Background and Development of Postgraduate Education in a Peripheral Hospital

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It has been pointed out that since the inception of the National Health Service the non-teaching hospitals in Britain have become progressively upgraded and have developed uniformly well-qualified consultant staffs (Whitfield, 1968). Consultants freed from complete dependence on private practice have had time to develop academic interests and teaching. The experience gained in Grey’s Hospital during the last four years has revealed a similar trend which will be described, but before doing so, a brief general description of the background to this experience is necessary.

In common with the general situation, the provision of health services in South Africa is complex and does not permit a blanket solution such as the National Health Service in Britain. At the present time the responsibility for the hospitalisation of Africans rests mainly with the government. Many of the major hospitals for Africans have full-time consultants on their staffs, who take great pride in their work, providing a high standard of care. Some of these hospitals are highly esteemed for the excellence of the clinical training they provide.

White people above a certain income level are responsible for the payment of their own medical expenses unless they belong to a medical aid scheme, and private practice, both general and specialist, is flourishing. Whites and Coloureds (here denoting people of mixed descent) below this income level are entitled to treatment in hospital by full-time medical personnel, being charged according to their financial status. The charge varies from province to province but is always subsidised and may be little or nothing in deserving cases. These people may, however, elect to have treatment by a private doctor in hospital, except in the non-private beds in teaching hospitals which are generally closed to private practitioners.

More and more Whites and, latterly, some of the wealthier Coloureds are joining the ever-expanding medical aid programmes of private and State-aided health insurance, and the current situation is changing for the better. Some bolder spirits would prophesy that this is the beginning of universal
State Medicine and that those in full-time hospital employment would be wise to stay where they are despite the short-term allure of private specialist practice.

Grey's is a non-teaching hospital, with 500 beds, which caters for Whites, Coloureds, and Indian obstetric patients and it is recognised for the pre-registration training of housemen. Until 1966, the consultant staff all served in a part-time capacity and, in common with many peripheral and non-teaching hospitals here and elsewhere (Jones, 1962), there was a serious shortage of resident medical staff. At the beginning of that year, the resident staff of the Department of Medicine consisted of one house physician and one registrar while four years later the full complement of the department is two registrars and three house physicians. This improvement is also reflected in other departments.

The influence that the appointment of full-time consultants was likely to have on the recruiting of staff and on general standards seems to have been realised, for in July 1966 the post of full-time physician to head the Department of Medicine was created, followed later by the appointment of a surgeon, a gynaecologist and an anaesthetist, all full-time and all heads of their respective departments.

As the first incumbent of a full-time post of this nature, the provision of an adequate service in a hospital that did not on the whole present a particularly attractive image to prospective residents involved a four point challenge. First, junior staff had to be attracted. Secondly, to achieve this, standards had to be raised and maintained by careful supervision and teaching. The modern young doctor expects no less, and part-timers, busy outside in competitive private practice, may find it very difficult to make sufficient time. Thirdly, available services in the department had to be expanded and improved and, lastly, continuing postgraduate education for local general practitioners had to be provided, an idea inspired by recent impressive developments along these lines in peripheral hospitals in Great Britain.

It was felt that only by satisfying these four requirements could the existence of a full-time departmental head be justified.

**Attraction of Resident Medical Staff**

One of the earliest administrative tasks was to write to the deans of some of our medical schools informing them that this particular hospital was now going to have full-time consultants and asking them to bring this to the notice of final year students. Some of the work of the department was published to indicate the research activities of the hospital (Meiring, 1967; Meiring and Briscoe, 1968).
After a slow start the number of applicants increased steadily, helped by the provision of regular and punctual bedside supervision by a consultant who spent all day in the hospital. Recruiting gained further impetus from the recent completion of a block of comfortable flats for married residents, which is probably an essential step in the upgrading of any hospital today. We are now often in the happy position of having more applicants than posts available in the department.

THE SETTING AND MAINTENANCE OF STANDARDS
The enforcement of the strict discipline prevalent in most teaching units would probably have inhibited our initial recruiting campaign. Therefore, the department has always regarded its recruits as younger and less-experienced colleagues in need of friendly guidance and help. Most of these young men and women have amply repaid the faith placed in them and have proved to be responsible; rebukes for lapses of duty have been rare. Because of the close yet unobtrusive supervision it is unlikely that many patients have suffered from any lack of application of iron discipline.

The standard of clinical record-keeping was found to be poor, and in an effort at improvement random case sheets were examined from those kept by one of the early intakes of house physicians and were scored according to a set of predetermined marks. Obvious deficiencies were corrected by discussing their marks with individual house physicians. The standard of record-keeping was greatly improved, but the survey entailed a great deal of work and proved unpopular. Subsequently, case sheets have been examined after discharging the patients, and any significant and recurrent omissions brought to the attention of house physicians, without awarding scores. The knowledge that their notes are being examined in this way, even though they may be working at the time for consultants other than the head of the depart-
ment, seems to exert a considerable influence in producing better records, but it must be admitted that this tends to be an uphill battle. The setting in which these registrars and house physicians work is fairly standard, and the departmental organisation is shown in Fig. 1. The night calls of registrars and housemen and the arrangements regarding the roster of firms on intake would be applicable to almost any other similar hospital.

There is a weekly teaching round at which cases are presented to the assembled consultants, visiting consultants from a nearby hospital, and a number of general practitioners, who are encouraged to attend regularly. In addition, a weekly case demonstration, lecture, or journal discussion is held and the residents are rotated through all three firms during their six months’ sojourn in the department.

**Expansion of Existing Services**

During the course of three years a number of additions and improvements were made to existing services and equipment. The library was extended and subsequently taken over by the Provincial Library Service. This meant that books and journals became freely obtainable on loan from other libraries, and adequate photocopying facilities were made available as well as a fairly generous annual grant for buying new books.

The hospital social worker was integrated into the activities of the department and a joint survey was undertaken (Meiring and Phipson, 1968) to ascertain the types of problem most amenable to this comprehensive approach.

The buying of additional equipment, and the opening of an intensive care unit was of immediate benefit to the Department of Medicine and paved the way for the opening of a coronary care unit later.

**The Establishment of Postgraduate Education for General Practitioners**

Some of the visiting staff had previously hoped to start a programme of postgraduate education for general practitioners, but with totally inadequate resident assistance with their hospital work and busy private practices to maintain, it had never proved possible. With a full complement of resident staff a suitable climate for additional postgraduate efforts was achieved and at a meeting of the Medical Superintendent’s Staff Committee on 10th September 1968, a postgraduate subcommittee was established consisting of the full-time departmental heads, the medical superintendent, and two co-opted visiting specialists, one of whom was elected as chairman. Three week-end refresher courses for general practitioners have been held since then, lectures being given by both local and visiting specialists, including staff.
members of the University of Natal Medical School situated fifty miles away in Durban.

It must be admitted that attendances at all these courses has been disappointing. It is always the same few whose tired faces are seen, and these are invariably the best general practitioners in their neighbourhood. There is always the hope that eventually a climate of opinion compelling better attendances will develop and that a more attractive course will be evolved.

**DISCUSSION**

The establishment of departments headed by full-time staff in a non-teaching hospital has been of great benefit to departmental and community postgraduate education. Our local experience seems to confirm the impressions gained in Britain, but we have not, as yet, an equivalent to the Central Committee on Postgraduate Medical Education through which individual programmes can be affiliated with university departments and co-ordinated on a country-wide basis. However, a start must be made somewhere to establish the necessary foundation on which to base any future advance towards co-ordination at a national level.

These efforts are time-consuming and were not possible in Grey's Hospital while busy private practitioners were trying to run departments with inadequate assistance. And yet today's residents are not prepared to work in smaller centres that do not provide, in their opinion, adequate supervision, teaching, and the go-ahead image that goes hand in hand with active postgraduate education. A vicious circle is established that can be broken by the growth of full-time appointments at these hospitals and the spread of an academic approach to the periphery.

If there are any lessons to be learned from this attempt to provide an adequate service in a non-teaching hospital, they can be listed as follows—

1. The good resident is the backbone of a hospital's medical staff, and without him the standard of service suffers seriously. Makeshift arrangements, such as the employment of reluctant busy general practitioners on a part-time basis, have to be made, and there is little opportunity for such refinements as postgraduate education. Every effort must be made to attract good residents to hospitals which it is intended should be upgraded, and measures to do this include the provision of sympathetic supervision, adequate teaching, and comfortable married quarters.

2. A corps of full-time or nearly full-time consultants has become almost essential.

3. Publications must appear from the hospital.
4. A standard of equipment and facilities commensurate with the required standard of service must be provided, including an adequate library service, and its use by outside doctors must be encouraged.

5. The provision of community postgraduate education is probably essential to the development of the reputation so necessary for the continued attraction of resident staff of good quality. It is, moreover, an important community service that should be as attractive as possible.

In examining our own experiences in particular, and these trends in general, against the wider background of provision of medical services, the growth of full-time specialist services based on hospitals seems as inevitable as the eventual reduction of the volume of specialist work conducted in a purely private capacity.

Costs of modern investigation and treatment are often above the limit that any but the wealthy can afford to pay without some form of subsidy. Because those who pay the piper can hardly be blamed for calling the tune, this may take the form of outright provision, as in Great Britain, of nationalised health facilities. In this, and the implementation of too rigid a system of co-ordinating postgraduate training, lies the danger of stifling initiative and individuality. To find the happy medium in our changing societies is a challenge nowhere yet adequately met. The best that has been done so far is to have assessed trends and to have tried to fit ourselves to them.

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