Vocational Training — The KwaZulu Experience*

— Garth Brink

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Curriculum vitae

Dr Garth Brink is in general practice in Durban and has been a member of the Academy since its foundation. He has been Chairman of the Natal Coastal Branch of the Academy for the last five years and in 1984 was Chairman of the Steering Committee for the 4th GP Congress held in Durban. Dr Brink has a strong interest in vocational training and is the Regional Director of the Academy of Family Practice Vocational Training Programme for the Natal Region. He is a member of the General Practice Faculty Committee of the College of Medicine of South Africa.

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Summary

Vocational training for general practitioners in Southern Africa has lagged behind the rest of the world. Despite the reticence of the medical authorities to implement vocational training for general practitioners, the SA Academy of Family Practice/ Primary Care in conjunction with the KwaZulu Health Authorities established a vocational training programme in the KwaZulu/Natal area in 1985. The concept of vocational training was new to many of those who were involved in the training of the first incumbents of the programme, and considerable mistakes were made during the first phase of the programme. This paper discusses the programme which was instituted in 1985, as well as examines the problem areas which were encountered by those involved in the programme. One of the main problem areas which requires clarification is that of evaluation and assessment of the trainees, as well as to setting of uniform standards which will be applicable to trainees throughout Southern Africa. Recommendations and suggestions will be made regarding vocational training programmes with particular reference to the KwaZulu/Natal programme.

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South Africa provides few formal programmes for vocational training for the general practitioner. In 1985, the South African Academy of Family Practice/Primary Care, in association with the KwaZulu Health Authorities, commenced a vocational training programme based at Edendale Hospital and rural KwaZulu hospitals.

This paper describes the experiences of this particular programme, highlighting the problems which faced those who organised it, as well as facts which have been learnt through participation in this programme.

KwaZulu — facts and figures

KwaZulu is a self-governing state, situated in Natal. According to the 1985 population census, the total population of KwaZulu is 4 706 111 of which 4 697 067 are Black. The population of Natal, excluding KwaZulu is 2 437 216, of which 1 042 285 are Black. The population growth for Blacks is estimated to be 3,18% per annum.

The projected 1988 population figures for KwaZulu are 4 999 581, and Natal Blacks 1 109 413.

KwaZulu comprises 26 magisterial districts, situated as islands within Natal.

Hospital and Medical Establishment

Hospitals	26
Rural	19
Large	4
Polyclinic	1

The large hospitals are:
1. Edendale
2. Madedeni
3. Ngwelezana
4. Prince Mshiyeni Memorial

There is a large psychiatric hospital at Umbogintwini consisting of 1 200 beds; 800 beds are occupied by psychotics, the remainder by mentally defective patients.

There are four hospitals under the control of the Department of National Health and Population Development which are responsible for supervising certain KwaZulu clinics. These are:

1. Emmaus
2. Murchison
3. St Appolinaris
4. Itshelejuba

Total beds approved	9 313	
Fixed clinics	205	
Mobile clinics	413	
Clinic teams	30	
Doctors	416	— Of these 131 are situated in rural hospitals
Nurses	6 910	

Commencement

In 1983 the South African Academy of Family Practice/Primary Care convened a workshop in Pretoria to examine the provision of primary health care, and the availability of medical personnel in the undoctored areas.

Dr Daryl Hackland, currently Secretary for Health — KwaZulu, was present at the workshop, and saw the desirability of the KwaZulu Health Authorities combining with the South African Academy of Family Practice/Primary Care to provide a vocational training programme.

Aims of the vocational training programme

The programme would primarily be aimed at training doctors for general practice/primary health care, and most important, exposing them to the rural areas. It was hoped that, through such exposure, the trainees would be encouraged to remain in the rural areas on completion of their training.

The overall aim of the programme would be:

To produce a practitioner who is

- safe to practice independently
- sound in clinical judgement and practice management
- sensitive to what patients say and feel
- steady under fire
- self-aware and critical of his or her own work
- committed to continuing self-education

and who

- thinks and behaves in terms of health as well as disease and can apply techniques of prevention and health promotion as well as those of cure and rehabilitation
- thinks and behaves in terms of the family and community as well as in terms of the individual sick patient
- thinks and behaves in terms of membership of a health team consisting of doctors, nurses and other health services
- thinks and behaves in terms of making the best and most effective use of the financial material resources available
- thinks and behaves in terms of the country's pattern of health and disease and its relevant priorities.

Aiming at training doctors for general practice and exposing them to the rural areas.

In 1985, five trainees commenced the vocational training programme. At that stage, it consisted of two phases. The first phase was of eighteen months duration, and this time was spent at Edendale Hospital. The second phase was of six months duration, and this period was spent at an approved training hospital in rural KwaZulu.

The Programme

I was appointed as Regional Director for the programme, and Dr Sidney Mobbs of Pietermaritzburg, was appointed the Local Course Organiser. Neither of us had any previous experience in vocational training, but we shared common ideals and goals, and recognised the importance of vocational training. It was a question of sink or swim, finding out for ourselves where we went wrong, what changes should be introduced, and learning from our mistakes, of which there were plenty.

The Local Course Organiser

The Local Course Organiser is the key figure in any programme, for he carries the burden and responsibility of organising the entire programme. Perhaps a brief look at the attributes required of a Local Course Organiser is necessary.

1. He must be committed to the concept of vocational training.
2. He must be a diplomat of the highest order.

The Local Course Organiser has to deal with the Regional Director, the trainers, the trainees, the Hospital Superintendent, as well as the Heads of the various departments. He is the keeper of the peace, the negotiator, and much more.

3. He must be able to communicate well.

This obviously applies to interaction with the trainees, trainers, but particularly with the Regional Director. Ease of communication between the Regional Director and the Local Course Organiser allows for early identification of problems, and the institution of methods which permit solving of the problems before tragedy or disaster strikes.

4. He must be interested in education.

The approach to vocational training and the training of the trainees follows the adult education model — and this remains the basis of all vocational training.

Aiming at training doctors who are sensitive to what patients say and feel.

Without such interest, and knowledge, the traditional medical school model will dominate the trainer/trainee interaction, which will not permit full growth of the trainee in the vocational training programme.

The Trainers

Dr Mobbs was delegated the task of appointing trainers, a task which proved most difficult. We were dealing with new concepts, and the concept of vocational training was entirely new to most practitioners. In addition, most practitioners do not accept the need for vocational training, and likewise do not want to involve themselves in training. To make matters worse, we could offer no remuneration for the time spent as a trainer.

Being involved in training involves dedication, and time. Sacrifice and commitment. For a trainer, there is invariably loss of income. There is currently no incentive for a person to become a trainer, other than the positive effect that it has on one's own attitudes, and method of practice.

Four trainers were appointed, none of whom had any previous experience in teaching. One was at that stage busy with the M Prax Med degree at MEDUNSA.

The fact that none had any experience was a great stumbling block, and the trainees voiced this strongly. What they were being taught was not being seen in practice, and this obviously led the trainees to question seriously what we were attempting to teach, and achieve through vocational training.

Training the Trainer Workshops

These were instituted towards the end of 1985. Four such workshops have been held since, and these have been invaluable in allaying the fears that prospective trainers have with regard to training. Following the first workshop, the trainees commented that the standard of training by the trainers had improved.

The people that attended the workshop comprised the four that were appointed by Dr Mobbs, plus trainers of the rural KwaZulu hospitals, and others who had expressed an interest in being trainers in the future. The first workshop served to bridge the gap which existed between the urban and rural doctors, both coming to understand each other, and realising that there were goals and ideals common to both.

The continuation of these workshops is essential if one is to keep the trainers motivated in training, and to give them opportunity to voice grievances and problems which they encounter in training.

The Course

Initially the course/programme was over a period of two years. Eighteen months was spent at Edendale, and six months in a rural hospital. Trainees were expected to enrol for a M Prax Med Course, and thus far, all have done so. This is an extremely important facet of the training, and has contributed greatly to the success of the vocational training programme which is being held.

The Edendale Phase

Five supernumary posts were made available for the trainees. They had no direct appointment to a particular department. This, as far as we were concerned, was the ideal situation. It allowed for tremendous flexibility, and the rotations through the various departments could be tailored according to the requirements of the trainee. It permitted considerable leeway for the arrangement of day release courses, week release courses, and time for regular tutorial sessions.

Trainers need to be remunerated – they lose a lot of their time and their income.

The Local Course Organiser met with the Heads of Departments at the beginning of the training programme, outlined the specific needs and requirements of the trainees who would be spending time in a particular department.

The Local Course Organiser met with the trainees on a regular basis, and weekly tutorial sessions were held. These sessions would cover aspects relating to the discipline of family medicine, such as interviewing

skills, the consultation, dealing with terminal illness, patient-centred care.

Release courses were to community health services, in particular the Valley Trust Programme. Other day releases were to the trainers in general practice. These proved to be disappointing in that the trainee felt that they were not given the opportunity to experience general practice due to lack of time and continuity. Accordingly, this release has been abolished in favour of one week release, every six months, to different practices. This allows for a greater active participation of the trainee in the work, and has been more successful.

The topics dealt with in the tutorial sessions were largely determined by the trainees. This is in accordance with the concept of adult education, and this concept is explained to the trainees at the commencement of the course. Each trainee is asked to define for himself his own aims and objectives for the course. These are discussed with the Local Course Organiser so that a suitable course may be arranged. Flexibility of the programme is essential if this approach is to work well, and the Local Course Organiser must also be flexible. A rigid non-relenting approach will not achieve any results.

Following assessment with the trainees of this phase, it was felt that this phase could vary between 12 and 18 months, depending on the previous experience of the trainee. Certain other aspects regarding this phase have recently arisen, and to this I will refer at a later stage in this paper.

The entire training could be undertaken at a community based hospital.

The Rural Phase

This initially comprised six months at an approved rural hospital. The appointment of such hospitals was done in close liaison with the KwaZulu Health Authorities. They were aware of possible trainers and which rural hospitals were not overworked and understaffed. Having identified these hospitals, the trainees were given the choice of where they wished to continue with their training.

Several distinct problems arose during this phase.

Firstly, rural implies rural. These hospitals are not easily accessible, which made supervision by the Local Course Organiser and Regional Director extremely difficult. It was decided to appoint Dr Alan Mitchell of the KwaZulu Health Authorities as Local Course Organiser for this phase, as it was thought that he would have more opportunity to meet with trainers. The trainees would be attending the regular M Prax Med sessions and this would supposedly have given Dr Mobbs and myself the opportunity of meeting with them.

However, this was not a workable situation, as Dr Mitchell has an extremely busy time schedule without having to add additional work to his already overloaded fork. At the M Prax Med sessions, everyone was usually too exhausted at the end to evaluate the programme. This was probably unfortunate.

Very little support was given to either the trainers or trainees during this phase, and this is far from desirable. It has been decided to examine the feasibility of having one rural hospital, easily accessible, as a training hospital, to which all the trainees will go.

Following the end of the first rural phase, the trainees stated that six months was too short. This phase has accordingly been extended to eighteen months.

The entire programme covers a period of at least 30 months, and a maximum of 36 months.

Didactic, teacher-centred approach is antiquated and has no place in vocational training programmes.

The Trainees: Appointment

The trainees are employed by KwaZulu in localised posts. A contract of service, drawn up conjointly by KwaZulu and the SA Academy of Family Practice/ Primary Care, is signed by the trainee when he commences the programme. The trainee is directly responsible to the Superintendent of the hospital where he is stationed, but is under the jurisdiction of the SA Academy of Family Practice/Primary Care for the vocational training aspect of the training. Either parties (ie the KwaZulu Health Authorities of the SA Academy of Family Practice/Primary Care) can ask the trainee to leave the programme, as can the trainee request to be released from his training component of service.

The trainee receives no remuneration from the SA Academy of Family Practice/Primary Care, and the latter is responsible for the training component of the programme.

The appointment of trainees was through application by the trainee to the SA Academy of Family Practice/ Primary Care, the completion of a biographical data sheet, and an interview. This interview is important, and experience has shown us that the final interview must be held by either the Regional Director or the Local Course Organiser. A screening interview is recommended if the trainee is from another region, but the final interview, on the basis as stipulated above, is essential so as to avoid misunderstanding as to what is expected of the trainee and what the course entails. Only those who are directly involved in the programme

can adequately explain the commitment required of the trainee.

This is the situation at the moment. One of the first trainees withdrew from the course, as the anticipated ideals were not those which were presented by the programme. It was felt that had this trainee been interviewed by the persons locally involved in the programme, this problem might have been avoided.

Trainees: Present Situation

Five trainees commenced the course in 1985. One has withdrawn, as mentioned above, three have completed, and the fourth will complete his training at the end of July. His training programme was interrupted by his Defence Force National Service commitment.

Of those who have completed the programme, one has remained in a rural hospital, the other in a rural polyclinic, and the third is now the Local Course Organiser for the Edendale programme.

Three trainees have commenced the 1988 programme.

Trainees: Incentives

One of the greatest drawbacks in this programme has been the inability of the programme and the SA Academy of Family Practice/Primary Care to attract trainees.

There are a number of reasons as to why this problem exists:

1. Vocational training is a new concept, and for this reason many doctors do not wish to commit themselves for a further two to three year period. It is not compulsory, and does not lead to any greater financial remuneration. Many do not consider vocational training essential, and have no knowledge regarding the discipline of family medicine. A greater exposure at the under-graduate level would probably result in a considerable change in attitude, and encourage more doctors to enter general practice.
2. Many doctors have had to spend two years in the Defence Force, and wish to enter private practice, and not be subjected to an additional two year period of low salaries.
3. Edendale Hospital might no longer be the ideal hospital to provide the hospital-based phase of training, for various reasons. At the moment, there is no fulltime course organiser or head of department at Edendale. Co-ordinating and supervision of the Edendale phase is made more difficult by this fact.
4. Lack of accommodation — both at Edendale and during the rural phase. The trainees have to find their own accommodation during the Edendale phase of training, and accommodation provided at some of the rural hospitals is not ideal.
5. No housing allowance is payable.
6. Pension fund and medical aid scheme was not available for the trainee initially. This has changed, and trainees may now contribute to such funds.
7. Lack of social amenities at the rural hospitals, and the hospitals being relatively inaccessible from the major cities/towns.

Standards

This has proved a most vexing problem — how do we know what standards to set, and that what we are doing is in fact what should be done?

The determining and setting of standards is an extremely difficult task, and requires greater clarification and uniformity than is currently the situation.

This leads on to the next aspect of the training programme, namely that of assessment and evaluation.

Assessment and evaluation

This has caused Dr Mobbs and myself many a headache. There are many aspects which require assessment:

1. The programme itself, ie the main aims and objectives, as well as the aims and objectives of each individual trainee.
2. The programme content — ie the release courses, tutorials etc.
3. The trainers
4. The Local Course Organiser
5. The Regional Director
6. The trainees

One has to decide what requires evaluation, and how it is to be evaluated. The problem arises with regard to frequency of such evaluation, and what to do with the information gained from such evaluation. It is difficult to assess attitudes, and behaviour.

During the first programme, very little formal assessment was carried out. I am of the opinion that we were too lenient in this aspect, and insisted on report backs by the trainees on several aspects of the programme. Unfortunately, this produced little helpful information, due to the pressure of work under which the trainees found themselves. This was probably compounded by the fact that the programme does not have a local Administrative Secretary to type out reports for the trainees.

What has been of value is to observe the trainees at work, but this is not always possible. We still have to determine methods by which the various aspects of the programme can be assessed so as to be confident that what we are doing is indeed correct and applicable to where the trainees will eventually be working.

Perhaps this means that the programme needs to set more specific aims and objectives.

Administration

We encountered considerable administrative problems from KwaZulu. It must be understood that this was an entirely new venture, and that teething problems were bound to occur. Through the patience of both Drs Hackland and Mitchell, these problems have to a large extent, been overcome.

Training the Trainer workshops is a necessity in any vocational training programme.

Funding necessary for: 1. Trainers/Local Course Organiser/Regional Director/Lecturers 2. Equipment 3. Staff 4. Accommodation 5. Workshops

Incentives: This is essential if the programme is to attract greater numbers.

Sharing of information and experience: So often a local programme loses sight of important issues, and the sharing of experiences can only lead to improvement and renewed commitment to the vocational training programmes throughout the country.

A vocational training programme requires time, commitment and dedication.

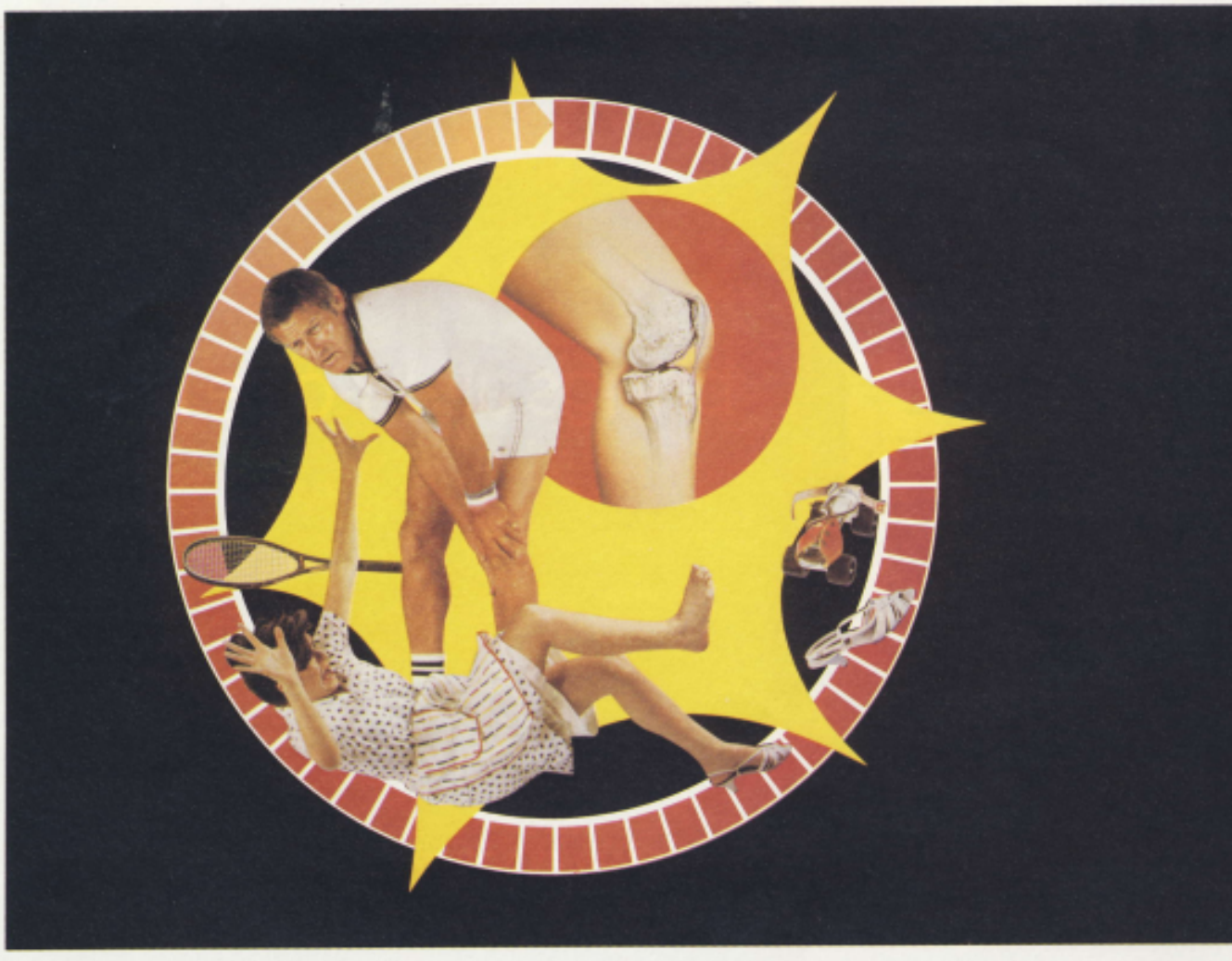
At the moment recognition for vocational training is still required, and until this has been achieved, the providing of vocational training programmes will be under difficult circumstances. Greater infrastructure, resources, and standardisation is required if the potential of vocational training is to be realised.

Finally, I earnestly request all involved in vocational training programmes to constantly ask themselves the questions which Dr Daryl Hackland posed at the inaugural Training the Trainer Workshop held in Durban in 1985:

1. Where have we come from?
2. Where are we now?
3. Where do we want to be?
4. How do we get there?
5. How can we be sure we have arrived?

Acknowledgements

I wish to pay special tribute to Dr Sidney Mobbs, the first Local Course Organiser. He has sown the seeds of an excellent programme, and his commitment to the concept of vocational training is to be admired, and emulated. Without the unceasing and tireless efforts of both Drs Hackland and Mitchell, this programme would not have been conceived in the first place. For the opportunity of this experience, we are greatly indebted to them and the KwaZulu Health Authorities. To all those in the Academy who have had to put up with the Brink/Mobbs team and their idiosyncracies, I thank them for their patience, and placing their trust in us.



Regrettably, we do not have the use of a local Administrative Secretary, and this does create a problem in the running of the programme.

Equipment

I will not enlarge on this aspect, as it is evident that various items are required for the training programme. The establishment of a library with references relating to family medicine is a pre-requisite.

Funding

The lack of funds constitutes a major drawback in the programme. It is difficult to ask a trainer to give of his time, lose income through such commitment, and not to be able to remunerate him adequately. This requires urgent attention if the programme is to expand.

Conclusions

We have all learnt a great deal through this programme, so perhaps, in this aspect, it has been successful. However, this was not one of the aims or objectives of this programme!

In conclusion, I would like to highlight a few areas again:

Edendale Phase: We now question whether a hospital phase, such as we are providing at Edendale Hospital, is at all necessary. We believe that the entire training could be undertaken at a community based hospital, such as is found in the rural areas of KwaZulu. This aspect is undergoing further investigation and feasibility studies.

Flexibility: This is an essential pre-requisite if one is to follow closely the concept of adult education.

The interview and selection of trainees: It has already been mentioned that the final interview and selection must be done either by the Local Course Organiser or the Regional Director of the particular programme which the trainee wishes to enter.

Adult Education: The didactic, teacher-centred approach is antiquated, and has no place in vocational training programmes.

Trainers: The selection of appropriate and dedicated trainers is essential. Likewise, it is important to train such people, well in advance, and the institution of