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Reconsidering the second year of South African medical internship: Training value, generalist readiness and international comparison

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South Africa (SA)'s 2-year medical internship programme was introduced with an understandable educational rationale: to provide broader supervised clinical exposure before community service and independent practice. However, the model should now be re-examined within the wider continuum from final-year medical school to internship, compulsory community service and later generalist or specialist work. Readiness for community service is important, particularly in district hospitals with limited support, but 1 compulsory year of community service should not determine the structure of internship for every graduate. Many international comparator systems use a 1-year internship, postgraduate year 1 or specialty-linked model, while SA combines a 2-year internship with additional compulsory service time after graduation. This article questions whether the additional training value of a second internship year is sufficient to justify another compulsory year for every graduate. Recent stakeholder data caution against simply cutting the current programme in half, but do not exclude a redesigned model. A national review should assess whether the current second year remains the best use of training time, supervision and workforce resources.

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Medical internship remains essential to the safe transition from medical school to clinical practice. Newly qualified doctors require supervised responsibility, repeated clinical exposure, procedural practice, escalation experience and time to develop professional judgement. South Africa (SA)'s current 2-year internship warrants review to establish whether it remains the most educationally efficient preparation for practice.

The Health Professions Council of South Africa (HPCSA) Medical Internship Handbook describes internship as a 24-month period of supervised training in accredited facilities, followed by community service before independent practice.[1] It also recognises that supervised training for newly qualified doctors is accepted internationally, but that its form and duration vary.[1] SA's 2-year internship should therefore be treated as a policy choice requiring periodic review, not as an unquestionable norm.

This article argues that SA should re-examine the educational justification for the second internship year within the continuum of final-year medical school, internship, community service and later generalist or specialist practice. Second-year rotations provide valuable experience, but their additional contribution to readiness for independent generalist practice requires evidence.

Historical context: from 1 year to 2

Medical internship in SA was introduced as a 1-year programme in the 1950s, with community service added in 1999.[3] The shift to a 2-year internship was introduced in the mid-2000s; a contemporary *SAMJ* report noted planned implementation from 1 July 2004,[2] while later literature describes the period as beginning in 2005.[3] The rationale was understandable: concerns had been raised that newly qualified doctors required broader practical exposure and more supervised experience before independent practice.

The 2-year model was also linked to anticipated changes in undergraduate medical training, including possible shortening of the undergraduate curriculum from 6 to 5 years.[3] That historical logic should now be re-tested. Most SA medical schools retained 6-year programmes, meaning that the expected trade-off between shorter undergraduate training and longer internship did not fully materialise.[3]

One historical justification for the 2-year model was readiness for district hospital work during community service, including concerns about maternal mortality, clinical skills and anaesthetic competence.[3] That remains an important policy concern. However, a national internship programme should not be designed primarily around readiness for 1 compulsory year of community service. Community service is only one stage in a much longer medical career, which may include generalist practice, medical officer work or later specialist training. Internship should therefore prepare doctors for safe early-career generalist practice across settings, not only for community service.

Internship as part of a training continuum

Internship is often discussed as if it begins the transition from student to doctor. In reality, that transition begins earlier. Internationally, transition-to-internship courses and assistantship models have been used to strengthen the move from undergraduate training into clinical work.[4]

This raises a SA policy question: should the final year of medical school be standardised nationally as a clearer junior internship or transition-to-practice year?

SA universities are likely to differ in curriculum design, clinical exposure, student responsibility and assessment. Some variation is educationally defensible, but it complicates the relationship between medical school and internship. If one medical school's final year provides substantial intern-like ward exposure while another provides less direct responsibility, then a uniform 2-year internship may partly

compensate for uneven undergraduate transition structures rather than address a clearly defined national training need.

A more coherent model would standardise the final-year transition function across SA medical schools by defining minimum transition-to-practice capabilities before graduation: ward participation, clinical documentation, handover, procedural exposure, prescribing preparation, emergency recognition, escalation, referral communication and supervised management of common presentations. Internship could then build progressively on this foundation rather than repeat it.

Time served is not the same as training value

Internship will always be partly time-based. Clinical maturity requires repetition, responsibility, varied case exposure and professional socialisation. However, time alone is a weak proxy for training value. Two years of internship does not automatically produce better-prepared doctors than 1 year of well-structured, well-supervised training.

The same principle applies within rotations: 3 months in a discipline is not automatically superior to a shorter, better-supervised block with explicit generalist competencies and reliable assessment. Competency-based medical education provides a useful lens, not because internship should abandon time-based training, but because training time should be linked to defined outcomes.[5]

There is no obvious point at which additional medical training stops being useful. A third year of internship would almost certainly provide further experience, as would a fourth. The relevant question is therefore not simply whether additional training has educational value, but whether the additional benefit justifies the extra time, cost and opportunity cost. Internship duration should reflect a reasonable balance between educational benefit and the resources required to achieve it.

Internship already has clearly stated competencies. The HPCSA handbook and logbook set out expected training requirements and competency documentation.[1] The more important questions are whether those competencies are meaningfully taught, observed and assessed in practice, and how much training time is actually needed to achieve them. SA commentary notes that internship training is intended to occur under supervision, but that supervision is not always consistently implemented, while logbook completion remains the main record of achieved competencies.[3]

When service displaces education

The central risk in the current internship model is that service need can displace educational intent. In resource-limited hospitals, the immediate priority is often maintaining ward cover, after-hours rosters and patient flow. Under these conditions, supervision, teaching, feedback and direct observation are easily deferred.

This weakens the assumption that more time equals better training. A second internship year may increase exposure, but if that exposure is dominated by unsupervised service work, administrative duties or repetitive low-yield tasks, it may primarily increase the workforce contribution of interns rather than their readiness for independent practice. The educational value of internship therefore depends not only on duration, but on whether training is protected from service pressure.

International comparison and the 1-year norm

International comparison does not prove that SA should copy another country. Health systems differ in disease burden, supervision capacity, workforce density, funding and regulation. However, comparison challenges the assumption that a 2-year standalone internship is inherently necessary.

Several comparator systems use a 1-year internship or equivalent early postgraduate bridge. Ireland has a 1-year intern year.[6] Australia requires 47 weeks of postgraduate year 1 training before general registration, with structured supervised experience across undifferentiated illness, acute and critical illness, chronic illness and peri-procedural care.[7] India requires a 12-month compulsory rotating medical internship.[8] These examples do not prove that SA should adopt a 1-year model, but they show that broadly trained early-career doctors can be produced through shorter, structured transition models.

Other systems link postgraduate clinical training more directly to specialty training. In the USA, postgraduate year 1 is part of graduate medical education and residency training.[9] In Germany, postgraduate training is organised through specialist training regulated by the State Chambers of Physicians after basic medical qualification.[10] These systems are not directly comparable with SA, but they show that prolonged general internship is not the only possible bridge between medical school and later specialist practice (Table 1).

The UK is the major counter-example because it uses a 2-year Foundation Programme. However, UK medical degrees normally last 5 years, or 4 years for graduate entry, and doctors in training operate within a regulated working-time framework generally based on a 48-hour average working week.[11,12] By contrast, SA internship follows a generally longer undergraduate pathway and includes formal overtime, with evidence that actual overtime may exceed the nominal framework in some settings.[1,13] The UK programme therefore does not directly justify SA's current model.

Stakeholder caution and the need for redesign

A recent Western Cape survey by Boden *et al.*[14] provides an important caution against simplistic reform. Most respondents favoured retaining the 2-year internship: 68% believed reducing the programme to 1 year would be harmful, and 75% preferred the current 2-year duration. Respondents anticipated reduced clinical exposure and teaching time, and many were concerned that shortening internship would compromise readiness for independent practice.[14] These findings should be taken seriously: simply cutting the existing programme in half would be unsafe and unacceptable to many stakeholders.

However, this does not settle the question addressed here. The relevant policy question is not whether the current 2-year model can be mechanically shortened, but whether the full continuum from final-year medical school to internship and community service can be redesigned to produce equivalent or better generalist readiness in less duplicated time. Boden *et al.*'s[14] own findings support this framing: respondents prioritised diagnostic skills, procedural skills, supervision and readiness for independent care, while many also supported flexibility in rotations and rotation length.

Reconsidering the second internship year

High-risk district-hospital skills remain essential, particularly where community service doctors face obstetric emergencies, trauma, acute paediatric illness and limited specialist backup. The training required for these responsibilities deserves closer examination. A focused generalist curriculum, supplemented by preparation for specific community-service placements, may provide these competencies without requiring every graduate to complete a second internship year.

Table 1. International models of postgraduate medical internship

Model type	Examples	Relevance to South Africa
One-year internship/postgraduate year 1	Ireland, Australia, India	Challenges the assumption that 2 years are always necessary
Two-year bridge	UK Foundation Programme	Relevant comparator, but not a direct justification for SA's model
Specialty-linked postgraduate training	USA, Germany	Contrasts with SA's separated internship-community service-specialist pathway

Emergency-care competencies can be embedded within internal medicine, paediatrics, obstetrics and gynaecology, surgery and a dedicated acute-care block. Family medicine competencies can be integrated through primary care exposure, district-health rotations, chronic disease clinics, community-based care and supervised management of common undifferentiated presentations. These areas may also be strengthened through a nationally standardised final-year junior internship.

By contrast, the marginal value of prolonged standalone exposure to more hospital-specialist rotations requires scrutiny. Orthopaedics, anaesthesia and hospital-based psychiatry can all contribute useful skills, but their current form may not be optimally aligned with the needs of an independent primary-care doctor. A future general practitioner requires musculoskeletal assessment, fracture recognition, pain management, referral decisions, mental health assessment, suicide risk assessment, sedation awareness, airway basics and emergency stabilisation. These competencies do not necessarily require full traditional specialist rotations if they can be delivered through shorter, targeted generalist modules.

Anaesthesia illustrates the point. The HPCSA handbook notes that the anaesthetic rotation does not qualify interns for independent anaesthetic practice.[1] Its educational purpose is therefore exposure, safety awareness and supervised basic capability rather than independent anaesthetic competence. This supports redesigning such content around generalist-relevant outcomes.

This distinction also matters for caesarean section and anaesthetic exposure. If the policy concern is that a community service doctor may encounter emergency obstetric or anaesthetic risk in a district setting, then the educational response should be targeted: recognition of obstetric emergencies, safe escalation, perioperative risk awareness, airway and resuscitation basics, referral thresholds and supervised procedural exposure where appropriate. These risks do not, in themselves, justify requiring every graduate to complete a full additional year of internship organised around traditional hospital-specialist rotations.

Family medicine and emergency medicine should be central to a redesigned 1-year internship, with the most useful elements of current second-year rotations incorporated into a focused generalist curriculum.

Salary, overtime and service burden

A full cost analysis belongs in a separate article. However, the cost implications of the current internship model cannot be ignored. SA interns are not supernumerary learners. They are salaried doctors in formal public-sector posts, and their remuneration includes base salary and commuted overtime arrangements.[1] This reflects the reality that interns are not only being trained; they are also being used as part of the service platform.

The formal framework assumes substantial service contribution through normal working hours and commuted overtime arrangements.[1] This highlights that internship is not protected training time alone, but also a salaried workforce model in which interns contribute significantly to service delivery.

The educational justification for internship should therefore be assessed against the opportunity cost of using doctors-in-training for routine service delivery. Where interns perform work that develops clinical judgement, procedural competence, emergency decision-making or readiness for independent practice, this cost may be justified. Where they spend substantial time on repetitive phlebotomy, administrative co-ordination, patient-flow tasks, clerical duties or other work of low educational value, the justification is weaker. SA literature on clinical associates suggests that mid-level cadres can contribute meaningfully to service delivery where roles are clearly defined and integrated into clinical teams.[15]

This creates a practical reform opportunity. A shorter, competency-focused 1-year programme could potentially reduce salary and overtime expenditure while protecting the highest-value educational experiences. Such a model should not simply be cheaper; it should be more focused. Any savings should be evaluated for possible reinvestment into supervision, simulation, procedural training, primary care exposure, emergency care training, appropriate support cadres, additional medical officer posts and expanded registrar training opportunities.

Discussion: towards a 1-year, better-structured model

A national review should evaluate the additional contribution of the second internship year to readiness for practice, alongside its costs and workforce implications.

A defensible 1-year internship would require curriculum redesign around the competencies of a safe early-career generalist doctor. Internal medicine, paediatrics, surgery, and obstetrics and gynaecology should remain central, but their duration should be justified by defined outputs rather than tradition alone. Some components require time because they develop clinical judgement through repetition; others may be taught through focused modules, simulation, supervised procedural lists, acute-care exposure or primary-care integration.

Such a model could include a nationally standardised final-year junior internship; a focused 1-year internship built around internal medicine, paediatrics, surgery, obstetrics and gynaecology, primary care and acute care; integration of emergency medicine across major rotations; a dedicated family medicine/primary-care component; targeted modules in mental health, musculoskeletal care, anaesthetic safety, resuscitation, procedural skills and pain management; strengthened supervision and feedback; clear readiness criteria for community service or independent generalist practice; targeted additional preparation where specific community-service placements require particular competencies; and separation of educational work from routine service tasks that could be performed by other cadres.

A further reason to reconsider the second internship year is the length of the broader post-medical-school pathway. SA graduates may complete 6 years of undergraduate medical training, 2 years of internship and 1 year of compulsory community service before full independent practice. For those pursuing specialist training, this may be followed by additional time in medical officer posts while waiting for registrar entry. A focused 1-year internship could shorten the

early-career training pathway, provided it is supported by stronger supervision, clear competency requirements and integration with final-year medical school and community service.

Areas for further research

Further work should assess readiness for independent generalist practice, rotation-level educational value, final-year transition-to-practice training, intern workload and supervision, and the cost implications of the current 2-year internship v. a redesigned 1-year internship model.

Highlights/policy implications

- SA's 2-year internship should be reviewed as a policy issue, not only an educational tradition.
- Community service is an important stage of early medical practice, but should not determine the structure or duration of internship for every graduate.
- Stakeholder concern about shortening must be taken seriously, but should not prevent evaluation of a redesigned 1-year model.
- The fact that a second internship year adds educational value does not by itself justify requiring it for every graduate.
- A nationally standardised final-year junior internship could improve readiness for internship and reduce duplication.
- Hospital-specialist content should be redesigned around generalist-relevant competencies.
- Internship reform should distinguish educationally valuable doctor training from service work that could be performed by other cadres.

Conclusion

SA's 2-year internship model had a rational historical basis, including concern about readiness for community service in district settings. Recent stakeholder data caution against simply shortening the current programme. However, community service is 1 compulsory year in a much longer medical career, and should not be the endpoint around which the entire internship programme is designed. Many comparable international systems use a 1-year internship, postgraduate year 1 or specialty-linked postgraduate model. SA combines a 2-year internship with compulsory community service and, for many doctors pursuing specialist training, possible further time as medical officers before registrar entry. A second internship year will inevitably provide additional experience. That additional benefit must be weighed against the financial, workforce and opportunity costs of requiring another compulsory year for every graduate. A more coherent model may involve a nationally standardised final-year junior internship, a focused 1-year internship, targeted preparation for the needs of specific community-service placements and clearer alignment between internship, community service and later career pathways.

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