

Burnout of junior doctors and skills retention

To the Editor: Stodel and Stewart-Smith¹ paint a dismal picture: 95% of junior doctors at the Red Cross Children's Hospital in Rondebosch, Cape Town, intend to leave at the end of their rotation.

However, the 95% is derived from only 22 of the 39 junior doctors who were mailed a questionnaire. The findings should be expressed as a proportion of all 39 junior doctors – an intention to treat analysis. Using 39 instead of 22 as the denominator implies that half of the doctors surveyed were burnt out; still a cause for concern, but a more credible number.

Senior house officers (SHOs) come to the Children's Hospital to learn, and to become competent and self-confident in managing seriously ill children, which is stressful for inexperienced doctors. Registrars are more experienced, training as specialists. To group them together as junior doctors is odd. The authors assert that poor working conditions and administrative inefficiency and incompetence cause unacceptable levels of emotional stress that poses a risk to patients. But this does not follow from the results, which are misinterpreted, and statistical measures and graphs do not support their serious assertion that children are placed at risk.

If dissatisfaction were great, would repeated reminders have been necessary to elicit only 22 (56%) responses from 39 eligible junior doctors? To say that this 'response rate represents a 90% confidence interval with a 10% margin of error' is meaningless and distracts from the fact that only just over half ultimately replied. Perhaps the junior doctors did not understand what the questionnaire was about because, to reduce bias, 'the questionnaire was presented as a survey on skills retention and did not make any mention of burnout.' I doubt whether that could disguise the fact that the questionnaire was about stress and dissatisfaction.

Conclusions about 'recruitment, improved management and planning, increased support, mentorship and a more empathetic administration' come presumably from the 'semi-structured' interviews of 4 selected registrars, and therefore reflect the opinion of only 10% of 39 eligible junior doctors.

That 95% of junior doctors intended leaving after their rotation does not confirm that they were discontented and burnt out. Contracts determine when junior doctors leave: for SHOs, 6 months to a maximum of 1 year, and registrars at the end of their training period. Had junior doctors been asked whether they would like to remain if a post were available, could not very different results have been obtained?

Considering ethics: how was the journal's ethical requirement for Research Ethics Committee approval circumvented? Accepting that the phrase 'business ethics' is a contradiction in terms, it still comes as a shock to discover how insensitive to ethical concerns the academic business community seems to be.

Junior doctors are often exploited and work under unfavourable circumstances without proper supervision and support in State hospitals – particularly when away from the big centres. It is puzzling why burnout was studied at the Children's Hospital, a better-staffed and -resourced teaching institution.

If the authors' intention was to help the junior doctors, they have done them a disservice by presenting flawed data. Their fatal error is the title phrases 'junior doctors' and 'skills retention'. Explicitly defining these abstract terms would have made it obvious that they are incompatible concepts. Junior doctors are students employed on defined period contracts – similar to articulated clerks in law and accountancy. Skills retention refers to conserving the permanently employed skilled workforce. Mistaking students for skilled permanent staff has portrayed the Children's Hospital's stunning success in the training of health care professionals as a problem.

Dr Richard Asher² warned of the trap that the authors fell into: 'It is often helpful to straight thinking to pause and consider what we are meaning by a word, for we may find it is playing tricks on us';³ and that 'with the aid of abstract terms it is easy to parade such a brave show of words in front of one's thoughts that it is extremely difficult to see if there is any idea behind them.'⁴

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1. Stodel JM, Stewart-Smith A. The influence of burnout on skills retention of junior doctors at Red Cross War Memorial Children's Hospital: A case study. *S Afr Med J* 2011;101(2):115-118.
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PSA results require age-related reporting

To the Editor: There is a concern that no cognisance appears to be taken of age-related normal ranges in reporting the results of total prostate specific antigen (PSA) tests in South Africa. This omission may result in many patients being subjected to unnecessary invasive procedures resulting in high costs to medical schemes and, more importantly, unnecessary prostate surgery.

South African private pathology laboratories do not reflect an age-related normal range for total PSA, unlike numerous other countries, e.g. Australia, Canada, the UK and the USA, who do so. Medicare in Australia will not reimburse claims for a free PSA if the total PSA result is not accompanied by the age-related normal range. South African laboratories have accepted that the upper limit of normality is 4 ng/ml, regardless of age. Workers in the USA have produced the following table:¹

Age	ng/ml
40 - 49	0 - 2.5
50 - 59	0 - 3.5
60 - 69	0 - 4.5
70 - 79	0 - 6.5

There are also racial differences in the normal ranges in the diverse South African population groups that appear not to have been considered.

Should the total PSA result exceed 4 ng/ml, the laboratories do a reflex test for free PSA and, should the age-related normal

range not have been applied, an investigative cascade may commence unnecessarily. I submit that age-related tables should accompany all PSA total results.

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Child consent in South African law – implications for researchers, service providers and policy-makers

To the Editor: Our article¹ compared and contrasted the ages at which South African children could consent independently to various health-related interventions at the time of publication and

when the Children's Act (No. 38 of 2005) became fully operational. As this Act has been fully implemented, all the ages of consent that we indicated would come into operation are now in force. We would like to bring this fact to your readers' attention and ask that they read the original article together with this letter.

Tables I and II highlight where information has been updated. Table I shows the ages at which children can consent independently to 7 key health-related interventions, previously, currently and in the future.¹ The only procedure where there may be change in the future, is consent to health research – if s71 of the National Health Act (2003) as drafted is implemented, the age of independent consent to research will be 18 years and older. Children from the age of 12 can now consent to 4 of the 7 interventions, indicating a shift towards children of this age and older having the ability to consent to various health-related activities. Certain of the health interventions have different requirements, e.g. children need 'sufficient maturity' to consent to medical treatment while they need to simply demonstrate that they are 12 in order to consent to HIV testing.

Table II sets out the persons who can provide proxy consent for children who do not have the capacity to consent themselves. Again, research is the only area where there may be future changes. The key

change introduced by the Children's Act (2010) is the recognising of caregivers as authorised to provide proxy consent.

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Table I. Health procedures/interventions for which children can consent independently: previous, current and future

Procedure/ Intervention	Previous age at which child could consent independently	Age at which child can consent independently now	Future changes
Medical treatment	14	12 + 'sufficient maturity'	No proposed change
Operations	18	12 + 'sufficient maturity' + parental/guardian assistance	No proposed change
HIV testing	12	12	No proposed change
Access to contraceptives	12	12	No proposed change
Termination of pregnancy	Any age	Any age	No proposed change
Male circumcision	18	16	No proposed change
Research	No age specified in law	No age specified in law	18

All changes are in bold font.

Table II. Persons who can consent when children do not have capacity: current and future

Activity/ intervention	Previous set of persons eligible to provide proxy consent	Current persons eligible to provide proxy consent	Future changes
Research	No legal guidelines	No legal guidelines	Parent/legal guardian must consent (if s71 of NHA (2003) is implemented)
Medical treatment	Parent/legal guardian and a range of other persons could consent	Parent/legal guardian, caregiver and a range of other persons can consent	No proposed change in the future
Operations	Parent/legal guardian had to consent	Parent/legal guardian must assist	No proposed change in the future
HIV testing	Parent/legal guardian, care-giver and a range of other persons could consent	Parent/legal guardian and a range of other persons can consent	No proposed change in the future
Male circumcision	Parent/legal guardian had to consent to operations	Parent/legal guardian and a range of other persons can consent	No proposed change in the future

All changes are in bold font.