for purposes of internship training).

There should be provision for the appointment of deputies per domain of training which would report specific areas of concern to the intern curator.

11.2 SPECIFIC RESPONSIBILITIES

The Intern Curator is to assist the CEO/Medical Manager with the following:

i. Selection of interns (this has not been necessary in view of the appointment of interns at Provincial and/or National level).

ii. Organising the welcome and orientation programme for new interns. The following example can be used for the orientation programme

iii. The following persons from the Hospital Management Team to be invited for the orientation programme:

Hospital CEO
Medical Manager
Nurse Manager
Administration Manager/HR
Intern Curator
Domain Supervisors/Clinical Head
Head of Support Services

Suggested programme to be followed:

Welcome - Intern Curator (Programme Director)
Introduction
Presentation on Hospital Services - Hospital CEO/Medical Manager
Hospital policies and protocols including needle stick policy – Medical Manager/Nurse Manager/Admin Manager/CEO
Duty Roster and Intern rotation plan – Intern curator
Meet the domain supervisors – short presentation by Clinical Heads/domain supervisors and distribution of departmental protocols and clinical guidelines
Meet Heads of support services
Election of the intern representative
Refreshments
Hospital Tour

Providing a “starter pack” giving details of conditions of service, communication channels, key personnel members in the facility, allocations, etc.

Establishing a representative Intern Committee to meet monthly with Management and the Intern Curator. Minutes of discussions should be kept and circulated to relevant individuals.

The Human Resources Representative/Clinical Manager of facility to attend meetings as required.
Meetings with Domain Supervisors regularly including the end of each rotation. Domain supervisors are to ensure appropriate supervision and guidance in the specific domain, and importantly to review and sign completed logbooks before the end of each rotation.

Ensuring that the different departments provide interns with written job descriptions, specifying duties, as well as the training that will be offered.

Ensuring that on-going evaluations of interns per domain are carried out, and that the Logbooks are completed and signed by the domain supervisors and Heads of Departments.

Investigating the failure of an intern to meet the requirements of a domain. The early detection of such an intern is most important to help the intern.

Dealing with personality problems or disciplinary issues pertaining to interns. The Intern Curator should recruit suitable counsellors to help him or her.

Resolving conflict between interns and management, or between interns and trainers.

Facilitating the accreditation visit or inspection of internship training by the evaluators appointed by the Board.

12. PRACTICAL DETAILS

12.1 TRAINING OF INTERNS

During internship training, the intern will develop and improve his or her skills in the evaluation of patients and decision-making at the levels of diagnosis, further investigations and management. It is also a training period in which new practical skills will be acquired.

The intern should have the opportunity to gain a wide spectrum of experience in the management of medical and surgical emergencies and, where feasible, to perform those procedures himself or herself under supervision. Thus, attendance of ward rounds and service under constant supervision in casualty departments and in critical or high-care units, are of crucial importance in gaining insight into the management of seriously ill patients.

In principle, the intern should assist with major surgical interventions and perform lesser procedures under supervision. He or she should also become familiar with certain common procedures, such as opening and closing of the abdomen, and appropriate parts of operations performed by senior doctors. Special emphasis should be placed on training in pre- and post-operative evaluation and care.

Emphasis should be placed on the importance of daily or, where needed, more frequent evaluation and management of patients.

All supervisors should train interns to assess the spiritual and psycho-social needs of patients and to act accordingly. Furthermore, specific attention should be given to the care and counselling of the dying patient and the support of relatives. Supervisors should consistently assist interns with this function.

12.1.1 Domain supervisors

Clinical Departments should have a specific supervisor who was responsible for the training of interns in that domain. The supervisor was to assist the Intern Curator who was appointed for a whole facility. In large hospitals it was not possible for the Intern Curator to keep in touch with the many interns in the various departments.

The responsibilities of a domain supervisor:

a. Welcome and orientate interns into the domain.
b. Provide job descriptions.
c. Allocate interns within the domain.
d. Act as liaison between the interns and staff whether nursing or medical.
e. Draw up the duty roster.
f. Supervise leave arrangements including sickness.
g. Co-ordinate the evaluation of interns.
h. Ensure completion and signing of logbooks.

The majority of the minor complaints of interns related to “in-house” issues should be resolved by the domain supervisor. More serious problems (operational and/or personal) should be reported to the Intern Curator.

Referral of patients to other disciplines for consultation or for taking over the patient, should preferably not be left to interns, except in the event of an emergency where the registrar or another senior practitioner is not available.

The above guidelines have specific implications for academic hospitals where interns are often far removed from the mainstream of activities. The extensive hierarchical personnel structure militates against opportunities for the practical experience of interns. Steps should, therefore, be taken to correct this tendency.

12.2 APPLIED THEORETICAL AND ACADEMIC TEACHING

The intern shall receive teaching during ward rounds and informal discussions which are directed at patient care. It is important that the intern be given opportunities to test and apply his or her knowledge and experience during ward rounds.

Weekly departmental or inter-departmental discussions should be held. It is important that specific problems, such as cardiac arrest, respiratory failure and their management should be discussed with a special view to internship training. Alternatively, interns may be asked to do case presentations.

Interns should be encouraged to express opinions and make proposals during ward rounds.

The intern should be taught by precept and example to care for the patient and his or her family with empathy and to realise that the patient is not simply another case.

Where hospitals conduct statistical, mortality and medical audit meetings, they should be arranged at suitable times to ensure compulsory attendance by interns.

12.3 HISTORY-TAKING, SPECIAL INVESTIGATIONS AND RECORD-KEEPING

The importance of proper recording of a comprehensive history, a full clinical examination and follow-up examinations should be emphasised. The supervisor must satisfy himself or herself that these records are of an acceptable standard.

Because doctors may sometimes find themselves in situations where minimal facilities are available, interns should be taught how to evaluate and treat patients on the basis of a thorough history and physical examination without the benefit of special examinations.

It follows that interns should be taught not to subject patients to needless special and X-ray investigations.

The importance of ethical practices and medico-legal risks in practice must be brought home to interns.

12.4 COST AWARENESS

Cost is a major determinant of individual patient care and hospital budgets. It is, therefore, important to foster cost awareness, paying special attention to the following:

The cost and choice of pharmaceutical agents, as well as their safety. Regular consultations with and participation in relevant training, where applicable, by the hospital pharmacist(s), is therefore essential.

The desirability of requesting selected laboratory tests only, as well as the costs involved.

The importance and cost of relevant X-ray examinations. The dangers of radiation should be emphasised and guarded against.

Costs of other investigations and treatment modalities.

12.5 PATIENT ALLOCATION AND WORKLOAD

The Board has as a guideline recommending that 25 beds per intern should not be exceeded.

Unnecessary administrative duties and red tape are discouraged. Elimination of unnecessary procedures, the use of alternative personnel and modern technology, should be pursued. For example, an intern should not be expected to search for vacant beds for patients.

Each department should, in conjunction with the Medical Manager, draw up a job description for interns, specifying duties, as well as the structured training programme which will be offered.

Departments should also decide how to prevent and deal with stress and unreasonable demands on the intern.

12.6 HOURS OF DUTY

The intern is part of the health team and must learn to fulfil his or her responsibilities to patients. The following are, therefore, guidelines and not fixed rules. The interns' duties should be organised as follows:

Interns should work forty (40) hours per work week during normal hours

Interns should not exceed twenty (20) hours of commuted overtime per week, resulting in a maximum of 60 hours per week and an average of 16 hours/week.

Eighty (80) hours overtime per month should not be exceeded in a four-week cycle.

Interns are not permitted to sign any additional contracts regarding specified overtime requirements.

12.6.1 Guidelines for after hour duty

The continuous working hours of 30 hrs may be excessive and can lead to fatigue, compromising the intern's ability to provide appropriate patient care. The workload in different hospitals and different clinical domains may vary across the country. Periods of rest within this continuous 30 hrs may also vary from hospital to hospital and domain to domain. It was further. noted that the interns should be part of the post intake rounds for training and teaching purposes. Hence the it was. recommended that the number of continuous working hours an intern may work be reduced from thirty (30) hours to a maximum of twenty-six (26) hours. This is to accommodate training requirements and to avoid fatigue related negative outcomes. However individual hospitals and clinical domains are requested to modify the roster with shorter shifts depending on the workload and taking into consideration the possibility of periods of rest within a call. The National Department of Health to engage with provincial departments to implement this approach.

Interns should not work full weekends, unless there is a 12-hour break during the weekend.

The frequency of night duties should allow for sufficient recuperation. Being on duty every second night would be unacceptable.

Interns should be off at least one weekend per month from 17:00 on a Friday to 07:00 on a Monday.

Night duty is a valid and essential learning experience where competencies and skills development take place and allows for exposure to very specific aspects of medicine which differ from the normal day-time exposure.

A medical practitioner (including any intern in medicine) remained personally responsible for the care and treatment of his or her patients for as long as the patients required such care and treatment.

It was within the professional responsibility and discretion of a medical practitioner (including any intern in medicine) to decide when to leave a patient for whom he or she was personally responsible, bearing in mind, however, that should such patient suffer unduly or die as a consequence, the practitioner concerned would be held professionally accountable for his or her actions.

In the case where an intern had met the training requirements, both elective and emergency training requirements for a specific domain of training, interns could be utilized to cover other Departments' after-hour calls, as long as the guideline of 80 hours overtime per four-week cycle was not exceeded, and that no further contracts pertaining to overtime were agreed to or signed.

12.7 ACCOMMODATION AND FACILITIES – INFRASTRUCTURE INCLUDING ACCOMMODATION (HOUSING), ON-CALL ROOMS AND TRANSPORT

The Board. has for some time deliberated on the infrastructural and support issues needed for internship training. These include accommodation, on-call facilities and transport especially where there are hospitals and clinics grouped into a complex. A need has arisen for the Board. to deliberate on guidelines for the aforementioned infrastructure.

Overnight accommodation (call rooms) should be provided on site for Interns that are on call.

Housing for interns is a competency of the employing authority. If accommodation is provided for interns the guidelines as set out in the internship guidelines document must be applied to ensure minimum standards. Employers must let the interns know of available accommodation in each accredited facility so that an informed decision can be taken by the interns before applying for a post.

12.7.1 Accommodation

As far as possible, single rooms to be provided (15 $m^{2)}$ with a locker, a safe, a telephone, wash basin, cupboard, desk, chair and single bed. Ideally, en suite bath and ablution facilities should be provided with all amenities including hot water. In the event of communal bath and ablution facilities being provided, then a maximum of two persons should share these communal facilities.

For married couples, a 25 m^2 room should be provided with a double bed and additional furniture plus en-suite bath and ablution facilities.

Security of the accommodation is important.

Additional support facilities of kitchen, lounge, laundry and garaging for motor vehicles to be provided.

The rooms to be cleaned at least three times per week.

The intern should ensure that he/she has adequate insurance cover for personal and household goods and vehicles.

12.7.2 On-call facilities

Satisfactory sleeping and recreational facilities for interns, especially when on duty, should exist in each accredited facility. Sleeping accommodation should be such that the intern may rest and sleep while awaiting the next patient or operation.

Meals and snacks should be available for persons on emergency duty, especially at night.

A room/area with recreational facilities and refreshments would enhance social interaction between interns. This would greatly improve job satisfaction and acceptance of the work environment.

On-call facilities must be provided as close as possible to the ward or health unit to be covered in the event of there not being accommodation on site.

As far as possible, single rooms to be provided (15 m^2) with a locker, a safe, a telephone, wash basin, cupboard, desk, chair and single bed. Ideally, en-suite facilities should be provided.

The on-call facility must be dedicated for the use of the on-call doctor.

Given the multiuser nature of on-call rooms by doctors, they need to be cleaned and inspected daily.

The facility must have adequate security.

12.7.3 Transport

In general, transport need not be provided for interns except where the intern has to travel to different facilities.

The intern should use a Health Department vehicle (if he/she has a valid driver's license) or be driven to the facility using the Health Department transport pool.

In the event of the intern using his/her own transport, then this should be agreed upon with the management in writing and the applicable tariffs will apply with due documentation/logbooks on a monthly basis being submitted to management. The intern to ensure that he/she has appropriate vehicle insurance cover for business and private use.
The facilities offering internship training should have a budget line for the above.

12.8 TERMINATION OF PREGNANCY

In September 2005 the Board confirmed that although an intern, who was required to perform an abortion, could refer the patient to another practitioner on conscientious grounds, even though "The Choice on Termination of Pregnancy Act", (Act 92 of 1996), did not provide a conscientious objection clause. It was however again re-iterated that interns could not refuse to provide emergency treatment in respect of bleeding or an emergency evacuation of the uterus since such procedures formed part of the essential skills of medical practitioners in South Africa and interns were required to attain those skills during their internship training.

12.9 INTERNS WORKING ON EMERGENCY HELICOPTERS/AMBULANCES

Interns are allocated to facilities with a specific accreditation which requires them to work in a specific facility under direct supervision. They are specifically excluded from working outside of this and may also not work in private practice, irrespective of whether they are paid or not.

Under **NO** circumstances could an intern fly on a helicopter or work outside of the accredited facility. A medical practitioner registered in the category community service could do so, if he or she had permission form their Chief Executive Officer/ Medical Manager and was allowed to fly "as on duty".

Any intern that did work outside of their accredited facility, either on an aircraft or road ambulance and was not registered to do so would be held liable by HPCSA. Should an intern be registered as an emergency care practitioner, their scope of practice was regarded as such until they were fully registered as medical practitioners, they were not allowed to prescribe medication, or exceed their scope of practice.

Any service which "employs" an unregistered medical practitioner, e.g. and intern, is guilty of a criminal offence, and can be prosecuted. This applies whether the individual is paid or not. The blanket comment, "in the interest of saving a human life" as a claimed exemption, does not apply, as anything covered by the above would be regarded as prospectively planned or rostered, and therefore not an emergency.

The same policy would apply for the transportation of patients by ambulance i.e. that the supervisor be physically present with the intern.

13. INTERN RESPONSIBILITIES

Although interns, under supervision, are primarily responsible for patient care, they form an important part of the health team and should learn to work together with colleagues in the wider spectrum of medical and other health care services. The professional responsibilities of the intern should include the following important aspects:

Interns are required to keep carefully documented notes. Notes should be made immediately (on the spot; date and time) after assessing each patient. They are responsible for following-up all investigations ordered, and to ensure that all results are available and charted in the bed letter. They should co-operate with medical, nursing and the relevant other health care professionals, e.g. physiotherapy, social work, occupational therapy - especially in relation to their personal cases. Case summaries must be completed on patient discharge. A concise summary should be given to the patient on discharge to be available at follow-up clinics.

The intern should play an active role in Out-Patient Departments, particularly regarding the follow-up of their own patients. A balance should be struck between exposure to hospitalised and ambulatory patients.

Interns should be aware of the Charter on Patient Rights (see Annexure F) and the investigation and management of patients should be in line with those guidelines.

The intern's care of the patient should be holistic. As the primary medical care giver, the intern is a very appropriate person to deal with emotional, spiritual and family problems that are often present in addition to the physical illness. Confidentiality is imperative.

Interns must be aware of their limitations, both in knowledge and skills, and not hesitate to seek advice from senior colleagues. Such referral is not a sign of weakness, but of maturity and is to the benefit of the patient.

Continuity of care is vital in a hospital situation. Appropriate hand-over of patients is essential.

Interns should avail themselves for formal teaching, as well as of the use of a library or reference books. Reading around patient problems will foster the habit of on-going medical education.

NOTE

The responsibility of registration with the Board as an intern, as a medical practitioner to perform community service and finally, as medical practitioner (independent practitioner) in terms of the *Health Professions Act,* 1974, rests with the individual. However, it should be noted that no person may undergo internship training or perform community service in South Africa without having been so registered (see Annexures A, D and E).

14. EVALUATION AND REGISTRATION

Interns should have monthly. assessments during their training. They should be praised when deserving and receive constructive criticism when necessary.

During each rotation, an evaluation of the Intern's performance should be conducted monthly/bimonthly as well as end of block, using the prescribed form for evaluation of intern rotations and experience, as per the Logbook for Interns. This form has two components: A

section to be completed by the intern, and one by the Domain Supervisor and be validated by the Clinical Manager. The latter should do so in conjunction with his or her colleagues. The assessment must be discussed with and signed by the intern. The form must also be signed by the Head of Domain. This will facilitate the early recognition and correction of problems. A confidential counselling service, separate from the appraisal system, should be available.

At the end of the year, the CEO/ Medical Manager, together with the Heads of Domains, will certify whether an intern has satisfactorily completed his or her training by issuing the Intern Duty Certificate (see Annexure B), thus enabling the Board to register him or her as a medical practitioner to perform community service.

Should an intern have failed to satisfactorily complete part or the whole of his or her training, the Board may demand additional training or re-do the internship before granting such registration (see Annexure C).

Interns are reminded that it is illegal for them to work in any form of practice outside accredited facilities and performance of such activities can lead to disciplinary procedure initiated by the Board against the intern and also against the practitioner who employs the intern.

Accredited facilities should be aware that the Board could withdraw accreditation for internship training should it find that the facility was aware of interns performing locums.

15. LOGBOOK

Submission of the completed Logbook forms part of the prerequisites for registration as a medical practitioner to perform community service. The Intern Duty Certificate as well as the prescribed registration form is included in the Logbook. Every intern must ensure that he or she has a copy of the Logbook which is provided by the Board upon registration as an intern in medicine.

16. RESOLUTION OF CONFLICT

It does happen that conflicts arise as to the training and employment of interns. This may be due to the physical unsuitability of the facility, the terms of service, the trainers or the intern(s).

Most minor issues usually can be resolved through negotiation between the various parties. In this regard the Intern Curator plays a crucial role. The Evaluator(s) of Internship Training appointed by the Board may also help by drawing attention to deficiencies or by acting as independent facilitator(s).

Should serious problems regarding professional conduct arise; the Board will deal with such matters. This will consist of an investigation of the issues by means of a round-table discussion. The purpose of such inquiry is to verify alleged facts and to resolve the problems in a constructive manner. However, it should also be noted that the “ethical rules” (see Annexure E), and the professional conduct procedures of the Board, equally apply to interns as to medical practitioners.

Apart from the above, it needs to be remembered that interns are in the employ of the relevant Health Authority. As such, their conduct falls under the provisions of the *Public Service Code*. Disciplinary matters in terms of those provisions should be dealt with in accordance with the said *Code* or the *Labour Relations Act*. A copy of any warning letter addressed to an intern should, however, be sent to the Board for its notification.

17. PROCEDURE FOR DEALING WITH IMPAIRED / UNDERPERFORMING INTERNS

17.1 Impaired Intern Due to Health Reasons

The expression “impaired” in terms of the Act “means a mental or physical condition, or the abuse of or dependence on chemical substances, which affects the competence attitude, judgement or performance of a student or another person registered in terms of this Act”.

In principle, the procedures of the Health Committee in relation to individual impaired persons are confidential as in the case of a doctor/patient relationship. This principle has positive results in creating a relationship of trust between the Committee and the different stakeholders concerned.

It needs to be emphasized that management of stress in the study and practicing of medicine and dentistry requires special attention at all levels, but especially in students, interns and young practitioners. Factors creating stress need to be identified urgently and addressed, where possible.

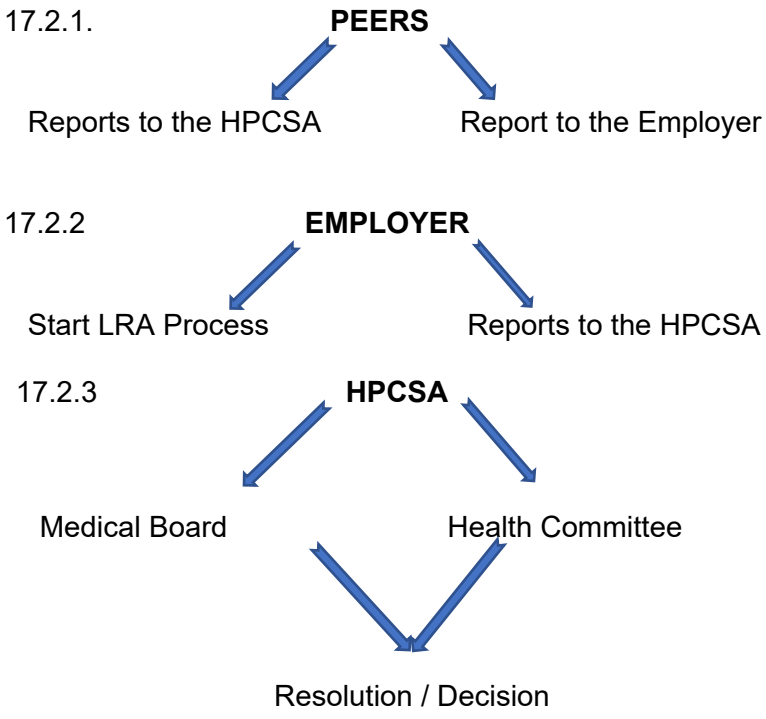
In view of the above, the importance of early identification of impairment in students must be stressed once again, as well as the important role and responsibility of Deans of Faculties or Heads of Schools of Medicine in this respect.
There is a responsibility and duty for colleagues and supervisors to report impaired practitioners to the Health Committee. Please also note that specific reference is made to Interns in this document.

Reporting of an Impaired Intern

17.2 VOLUNTARY DISCLOSURE:

Voluntary disclosure can be reported to: Peers, Employer or HPCSA by the intern.

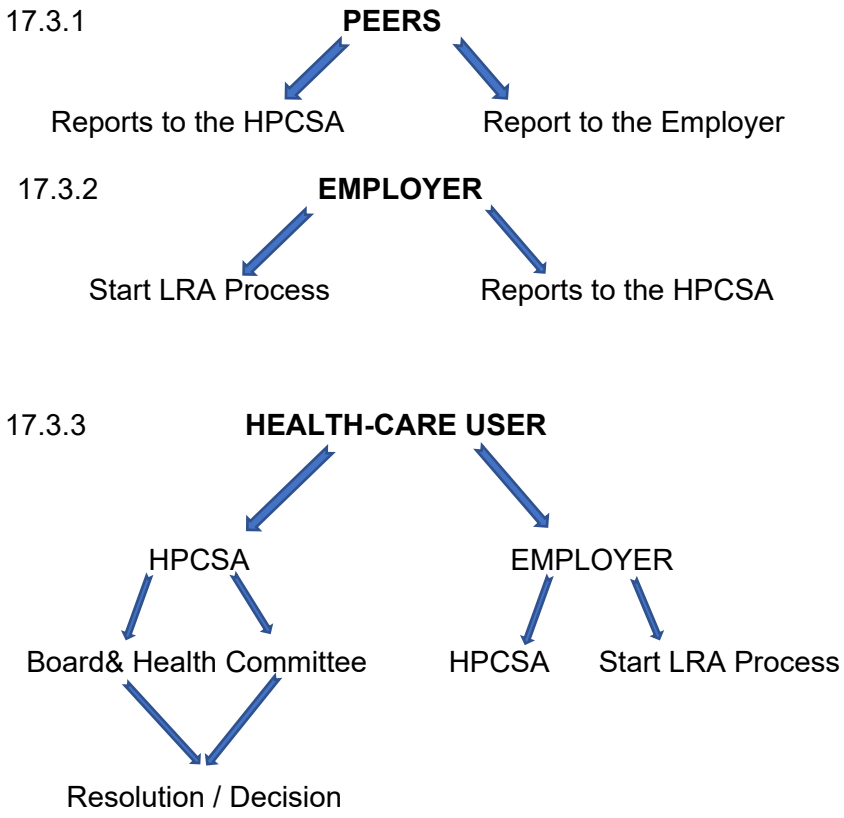
Please see the following chart for further steps:



17.3 PERCEIVED/SUSPICION

Perceived/Suspicion can be reported to: Peers, Employer and Health-Care User

- There must be an evidence collection
- There should be a formal complaint with evidence where possible



Refer to the Health Profession Act Regulation 2 of Suspension Regulation
LRA: Labour relations act

17. 4 UNDERPERFORMING INTERNS

This section deals with an intern who is underperforming due to:–

- Lack of adequate knowledge
- Lack of commitment to work

Continuous assessment, mentorship and corrective measures by supervisors are the best way to address the situation. However, the formal process to assess performance is the midblock evaluation and end of block evaluation.
In instances where misconduct cannot be corrected by mentorship and counselling, disciplinary processes must be initiated as required by the public service regulations and labour relations act.
If impairment is suspected as a cause of underperformance all the steps in 17.2.2 should be followed

Extension of training is the formal corrective step if continuous corrective supervision did not yield positive results. Indication of possible extension should be conveyed to the intern at midblock evaluation if the performance is not satisfactory in the first half of the rotation. Extension of training is recommended by the Clinical Head of the Domain at the end of the block. This should be supported by the Clinical Management team of the Hospital.

The period of extension can be decided by the Clinical Management team in consultation with the clinical head of the domain for a period not exceeding the total duration of training in the specific domain.

Such a decision should be notified to the Board of the HPCSA for ratification. If at the end of the maximum allowed period of extension in that domain the intern is still found to be underperforming, then the matter should be referred to the Board for an appropriate decision.

The Board then would send appropriate independent evaluators to the site to determine the causes of incompetence/underperformance. Interviews are done with the intern and all the relevant stakeholders. Logbooks are reviewed in full and the training site inspected. The matter may also be referred to the health committee if not already done by the institution, if impairment is suspected. In such instances, remedial measures as recommended by the health committee needs to be put in place. The Committee on receiving all the information shall determine whether further additional training is required to achieve competence. In such an instance extension of training is recommended in an alternate accredited site for the full duration of the domain/domains.

If successful, the intern shall be registered as a medical practitioner. If unsuccessful the intern shall be deemed unfit for registration as medical practitioner. The Board shall refer the matter to the board with recommendation as to whether any other future can be charted for the intern.

If an intern is unable to perform any clinical work either due to impairment or incompetence for 10 years or more, a competency reassessment (board examination) has to be successfully undergone before reinstating internship training.

18. PROVINCIAL INTERN CO-ORDINATOR

18.1 INTRODUCTION

The need for a clearly identified co-ordinator of intern matters has been highlighted by the various problems experienced with internship training and related matters in some provinces.

The function of the Provincial Intern Co-ordinator is currently not clearly defined in terms of role and responsibilities. This results in problems being experienced at all levels and especially by interns. The need for a uniform consistent and readily identifiable Provincial Intern Co-ordinator is essential.

The primary role of a Provincial Intern Co-ordinator (PIC) would be to ensure that all matters relating to internship training, emanating both from the National Department of Health and the Board are transmitted accurately and timeously to all parties involved in internship training with special emphasis being placed on all training facilities, especially Hospital Managers, Intern Curators and Clinicians.

In addition to providing information, the PIC should on an on-going and programmed basis ensure that matters relating to internship training are complied with. This would include orientation and induction programmes, completion of evaluation forms, information to facilities on completion of Forms 10-A and 11-A so that there is both uniformity and adherence to a programme.

The mandate of the PIC extends to ensuring that support is provided to interns at training facilities. This includes having an updated list of Intern Curators as the visits of Evaluators of Internship Training are not necessary on an annual basis.

The PIC provides a valuable identifiable link between the National Department of Health, the Board, Evaluators of Internship Training, training facilities and academic institutions, where applicable.

The above is read in conjunction with the functions of the PIC which could be included in his or her job description.

The position of a Provincial Intern Co-ordinator (PIC) in each province should be clearly defined to ensure uniformity in the role and responsibilities of PIC's.

18.2 JOB PURPOSE

To provide an identified person in each province for liaison on internship matters between the National Department of Health, the Provincial Authorities, the Board, Schools of Medicine, and all facilities accredited for internship training.

18.3 JOB DIMENSIONS

The PIC should preferably be based in the Provincial Head Office to facilitate communication between the respective role players. The main functions will be advisory, supervisory, co-ordinating and facilitating of internship programmes at all levels. The position should be at a Medical Advisor level.

18.4 KEY RESPONSIBILITIES

18.4.1 Communication with the Board

The Board is to liaise directly with the PIC in respect of all information that requires to be disseminated to the Provincial Authorities and facilities. The PIC provides a clear channel of communication to ensure that all information from the Board, National Department, and the Provincial Head Office regarding internship matters reaches institutional managers. The PIC ensures that reports from training facilities to the Board are processed within a specified time frame.

18.4.2 Communication with the National Department of Health

The PIC is available to liaise directly with the National Co-ordinator. He or she represents the Provincial Authorities at the Board meetings and gives the necessary feedback. He or she relays information pertaining to internship matters, e.g. yearly schedule, allocations, etc. to the facility on a programmed basis.

18.4.3 Communication with the Provincial Authorities

The PIC acts as a liaison person between the National Department of Health and the Board. He or she provides communication pertaining to policy from the Provincial Authorities to facilities and follow-up on responses. There needs to be a dynamic two-way process. The PIC informs facilities of intern allocation changes.

18.4.4 Communication with accredited facilities

The PIC is to be available to provide information to training facilities on all matters relating to internship training and supervision. He or she informs the management of facilities and Intern Curators of visits by Evaluators of Internship Training and ensures that all relevant documentation is submitted in time. He or she is to be informed about problems relating to interns. The PIC ensures that facilities are updated on intern matters on a regular basis.

18.5 CO-ORDINATION

The PIC is the co-ordinator of accreditation visits/evaluations and must: Be informed by the Board of visits/evaluations. Inform facilities of proposed visits/evaluations. **Be present at visits/evaluations** and provide the Evaluators of Internship Training with information on provincial policy. Relay urgent problems and concerns of Evaluators of Internship Training to the Provincial Authorities. Liaise with facilities to ensure compliance with recommendations made by the Evaluators of Internship Training. Conduct *ad hoc* evaluations at training facilities where problems have been identified and discuss remedial measures/actions with Evaluators of Internship Training.

18.6 INFORMATION

To facilitate a provincial workshop of key role players on an annual basis to provide an update on internship training matters and to discuss concerns in respect of intern training and supervision. To provide information on allocation of interns to accredited facilities.

To provide information in appropriate time to expedite the annual registration of interns. This alleviates the problem of individual facilities requesting information from the Board, e.g. on registration fees, dates for submission, etc.

18.7 PROVINCIAL REPRESENTATIVE

To represent the Provincial Authorities at the National Department of Health and Board meetings so that there is continuity. The PIC should have the necessary delegated authority to make decisions.

18.8 CONTACT PERSON AT TRAINING FACILITIES

The PIC must be known to all facilities accredited for internship training in the province. He or she must be well informed to assist in all internship training matters as there may be a lack of or discrepancy in the information which the facility managers have. This situation is aggravated by the somewhat rapid turnover of managers and intern curators, some of whom take on the position by default.

PART II
GUIDELINES PERTAINING TO THE CONTENTS OF TRAINING PER DOMAIN

1. INTRODUCTION

1.1 GENERAL REMARKS

Part I of the Handbook described the aims and purposes of internship training, and the general guidelines as to how and where the training should take place.

Part II provides more specific guidelines about the objectives and criteria for each domain through which the intern may rotate. It is meant to be a guide and aid for both the trainers and trainees, recognising that patient profiles and health services may differ widely in different hospitals and clinics.

The overriding goal of the intern year(s) is to expose the trainee to a wide range of patients and common conditions to further develop his or her clinical skills. Internship training is a step in the process of professional development and should not be seen as the completion of training as a medical practitioner.

1.2 EMPHASIS IN TRAINING

The emphasis in training should be on the core values and skills of:

a. History taking.
b. Examination.
c. Clinical diagnosis.
d. Appropriate and cost-effective investigations.
e. Patient management.
f. Need for referral and/or follow-up.

The importance of keeping case records and completing official documents cannot be over-emphasised, both for patient care and for medico-legal purposes.

1.3 ROTATION THROUGH SPECIFIC DOMAINS

The purpose of interns rotating through specific domains is to ensure adequate exposure to and training in that domain. It allows trainers to impart to trainees the knowledge, skills and attitudes of that particular aspect of medical practice. Continuity of training is essential, and blocks should not be broken up. It is recognised that night duties may entail cross-over, but during the day the intern should remain in his or her domain.

1.4 SUPERVISION

Because of the importance of supervision and adequate training, the Board will expect for interns to be trained by practitioners with the following qualifications and experience, namely:

a. A full-time specialist; or
b. A part-time specialist consultant providing at least ten (10) hours of on-site service per week; or –
c. full-time medical officer with a diploma in that domain; or
d. full-time medical officer with at least THREE (3) years' post internship training experience in that domain.

Access to a trainer should be available twenty-four (24) hours per day. Interns must be supported by at least one medical officer or registrar on the hospital premises.

1.5 JOB DESCRIPTIONS

Each hospital and domain must specify what is expected of the intern in terms of –

a. in-patient responsibilities
b. out-patient duties
c. casualty department cover
d. night and weekend duties
e. administrative duties

1.6 EDUCATIONAL OBJECTIVES

Each facility and domain must specify what educational aids and opportunities are available to interns. These would include all or some of the following:

a. Standard management protocols for common conditions.
b. The Standard Treatment Guidelines and Essential Drugs List (provided by the National Department of Health).
c. A checklist of conditions which interns are expected to encounter and/or learn about.
d. A checklist of skills to be acquired and procedures to be observed. (Such a list will depend on the diseases seen at the specific site, and the investigation and management will depend on the facilities available.)
e. Departmental meetings.
f. Presentations by interns.
g. Journal clubs.
h. Medical audit meetings.
i. Courses towards acquiring diplomas.

NOTE

Hospitals should make it possible for all trainees to do an ATLS course.

1.7 EVALUATION

The evaluation of both the training programme and the progress of the intern should be taken extremely seriously. Evaluation should be on-going. There should be an interim assessment monthly through a rotation to institute any correctional steps that may be required. A formal evaluation, using Form 139 (included in the Logbook), should be completed by each individual intern during his/her rotation (midblock) as well as at the end of the rotation. Domains may also decide to include the following in their formal evaluation of trainees, namely: –

a. A completed checklist;
b. A more specific evaluation form.

NOTE

Interns who have failed to satisfactorily complete part or the whole of their training, will be required to undergo additional training.

2. GUIDELINES: DOMAIN OF GENERAL MEDICINE

The following guidelines **should be read in conjunction with the introduction to Part II**

Trainees in this domain should be exposed to the diagnosis and management of common internal medicine conditions and medical emergencies under appropriate supervision. As there will be some overlap with certain topics / skills in the trainee's Family Medicine rotation, emphasis in the General Medicine domain should be on developing robust interpretative diagnostic skills as well as strengthening clinical management in the more complex patient.

2.1 COMMON GENERAL MEDICAL CONDITIONS AND MEDICAL EMERGENCIES FROM THE FOLLOWING SUBSPECIALTIES SHOULD BE COVERED

1.1 Cardiology

1.2 Pulmonology

1.3 Endocrinology including diabetes mellitus

1.4 Haematology

1.5 Gastroenterology and Hepatology

1.6 Rheumatology

1.7 Neurology

1.8 Geriatrics

1.9 Nephrology

1.10 Infectious diseases including HIV and Tuberculosis

1.11 Dermatology

2.2 CORE SKILLS

All procedures should be performed under supervision. The trainee should participate in all stages of the procedure namely:

a. Counselling the patient and obtaining informed consent
b. Performing the procedure with assistance, as needed
c. Documenting the procedure performed
d. Monitor the patient for post procedural com

Please refer to logbook for more details.

3. GUIDELINES: DOMAIN OF GENERAL SURGERY (INCLUDING SURGICAL TRAUMA)

The following guidelines **should be read in conjunction with the introduction to Part II**

The emphasis in this domain should be on exposure to and management of common conditions under appropriate supervision.

3.1. SPECIFIC OBJECTIVES

3.1.1 To understand the importance of the pre-hospital phase and the communication with paramedical personnel.

3.1.2 To understand the “Chain of Survival”.
3.1.3 To observe the correct immobilization of an injured patient.
3.1.4 To learn how to prepare for receiving a medical emergency.
3.1.5 To understand the concept of triage during mass casualties.
3.1.6 To understand the importance of the mechanism of injury and to search for injuries based on the mechanism of injury.
3.1.7 To witness and assist with resuscitation:

- To understand the concepts of the primary and secondary surveys.
- To learn the essential special investigations required for trauma patients.
- To learn how to move and transport trauma patients.
- To learn the importance of continued monitoring of an injured patient, also when referred to X-ray Department, etc.
- To learn how to accurately document findings and to consider medico-legal issues.

3.1.8 To understand the concept of organ protection and the prevention of secondary injuries.

3.2 GENERAL SURGICAL CONDITIONS

a. Soft tissue infections, tumours.
b. Gatroenterology and hepatobilliary conditions.
c. Vascular conditions.
d. Breast conditions.
e. Surgical endocrine conditions.
f. Pre and post-operative assessment and care.

3.3. ADULT SURGICAL EMERGENCIES

Assessment, resuscitation and management of the following including preparing for theatre:

g. Neurogenic, septic and hypovolaemic shock
h. Upper and lower GIT bleeding
i. Acute surgical abdomen.
j. Peripheral vascular emergencies,
k. Penetrating neck, chest and abdominal injuries
l. Blunt abdominal trauma

3.4 ESSENTIAL SKILLS

a. Rectal examination, including protoscopy and rectal biopsy.
b. Assistance at upper and lower GI endoscopy.
c. Excision of minor skin and subcutaneous lesions.
d. Fine needle aspiration – cytology and needle core biopsy of soft tissue lesions.
e. Venepuncture and venous cannulation for intravenous infusions.
f. Technique of endotracheal intubation, insertion of central venous lines, intercostal drains, bladder catheterisation.
g. The technique of cardiopulmonary resuscitation.
h. Minor surgical procedures like suturing of wounds, drainage of abscesses, peri-anal fistulectomy, debridement of wounds etc.
i. Diagnostic skills for trauma abdomen including ultrasound examination. and/or diagnostic peritoneal lavage.

j. *Exposure to debridement.*

NOTE

ATLS (Advanced Trauma Life Support) should be used as a guideline for training.

4 GUIDELINES: DOMAIN OF PAEDIATRICS AND CHILD HEALTH

The following guidelines **should be read in conjunction with the introduction to Part II.**

The emphasis should be on exposure to, and management of common conditions under appropriate supervision.

4.1 EDUCATIONAL OBJECTIVES

a) Three hours teaching per week (formal and/or bedside)
b) Exposure to the range of conditions in the paediatric and neonatal wards.
c) Exposure to the range of conditions presenting in the out-patient department.
d) Exposure to paediatric emergencies (medical and surgical)
e) Knowledge of the requirements regarding notification of a disease, and responsibility for competently notifying cases which are being managed by the Intern.
f) Attendance at mortality and morbidity meetings and an understanding of health statistics, particularly as they relate to the hospital/facility.
g) Knowledge of the requirements for a forensic post-mortem as well as the completion of natural death certificates.
h) One presentation to a departmental meeting per rotation
i) Insight into the interconnected roles and responsibilities of various facilities in the region including CHC's.
j) Knowledge of the Child Health Act and the legal obligations of a health care worker when face with cases of child abuse or neglect.
k) Exposure to issues surrounding consent /assent.

4.2 SPECIFIC TOPICS TO BE COVERED DURING TEACHING AND/OR PRESENTATIONS *

a) The management of preterm and low birthweight infants
b) Congenital infections with emphasis on HIV and syphilis.
c) Prevention and management of birth asphyxia.
d) The management of common conditions responsible for childhood mortality in South (including but not limited to acute gastroenteritis, pneumonia, malnutrition, neonatal sepsis, meningitis, TB, sepsis and shock).
e) The management of common chronic conditions of childhood (including but not limited to asthma, jaundice, congestive cardiac failure, epilepsy, eczema etc.).
f) The expanded programme of immunisation.
g) Use of the Road to Health Card.
h) Optimal infant feeding practices particularly nutritional rehabilitation for malnutrition and PMTCT.

4.3 SPECIFIC CORE PAEDIATRIC SKILLS TO BE ACQUIRED

You will be expected to be competent in the following skills by the end of your paediatric rotation. Please assess your ability to perform the following core skills on a scale of 1 – 3 where 1 is unable to manage this condition, 2 is competent but not able to teach others, and 3 is where you feel competent to teach others how to manage this condition.

This self- evaluation must be discussed with your supervisor in order to guide your learning during the block, to address specific skills deficits and to structure remediation plans.

4.4 CLINICAL PROTOCOLS

Clinical areas should have standard operating procedure protocols for condition regularly admitted to the hospital/facility at both in and out-patient levels.

4.4.1 In-patients

Examples include –

- treatment of severe malnutrition;
- community acquired pneumonia;
- treatment of HIV - infected infants and children;
- cardiac failure;
- gastroenteritis with dehydration;
- diabetic ketoacidosis;
- nephritis and nephrosis;
- bacterial meningitis;
- asthma.

4.4.2 Out-patients

Examples include –

- failure to thrive;
- the unimmunised infant;
- developmental delay;
- tonsillitis;
- otitis media;
- constipation;
- infectious diseases;
- fever;
- anaemia;
- jaundice.

4.4.3 Casualty

Examples include –

- drowning;
- near-miss SIDS;
- convulsions and coma;
- epilepsy;
- hypoglycaemia.

4.5 LOGBOOKS AND CLINICAL RECORDS

The following must be recorder into a logbook at monthly intervals and verified by the supervisor:

a. The five most common conditions (with number of admissions for each of the five).
b. The total number of children attending the general out-patient area per week.
c. The five most common conditions/problems encountered in the out-patients area for the time (with number of encounters for each of the five).
d. Conditions listed in paragraphs 2.1, 2.2 and 2.3 for which no clinical/ protocols were available.
e. Listed procedures which were not performed during the period under review.
f. Number of days on which no teaching took place.
g. Topics formally presented to the department.
h. Autopsies witnessed (diagnosis and causes of death) and number of death certificates completed.
i. Notifiable conditions seen, and number of cases notified to the health authority

5 GUIDELINES: DOMAIN OF OBSTETRICS AND GYNAECOLOGY

The following guidelines **should be read in conjunction with the introduction to Part II**.

The emphasis should be on exposure to and management of common conditions under appropriate supervision.

5.1 CORE OBJECTIVES

5.1.1 OBSTETRICS

To become competent in the management of:

antenatal patients,
labour and delivery,
obstetric emergencies,
postnatal care including the early identification of potential risk factors that contribute to maternal morbidity and mortality
adverse neonatal outcomes such as fetal hypoxia.

5.1.1.1 To become competent in neonatal care (including emergency resuscitation and routine care),
5.1.1.2 To become competent in counselling on breastfeeding practices and contraception;
5.1.1.3 To gain an understanding of the role of community-based obstetric units and postnatal clinics, including criteria for appropriate referral;
5.1.1.4 To develop competency in the counseling and management of antenatal, intrapartum and postnatal care of HIV-positive mothers and their infants;
5.1.1.5 To perform basic ultrasound (both in Obstetrics and Gynaecology) and develop competency in the performance and interpretation of cardiotocographs and partograms;
5.1.1.6 To attend scheduled departmental meetings including maternal and perinatal mortality and morbidity meetings in order to appreciate strategies for future prevention of these catastrophes, including their early diagnosis and effective management;
5.1.1.7 To gain competence in ESMOE (Essential Steps in the Management of Obstetrics Emergencies).

5.1.2 GYNAECOLOGY

5.1.2.1 To gain proficiency in the performance of vaginal examinations. (Gynaecological and Obstetric), speculum and rectal examinations;

5.1.2.2 To gain competence in the prevention, diagnosis and management of common gynaecological conditions;

5.1.2.3 To gain competence in basic gynaecological procedures and operations, including post-operative care, and to gain exposure to major gynaecological operations;

5.1.2.4 To perform counselling, conduct testing and offer treatment to HIV-positive patients and their partner/families;

5.1.2.5 To gain a knowledge of contraception including counselling, different methods and side effects, and to promote its usage.

5.1.2.6 To develop an understanding of the prevention, early diagnosis and treatment of gynaecological malignancy including screening for cervical cancer.

5.1.2.7 To develop an empathetic understanding of human sexuality, marital life, fertility and infertility, and offer relevant counselling and referral.

5.2 PROCEDURES IN OBSTETRICS: PERFORMED UNDER SUPERVISION OR OBSERVED

5.2.1 External cephalic version and amniocentesis.
5.2.2 Induction of labour (medical and surgical).
5.2.3 Normal vaginal delivery, episiotomy and its repair.
5.2.4 Abnormal vaginal delivery (twins, breech, forceps, vacuum extraction, prolapsed cord, impacted shoulders, postpartum haemorrhage, repair of a third-degree tear, manual removal of the placenta).
5.2.5 Caesarean section, B-lynch sutures, stepwise devascularisation and the management of inversion of the uterus.
5.2.6 Emergency management of eclampsia and foetal distress.
5.2.7 Tubal ligations (open or laparoscopic) including postpartum sterilisation (mini laparotomy).
5.2.8 Examination of the neonate, Apgar rating, clearing of airways and endotracheal intubation.

5.3 PROCEDURES IN GYNAECOLOGY: PERFORMED UNDER SUPERVISION OR OBSERVED

5.3.1 Ectocervical, endocervical and endometrial sampling procedures.
5.3.2 Colposcopy, VIA, cone biopsy and Lletz procedure.
5.3.3 Laser coagulation of the cervix, vagina and vulva.
5.3.4 Open or laparoscopic sterilisation and other laparoscopic procedures.
5.3.5 Insertion of an intra-uterine contraceptive device (IUCD).
5.3.6 Hysteroscopy.
5.3.7 Marsupialisation/ drainage of a Bartholin's / labial abscess.
5.3.8 Evacuation and/or manual vacuum aspiration of the uterus.
5.3.9 Laparotomy for an ectopic pregnancy.
5.3.10 Hysterectomy (abdominal and vaginal).
5.3.11 Pap smear and liquid based cytology for cancer of cervix screening.
5.3.12 Wet smear microscopy of urine and vaginal discharge.

6 GUIDELINES: DOMAIN OF ANAESTHESIOLOGY

The following guidelines **should be read in conjunction with the introduction to Part II**

6.1 GENERAL

Trainees who undergo the two-month Anaesthesiology domain will have to accept that the aim is to learn the basic skills of anaesthesia. At the completion, the trainees would, however, have gained significant benefits from the introductory course by acquiring the skills and competencies outlined below. They will be able to utilise these in many other fields of medicine, including Emergency Medicine and Critical Care.

6.2 OBJECTIVES

During the two-month anaesthesia training period, intern training will focus on the following interlinked aspects (objectives) of perioperative management:

- Knowledge and understanding of basic anaesthesia.
- Knowledge and understanding of basic resuscitation.
- Recognition of factors playing a role in perioperative risk.
- In addition to the above, there are three critical skills that the intern needs to attain during the anaesthesia training period:

Skills in obstetric anaesthesia. The causes of anaesthesia related maternal death emanating from the Confidential Enquiry into Maternal Deaths include failed intubation, aspiration of gastric contents, high spinal anaesthesia, and hypotension during spinal anaesthesia, with 90% of these deaths considered to be preventable. These causes of death emphasize the need for the intern to develop a safe, competent approach to the obstetric patient requiring anaesthesia care.

Management of the trauma patient or patient suffering hemorrhage. Developing good basic skills, as outlined in the guidelines below, will facilitate management of these patients.

Cardiopulmonary resuscitation. The intern needs to develop knowledge and skills of CPR. It is a prerequisite for completion of the form that the intern demonstrate competence in CPR during the anaesthesia training period.

Completion of the two-month rotation enables the intern to provide an anaesthetic service under supervision. It does not constitute adequate training for the provision of independent anaesthetic practice.

6.3 PREREQUISITES FOR TRAINING

6.3.1 **Adequate equipment:** Theatres and recovery rooms to be equipped according to the standards recommended by the latest SASA Guidelines to Anaesthetic Practice.

6.3.2 **Adequate supervision:** Constant supervision of the intern is of critical importance.

6.3.3 The most acceptable form of “adequate” supervision is the presence of a specialist anaesthesiologist or a registrar in anaesthesiology. In the absence of a specialist, the supervisor should preferably possess the Diploma in Anaesthesia from the College of Medicine of South Africa, or at a minimum, have three (3) years full-time experience of administering anaesthesia as a medical officer. Irrespective of the qualification, the

constant presence of the senior physician on a one-to- one basis, is strongly recommended.

6.4 CORE SKILLS AND KNOWLEDGE

6.4.1 Pre-operative evaluation of the patient:

6.4.1.1 Emphasis should be placed on eliciting airway, respiratory and cardiovascular symptoms and signs.

6.4.1.2 Other medical or surgical problems that may complicate anaesthesia must be identified pre-operatively.

6.4.1.3 Evaluation of the airway.

6.4.1.4 Previous anaesthesia related problems.

6.4.1.5 Drugs currently and previously being taken.

6.4.1.6 Family history, especially of malignant hyperthermia or porphyria.

6.4.1.7 Appropriate use of pre-operative side-room and special investigations. The pre-operative evaluation should result in the following:

a) The ASA pre-operative classification of the patient. After two months interns should be able to electively manage ASA 1 (normal healthy patients) and ASA 2 patients (patients having mild systemic disease under good control) only.
b) A written summary of the main problems.
c) Evaluation of whether the patient in optimal condition pre-operatively. The anaesthetist must consider whether (further) pre-operative resuscitation or optimization is in the best interests of the patient.
d) An anaesthesia plan needs to be formulated.
e) Pre-medication should be prescribed if indicated.

6.4.2 Preparation for anaesthesia

6.4.2.1 Theatre preparation should include:
Machine and breathing circuit check. This includes:

a. Presence of self- inflating resuscitation device (Ambu bag or equivalent device);

b. Suction apparatus.

6.4.2.2 Checking for the presence of emergency drugs.

Availability of a functional defibrillator. The practitioner must be comfortable with the use and checking of a defibrillator.

6.4.2.2.1 Equipment for airway management.
6.4.2.2.2 Anaesthesia drugs.
6.4.2.2.3 Patient preparation should include placement of intravenous cannulae.
6.4.2.2.4 Monitoring needs to be instituted before induction of anaesthesia.

6.4.2.3 The most essential monitor is the vigilant presence of an anaesthesiologist at all times during surgery.

6.4.2.4 Minimum monitoring: the use of oximetry and availability of capnography, non-invasive blood pressure, ECG are considered mandatory, while the facility for temperature monitoring should be available.

6.4.2.5 Minimum monitoring includes continuous monitoring of the inspired oxygen partial pressure.

6.4.3 **Maintenance of physiological homeostasis**

6.4.3.1 The intern needs to understand the deleterious effects of anaesthesia on the airway, respiratory and cardiovascular systems.

6.4.3.2 The intern needs to understand both the need for, and how to, maintain physiological homeostasis while anaesthesia is being administered.

6.4.4 **Airway management**

6.4.4.1 Airway maintenance basic:

a. Application of basic airway maneuvers (jaw thrust, chin lift)
b. Simple airway devices (oropharyngeal airways)
c. The use of supraglottic devices (Laryngeal mask airway).

6.4.4.2 Endotracheal intubation

a. Equipment and drugs needed.
b. Attainment of the sniffing position.
c. Correct use of the rigid laryngoscope.
d. Use of introducer.

6.4.4.3 Confirmation of endotracheal tube position use and value of the capnograph.

6.4.4.4 Management of failed intubation and ventilation. A simple approach such as the “DAMIT” airway algorithm (reference) is strongly encouraged. (This algorithm incorporates three steps:

Step 1 – basic airway maneuvers and devices followed by a single laryngoscopy attempt if ventilation is still difficult.
Step 2 – use of a supraglottic airway (e.g. LMA or iLMA) to facilitate ventilation (and possibly intubation).
Step 3 – infraglottic airway access.)
Safe extubation of patients.

6.4.4.5 Airway protection from aspiration of gastric contents.

a. “Nil per os” guidelines.
b. Pre-operative recognition of the (potentially) full stomach.
c. Actions to prevent aspiration before anaesthesia commences.
d. Correct management of rapid sequence intubation. Attention must be specifically paid to the following:
   - Prior airway evaluation.
   - Correct pre-oxygenation technique. Correct application of cricoid pressure.
   - Correct sequence and dosage of induction agent and succinylcholine. Confirmation of endotracheal intubation.
   - Management of failed intubation.
   - Basic management should aspiration occur.

6.4.4.6 Maintenance of respiration (ventilation)

a. Spontaneous respiration with mask supplemented with an oropharyngeal airway if needed, or with the use of a supraglottic airway.

b. Take over ventilation manually if spontaneous respiration has been abolished or becomes inadequate.
c. Use of a basic anaesthesia ventilator.
d. Availability of and use of a self-inflating resuscitation device (Ambu bag or equivalent), especially in case anaesthesia machine failure.

6.4.4.7 **Hypoxia**

6.4.4.7.1 Basic understanding of the causes and management of hypoxia.
6.4.4.7.2 Basic understanding of oxygen therapy.

6.4.5 **Equipment for support of airway and respiration**

6.4.5.1 Airway equipment (facemasks, oropharyngeal airways, laryngoscopes, supraglottic devices, endotracheal tubes, introducers).
6.4.5.2 Understanding and check of anaesthesia machine.
6.4.5.3 Understanding of assembly, limitations, advantages and fresh gas flow required in the following anaesthesia breathing circuits:

a. Circle system.
b. Ayres T piece.
c. Magill system – dangers and appropriate use only in spontaneously breathing patients.

6.4.6 **Cardiovascular system**

6.4.6.1 Pre-load

a. Pre-operative recognition of the four degrees of hypovolaemia.
b. Fluid resuscitation – volumes needed, different types of fluid including the use of colloids.
c. Placement of intravenous cannulae.
d. Oxygen delivery

6.4.6.2 Importance of adequate hemoglobin concentration.
6.4.6.3 Blood transfusion – indications and complications.
6.4.6.4 Importance of an adequate cardiac output.
6.4.6.5 Determinants of cardiac output.
6.4.6.6 Hypotension

a. An approach to the etiology of hypotension.
b. A balanced approach to the treatment of hypotension using fluids, vasopressor and inotropes.
c. Availability of vasopressors – knowledge of how to dilute these drugs and use in severe hypotension.
d. Anaphylaxis – diagnosis and management.

6.4.6.7 Cardiopulmonary resuscitation (CPR)

a. It is a pre-requisite for certifying competence in anaesthesia that the intern demonstrates both knowledge of and practical competence in basic and advanced CPR. Three alternate routes to certification of competence in CPR are available:
b. Ideally, this should take place in a laboratory type setting where mannequins are available.

c. Alternatively, a question and answer session by the anaesthesia supervisor can be held with the intern.

d. A current valid ACLS certification is also an acceptable way to fulfill this requirement.

6.4.7 Anaesthesia drug pharmacology

6.4.7.1 Induction agents.
6.4.7.2 Inhalation anaesthesia agents and nitrous oxide.
6.4.7.3 Muscle relaxants.

a. Depolarizers – Succinylcholine
b. Non-depolarizers
c. Reversal of non-depolarizers
d. Opioids – intra-operative and post-operative use
e. Non-opioid analgesics – paracetamol – non-steroidal anti-inflammatory drugs.
f. The concepts of balanced anaesthesia including the synergistic and addictive interactions between various drugs.

6.5 SPECIFIC INTRA-OPERATIVE PROBLEMS

6.5.1 The obstetric patient

6.5.1.1 The physiological changes of pregnancy that affect anaesthesia management, especially airway, respiratory system, cardiovascular system, aorta-caval compression.
6.5.1.2 The safe performance of a subarachnoid (spinal) anaesthetic for the obstetric patient (drugs, dose, spinal needles, safe levels of injection, prevention and management of hypotension) is considered a core competency for interns rotating through anaesthesia. In this regard, it is essential that the interns possess a detailed knowledge of the following article on management of spinal anaesthesia for caesarean section: Prevention and treatment of cardiovascular instability during spinal anaesthesia for caesarean section. R A Dyer, C C Rout, A M Kruger, et al. SAMJ March 2004, Vol 94, No. 3 (available free on “Pubmed”).
6.5.1.3 The causes of anaesthesia related maternal death emanating from the Confidential Enquiry into Maternal Deaths.
6.5.1.4 Pre-eclampsia and anaesthesia.

6.5.2 Regional anaesthesia

6.5.2.1 Spinal (subarachnoid) anaesthesia – see above.
6.5.2.2 Pharmacology of local anaesthesia agents. Safe dosages, complications, how to avoid accidental intravascular injection, correct use and abuse of added vasoconstrictors with local anaesthetics.
6.5.2.3 Peripheral nerve Domains – knowledge of the following is useful – infiltration techniques, digital nerve Domains, Bier’s block.

6.5.3 The trauma patient, hypovolaemic shock and emergency anaesthesia

6.5.3.1 Recognition and management of problems with the airway, respiration, hypovolaemia, hypotension, anemia, head injury and the injured cervical spine.
6.5.3.2 Choice of anaesthesia agents in hypovolaemic shock.

6.5.4 Paediatric anaesthesia

6.5.4.1 Airway management of the child.
6.5.4.2 Paediatric fluid management.

6.5.4.3 Basics of paediatric anaesthesia.

6.5.5 **Essential administrative functions of anaesthetics**

6.5.5.1 Consent.
6.5.5.2 Maintenance of a contemporaneous anaesthesia record.
6.5.5.3 Post-operative instructions.

6.5.6 **Post-operative management**

6.5.6.1 An approach to delayed awakening from anaesthesia.
6.5.6.2 Written post-operative instructions.
6.5.6.3 When can the patient be left in the care of a nurse?
6.5.6.4 Post-operative complications (airway, breathing, circulation) that need to be watched for –
6.5.6.5 Opioids – uses, advantages, dangers, correct dosing and intervals, endpoints of therapy.
6.5.6.6 Non-opioid analgesia – uses, limitations, complications, contra-indications.
6.5.6.7 Use of simple regional techniques and infiltration of local anaesthetics for post-operative analgesia.

6.5.7 **Assessment/evaluation**

6.5.7.1 A detailed logbook of all anaesthetics administered, including the name, age and hospital number of the patient, nature and date of surgical procedure and drugs used, is to be kept by each intern. All entries are to be signed by the supervisor on an on-going basis. The Logbook will assist in ensuring that interns are adequately exposed to all aspects of anaesthesia. The Logbook in addition to a general section, will contain specified sections to ensure exposure to areas of anaesthesia which are considered essential to the training process (e.g. caesarean sections, D & C procedures, emergency surgery and paediatric anaesthesia).

6.5.7.2 CPR competence must be assessed.

7 GUIDELINES: DOMAIN OF ORTHOPAEDICS/ORTHOPAEDIC TRAUMA

The following guidelines **should be read in conjunction with the introduction to Part II.**

The emphasis should be on exposure to and management of common conditions under appropriate supervision (included at the end of this section for ease of reference).

7.1 OBJECTIVES

7.1.1 The objective of this training period is to expose the intern to the diagnosis and management of musculoskeletal diseases and trauma. He or she must be able to obtain and record the relevant information in a systematic manner, identify the problem(s) of trauma management and make decisions on the level of management. He or she should have the knowledge and ability to foresee and diagnose possible complications and should know the steps to be taken to prevent and/or treat these complications.

7.1.2 The trainee should develop the skills to treat less complex fractures, dislocations and soft tissue injuries, and should be able to resuscitate, splint, manipulate and reduce

fractures and dislocations, apply Plaster of Paris (POP) casts to the limbs and apply both skeletal and skin traction, where applicable. He or she should be able to perform minor operations, where indicated, on trauma patients.

7.2 SPECIFIC OBJECTIVES

7.2.1 Primary management of dislocations of the shoulder, elbow, hip and knee, wrist, hand, ankle, foot and toes.

7.2.2 Recognition of joint injuries, including intra-articular fractures and ligament disruptions. Closed methods of treatment, where applicable.

7.2.3 Recognition of and closed methods of treatment for the common metaphysical and diaphysial fractures in adults and children.

7.2.4 Diagnosis of tendon injury and nerve injury to the upper and lower limbs.

7.2.5 Diagnosis and emergency treatment of spinal injuries and pelvic injuries.

7.2.6 Recognition and management of open fractures (Gustilo plus Anderson classification), with primary debridement of open wounds.

7.2.7 Management of fingertip injuries and traumatic amputation of digits.

8 GUIDELINES: DOMAIN OF PSYCHIATRY

The following guidelines **should be read in conjunction with the introduction to Part II.**

The domain of Psychiatry will facilitate the experience of the integration of the management of psychiatric disorders at primary care level within a health team.

The specific rotation through Psychiatry should be decided on by each accredited facility based on its resources, but in accordance with the Guidelines.

8.1 FACILITIES REQUIRED

The placement and exposure to psychiatric practice must be such that a full range of disorders is managed at the various levels of severity, under supervision. The facilities utilised should have referral to specific psychiatric services within the complex or cluster of services. There should be exposure to services in facilities for inpatient and out-patient care, treatment, and rehabilitation, as well as consultation-liaison and emergency services and outpatient management as part of community-based psychiatric services by multidisciplinary teams (MDTs) in districts. Services at inpatient specialist facilities should include a MDT program and supervising specialist psychiatrist, in an psychiatric inpatient unit either in a general specialist or specialized psychiatric hospital. There should be the same standard of clinical care as in other disciplines and the full range of special investigations must be available.

8.2 SUPERVISION / HUMAN RESOURCES REQUIRED

8.2.1 There must be adequate number of supervisors allocated for supervising the interns.

8.2.2 The grade of experience of the supervisor must be that of a specialist psychiatrist (consultant), psychiatric registrar or a medical officer with at least three (3) years post registration experience in the field of psychiatry.

8.3 SUPPORT

There should be consistent and immediate access to support in the form of a registrar, medical officer and/or consultant.

8.4 JOB DESCRIPTION

8.4.1.1 This should be completed and provided by each complex in view of local differences and services available. The duties to be included are to be specified in relation to the site and lines of authority.

8.4.1.2 The responsibilities of the intern should be designated to include emergency care and assessment, as well as acute and/or longer-term in-patient and out-patient care of the spectrum of psychiatric disorders, medical disorders presenting with psychiatric symptoms (including delirium), as well as substance-related disorders/conditions and intellectual impairment.

8.4.1.3 The intern should also be competent with regard to responsibilities in terms of the Mental Health Care Act, No 17 of 2002 and the appropriate referral of patients between levels of care. Attendance at specialist psychiatric community-based clinics in districts, where available should be included if based at a psychiatric facility. Emergency duties in general hospitals and after hour duties under supervision must form part of the experience.

8.4.1.4 Duties in relation to report writing and record keeping must be monitored and evaluated.

8.5 OBJECTIVES

8.5.1 The aim of the postgraduate experience is to provide the intern with the capability to effectively manage common clinical problems of Psychiatry as a general medical practitioner.

8.5.2 There must be allocation of teaching time in the form of case presentations/ward rounds, tutorials and attendance at departmental meetings.

8.5.3 There must also be exposure to common conditions and the range of adult and child/adolescent disorders in clinical and emergency settings, as well as the rehabilitative role of community clinic duties.

8.5.4 Familiarity with the workings of the Mental Health Care Act, no 17 of 2002, other relevant legislation, national and provincial policy, as well as the ethical principles relevant to Psychiatry must be achieved.

8.5.5 There could be some exposure to subspecialties such as child, forensic, substance abuse and addiction psychiatry and old age psychiatry, where applicable, in the clinical setting.

8.5.6 During the placement, there should be experience and exposure to emergency and crisis situations, as well as the psychosocial rehabilitation processes in the context of a multi-disciplinary professional team functioning wherever possible.

8.6 SPECIFIC SKILLS AND COMPETENCE TO BE ACQUIRED

8.6.1 Skills in psychiatric evaluation, management and counselling should be achieved, with a bio-psychosocial approach, seeing the patient as a person in a holistic fashion within the various contexts.

8.6.2 Exposure to cognitive-behavioural therapy, anxiety/stress management programmes or substance rehabilitation programmes is recommended.

8.6.3 Specific skills and confidence in the management and evaluation of violent/ dangerous patients and suicidal risk assessment should be achieved.

8.7 CLINICAL PROTOCOLS

There should be standard treatment protocols available in all areas which reflect the standard to be followed. These could have been formulated by the provincial or national Mental Health Directorate of a Department of Health. Familiarity with such to include the following:

8.7.1 Admission criteria and procedures in terms of the Mental Health Care Act, No17 of 2002.
8.7.2 Management of the violent or dangerous patient.
8.7.3 Diagnosis and management of delirium
8.7.4 Management of schizophrenia and other psychotic disorders.
8.7.5 Management of alcohol and other substance dependence and withdrawal.
8.7.6 Investigations at first presentation/admission of a patients with psychiatric symptoms, to exclude/confirm underlying or co-morbid medical conditions.
8.7.7 Management of Mood Disorders.
8.7.8 Management of Anxiety Disorders.
8.7.9 Management of Cognitive Disorders
8.7.10 Management of Personality Disorders
8.7.11 Management of acute and long-term side-effects of psychiatric medications

8.8 ASSESSMENT AND EVALUATION

8.8.1 A record should be kept of the experiences of the intern using log- books of clinical cases managed. This should aim to record the numbers of, and categories of admissions clerked, presented, out-patients seen, reviews of cases, certification process, journal club, lectures, ward rounds attended, etc.
8.8.2 Objective evaluation forms to be completed during and again after the placement with the opportunity of feedback on progress to the intern at set intervals.

8.9 KNOWLEDGE

A basic knowledge of general psychiatry, as expected at MBChB level, must be supplemented during the placement to include:

8.9.1 Diagnostic criteria (DSM), adult and common childhood disorders.
8.9.2 Therapeutic management and investigations.
8.9.3 Preventative and rehabilitative interventions.
8.9.4 Psychopharmacology.
8.9.5 Aetiology.
8.9.6 Human development.
8.9.7 Assessment and interviewing skills.
8.9.8 Cultural context and issues.
8.9.9 Interpersonal dynamic and therapeutic relations with patient, family and staff

8.10 PROFESSIONAL THINKING, ATTITUDE AND ETHICAL STANDARDS

An awareness of transference/counter-transference reaction should be aroused.

8.11 STANDARDS

An awareness of transference/counter-transference reaction should be aroused. There should be an opportunity in supervision for feedback by the intern on progress and feelings and to develop a sensitivity to ethical standards and appropriate attitudes to psychiatric patients and their management.

9 GUIDELINES: DOMAIN OF FAMILY MEDICINE/PRIMARY CARE

The following guidelines **should be read in conjunction with the introduction to Part II.**

The emphasis should be exposure to and management of undifferentiated conditions under appropriate supervision.

9.1 GENERAL

The domain of Family Medicine/Primary Care gives the intern the opportunity to manage the spectrum of patients who present in the context of primary care. This includes the management of undifferentiated conditions, chronic diseases, palliative care and clinical forensic medicine. Interns must learn to integrate the experience, knowledge and skills gained in all other domains and learn to work in health care teams. Opportunities for collaboration with other primary care workers such as nurses, allied health professionals must be created. Colleagues working in other specialties at secondary and tertiary levels of care must provide continued support and assist towards capacity-building when performing structured outreach at facilities where interns are based. In instances where certain core competencies were not achieved in the other domains arrangements will be made to obtain those competencies from those domains while in Family Medicine.

The specific rotation through the domain of Family Medicine/Primary Care should be decided on by each accredited facility based on its resources, but in accordance with the Guidelines.

The six (6) month rotation in the domain of Family Medicine/Primary Care should be completed during a single period.

9.2 AIMS AND OBJECTIVES

To produce a generalist doctor who at the end of the 2-years of internship training will:

9.2.1 Have the knowledge and skills to be able to be function at a District Hospital with appropriate access to supervision, support and referral systems.
9.2.2 Be able to function independently in **ambulatory care** in the context of the district health system
9.2.3 Be able to contribute to the management of the spectrum of patients who present at any primary care facility
9.2.4 Be able to apply appropriate knowledge, skills and attitudes in the management of all patients presenting in primary care settings in collaboration with other primary care practitioners and to be able to identify patients that warrant referral

9.3 EXPOSURE AND RESPONSIBILITIES

9.3.1 The domain of Family Medicine/Primary Care should be the entry point into the health care system where interns should be exposed to first contact patientcare of both routine ambulatory care and emergencies, combined with responsibilities for patients in wards under their care.

9.3.2 The programme should show evidence of a continuum of training from ambulatory care in the community clinics, community health centres and district hospitals.

9.3.3 Interns will have the opportunity to perform relevant side-room tests and investigations with respect to their level of care and service ("Norms and Standards for District hospitals" Department of Health, Pretoria, 2002.). They should also be able to perform (minor) surgical procedures under supervision until they are competent to do so independently.

9.3.4 Every effort must be made to ensure personal follow-up of patients previously seen by the intern to provide continuity of care to patients, and for the intern to learn to form professional relationships with patients that last over an extended period.

9.3.5 Interns must work together with other health care providers such as nurses, physiotherapists, social workers, dietitians, etc., in the care of their patients, in order to learn the team approach to health problems in primary care practice.

9.3.6 Interns must have the opportunity to refer patients to health care providers in medical specialties, as well as receive patients back after consultations with specialists.

9.4 KNOWLEDGE AND SKILLS

9.4.1 Having completed all year one domains prior to starting FM, interns will have a set of knowledge and skills signed off in these domains. As Family Medicine is an integrated rotation, interns will be expected to proficient in these skills.

9.4.2 There is a list of skills which interns should self-assess their knowledge and competencies as these will not be signed off again in the Family Medicine rotation.

9.4.3 During the Family Medicine/Primary Care domain, the intern should acquire the following knowledge and skills:

9.4.3.1 Diagnosis and appropriate management of undifferentiated conditions in an out-patient / ambulatory care facility. The range of the conditions will be dictated by the morbidity profile of the community where the health care facility is situated.

9.4.3.2 Diagnosis and appropriate management of undifferentiated diseases related to lifestyle, such as tuberculosis, AIDS and HIV-infection, hypertension, diabetes, stress disorders, headaches, backache and depression.

9.4.3.3 Diagnosis and appropriate management of undifferentiated diseases related to stress of day to day living such as anxiety, depression, drug and alcohol abuse.

9.4.3.4 Diagnosis and management of undifferentiated conditions that are amenable to short duration surgery under local anaesthesia such as the following: Suturing of lacerations; finger/hand injuries; excision of subcutaneous lumps; removal of foreign bodies (ear, nose, cornea); aspiration and injection of joints (knee, wrist, ankle, shoulder); reduction of paraphimosis /dorsal slit; excision cautery / cryotherapy of skin lesions, removal of toenails; etc.

9.4.3.5 The appropriate generalist management of all emergencies; resuscitation of patients in shock; the stabilisation and transport of the severely ill patient.

9.4.3.6 The appropriate intervention in family crises e.g. domestic violence; disability; death; substance abuse; infertility; abortion; divorce.

9.4.3.7 The appropriate clinical forensic medicine skills for managing e.g. Rape; inter- personal violence; drunken driving.

9.4.3.8 Appropriate skills in palliative care.

9.4.3.9 Rational prescribing habits: A thorough knowledge of the drugs on the Primary care Essential Drug List used by the facility, their indications, contra-indications important drug interactions and cost implications.

9.4.3.10 A sensitivity to cultural differences with respect to illness experience and its influence on the causation of disease, healing and compliance with medical interventions.

9.4.3.11 An awareness and understanding of the total spectrum of health care resources in the community, and an approach to the optimal use of these resources for the health of the community and individual patient care.

9.4.3.12 The knowledge and skills to render appropriate inpatient care at generalist level.

9.4.3.13 The knowledge and skills to render appropriate mental health care at generalist level.

9.4.3.14 An approach to the management of common conditions presenting in primary care.

9.4.3.15 An approach to the management of common dermatological conditions.

9.4.3.16 Specific objectives for Public Health Medicine:

- Improve quality of care by facilitating quality improvement cycles (including the audit of clinical care as one step in the cycle)
- Improve cost-effectiveness through reflection on routinely collected data, particularly rational prescribing and use of investigations
- Critically appraise new evidence
- Make a community diagnosis, and interpret and prioritise health indicators
- Promote health in communities
- Report notifiable conditions (measles, TB, malaria etc)
- Use routine data for disease surveillance
- Apply an appropriate Monitoring and Evaluation (M&E) framework (e.g. inputs, process, outputs, outcomes, impact) to monitor and evaluate a health intervention
- Explain a population-level approach to disease prevention and apply the 'levels of prevention' framework to recommend disease prevention interventions
- Describe the main health indicators (e.g. IMR, MMR) and their use in planning

9.5 LIST OF ETHICAL ISSUES TO WHICH INTERNS SHOULD BE EXPOSED

Please refer to the Ethics, Human Rights, Clinical Governance and Medical Administration Section of the Logbook

Training sites

The training sites include accident and emergency department, district hospital, community health centres and primary health care clinics.

The areas of exposure must include:

- Accident and Emergency care (1 month)
- Maternal care
- Child health, IMCI, neonatal care
- Integrated Chronic care management including exposure to the management of HIV and tuberculosis
- Acute care
- In patient care

Please fill in the table below.

Site	From	To	Supervisor's signature
District hospital (minimum of 1 month)			
Accident and emergency (1 month)			
General outpatients			
Antiretroviral Clinic			
Gateway Clinic			
Community Health Centres (CHC)			
Day hospital			
Primary Health Clinic (PHC)			
Family medicine OPD departments			
Other			

After-hours work is compulsory for interns and can be done at the accident and emergency department at the tertiary, regional or district hospital or CHC

In addition, interns should be involved with a Quality improvement project, reporting on patient safety issues, morbidity and mortality meetings and actively participate in CPD programmes at the different sites

9.6 SUPERVISION

9.6.1 Supervision must be provided by a Family Physician or a general medical practitioner with at least three-years post-internship experience in primary care domain, who must be accessible for support.

9.6.2 An MO/FP must be physically present when an intern is allocated to work in the following areas: A & E, labour ward, high care / ICU or theatre.

9.6.3 A Public Health Medicine specialist at the affiliated university or training hospital can be consulted for guidance for all public health-related topics and activities.

9.7 EVALUATION

9.7.1 Ongoing evaluation by the supervisor should take the form of direct observation of consultations, patient record reviews, and case discussions.

9.7.2 A checklist of required skills is provided to the intern for determining what specific skills need to be acquired and documented during the Family Medicine domain.

9.7.3 At the end of each rotation both intern and supervisor must complete, discuss and sign the general assessment form. The Head of Family Medicine will sign the intern off at the end of the 6 months rotation.

PART III
GUIDELINES PERTAINING TO MEDICO-LEGAL AND ETHICAL ASPECTS OF INTERNSHIP TRAINING

1. DUTIES OF A MEDICAL PRACTITIONER REGISTERED WITH THE MEDICAL AND DENTAL PROFESSIONS BOARD

Patients must be able to trust doctors (medical practitioners) with their lives and wellbeing. To justify that trust, we as a profession have a duty to maintain high standards of good medical practice and care and to show respect for human life. Medical practitioners need to ensure the following:

a. Make the care of their patient their first concern.
b. Treat every patient politely and considerately.
c. Respect patients' dignity and privacy.
d. Listen to patients' and respect their views.
e. Give patients information in a way they can understand.
f. Respect the rights of patients to be fully involved in decisions about their care.
g. Keep their own professional knowledge and skills up to date.
h. Recognise the limits of their professional competence.
i. Be honest and trustworthy.
j. Respect and protect confidential information.
k. Make sure that their personal beliefs do not prejudice their patients' care.
l. Act quickly to protect patients from risk if they have good reason to believe that they themselves or a colleague may not be fit to practice.
m. Avoid abusing their position as a doctor.
n. Work with colleagues in ways that best serve patients' interests.

In all these matters doctors must never discriminate unfairly against their patients or colleagues and must always be prepared to justify their actions.

2. LIST OF ETHICAL ISSUES TO WHICH INTERNS SHOULD BE EXPOSED

Obtaining informed consent from patients, including taking informed consent from the parent of a child, from the guardian of a mentally ill patient, as well as obtaining consent from a patient to participate in a research study.

Respect for confidentiality. It is necessary to have some insight into the limits of confidentiality and how, for example confidentiality would be broken if one wished to inform the partner of a patient with an infectious condition of the risk of contagion.

Respecting the dignity of persons (autonomy).

Informing patients of bad news.

Counselling families.

Dealing with procedures for withholding or withdrawing treatment and communicating with families regarding such procedures and why that is done.

Having knowledge of potential human rights abuses and of the available mechanisms to report such abuses.

3. INTERNS AND LEGAL LIABILITY

3.1 LEGAL STATUS OF AN INTERN IN MEDICINE

The intern in medicine is, of course, not yet a doctor (medical practitioner). He or she has successfully completed at least five years of university study as a registered medical student and must now undergo training for a further period of time. For that purpose, he or she must register with the Health Professions Council of South Africa as an intern in medicine. The intern can, therefore, be described as a "trainee doctor" who will receive supervised instruction in medical practice in an accredited facility.

An experienced medical practitioner who is a staff member of an accredited training facility at which the intern will receive training is appointed as Intern Curator who will oversee the process of internship training under supervision of experienced trainers. The intern will, therefore, perform his or her functions under supervision. It goes without saying that the intern will not only be observing the work done by experienced doctors but will begin to become increasingly involved in performing – under supervision – medical procedures himself or herself. That is the only way in which practical skills can be acquired. In so doing, the intern from the outset assumes legal and ethical responsibilities and in this section the implications thereof will be briefly addressed.

It is important to emphasise that it is not the function of the intern to undertake independent functions off his or her own bat, as it were, without proper supervision and guidance. Should the intern do so, he or she will expose himself or herself to legal liability and such action may also result in liability being incurred by his or her employer.

3.2 EMPLOYER – EMPLOYEE RELATIONSHIP

Interns are trained in public sector facilities (i.e. hospitals or clinics) and receive their salaries as part of the public sector. Legally speaking, therefore, the intern is an employee of government or the State. This has important implications as far as potential legal liability is concerned. It may lead to what is known as "vicarious liability", on which more information will be given below.

3.3 STANDARD OF CARE REQUIRED FROM INTERNS

It is a principle of South African law that, in performing medical procedures or in treating patients medically, a qualified medical practitioner's conduct must conform with certain standards. Should the doctor's performance fall short of those standards, his or her conduct will be judged to be negligent, which may result in legal liability for damage should the patient have sustained harm and loss.

South African courts have on numerous occasions held that the standard of care required of a doctor who undertakes the treatment of a patient is not the highest possible degree of professional skill, but reasonable skill and care. But the courts will, in assessing culpability, take into consideration the branch of the profession to which the practitioner belongs. Thus, a general practitioner will be judged in the light of the knowledge, skill and proficiency expected from the reasonable general practitioner. In the case of a specialist, the practitioner's conduct will be assessed by having regard to the standards reasonably required in his or her specialty.

If a general practitioner were to embark upon procedures usually performed by specialists, the general practitioner must expect to be judged in accordance with the standards pertaining to that specialty. The same principle applies to specialists venturing into fields of specialty for which they

have neither been qualified, nor registered. This, in effect, means that the doctor venturing beyond his or her own field and must expect to be judged much sterner than would otherwise be the case.

What does this imply for the intern? It means, simply, that the intern's conduct will in the event of an allegation of negligence on his or her part, be measured not against the standard of competence required from a fully qualified, experienced doctor, but against the standard of competence that may be expected from the reasonable intern. It may be assumed that an intern who has already gained a lot of knowledge and practical experience and is nearing the end of his or her period of internship training, may expect to be adjudged against a somewhat sterner measure than that of the intern who has just started.

What had been stated thus far, applies to the usual, routine situation. In cases of dire emergency, different considerations apply. This aspect shall be returned to below.

At this point it must be emphasised that the Intern Curator and qualified doctors under whose guidance and supervision interns work, bear a heavy responsibility towards interns. If they were to observe an intern performing an assigned task wrongly, dangerously or clumsily – with potential harm to a patient – they should give clear and proper instructions and even an admonition, forthwith. Otherwise these supervisors may run the risk themselves of being charged with negligence.

3.4 LEGAL CONSEQUENCES OF MEDICAL NEGLIGENCE

It is not necessary to say much about this subject. During the academic education and training of medical students, they are constantly being made aware by their teachers of the dire legal consequences that negligent treatment of a patient may have. These may include the following:

Firstly, there is the possibility of an action (lawsuit) for damages by the patient or his or her dependents being brought against the offending doctor or his or her employer. Today there is world-wide a greater awareness of patients' rights than ever before. A lawsuit is invariably unpleasant, time-consuming and usually very costly, and there is also the possibility of negative publicity in the media.

Secondly, in the unhappy event of a patient dying in consequence of medical negligence, there is the possibility of a criminal charge of culpable homicide being brought against the practitioner(s) involved. This is invariably a highly unpleasant and embarrassing experience. A successful prosecution may result in a very severe fine being imposed or even a sentence of imprisonment.

Thirdly, there is the possible sequel of a complaint of unprofessional conduct being lodged with the Medical and Dental Professions Board. Should an inquiry follow, it will take place in public and in the full glare of media attention.

3.5 HOW TO AVOID ALLEGATIONS OF NEGLIGENCE

The staff situation in public sector facilities may on occasion not be ideal and it is possible that interns may be called upon to perform tasks of which they have not yet had adequate experience or gained sufficient proficiency. Save in the absence of a dire emergency, however, the intern should never undertake such a task unless guidance and advice has been sought from an experienced supervisor. There is no reason why the intern should be expected to stick out his or her neck, as it were, and thereby risk exposure to legal action – not to mention the possibility of causing harm to the patient.

In this regard an interesting 1965 South African case should be mentioned: An intern who was on duty over an Easter weekend administered a massive overdose of medicine intravenously

to a patient in a case of suspected epilepsy. She died within 15 minutes. The intern was charged with and convicted of culpable homicide. The court refused to uphold his defense of inexperience. It

ruled that he should first have telephoned a senior or consulted a textbook or sent for a nurse for assistance.

3.6 VICARIOUS LIABILITY (EMPLOYERS' LIABILITY)

In terms of this legal doctrine, the employer may incur liability for the wrongful act of his or its employee. First, a person may be held legally liable for damages if he or she has ordered or authorised another to perform a wrongful act. Thus, a doctor who has instructed his or her professional assistant or an intern to perform an unlawful procedure cannot later seek refuge in the excuse that he or she did not perform the procedure with his or her own hands.

Ordinarily, however, the question of vicarious liability will arise where a person or an organisation (such as the State) employs another to perform a lawful activity and the employee then does not proceed with the required or expected measure of skill and care and causes harm to others. There have been numerous cases in South Africa in which a hospital authority incurred liability for damages on account of the negligence of personnel employed by it.

A requirement of employers' liability is that the act of the employee complained about, must have taken place within his or her scope of employment. It goes without saying that a body employing people cannot be held liable for acts performed by an employee in his or her own time which is unrelated to the job for which the employee was engaged.

It should be emphasised that "scope of employment" does not mean that, at the time when the harmful act was perpetrated, the employee must have worked under the actual, direct or physical control of the employer. In modern times the emphasis has shifted from actual control by the employer to the **right** of control. For a court to hold the employer liable, all that is required is that the relationship was such that the employee could lawfully receive directions from his supervisors in the manner of performing the act in consequence.

This, in practical terms, means that the State can be held liable for a negligent procedure performed by an intern even if his or her superiors were not looking over his or her shoulder at the time when the procedure was performed. This truth again underlines two important aspects: Firstly, senior staff members should ensure that sound instructions are constantly issued to interns and they should be allowed to watch procedures done by experienced staff who should keep them informed on what is being done and why. Secondly, if an intern is uncertain on the correctness of a procedure, he or she should not hesitate for a moment to seek advice and assistance from experienced staff.

There is yet another point to be made in regard to vicarious liability: The intern who has acted negligently does not only incur liability on the part of the State, but he or she himself or herself can be held liable in his or her personal capacity. In practice aggrieved parties who sue for damages will usually target the party with the "deepest pocket" - which will be the State – but there is nothing to prevent them from suing also the intern. The intern may be a penniless young man or woman, but once a court judgment has been obtained, it may lead to attempts in future to enforce it against the intern who has in the meantime become a doctor with something to his or her name. There is one consolation, however: If the intern has acted in good faith when performing the act complained of, the State's lawyers will normally defend also the intern.

3.7 EMERGENCIES

Emergencies arising have already been alluded to. In a case of a dire emergency, where a patient is at death's door and remedial action is required immediately in a hope to save his or

her life, desperate measures by someone who is not medically qualified may be legally justified. If no doctor, experienced nurse or paramedic is readily available and the time factor is crucial, an intern can take such steps as he or she regards necessary.

It goes without saying that an intern who has had at least five years' university education and training and some clinical experience, would be in a far better position to come to the rescue of a person than a complete layperson as far as medicine is concerned. Even if the rescue attempt is unsuccessful, the intern should expect praise from the law rather than condemnation.

In this regard a rather sensitive situation that arises occasionally in hospitals should be addressed briefly. In the course of the medical treatment of a patient in hospital or an operation being performed in theatre, a nurse or an intern may notice that the doctor commits a serious error or is physically or mentally unfit at the time, for example because he happens to be intoxicated. What may, or should the nurse or intern do? This, of course, is a kind of emergency and may require immediate action. Particularly if the patient is in serious danger of being harmed, the nurse or intern should be bold enough to point out in polite terms to the doctor what is going wrong and should further take immediate steps to summon another doctor to intervene to the extent that it is necessary. A full report in writing should be made to the intern's curator at the earliest opportunity.

3.8 INFORMED CONSENT AND PATIENT PRIVACY

A patient's right to personal autonomy and privacy is fully recognised and protected by the common law, as well as the South African Constitution and should be respected by medical personnel at all times. An unjustifiable invasion of his or her privacy can result in serious legal consequences.

The taking of an informed consent is primarily the responsibility of the doctor who is in charge of the case and certainly not that of interns who are still in the process of being trained. Doctors frequently delegate the function of taking a written consent to the administrative or nursing staff of a hospital. The cautious doctor should check that a proper consent has been taken. Interns are ordinarily not involved at all in the consent formalities. It is only where it comes to the attention of an intern that the patient is apparently unwilling to undergo the proposed procedure or is dissatisfied because of a lack of information that the intern should tactfully take it up with the doctor in charge of the case or a senior nursing sister.

It should always be borne in mind that the normal adult patient who is *compos mentis* is entitled to refuse medical treatment or an operation unless the procedure has already commenced. The patient may in other words, freely revoke a consent previously given.

As far as the patient's right to privacy is concerned, unauthorised outsiders should never be allowed to be present at a medical examination, medical treatment of or an operation performed on a patient, unless the patient has given consent thereto.

Confidentiality of patient information should at all times be kept in mind. Any unwarranted disclosure of details to outsiders may have serious consequences for the intern, both legally and ethically. Patient particulars may, however, be recorded in the prescribed manner and made available to the hospital's administrative staff and the patient's medical aid scheme (if any) to the extent necessary.

3.9 PATIENT RECORDS

The importance of accurate and complete patient records cannot be over-emphasized. Several members of the hospital staff, as well as treating doctors are charged with the responsibility of making entries in the patient's file, charts or the bed record. To the extent that an intern is required to make any entries, he or she should ensure that it is done reliably,

accurately and legibly. It is a trite saying amongst lawyers that the first line of defence of a hospital, doctor, nurse or staff member in the event of a lawsuit, disciplinary inquiry or inquest, is invariably accurate patient records.

3.9 MISCELLANEOUS ASPECTS

3.9.1 An intern seeks assistance from senior personnel, but receives no response

It was pointed out in paragraph 3.1 that save in a situation of dire emergency, the intern should not perform a task, which is beyond his or her competence unless guidance has been sought from an experienced supervisor. If telephone assistance is sought from senior personnel, but the senior(s) fail to respond, the intern should not perform the task but forthwith make a written report, sign it and hand it to the superintendent of the hospital, keeping a copy for himself or herself. (If a dire emergency arises, the situation is as described in paragraph 3.7).

3.9.2 Protection of interns in matters of professional liability

As was observed previously, an intern may incur personal legal liability for acts of negligence and other forms of medical malpractice such as violation of the right of privacy of a patient. Many medical practitioners hold malpractice insurance which offers protection in the form of legal representation being provided in lawsuits for damages brought against doctors and cover against eventual liability, as well as in professional conduct inquiries conducted by the Medical and Dental Professions Board. Because of the ever-present danger of aggrieved patients suing medical personnel who attended to them for damages – sometimes huge amounts are claimed – it is advisable for doctors to take out professional indemnity insurance such as that provided by Glenrand MIB or membership of the Medical Protection Society. Membership is available also to interns and student interns. Information may be obtained from the following contact addresses:

Medical Protection Society
P O Box 74789
LYNNWOOD RIDGE
0040

Glenrand MIB
Medical Malpractice Division
P O Box 2544
RANDBURG
2125

3.9.3 Certificates signed by interns

During the performance of their duties, doctors may be called upon to sign a variety of documents, such as sick certificates, death certificates and certificates relating to accidents and injuries sustained or illnesses contracted by employees in the course of their employment. In terms of the Health Professions Act, 1974, (Act No. 56 of 1974), section 36(2), interns may issue any certificate or document, which in terms of any law, other than this Act, may be issued by a medical practitioner. In so doing the intern may describe himself or herself as a medical practitioner. In practice it is wise for interns who are called upon to sign important documents, particularly death certificates, to seek guidance from those doctors under whose supervision they work. (Note that student interns may also issue documents pertaining to the service they perform under the supervision of a medical practitioner in respect of the performance of their duties (see section 36(2) (aA) of Act No. 56 of 1974.))

Please note that official documents to be signed such as reports, certificates or prescriptions, need to be signed next to the name of the practitioner in printed letters (see Ethical Rule 15).

4. INTERNS PERFORMING LOCUMS

Interns are reminded that it is illegal for them to work in any form of practice outside accredited facilities.

During recent evaluations and inquiries pertaining to internship training, the various delegations, including the intern delegations, confirmed their awareness of the fact that interns were legally restricted to practicing under supervision in facilities accredited by the Board for the purpose of internship training.

Despite the above paragraphs, it had become necessary to recommend to the Board that urgent steps be taken to advise all interns and medical practitioners that the employment of interns in any clinical practice outside accredited facilities was illegal and could lead to disciplinary action on the part of the Board against any intern who might engage in such practices, as well as against any medical practitioner who might be found to employ an intern as a *locum* or in any other fashion outside accredited facilities.

Accredited facilities should be aware that the Board could withdraw accreditation for internship training should it find that the facility was aware of interns performing locums.

5. DEATH CERTIFICATES

Interns are registered and can therefore sign death certificates. But it is much safer and kinder to the intern that a more senior person does so. It places undue medico-legal responsibility on the intern, which can be avoided in a big hospital.

6. TERMINATION OF PREGNANCIES

In September 2005 the Medical Education and Training Committee confirmed that although an intern in medicine, who was required to perform an abortion, could refer the patient to another practitioner on conscientious grounds, despite the fact that "The Choice on Termination of Pregnancy Act", (Act 92 of 1996), did not provide a conscientious objection clause. It was however again re-iterated that interns could not refuse to provide emergency treatment in respect of bleeding or an emergency evacuation of the uterus since such procedures formed part of the essential skills of medical practitioners in South Africa and interns in medicine were required to attain those skills during their internship training.

7. RENDERING AFTER HOURS SERVICES

A medical practitioner or casualty officer who receives a patient, remains responsible for the safety and well-being of that patient until such time as the patient has been handed over into the care of another medical practitioner who accepts responsibility for that patient.

A medical practitioner remains personally responsible for the care and treatment of his or her patients for as long as they require such care and treatment.

It is, nevertheless, within the professional discretion of a medical practitioner to decide when to leave a patient for whom he or she was personally responsible, bearing in mind, however, that, should such patient suffer unduly or die as a consequence, the practitioner concerned will be held professionally accountable for his or her actions.

Should a critically ill patient, therefore, be referred to a medical practitioner or dentist for treatment, the welfare of such a patient outweighs any policy decision regarding the treatment of patients by the State or any other health care employer agency and, thus, any critically ill patients shall appropriately be treated by the medical practitioner or dentist concerned.

8. OVERTIME REQUIREMENTS DURING INTERNSHIP TRAINING

The Medical Education and Training Committee holds the view that overtime has to be performed by interns; that it is expected of interns to be on duty for a maximum of 80 hours per week; that overtime is part of service delivery; and that interns are not permitted to refuse to work overtime. Furthermore, the Committee agrees that night duty is a valid and essential learning experience where development of competencies and skills takes place and exposure to very specific aspects of medicine is possible which differs from the normal daytime exposure.

It be confirmed that interns in medicine had to perform overtime duties. It was expected of interns to be on duty for a maximum of 60 hours per week and that overtime was part of service delivery. Interns were not permitted to refuse to work overtime.

In June 2006 it was again confirmed that interns in medicine were required to perform overtime duties. It was, however, indicated that due to exhaustion and the possible risk to patients as a result, interns should not be required to be on duty for more than 60 hours per week which would include overtime duties as part of service delivery. In terms of the agreement with the Department of Health and because of emergencies, interns could not refuse to perform overtime duties.

The ruling of the Board of December 1999 referred to in paragraphs 6.2 and 6.3 above (Rendering after hours services) needs to be kept in mind and guide responsibilities pertaining to overtime.

9. THE IMPORTANCE OF ADOPTING GOOD, SOUND AND ETHICAL FINANCIAL MANAGEMENT

The acquisition of medical education and training, whether undergraduate or postgraduate, is a very expensive exercise. Furthermore, the purchase of items necessary or essential for practicing the profession such as cars, stethoscopes, diagnostic sets etc. are a heavy drain on any family's financial resources.

When being an independent medical practitioner, the purchase, setting up and furnishing of a practice is another big drain on precious financial resources. Thus, the long road to a successful medical career involves the constant need for money discipline, sacrifice, dedication and the need for hard work.

The medical student is an unproven item and is financially dependent upon his or her family, banks, loans, bursaries or scholarships to exist. As an unproven item it is very difficult for him or her to obtain loans or other financial assistance.

In contrast, the medical graduate has a medical degree to offer as collateral with guaranteed work as an intern or community service doctor with regular pay cheques. Consequently, the doctor is a strong attraction to those who profit or earn a commission by offering a service, soft loans and luxury items on tick.

The medical graduate, whilst skilled in medical knowledge, is often very naïve in financial matters and can sometimes fall prey to unscrupulous sales people.

It is a human desire and very understandable that, upon qualifying, the intern wishes to enjoy the fruits of his or her hard work, sacrifice and dedication. However, upon graduation the graduate enters a new world governed by the Hippocratic Oath, Regulations and Rules enacted via the Medical and Dental Professions Board, which grant him or her license to practice. Any transgression of such Regulations and Rules may result in an injury into unprofessional conduct and its possible consequences. Thus, it is incumbent for every graduate to earn his money ethically and honestly.

A good starting point to learn money management principles and avoid pitfalls is good communication and preparedness to listen to wise counsel from senior colleagues, Intern Curators, hospital superintendents, bank managers and accountants.

The following are examples of “do’s” and “don’ts” –

a. Do not spend money that you have yet to earn.
b. Being a medical practitioner is both a dedication and a vocation. It is never a vehicle to amass a big fortune.
c. Never practice medicine outside of the prescribed guidelines, such as performing locums for gain whilst still being a medical student or intern.
d. The internship training period requires so much of your time and attention that it is prudent and wise to delay the purchase of expensive cars, electronic goods, etc., until there exist more opportunities for leisure time.
e. Lastly, the intern needs to remember that he or she has a legal and moral obligation to repay all outstanding student loans.

10. ETHICAL GUIDELINES FOR GOOD PRACTICE IN MEDICINE, DENTISTRY AND MEDICAL SCIENCES

The Medical and Dental Professions Board has embarked on a project to bring together ethical and professional guidelines for doctors (medical practitioners), dentists, and medical scientists. However, a Handbook on Good and Ethical Practice will be provided to all persons registering for the first time as medical practitioners. The following Booklets are separately available:

Booklet 1: Guidelines good practice

Booklet 2: *General ethical guidelines*

Booklet 3: Patients' Rights Charter

Booklet 4: Informed Consent

Booklet 5: Confidentiality Protecting and Providing Information

Booklet 6: Gen Ethical Guidelines for management of Patients with HIV

Booklet 7: Guidelines withholding and withdrawing treatment

Booklet 8: Reproductive Health

Booklet 9: Keeping of Patients Records

Booklet 10: Telemedicine

Booklet 11: Guidelines on over servicing perverse incentives and related matters

Booklet 12: Guidelines for the management of health care waste

Booklet 13: Gen Ethical Guidelines for Health Researchers

Booklet 14: Biotechnology Research in SA

Booklet 15: Research Development and use of Chemical and Biological Weapons Business Practice