



So what is the answer to these issues? We would support change from within. Perhaps we should consider a basic tier of SAMA membership which is cheap, recruits members actively from all sectors of medical and allied medical staff, functions effectively as a union (with dedicated staff) and forms strategic partnerships with other organisations. Membership of the important professional limb of the organisation could be separate and additional. Creating the impetus for such fundamental changes would involve co-operation at many levels.

We invite open and active debate on this topic in order to try to find a way forward that would achieve the necessary representation for doctors. The Health Minister has made vague promises about rectifying some of the injustices of the OSD in April 2010. However, we need to ensure that we are able to bargain effectively so that we retain experienced doctors in our public health care system and leave a legacy of high-quality teaching and optimal health care in all sectors of our country.

## PERSONAL VIEW

### Medical electives in South Africa

Matthew Anthony Kirkman

The elective is a highlight of most medical students' undergraduate training. Medical electives in South Africa are well known for hands-on clinical experience; however, I was not expecting the level of responsibility that I experienced.

It was the beginning of another 24-hour on-call shift in a trauma and surgery department of a Gauteng hospital when I was called to assist a specialist registrar in theatre. The patient was a 24-year-old male victim of violence. His legs had been doused with petrol and set alight, and he had deep burns to both legs requiring regular debridement and dressing; this was his third such procedure.

I understood my role as holding and passing equipment when required, with no active involvement in the surgery; responsibility which I had been afforded previously and felt comfortable with. When I arrived, the patient was under general anaesthetic, and I was unsure whether consent had been obtained for my role as assistant. During the procedure, the doctor complained incessantly that he had gone without food for 12 hours; as the final pieces of debris were cleared from the patient's left leg, he ripped off his gloves, declaring: 'I'm going to eat before I collapse. Can you finish?' and left before I was able to respond. The wounds were left debrided but undressed, exposed to air. The staff remaining in theatre were the anaesthetist and theatre assistant.

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One can discuss the ethics of allowing doctors and medical students to work long shifts without breaks and the effect on patient care, and of a doctor foregoing his professional commitment to a patient because of hunger. However, my concern was the ethics of myself, as an unqualified medical student, dressing wounds without patient consent. Asking the doctor to return was futile, according to my colleagues in theatre, and attempts to find another doctor to help failed. Bringing the patient out of anaesthesia to ask for consent seemed pedantic, and neither the theatre assistant nor the anaesthetist would complete the procedure. I therefore used my limited experience of observing wound dressing to complete the procedure (successfully).

Official guidance for health care professionals in South Africa is found in the National Patients' Rights Charter, published by South Africa's Department of Health,<sup>1</sup> and guidelines from the Health Professions Council of South Africa<sup>2,3</sup> which – ironically – contained verbatim statements from the UK General Medical Council's 'Good Medical Practice' Guidance.<sup>4</sup> To my horror, this literature practically condemned my actions. The legal literature revealed that, by touching the patient without consent, I could be sued for battery, without being able to claim exemption as a student.

The ethical principles (autonomy, beneficence, non-maleficence and justice) are important considerations in such a scenario.<sup>5</sup> Beneficence concerns itself with doing good for patients and acting in their best interests, and we are taught that these lie at the heart of medicine and the doctor-patient relationship, but *who* judges *what* is best for a patient? I felt that the patient's best interests were to reduce his infection risk



by promptly dressing the wounds. Informed consent indicates that patient autonomy has been respected. Valid informed consent requires the mental capacity to make rational decisions, which the patient lacked because he was under general anaesthesia. Although consent is not required in emergencies, what constitutes an emergency is poorly defined in law. Since not asking for consent violates autonomy, a conflict between the ethical principles of autonomy and beneficence/non-maleficence emerged in this case. Although concerned about the lack of consent, without an official hierarchy of the ethical principles, I deemed beneficence/non-maleficence to take precedence.<sup>6</sup>

While the procedure of dressing a wound may seem trivial to some, the situation and pressure imposed on me was challenging. I do not feel that the importance of ethical reasoning correlates with the complexity of the procedure. The absconding doctor is easily blamed, but it's more a reflection on the working conditions for doctors in that hospital. Being abandoned in theatre made me question whether I had any autonomy myself. How many other students have been placed

in similar or worse situations while on elective, or was I just unfortunate? I encountered several other ethical dilemmas during my month in South Africa.

I do not regret my time in the country; my experiences were life-changing. I have many fond memories and feel sure that such situations are encountered around the world. My experience illustrates that much more is expected of students and junior doctors in South Africa than in the UK. Elective medical students must be professional and aware of the boundaries of their abilities, remembering that ethical and professional behaviour are international standards to be adhered to at all times.

1. Health Professions Council of South Africa. *National Patients' Rights Charter*. Pretoria: Health Professions Council of South Africa, 2002.
2. Health Professions Council of South Africa. *Ethical and Professional Rules of the Health Professions Council of South Africa*. Pretoria: Health Professions Council of South Africa, 2007.
3. Health Professions Council of South Africa. *Seeking Patients' Informed Consent: The Ethical Considerations*. Pretoria: Health Professions Council of South Africa, 2007.
4. General Medical Council (UK). *Seeking Patients' Consent: The Ethical Considerations*. London: General Medical Council, 2006.
5. Beauchamp T, Childress J. *Principles of Biomedical Ethics*. 5th ed. Oxford: Oxford University Press, 2001.
6. Ross W. *The Right and the Good*. Oxford: Oxford University Press, 1930.7.