Medical students' intentions to practise in rural areas

To the editor: In response to the article by Van Wyk et al regarding medical students' intentions to practise in rural areas,[1] a number of limitations of the study need to be pointed out which were overlooked by the authors. Firstly, the choice of an arbitrary definition of rural origin without reference to previous studies, contradicts one of the stated aims of the study which was to "compare the findings of other national and international studies". Tumbo et al,[2] defining rural as areas outside major urban areas, provincial capitals and towns using postal codes, found that UKZN had a rural origin student population of 23,5% in 2002, more than twice that found in this study. Secondly, there is the effect of a response bias, in that the 25% of students who did not respond to the survey may have contained a higher or lower proportion of those of rural origin. The method of data collection was not described, so no assessment of the respondents' perceptions of pressure by the authors to respond can be made. Thirdly, the findings of the study are based on final year students' intentions as opposed to their actual choices which are likely to differ significantly after two years of internship plus a year of community service. The cross-sectional study design and the weak link between intention and actual choice render the data insubstantial in terms of the actual situation. Finally, and most importantly, the numbers of respondents from rural and semi-urban areas was too low (all in single figures) to make valid statistical comparisons between the sub-groups. Despite the proviso being given that "due to small sample sizes in some cells the results should be treated with caution", the authors go on to conclude that "students of rural origin are unlikely to return to a rural practice". This conclusion is not justified by the quality and quantity of the data from the study.

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References

1. Van Wyk J, Naidoo SS, Esterhuizen T. Will graduating medical students prefer to practice in rural areas? SA Fam Pract 2010;52(2):149-153.
2. Tumbo JM, Couper ID, Hugo JF. Rural origin health science students in South African universities. South African Medical Journal 2009;99(1):54–56.

The authors responded as follows:

The authors highlighted and referenced the lack of agreement regarding a single best definition of "rurality". The authors also explained why the definition of *rural origin* needed review in the South African context and how it might have influenced the results of the current report.

Re: "insufficient description of method and inadequate sampling." The study design was clearly explained in the relevant section. The participants were not purposefully sampled. The authors therefore interpreted all responses and reported accordingly.

With reference to the gap between intention and actual choice, this study highlighted that a substantial number of respondents were still undecided at the time of the survey. A longitudinal study may confirm whether the trend reported in this case persists beyond community service. This cohort specific cross-sectional study was, however, not designed to fulfil that purpose.

The shared consultation

To the editor: I was interested in Couper's account[1] of the shared consultation because I have often found myself puzzling over issues such as professional roles, boundaries, clinical accountability and patient wellbeing after sharing consultations with nurses and other staff in primary care clinics. I eventually came to realise that, rather than disempowering me, empowering other workers freed me to get on with other pressing work.

The authors also note that research into shared consultations could shed light on these intriguing encounters which are so much part of the South African primary care scene. To better understand my work at Tafelsig CHC in Mitchells Plain, I undertook two simple clinical audits. In one study[2] I examined the pool of clinical competence in the CHC against the blocks that staff encountered in meeting their patients' needs, and in the other study[3] I noted whether or not the application of Shahady's six principles of family medicine facilitated the delivery of good patient care. There is a real place for ad hoc *'n boer maak 'n plan* audits that will allow us to better understand our work, and I look forward to reading the authors' findings from their work.

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2. Whittaker DE. Clinical competencies necessary for the development of a comprehensive primary health care service in Cape Town: a study of ten patients. Abstracts 9th International Ottawa Conference on Medical Education, Cape Town 2000; 232.
3. Whittaker DE. Notes from the Coalface: Family Medicine in the Public Sector. Abstracts 11th General Practitioner's Conference 'The Art of Holistic Care'1998 Free Papers 35.