

# Hands-on student training in private hospitals has arrived



**Mediclinic and Stellenbosch University have successfully piloted the first standardised rotation of 4th- and 5th-year medical students through a**

**private hospital – and plan to quadruple the intake to broaden the inadequate national training platform and diversify student disease profile exposure.**

The partnership, enthusiastically backed by the Western Cape health department, saw 32 Matie medical undergraduates each spending a month at the Durbanville Mediclinic in an internal medicine (IM) rotation during 2014, supervised by locals: radiologist Dr Rene Truter and IM specialist Dr Rust Theron. All the private specialists (who volunteered their time) underwent a special short course at the Stellenbosch University Faculty of Medicine and Health Sciences (FMHS) to 'ensure they would optimally transfer the right skills and knowledge' to their young charges. From next year the plan is to put 140 Matie medical undergraduates through the four Mediclinic hospitals in the northern suburbs (adding Cape Gate, Louis Leipoldt and Panorama hospitals to the list) via a 'memorandum of agreement' signed by the two contracting parties. According to Prof. Marietjie de Villiers, Deputy Dean of Education at the FHMS, this is not the first time the private sector has contributed to the training of medical undergraduates – but the 'scale and standardisation' of the current project is a major departure from the historical norm.

## Outdated training laws not serving the National Development Plan

The Wits Donald Gordon Medical Centre in Gauteng (in which Mediclinic is a minority shareholder) is an accredited training hospital, and various other initiatives across the country have involved the private sector in the training of medical undergraduates. The Health Professions Council of South Africa (HPCSA) does not prohibit training of undergraduates in the private sector – private general practitioners have been helping out with training for years. However, in terms of existing legislation, postgraduate training remains confined to public sector tertiary and regional hospitals, something of which both the academic and private medical communities at the launch of the latest undergraduate private initiative were highly critical, given the dire shortage of qualified healthcare professionals.

Koert Pretorius, CEO of Mediclinic Southern Africa, said that the HPCSA would not accredit private hospitals for training purposes (Wits Donald Gordon being an exception). 'They made it clear to us that if Mediclinic ever became a majority shareholder at Wits Donald Gordon, their training accreditation would fall away – so from that perspective it's been problematic.' He said that if the country was to deliver on the over-arching National Development Plan, outdated legislation, including the prohibition on hiring doctors by private hospitals, would have to be urgently revised. 'We operate private

hospitals in Dubai and Switzerland where we employ the doctors. We fundamentally do not understand why doctors are not allowed to choose where they may be employed. Our experience is also that most of our supporting specialists are very interested in giving back via training. By definition, because of their years of training, they're academics – and they're keen to plough their skills back in and mentor, creating an enabling environment for healthcare delivery in this country,' he added.

Asked to elaborate on Mediclinic's view on the current ethical rules around employment of doctors, fee-sharing and doctor co-ownership of facilities, Pretorius said the point of departure 'should not be that all doctors are susceptible to over-servicing pressures'. He saw the future of healthcare as embracing a more integrated approach between service providers instead of the current approach where the hospital, clinical radiologists and pathologists worked 'in silos'. Clinical independence and decision making should remain with doctors while allowing them to take part in other business models that would create 'better and more informed decision making, enabling them to be part of the solution'. While he understood the HPCSA's ethical concerns, an enabling environment for more integrated and efficient models would keep costs down and improve the quality of healthcare delivery. 'I think the concern from the HPCSA is that once you have corporate involvement or ownership of doctors' practices, there will be pressure to over-serve and generate unnecessary income – but that can be dealt with.' He alluded to the R20 million Da Vinci robotic surgery system, of which Mediclinic recently imported five (used mainly for prostatectomies), saying that his company sacrificed short- to medium-term profits in favour of exposing urologists to the best available research and technology – hugely benefiting patient outcomes and recovery periods. 'We want funders to contribute, but we're also prepared in the initial introductory phase to make a contribution in the sense that we'll not recover our full costs,' he added.

## Even more collaboration needed – Volmink

Prof. Jimmy Volmink, Dean of the Stellenbosch University FHMS, said the HPCSA was 'out of line with what's happening



Stellenbosch University medical undergraduates Gys Neethling and Victoria van der Schyff, with their internal medicine consultant tutor Dr Rust Theron, check on 'patient' Mariana Wilders.

in the rest of the world – this [private training] is an idea whose time has come. The public and private sectors needed to collaborate to help solve some of the fundamental problems South Africa [SA] faced. I think we're pushing the envelope here; there simply wasn't a push for the private sector to become involved before,' he added, alluding to national health minister Dr Aaron Motsoaledi's numerous overtures to and partnerships with the private sector.

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Asked what was behind the HPCSA's seeming aversion to open up doctor training to both sectors, Volmink said there was 'probably reluctance that somehow the private sector would cannibalise the public sector – I think we need to do more to try and reassure them – and the private sector needs to be more clear about its goals in addressing the broader needs of the population. Also if you look at education generally in the private sector, there are a number of degree and certification programmes that are very poor, with quality assurance not always what it should be – that could be another reason.' Previous Western Cape Health MEC Theuns Botha, who attended the announcement of the pilot scheme's success at Durbanville Hospital on 18 November 2014, said there had been a radical political shift from the days of apartheid when there was a 'differentiated level of responsibility towards different population groups'. 'The argument was we have enough in terms of what is required to look after the white population of the country'. This had shifted towards universal health coverage, yet the legislation was 'not developed for this purpose' and needed urgent renewal. Botha said that while ensuring that every South African had access to decent quality healthcare, there was 'no reason' why people should not be able to choose

private healthcare services. 'In my opinion a normal, growing, vibrant economy will result in 10% of the population driving luxury sedans and 85% of the population driving an affordable Japanese model car. Why should healthcare be any different? You should be able to decide where you get your healthcare service. This is not Cuba.' Botha predicted that the entire medical training platform would soon look very different, with his province probing the addition of newly established primary healthcare facilities to public tertiary hospital doctor training. De Villiers said they were not expecting any bureaucratic resistance or interference with their initiative because all doctors taking part were accredited by the HPCSA as teachers, with the hospital easily meeting the required minimum training standards.

### **Ageing doctor cohort – and training pipeline 'thin'**

Theron said he and his colleagues had realised that the doctors coming through the Mediclinic hospitals were 'ageing and there were not a lot of new people coming through – a reflection of the shortages nationwide'. All eight medical schools were currently producing at maximum capacity, with Motsoaledi adding pressure by asking them to expand to help 'reorientate' what will soon be 1 000 per annum Cuban-trained SA undergraduates returning to local conditions and disease profiles. The programme that trains South Africans as doctors in Cuba will expand nearly tenfold over the next 5 years, pouring 1 000 undergraduates into our currently under-resourced local medical campuses every year from 2018 onwards. For the past 3 years, the annual output of Cuban-trained South Africans, 'polished up' in their final year at local medical schools, came to about 8% of the 1 300 graduates fully trained locally.

The sudden acceleration in Cuban training is a crisis intervention aimed at buying time to adjust and expand our local medical training platform so that it can increase local doctor output while continuing to better reorientate the Cuban 'returnees' towards SA's very different disease profile.

Theron described the response from all role-players in the current local private training initiative as 'overwhelmingly positive', with students exposed to a disease profile significantly different to what they would have seen at a major public sector hospital (e.g. HIV/TB v. diseases of

lifestyle). Theron said the student group gained hands-on experience in interpreting X-rays, pathology, microbiology and haematology, accompanying him and his colleagues on daily ward rounds. 'They spent more time explaining to patients what was going on, forcing us to explain our decisions and actions – so everyone got a better service,' he joked. Theron said that the paediatrics and cardiology consultants in the other Northern Suburbs Mediclinic hospitals had already expressed willingness to come aboard *pro bono* as the programme evolved. 'They're all willing to give time and expertise to make this really viable,' he added.

One of the medical students who took part in the pilot programme, Victoria van der Schyff, said that initially she and her colleagues were worried that the different (private) patient profile might 'threaten their marks' at the end of their academic block. However, every student performed above their own expectations, 'probably because of the excellent one-on-one teaching'.

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Volmink said that his faculty's teaching approach emphasised social accountability and the social determinants of health, plus exposure to rural healthcare. 'But I think they need to also see what happens in the private sector, the profile of patients and disease and how to function in it,' he added. Mediclinic, responding to the nurse production crisis in the early 1990s, began importing Indian-trained nurses to supplement their own staff and have since established six learning centres with satellite facilities that train more than 1 000 nurses per annum, with accreditation by the Department of Higher Education and Training.

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