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# Internship and community service require revision

Apprenticeship has long been established in the medical profession. This was graphically brought home to me when reviewing Mike du Preez's expanded document on the early years of Dr James Barry (personal communication). Dr Barry (1789 - 1865) was an army doctor who was posted to the Cape of Good Hope, among other appointments elsewhere in the world.[1] The drama of 56 years of hidden identity was revealed when Dr Barry died and was found to be a woman. After graduating from the Edinburgh medical school with an MD, Barry enlisted as Surgeon's Pupil at the United Hospitals of Guy's and St Thomas's. At that time it was possible for non-graduates to apprentice themselves to a surgeon for a period of 7 years in order to qualify to practise, but physicians required a medical qualification. This was why such surgeons were called 'Mr' and not 'Dr'. Today surgeons often still use the title Mr as a mild form of inverted snobbery.

Undergraduate clinical training in medicine even today contains elements of apprenticeship, and long ago apprenticeship in the form of internship was introduced to provide a bridging period of practice under supervision before being able to practise independently. Formal postgraduate training towards graduating in a specialty, or simply to become expert at whatever practice doctors find themselves in, generally provides a graduated apprenticeship, with initial closer supervision and then increasing responsibility. The Medical Board of the Health Professions Council of South Africa (HPCSA) stipulates the requirements for each stage of this postgraduate experience. For specialty training posts to be recognised it must be demonstrated that adequate experience and supervision are available.

Some years ago the Department of Health (DoH) and some zealous educationists in the HPCSA extended internship to 2 years, arguing that newly graduated doctors lacked skills and that they needed practical exposure to all the major disciplines.[2] The rationale for the 2 years' internship was to accommodate a reduced undergraduate study period from 6 to 5 years. This was based on the fond but mistaken belief that excellent supervised practical experience would compensate for the reduced educational period. HPCSA evaluations of internship posts have repeatedly shown that supervision is often lacking, and that even where supervision is present in the teaching hospitals, the internship experience is far from satisfactory.[3]

At the same time the DoH introduced a compulsory year of community service. Our previous government required compulsory military service of white doctors. The debates at that time included the view that all doctors should do community service of some kind, one form being an army doctor. Now community service is applicable to all South African medical graduates. Again the HPCSA considered it appropriate that these doctors, fresh out of internship, should continue to work under supervision. However, the community service doctors are often placed in public hospitals not of their first choice, and are overworked and poorly supervised.[4]

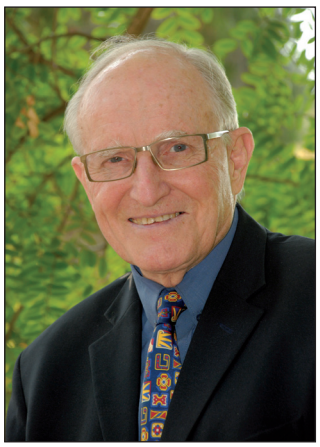
In this issue Nicolette Erasmus argues strongly on legal grounds against the exploitation of our medical professionals during their compulsory internship and community service duties.[5] Since the compulsory double-dose internship and 1-year community service have been in operation for some years, it is time to take stock of their utility.

Firstly, the 5-year medical curriculum in South Africa was a misguided exercise given the educational backlog of many matriculates who enter the universities. Time and resources are required by the universities to make up this deficit before they can get on with their real educational tasks. An extra year at university under ideal learning conditions is preferable to 2 years' poorly supervised activities thereafter. Secondly, time spent in rapid rotation between many disciplines during internship could better be spent on acquiring better skills in fewer areas. It makes little sense for someone who has decided to specialise in psychiatry to spend time setting fractures in an orthopaedic rotation while denying the aspirant surgeon this opportunity. Burch and Reid[6] observe that '... it appears that obligatory service may have negative unintended consequences, and it could be seen as "immunising" young graduates to further work in the public service'. Thirdly, both interns and community service doctors lack supervision. A further important consideration is that many students complete their study with heavy financial loans that have to be repaid, and the additional 3 years in low-paid posts add to that burden.

Given these problems of the compulsory internship and community service, the following solutions present themselves:

- Return to the 6-year undergraduate medical curriculum – all bar one of the medical schools have done so.
- Restructure the 3-year compulsory internship and community service into a 2-year programme. If this is done by returning to a 1-year internship, the following community service year could be nuanced to accommodate important missing experience.
- Increase the number of medical officer posts (many were lost to fund the second year of internship), using the funds released by introducing the 2-year programme. This would greatly improve service delivery and supervision. Again Burch and Reid[6] note that 'For continuity it is better to have one doctor in a post for 5 years than five doctors for 1 year each.'

Erasmus[5] concludes: 'What is left is to "address the structural concerns, including policy and labour market failures that give rise to forced labour in the first place"'. Simple changes can contribute significantly to a long-term improvement in our medical services, and the public service in particular would benefit.



**J P de V van Niekerk**
*Managing Editor*
*jpvann@hmpg.co.za*

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