Interns in South Africa - a new two year challenge for family physicians.

The Health Professions Council of South Africa (HPCSA) has adapted the regulations for interns based on the changing medical training in the country. As many universities are moving towards a five year undergraduate medical curriculum, medical students are released into practice in their sixth year after entering the programme. These interns have to do a two year rotation in accredited facilities and family medicine including mental health have been combined in a four month block. During this block there are certain tasks and skills which should be monitored by a trained family physician.

In the Southern district of the North West province, nine of the total intake of interns fall into the category of "two-year" interns. They are graduates from the University of Transkei and Bloemfontein University. They have been allocated placements over the next two years in the different departments and family medicine is supervising two interns at any given time.

The HPCSA provides guidance by means of an intern logbook and directives. These documents however only provide a framework which needs to be filled with constructive meaning for the professional and personal development of these newly qualified doctors.

The two interns in the Southern district are working in different sub-districts with different managers deploying them. They have weekly supervisory visits from the family physician and furthermore they work under the guidance of medical officers, either at clinics, casualties or a district hospital.

The format of the weekly supervisory visits has been to see patients together and/or to discuss documented patients. The patients for discussion have been chosen by the interns because of triggers, such as clinical uncertainty, strong emotions felt by the intern, behaviour observed in colleagues which were deemed unacceptable and questions relating to prescribing, and others. The following are examples of such patients and situations.

A patient was brought into casualty, already dead and when her husband and small child arrived, they were informed by the medical officer, in the middle of the casualty department, that she was no longer alive. The information took a few minutes to impart and there was no privacy, compassion or caring demonstrated. This upset the intern and we managed to search for applicable articles on "breaking bad news" after discussing how it should have been done. She felt affirmed by the objective information which supported her feelings of the correct processes that should have been followed and she has subsequently been able to deliver bad news to a number of patients with relative confidence.

Community service doctors are sometimes included in the clinical discussion as they share the problems at the clinics. In such a shared discussion, an 84 year old woman was presented. She had a slightly high blood pressure and was confused at times. The family's agenda was to get her tablets and have the blood pressure controlled. The community service doctor (CSD) heard an atrial murmur, on examination. She felt that it probably wasn't significant within the context to act aggressively but phoned the hospital for an opinion. The medical officer berated her for even considering non-referral of the patient. The intern happened to be in the hospital casualty when the family arrived at the hospital and observed the consternation and disturbed equilibrium of the whole family. The old lady was admitted, an ECG and echograph was done and she returned home after nothing had changed in her treatment. It was a good example of understanding the context, the agenda and the appropriate primary health care management of such a patient. It also confirmed to the CSD that her gut feeling had been correct and that she had not needed to over-react the way the senior doctor had expected her to.

There have also been discussions about how to manage a patient presenting with sexual difficulties, the value of crying with a patient about traumatic news, the diagnosis and management of porphyria, hysteria, keloids on the earlobes, the use of symphysis fundal heights and the antenatal card and many others. We are searching together for evidence based answers to questions and trying to address systems' problems like lack of drugs or inadequate equipment.

In the short time since the programme has been implemented, it has been a challenge and a learning curve for both the interns and the supervisor involved and at least one of the parties feels much richer for the experience!

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