



MEDICAL AND DENTAL PROFESSIONS BOARD

**HEALTH PROFESSIONS COUNCIL OF
SOUTH AFRICA**

HANDBOOK ON INTERNSHIP TRAINING

**GUIDELINES FOR INTERNS, ACCREDITED FACILITIES
AND HEALTH AUTHORITIES**

**PRETORIA
2017 EDITION**

PREFACE

On behalf of the Subcommittee for Internship Training of the Medical and Dental Professions Board (MDB), I have the pleasure of making this Handbook available to all Interns, Intern Curators, and Accredited Facilities for Internship Training and Health Authorities who are involved with internship training and who employ interns.

The Subcommittee had come to appreciate the need in practice to obtain clear guidelines for internship training. Thus, based on experiences of members of the Subcommittee and the Evaluators of Internship Training and inputs of those who went through Internship Training this *Handbook for Internship Training* has been revised and I trust that it will be relevant as a guideline that will serve the needs of Interns and those responsible for their training.

On behalf of the Subcommittee, I wish to thank all persons who have contributed to this document, and this include members of the Subcommittee for Internship Training, Panel of Evaluators of Internship Training and all those who have worked tirelessly in the revision of this Handbook.

The MDB looks forward to ongoing improvement in the nature and quality of internship training as part of its role and mission of "Protecting the Public and Guiding the Professions". Part of this improvement is through the feedback and inputs from all our interns during their internship training.

The Subcommittee would appreciate your input on this document. Please address your comments to Ms. Tlamelo Majatladi, Subcommittee for Internship Training, P O Box 205, Pretoria, 0001.
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TABLE OF CONTENTS

PREFACE	1
INTRODUCTION	1
PART I	
GUIDELINES PERTAINING TO THE NATURE, STRUCTURE AND	3
DOMAINS OF INTERNSHIP TRAINING	3
1 AIMS AND PURPOSE OF INTERNSHIP TRAINING	3
2 FUNCTIONS OF THE MEDICAL AND DENTAL PROFESSIONS BOARD	3
3. CRITERIA FOR THE TRAINING OF INTERNS	3
4. CRITERIA PERTAINING TO THE TWO YEAR INTERNSHIP TRAINING PROGRAMME	4
5. LEAVE DURING THE TWO YEAR INTERNSHIP TRAINING PROGRAMME	4
6. INTERNSHIP REQUIREMENTS FOR PERSONS GOING OVERSEAS	5
7. OVERTIME DUTIES PERFORMED BY INTERNS IN MEDICINE	5
8. REQUESTS FOR TRANSFERS	6
9. ACCREDITED FACILITIES	6
10. SUPERVISION OF AND RESPONSIBILITY FOR TRAINING	8
11. THE INTERN CURATOR	9
12. PRACTICAL DETAILS	12
13. INTERN RESPONSIBILITIES	18
14. EVALUATION AND REGISTRATION	18
15. LOGBOOK	20
16. RESOLUTION OF CONFLICT	20
17. PROCEDURE FOR DEALING WITH IMPAIRED INTERNS	20
18. PROVINCIAL INTERN CO-ORDINATOR	21
PART II	25
GUIDELINES PERTAINING TO THE CONTENTS OF TRAINING PER DOMAIN	25
1. INTRODUCTION	25
2. GUIDELINES: DOMAIN OF GENERAL MEDICINE	27
3 GUIDELINES: DOMAIN OF GENERAL SURGERY (INCLUDING SURGICAL TRAUMA)	28
4 GUIDELINES: DOMAIN OF OBSTETRICS AND GYNAECOLOGY	29
5 GUIDELINES: DOMAIN OF PAEDIATRICS AND CHILD HEALTH	30
6 GUIDELINES: DOMAIN OF FAMILY MEDICINE/PRIMARY CARE	32
7 GUIDELINES: DOMAIN OF PSYCHIATRY	35
8 GUIDELINES: DOMAIN OF ANAESTHESIOLOGY	37
9 GUIDELINES: DOMAIN OF ORTHOPAEDICS/ORTHOPAEDIC TRAUMA	42

PART III: GUIDELINES PERTAINING TO MEDICO-LEGAL AND ETHICAL ASPECTS OF INTERNSHIP TRAINING.....	45
1 DUTIES OF A MEDICAL PRACTITIONER REGISTERED WITH THE MEDICAL AND DENTAL PROFESSIONS BOARD	45
2 LIST OF ETHICAL ISSUES TO WHICH INTERNS SHOULD BE EXPOSED.....	45
3 INTERNS AND LEGAL LIABILITY.....	46
4 INTERNS PERFORMING LOCUMS.....	50
5 DEATH CERTIFICATES.....	51
6 TERMINATION OF PREGNANCIES.....	51
7 RENDERING AFTER HOURS SERVICES	51
8 OVERTIME REQUIREMENTS DURING INTERNSHIP TRAINING.....	51
9 THE IMPORTANCE OF ADOPTING GOOD, SOUND AND ETHICAL FINANCIAL MANAGEMENT	52
10 ETHICAL GUIDELINES FOR GOOD PRACTICE IN MEDICINE, DENTISTRY AND MEDICAL SCIENCES.....	53

REGISTRATION

ANNEXURE A: REGULATIONS RELATING TO THE REGISTRATION AND TRAINING OF INTERNS IN MEDICINE	55
ANNEXURE B: INTERN DUTY CERTIFICATE FOR COMPLETION OF A TWO YEAR INTERNSHIP TRAINING PROGRAMME (FORM 10A).....	59
ANNEXURE C: DELAYED REGISTRATION OF AN INTERN AS A MEDICAL PRACTITIONER	61

ACT AND RULES:

ANNEXURE D: HEALTH PROFESSIONS ACT, 1974: EXTRACTS: SECTIONS 17, 19 AND 36.....	63
ANNEXURE E RULES SPECIFYING THE ACTS OR OMISSIONS IN RESPECT OF WHICH THE COUNCIL MAY TAKE DISCIPLINARY STEPS.....	67
ANNEXURE F NATIONAL PATIENTS' RIGHTS CHARTER: DEPARTMENT OF HEALTH	133
ANNEXURE G BATHO PELE PRINCIPLES	135
ANNEXURE H: GUIDELINES FOR THE MANAGEMENT OF PATIENTS WITH HIV INFECTION OR AIDS.....	137
ANNEXURE I: CRITERIA FOR ACCREDITATION OF FACILITIES FOR INTERNSHIP TRAINING	147

ANNEXURE J:	LEVELS OF HEALTH CARE	155
ANNEXURE K:	LIST OF ACCREDITED FACILITIES FOR THE TWO YEAR INTERNSHIP TRAINING PROGRAMME.....	175
ANNEXURE L:	INTRODUCTION OF THE TWO YEARS OF INTERNSHIP TRAINING	201
ANNEXURE M:	CRITERIA FOR THE APPOINTMENT OF EVALUATORS OF INTERNSHIP TRAINING	205
ANNEXURE N:	HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA AND PROFESSIONAL BOARDS: INFORMATION DOCUMENT	213

INTRODUCTION

It is accepted and practised world-wide that there should be a period of supervised training for newly-qualified doctors before they can register as medical practitioners. This training is usually for one year, but in many countries further training is required before registration is possible for independent practice as a general practitioner, as is the requirement also for independent practice in any speciality.

Internship training refers to the period of training in an accredited facility, i.e. a hospital, clinic, health centre or Complex of facilities. The period of internship training will be of two years duration as from 1 July 2004 and this is preceded by at least a five-year undergraduate curriculum of medical education and training.

This document provides guidelines for the training of graduates in a two-year internship training programme. The principles underlying internship remain the same especially if offered in the same complex of facilities.

This *Handbook on Internship Training* consists of the following sections:

Part I which provides broad guidelines applicable to all facilities and domains (disciplines).

Part II which provides the specific criteria and objectives of internship training in each domain.

Part III which deals with ethical and medico-legal aspects of internship training.

It should be appreciated that these guidelines are based on the comments of many individuals and therefore, reflect a consensus of views. It should also be borne in mind that accredited facilities differ widely in their structure and the scope of the patient care services that they offer.

Apart from the above, this document contains a series of Annexures which should provide interns and the bodies/persons involved in their training, with some valuable information on the requirements for, as well as the nature and content of internship training, and the facilities which offer such training.

During the past years and based on a large number of accreditation visits (evaluations) at facilities for accreditation purposes, it had become obvious that guidelines for internship training were urgently required. This then is a Handbook which hopes to achieve that goal. The Subcommittee for Internship Training trusts that this Handbook will be serving that purpose in practice.

PART I

GUIDELINES PERTAINING TO THE NATURE, STRUCTURE AND DOMAINS OF INTERSHIP TRAINING

1 AIMS AND PURPOSE OF INTERSHIP TRAINING

The purpose of internship training is that interns will complete their medical training under supervision and guidance in accredited facilities. They should effect the transition from undergraduate students, with responsibility primarily to themselves, to professional persons with responsibilities to patients, the health team and communities. Internship training should provide opportunities to further develop interns' knowledge, skills, appropriate behaviour patterns and professional thinking, as well as to gain insight, understanding and experience in patient care to equip themselves to function as competent and safe medical practitioners.

Training should be comprehensive and complementary to the health care system being developed for South Africa which places emphasis on the primary health care approach. The training should provide exposure to a spectrum of clinical conditions in order to provide a wide base of experience as a first step towards further training and study with a view to private practice, specialisation or continued hospital practice. Skills in the management of common emergencies should also be developed.

The importance of cost consciousness, professional behaviour patterns and ethics in professional practice form additional components in this training, both at the informal and semi-formal levels, and by example. Interns should be aware of the *Charter on Patient Rights* (see the document compiled by the Department of Health as contained in Annexure F) as well as the Batho Pele principles (Annexure G). The investigation and management of patients should be in line with those recommendations.

2 FUNCTIONS OF THE MEDICAL AND DENTAL PROFESSIONS BOARD

Internship training should be a constructive, organised and progressive period of training. It therefore forms part of the responsibility of the Medical and Dental Professions Board (hereafter referred to as "the Board"), in co-operation with educational institutions and employing Health Authorities, to ensure that newly qualified practitioners are adequately trained and sufficiently competent when applying to the Board for registration as medical practitioners. As such, it falls within the Board's statutory obligation to act on behalf of the profession by guidance and in the interest of the public. Training will only take place at facilities accredited by the Board, and such status shall be subject to regular accreditation visits (evaluations) and adherence to the prescribed criteria and requirements. It shall be provided by trainers who are medical practitioners with adequate experience (i.e. at least three years post-internship) in that specific domain, and who are accredited by the Board.

3. CRITERIA FOR THE TRAINING OF INTERNS

The following are basic requirements which shall be complied with:

Internship Training shall only be recognised if the intern was registered in terms of the *Health Professions Act, 1974 (Act No. 56 of 1974)*, for the full period of training (see Annexures A, D and E) and provided that training took place in one or more of the facilities which were accredited by the Board for this purpose (see Annexure K).

Conditions of internship training -

Internship training commencing after **30 June 2006** shall be of not less than twenty four months' duration and, where it is broken or interrupted, it shall be completed with a continuous period of thirty six months.

4. CRITERIA PERTAINING TO THE INTERNSHIP TRAINING PROGRAMME

Internship Training shall take place during a **two year** training period, as follows:

The following rotations for the two year internship training programme were agreed to:

4 months compulsory rotations through the following domains:

General Medicine
General Surgery (including surgical trauma)
Obstetrics and Gynaecology
Paediatrics

3 months compulsory rotation through the domain of Family Medicine/Primary Care

2 months compulsory rotations through the following domains:

Anaesthesiology
Orthopaedics/Orthopaedic Trauma

1 month compulsory rotation through the domain of Psychiatry.

Leave should preferably be taken during the four month rotations.

The product of the two year internship training programme is to be a well-rounded medical practitioner equipped for general practice during the year of community service.

The two years of internship training should preferably be completed in the same facility/complex/cluster/geographical area.

In the case of interns who would be required to complete additional time due to training/skills needs, or any other reason that a facility may require, such time should be completed at the end of the internship training programme, and not at the end of a specific domain of training.

Any four month rotation should not be divided into a 2 X 2 rotation, but should be completed in a single, continuous rotation, unless an intern had commenced his or her internship training later than the rest of the group due to failure at university level. In the event of late starters, such interns should commence a domain but move on to the next rotation with the others in the group and only complete the initial domain after the second year. If not done in this manner, the intern would always be out of step with the rest of the interns.

5. LEAVE DURING THE TWO YEAR INTERNSHIP TRAINING PROGRAMME

The provision for leave benefits forms part of the conditions of service of the Department of Health and is in accordance with the Labour Relations Act, 1995 (Act No 66 of 1995).

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Interns should be aware of the fact that more than 2 months of leave in the 2 year period shall result in extension of training in domains where training requirements are not met.

The following arrangements regarding leave during the two year internship training program shall apply

1. Annual leave of 22 working days/year thus 44 days over a period of 2 years
2. Sick leave of 24 days over the period of 2 years
3. Family responsibility leave of 10 days/year thus 20 days over the period of 2 years
 - a. A maximum of 5 days for death of a direct family member or spouse
 - b. A maximum of 3 days of paternity leave
 - c. A maximum of 5 days for illness of direct family

Maternity leave could be granted for a period of four months resulting in the intern having to extend the internship training by an additional four months.

Special leave up to 7 days/year may be approved for job related courses like ATLS, ACLS etc

Leave days beyond two weeks in a block may result in extension of training in the affected domain.

6. INTERNSHIP REQUIREMENTS FOR PERSONS GOING ABROAD

Applications received from South African citizens, who qualified in South Africa, but completed their internship training abroad, would be dealt with in the following manner:

Applications would be dealt with on an individual, ad hoc basis.

Accreditation could be granted for such rotations through domains of an equivalent, acceptable standard in accordance with the guidelines for internship training in South Africa.

The domains not covered during training abroad, should preferably be completed within a single complex accredited for internship training.

Such practitioners would have to apply to the Department of Health for positions in order to complete the remainder of the internship training.

Practitioners would be encouraged to complete the requirements for training and registration with specific reference to internship training in South Africa rather than completing internship training overseas which might not be approved.

Practitioners would be expected to submit a satisfactory and current (not older than three (3) months) Certificate of Good Standing prior to registration.

7. OVERTIME DUTIES PERFORMED BY INTERNS IN MEDICINE

It be confirmed that interns in medicine had to perform overtime duties. It was expected of interns to be on duty for a maximum of 60 hours per week and that overtime was part of service delivery. Interns were not permitted to refuse to work overtime.

In June 2006 the Subcommittee again confirmed that interns in medicine were required to perform overtime duties. It was, however, indicated that due to exhaustion and the possible risk to patients as a result, interns should not be required to be on duty for more than 60 hours per week which would include overtime duties as part of service delivery. In terms of the agreement with the Department of Health and because of emergencies, interns could not refuse to perform overtime duties.

8. REQUESTS FOR TRANSFERS

The Subcommittee for Internship Training, in September 2007, resolved that the recommendation pertaining to the transfer (swopping) of interns be maintained, namely that it was preferable that interns completed their internship training programme within the same facility/complex and that, should special circumstances arise, management of the facility and provincial authorities concerned be mandated to solve the matter.

The following should be noted regarding a request for a transfer from one facility to another:

According to the Department of Health, transfers are not permitted.

Once the results of the allocation of interns are released, the respective Provincial Co-ordinators could decide whether to allow a transfer or not.

Should an intern request a transfer, the intern should make a written request to the applicable Provincial Co-ordinator. That Province should then release the intern (in writing).

The Province where the intern would want a transfer to, has to then accept the intern in writing.

All correspondence should then be forwarded to the National Department of Health for endorsement as well as copies thereof to the Board.

Should the province in question refuse the release an intern in medicine, the National Department of Health would not be able to permit such a transfer.

9. ACCREDITED FACILITIES

APPLICATION FOR ACCREDITATION OF FACILITIES

Facilities, on the recommendation of Provincial Authorities or the South African Military Health Services, may apply to the Board for accreditation as internship training facilities, whether district, regional, tertiary, central or specialised. This may be done singly or as a complex, which could include specialised facilities such as psychiatric or maternity hospitals. A group of accredited facilities may thus share interns in order to provide wider clinical experience and training. Similarly, community health centres may also participate in training; provided that they are complexed with a base hospital and meet the criteria for accreditation (see Annexure I).

FACILITIES RELATING TO CLINICAL DOMAINS

An accredited facility shall provide adequate opportunities for the intern to obtain a wide range of clinical experience with regard to in-patients, out-patients and emergency services. There shall be sufficient facilities to ensure a proper diagnosis and correct treatment under satisfactory conditions. The Board considers it desirable that the intern be responsible for

not more than twenty-five and not less than fifteen short-term in-patients (which may be reduced to ten patients, should the intern rotate through critical care units in appropriate domains) and that he or she be allocated to not more than two out-patient sessions per week as fixed duty.

FACILITIES RELATING TO FAMILY MEDICINE/PRIMARY CARE/MENTAL HEALTH (INCLUDING CASUALTY, TRAUMA AND OUT-PATIENT DEPARTMENTS)

The Departments of Family Medicine/Primary Care and Mental Health at teaching hospitals, as well as at other accredited clinics, should have adequate facilities available to ensure that the intern receives practical training in the requirements which especially apply to this wide domain of General Medicine, amongst others, the establishment, control and management of a practice.

SUPPORT SERVICES

Support services such as diagnostic radiological services, main laboratories (Haematology, Biochemistry, Microbiology, and in the other Pathology disciplines), the pharmacy, the services of other health care professionals, a library and other specialised services should be available. Interns should be encouraged to do their own ECG's and routine side-room tests.

ALLOCATION OF INTERNS

The appointment of interns and the number appointed at any accredited facility are the prerogative of the employing Health Authority. Although primarily training posts, it should be obvious that a smaller than recommended number of interns allocated to an accredited facility, will place a greater clinical burden on other categories of personnel.

It is recommended that at least 80 % of the accredited internship training posts be filled at all accredited facilities.

ACCREDITATION VISITS TO (EVALUATION OF) ACCREDITED FACILITIES

Regular visits/evaluations by the Board to accredited facilities will be arranged to ensure that the accredited facility is adequately fulfilling its training function and, if not, such status may be withdrawn.

Visits/evaluations at accredited facilities are carried out by Evaluators of Internship Training appointed by the Board for this purpose. Criteria for the appointment of Evaluators for Internship Training are contained in Annexure M. Liaison between the Evaluators and Provincial Co-ordinators of Internship Training, appointed by Provincial Health Authorities, will aid the planning, conducting, as well as an appreciation of the importance of such visits/evaluations.

For the purpose of these visits/evaluations, Medical Superintendents/CEO's/Hospital Managers are required to provide the Board with detailed information on the prescribed forms prior to a visit/evaluation taking place. This information must be the result of a self-analysis in terms of the *Criteria of Accreditation of Facilities* (see Annexure I and shall, amongst others, include the views of interns. This information is essential and forms the basis for the assessment of a facility/complex by the Evaluators of Internship Training for accreditation purposes.

10. SUPERVISION OF AND RESPONSIBILITY FOR TRAINING

The primary responsibility for interns firstly rests with the Chief Executive Officer/Chief Medical Superintendent/Medical Manager as representative of the Health Authority under which the facility functions. Thus, the CEO/Chief Medical Superintendent/Hospital Manager plays an important role in ensuring that the requirements of the Board are being met.

The secondary responsibility for the training of interns rests with the senior medical staff. The CEO/Chief Medical Superintendent/Hospital Manager is aided by Heads of Departments and other senior personnel who will supervise the training of interns on a daily basis to ensure that the aims and objectives of proper internship training are being met. Apart from their clinical obligation towards patients, it is essential that time be devoted to the training of interns. Furthermore, each relevant clinical department should have a named supervisor to co-ordinate training in that domain.

Domain supervisors

Clinical Departments should have a specific supervisor who is responsible for the training of interns in that domain.

The Supervisor is to assist the Intern Curator who is appointed for a whole facility. In large hospitals it is not possible for the Intern Curator to keep in touch with the many interns in the various departments.

Most of the minor complaints of interns relate to “in-house” issues that the Domain Supervisor can resolve. Obviously more serious problems (operational or personal) should be reported to the Intern Curator.

Responsibilities

Welcome and orientation of interns into the Domain.

Provide job descriptions.

Allocation of interns within the Domain.

Act as liaison between the interns and staff whether nursing or medical.

Drawing up of the duty roster.

Supervising leave arrangements including sick leave.

Co-ordinate the evaluation of interns.

Ensuring the completion and signing of Logbooks.

Interns should be supervised by a registered medical practitioner with at least three (3) years (post internship training) of clinical experience in that specific domain of training.

The ratio of interns, versus supervisors for the supervision of interns in medicine, be based on a ratio of 4:1.

Specialists, Medical Officers and other practitioners are, by virtue of their continual contact with interns, important components in their training and all of them are morally obliged to participate in such training. This applies also to part-time appointees.

Access to supervisors should be available 24 hours per day. Interns should be supported by at least one medical officer or registrar on the hospital premises.

After-hours call rosters should be drafted with an intern on duty, a medical officer on first call and a consultant on second call.

An intern should not work alone in any critical areas such as casualty, labour ward, ICU or theatre. The person supporting him or her must therefore remain on the premises of the health facility (suitable call rooms are imperative). In practice this may be a relatively junior person that can support the intern. Note that the responsibility of supervision and patient care rests with a more senior person whether a medical officer or consultant. He or she should be available at all times and personally assist the intern as required. The senior person on call carries the medico-legal responsibility, since supervision means the acceptance of liability for the acts of another practitioner.

In smaller hospitals, the CEO/Chief Medical Superintendent/Hospital Manager may personally perform these supervisory functions. In larger hospitals, the CEO/Chief Medical Superintendent/Hospital Manager should, however, appoint an Intern Curator to assist him or her. The functions of the Intern Curator are fully described in 11 hereunder.

11. THE INTERN CURATOR

This person, preferably an experienced member of the medical staff, fulfils a very important role in the training of interns. This is particularly so in large hospitals where the complexity of the structure may not always work to the advantage of the intern who is the most junior member of the medical team.

The responsibilities of the Intern Curator include the following:

Ensuring that the training of interns takes place according to the prescribed guidelines.
Serving as an easy channel of communication between management and interns.
Acting as a spokesperson on behalf of interns.

Especially assisting the CEO/Chief Medical Superintendent/Hospital Manager in the following:

- a. Organising the orientation programme for new interns at the commencement of the internship training year.
- b. Establishing a representative intern committee to meet monthly with the Intern Curator and keeping records of discussions.
- c. Ensuring that the different departments provide interns with written job descriptions, specifying duties, as well as the training that will be offered.
- d. Ensuring that on-going evaluations of interns per domain are recorded and the evaluation forms, as per the Logbook for Interns, are returned to the CEO/Chief Medical Superintendent for his or her assessment and signature.
- e. Dealing with any personality problems, impairment or disciplinary issues pertaining to interns.

To be available as a confidant to advise individual interns with serious personal or health problems.

The CEO/Chief Medical Superintendents/Hospital Manager and Intern Curators are to involve nursing staff in the orientation of interns at the commencement of the internship training year.

Intern Curators to liaise closely with the various Matrons of accredited facilities regarding internship training.

To recognise the advantages of having internal liaison committees between the various levels of health personnel which could include the CEO/Chief Medical Superintendent/Hospital Manager, Intern Curator, Matron and any other relevant role players where issues pertaining to, for example, scopes of practice, competencies, relationships and clinical skills could be addressed.

The following practical suggestions have been useful in several accredited facilities:

- a. Arranging for one or two interns from the previous year to address the new interns.
- b. Compiling a small handbook for interns pertaining to local services which effect or relate to the work, community or social environment of interns. The interns know from experience what constitutes key information and such handbook saves valuable time, especially for interns from other medical schools.

NOTE

Where different facilities form a training complex, one person should be the Senior Intern Curator to whom the other curators/trainers are responsible. This is necessary to achieve a co-ordinated overall training programme, an equitable rotation of interns and comparable duty hours.

- c. Intern Curators at accredited facilities could, on submission of appropriate motivation, request at any time that a re-visit/re-evaluation be conducted.
- d. It should not be expected of interns to draw up their own on-call rosters.

GUIDELINES FOR INTERN CURATORS

Introduction

Internship is an important period in the on-going development of junior doctors. Accredited facilities are charged with the responsibility of providing suitable facilities, supervision, guidance and evaluation of interns in medicine. The Board has laid down criteria and requirements for such training. The responsibility for interns rests with the Chief Executive Officer/Chief Medical Superintendent/Hospital Manager as the representative of the Health Authority under which the training facility operates.

In smaller hospitals, the CEO/Chief Medical Superintendent/Hospital Manager may personally supervise the training of the interns. In larger hospitals this is obviously not possible and he or she will be aided by the hospital staff who have daily contact with interns. The portfolio of an Intern Curator had been established to assist the CEO/Chief Medical Superintendent/Hospital Manager in ensuring that internship training fulfils the necessary requirements as specified by the Board.

The Intern Curator should play an important role in the lives of the interns. He or she should look after their interests. The term "Curator" is derived from Latin: *curare* - to care for. Interns are the most junior of the medical staff, are appointed on a temporary basis, and have minimal say in their training and service conditions, hence the need for somebody to act as spokesperson on their behalf.

Appointment of the Intern Curator

This responsibility rests with the Chief Executive Officer/Chief Medical Superintendent/Hospital Manager.

The Curator should be an experienced member of the medical staff. Where possible, the Curator should not be a Head of Department or part of the administration.

It is customary for a Deputy/Assistant Medical Superintendent to be given the task of organising the appointment and supervision of interns. This person should not necessarily be the Intern Curator.

Clinical departments should have a specific supervisor who is responsible for the training of interns in that department. This would involve allocations, duty rosters, job descriptions, leave, etc. This is not the same person as the Intern Curator who is appointed for a whole facility.

There should be provision for the appointment of an Intern Curator for the overall Complex (where two or more facilities had formed a Complex for purposes of internship training).

There should be provision for the appointment of a deputy intern curator per facility (where two or more facilities had formed a Complex for purposes of internship training).

There should be provision for the appointment of deputies per domain of training which would report specific areas of concern to the intern curator.

SPECIFIC RESPONSIBILITIES

The Intern Curator is to assist the CEO/Medical Superintendent(s)/Hospital Manager with the following:

Selection of interns (this has not been necessary in view of the appointment of interns at Provincial and/or National level).

Organising the welcome and orientation programme for new interns. The following example can be used for the orientation programme

The following persons from the Hospital Management Team to be invited for the orientation programme:

Hospital CEO
Medical Manager
Nurse Manager
Administration Manager/HR
Intern Curator
Domain Supervisors/Clinical Head
Head of Support Services

Suggested programme to be followed:

Welcome - Intern Curator (Programme Director)
Introduction
Presentation on Hospital Services - Hospital CEO/Medical Manager
Hospital policies and protocols including needle stick policy – Medical Manager/Nurse Manager/Admin Manager/CEO
Duty Roster and Intern rotation plan – Intern curator
Meet the domain supervisors – short presentation by Clinical Heads/domain supervisors and distribution of departmental protocols and clinical guidelines
Meet Heads of support services
Election of the intern representative
Refreshments
Hospital Tour

Providing a “starter pack” giving details of conditions of service, communication channels, key personnel members in the facility, allocations, etc.

Establishing a representative Intern Committee to meet monthly with Management and the Intern Curator. Minutes of discussions should be kept and circulated to relevant individuals.

The Human Resources Representative/Clinical Manager of facility to attend meetings as required.

Meetings with Domain Supervisors regularly including the end of each rotation. Domain supervisors are to ensure appropriate supervision and guidance in the specific domain, and importantly to review and sign completed logbooks before the end of each rotation.

Ensuring that the different departments provide interns with written job descriptions, specifying duties, as well as the training that will be offered.

Ensuring that on-going evaluations of interns per domain are carried out, and that the Logbooks are completed and signed by the domain supervisors and Heads of Departments.

Investigating the failure of an intern to meet the requirements of a domain. The early detection of such an intern is most important to help the intern.

Dealing with personality problems or disciplinary issues pertaining to interns. The Intern Curator should recruit suitable counsellors to help him or her.

Resolving conflict between interns and management, or between interns and trainers.

Facilitating the accreditation visit or inspection of internship training by the evaluators appointed by the Board.

12. PRACTICAL DETAILS

TRAINING OF INTERNS

During internship training, the intern will develop and improve his or her skills in the evaluation of patients and decision-making at the levels of diagnosis, further investigations and management. It is also a training period in which new practical skills will be acquired.

The intern should have the opportunity to gain a wide spectrum of experience in the management of medical and surgical emergencies and, where feasible, to perform those procedures himself or herself under supervision. Thus, attendance of ward rounds and service under constant supervision in casualty departments and in critical or high-care units, are of crucial importance in gaining insight into the management of seriously ill patients.

In principle, the intern should assist with major surgical interventions and perform lesser procedures under supervision. He or she should also become familiar with certain common procedures, such as opening and closing of the abdomen, and appropriate parts of operations performed by senior doctors. Special emphasis should be placed on training in pre- and post-operative evaluation and care.

Emphasis should be placed on the importance of daily or, where needed, more frequent evaluation and management of patients.

All supervisors should train interns to assess the spiritual and psycho-social needs of patients and to act accordingly. Furthermore, specific attention should be given to the care and counselling of the dying patient and the support of relatives. Supervisors should consistently assist interns with this function.

Domain supervisors

Clinical Departments should have a specific supervisor who was responsible for the training of interns in that domain. The supervisor was to assist the Intern Curator who was appointed for a whole facility. In large hospitals it was not possible for the Intern Curator to keep in touch with the many interns in the various departments.

The responsibilities of a domain supervisor:

- a. Welcome and orientate interns into the domain.
- b. Provide job descriptions.
- c. Allocate interns within the domain.
- d. Act as liaison between the interns and staff whether nursing or medical.
- e. Draw up the duty roster.
- f. Supervise leave arrangements including sickness.
- g. Co-ordinate the evaluation of interns.
- h. Ensure completion and signing of logbooks.

The majority of the minor complaints of interns related to “in-house” issues that the domain supervisor could resolve. More serious problems (operational and/or personal) should be reported to the Intern Curator.

Referral of patients to other disciplines for consultation or for taking over the patient, should preferably not be left to interns, except in the event of an emergency where the registrar or another senior practitioner is not available.

The above guidelines have specific implications for academic hospitals where interns are often far removed from the mainstream of activities. The extensive hierarchical personnel structure militates against opportunities for the practical experience of interns. Steps should, therefore, be taken to correct this tendency.

APPLIED THEORETICAL AND ACADEMIC TEACHING

The intern shall receive teaching during ward rounds and informal discussions which are directed at patient care. It is important that the intern be given opportunities to test and apply his or her knowledge and experience during ward rounds.

Weekly departmental or inter-departmental discussions should be held. It is important that specific problems, such as cardiac arrest, respiratory failure and their management should be discussed with a special view to internship training. Alternatively, interns may be asked to do case presentations.

Interns should be encouraged to express opinions and make proposals during ward rounds.

The intern should be taught by precept and example to care for the patient and his or her family with empathy and to realise that the patient is not simply another case.

Where hospitals conduct statistical, mortality and medical audit meetings, they should be arranged at suitable times to ensure compulsory attendance by interns.

HISTORY-TAKING, SPECIAL INVESTIGATIONS AND RECORD-KEEPING

The importance of proper recording of a comprehensive history, a full clinical examination and follow-up examinations should be emphasised. The supervisor must satisfy himself or herself that these records are of an acceptable standard.

Because doctors may sometimes find themselves in situations where minimal facilities are available, interns should be taught how to evaluate and treat patients on the basis of a thorough history and physical examination without the benefit of special examinations.

It follows that interns should be taught not to subject patients to needless special and X-ray investigations.

The importance of ethical practices and medico-legal risks in practice must be brought home to interns.

COST AWARENESS

Cost is a major determinant of individual patient care and hospital budgets. It is, therefore, important to foster cost awareness, paying special attention to the following:

The cost and choice of pharmaceutical agents, as well as their safety. Regular consultations with and participation in relevant training, where applicable, by the hospital pharmacist(s), is therefore essential.

The desirability of requesting selected laboratory tests only, as well as the costs involved.

The importance and cost of relevant X-ray examinations. The dangers of radiation should be emphasised and guarded against.

Costs of other investigations and treatment modalities.

PATIENT ALLOCATION AND WORKLOAD

The Board has as a guideline recommending that 25 beds per intern should not be exceeded.

Unnecessary administrative duties and red tape are discouraged. Elimination of unnecessary procedures, the use of alternative personnel and modern technology, should be pursued.

Each department should, in conjunction with the Medical Superintendent/Medical Manager, draw up a job description for interns, specifying duties, as well as the structured training programme which will be offered.

Departments should also decide how to prevent and deal with stress and unreasonable demands on the intern.

It should not be expected of interns to search for vacant beds for patients.

HOURS OF DUTY

The intern is part of the health team and must learn to fulfil his or her responsibilities to patients. The following are, therefore, guidelines and not fixed rules. The interns' duties should be organised as follows:

Interns should work forty (40) hours per work week during normal hours

Interns should not exceed twenty (20) hours of commuted overtime per week, resulting in a maximum of 60 hours per work week.

Eighty (80) hours overtime per month should not be exceeded in a four-week cycle.

Interns are not permitted to sign any further contracts regarding specified overtime requirements.

Guidelines for after hour duty

The Sub-Committee for internship training noted that continuous working hours of 30 hrs may be excessive and can lead to fatigue, compromising the intern's ability to provide appropriate patient care. The workload in different hospitals and different clinical domains may vary across the country. Periods of rest within this continuous 30 hrs may also vary from hospital to hospital and domain to domain. The subcommittee also noted that the interns should be part of the post intake rounds for training and teaching purposes. Hence the subcommittee recommended that the number of continuous working hours an intern may work be reduced from thirty (30) hours to a maximum of twenty six (26) hours. This is to accommodate training requirements and to avoid fatigue related negative outcomes. However individual hospitals and clinical domains are requested to modify the roster with shorter shifts depending on the workload and taking into consideration the possibility of periods of rest within a call. The National Department of Health to engage with provincial departments to implement this approach.

Interns should not work full weekends, unless there is a 12 hour break during the weekend.

The frequency of night duties should allow for sufficient recuperation. Being on duty every second night would be unacceptable.

Interns should be off at least one weekend per month from 17:00 on a Friday to 07:00 on a Monday.

The Subcommittee held the view that overtime had to be performed by interns. It was expected of interns to be on duty for a maximum of 60 hours per week and that overtime was part of service delivery. Interns were not permitted to refuse to work overtime.

Night duty was a valid and essential learning experience where competencies and skills development could take place and exposure to very specific aspects of medicine was possible which differ from the normal day-time exposure.

A medical practitioner (including any intern in medicine) remained personally responsible for the care and treatment of his or her patients for as long as the patients required such care and treatment.

It was within the professional responsibility and discretion of a medical practitioner (including any intern in medicine) to decide when to leave a patient for whom he or she was personally responsible, bearing in mind, however, that should such patient suffer unduly or die as a consequence, the practitioner concerned would be held professionally accountable for his or her actions.

In the case where an intern had met the training requirements, both elective and emergency training requirements for a specific domain of training, interns could be utilized to cover other Departments' after-hour calls, as long as the guideline of 80 hours overtime per four-week cycle was not exceeded, and that no further contracts pertaining to overtime were agreed to or signed.

ACCOMMODATION AND FACILITIES – INFRASTRUCTURE INCLUDING ACCOMMODATION (HOUSING), ON-CALL ROOMS AND TRANSPORT

The Subcommittee for Internship Training has for some time deliberated on the infrastructural and support issues needed for internship training. These include accommodation, on-call facilities and transport especially where there are hospitals and clinics grouped into a complex. A need has arisen for the Subcommittee to deliberate on guidelines for the aforementioned infrastructure.

Accommodation

As far as possible, single rooms to be provided (15 m²) with a locker, a safe, a telephone, wash basin, cupboard, desk, chair and single bed. Ideally, en suite bath and ablution facilities should be provided with all amenities including hot water. In the event of communal bath and ablution facilities being provided, then a maximum of two persons should share these communal facilities.

For married couples, a 25 m² room should be provided with a double bed and additional furniture plus en suite bath and ablution facilities.

Security of the accommodation is important.

Additional support facilities of kitchen, lounge, laundry and garaging for motor vehicles to be provided.

The rooms to be cleaned at least three times per week.

The intern should ensure that he/she has adequate insurance cover for personal and household goods and vehicles.

On-call facilities

Satisfactory sleeping and recreational facilities for interns, especially when on duty, should exist in each accredited facility. Sleeping accommodation should be such that the intern may rest and sleep while awaiting the next patient or operation.

Meals and snacks should be available for persons on emergency duty, especially at night.

A room/area with recreational facilities and refreshments would enhance social interaction between interns. This would greatly improve job satisfaction and acceptance of the work environment.

On-call facilities must be provided as close as possible to the ward or health unit to be covered in the event of there not being accommodation on site.

As far as possible, single rooms to be provided (15 m²) with a locker, a safe, a telephone, wash basin, cupboard, desk, chair and single bed. Ideally, en suite facilities should be provided.

The on-call facility must be dedicated for the use of the on-call doctor.

Given the multi user nature of on-call rooms by doctors, they need to be cleaned and inspected daily.

The facility must have adequate security.

Transport

In general, transport need not be provided for interns except where the intern has to travel to different facilities.

The intern should use a Health Department vehicle (if he/she has a valid driver's license) or be driven to the facility using the Health Department transport pool.

In the event of the intern using his/her own transport, then this should be agreed upon with the management in writing and the applicable tariffs will apply with due documentation/logbooks on a monthly basis being submitted to management. The intern to ensure that he/she has appropriate vehicle insurance cover for business and private use.

The facilities offering internship training should have a budget line for the above.

TERMINATION OF PREGNANCY

In September 2005 the Subcommittee for Internship Training confirmed that although an intern, who was required to perform an abortion, could refer the patient to another practitioner on conscientious grounds, despite the fact that "The Choice on Termination of Pregnancy Act", (Act 92 of 1996), did not provide a conscientious objection clause. It was however again re-iterated that interns could not refuse to provide emergency treatment in respect of bleeding or an emergency evacuation of the uterus since such procedures formed part of the essential skills of medical practitioners in South Africa and interns were required to attain those skills during their internship training.

INTERNS WORKING ON EMERGENCY HELICOPTERS/AMBULANCES

Interns are allocated to facilities with a specific accreditation which requires them to work in a specific facility under direct supervision. They are specifically excluded from working outside of this and may also not work in private practice, irrespective of whether they are paid or not.

Under **NO** circumstances could an intern fly on a helicopter, or work outside of the accredited facility. A medical practitioner registered in the category community service could do so, provided that he or she had permission from their Chief Executive Officer/Chief Medical Superintendent/Medical Manager, and was allowed to fly "as on duty".

Any intern that did work outside of their accredited facility, either on an aircraft or road ambulance and was not registered to do so would be held liable by HPCSA. Should an intern be registered as an emergency care practitioner, their scope of practice was regarded as such until such time as they were fully registered as medical practitioners, they were not allowed to prescribe medication, or exceed their scope of practice.

Any service which "employs" an unregistered medical practitioner, e.g. and intern, is guilty of a criminal offence, and can be prosecuted. This applies whether the individual is paid or not. The blanket comment, "in the interest of saving a human life" as a claimed exemption, does not apply, as anything covered by the above would be regarded as prospectively planned or rostered, and therefore not an emergency.

The same policy would apply for the transportation of patients by ambulance i.e. that the supervisor be physically present with the intern.

13. INTERN RESPONSIBILITIES

Although interns, under supervision, are primarily responsible for patient care, they form an important part of the health team and should learn to work together with colleagues in the wider spectrum of medical and other health care services. The professional responsibilities of the intern should include the following important aspects:

Interns are required to keep carefully documented notes. Notes should be made immediately (on the spot; date and time) after assessing each patient. They are responsible for following-up all investigations ordered, and to ensure that all results are available and charted in the bed letter. They should co-operate with medical, nursing and the relevant other health care professionals, e.g. physiotherapy, social work, occupational therapy - especially in relation to their personal cases. Case summaries must be completed on patient discharge. A concise summary should be given to the patient on discharge to be available at follow-up clinics.

The intern should play an active role in Out-Patient Departments, particularly in regard to the follow-up of their own patients. A balance should be struck between exposure to hospitalised and ambulatory patients.

Interns should be aware of the Charter on Patient Rights (see Annexure F) and the investigation and management of patients should be in line with those guidelines.

The intern's care of the patient should be holistic. As the primary medical care giver, the intern is a very appropriate person to deal with emotional, spiritual and family problems that are often present in addition to the physical illness. Confidentiality is imperative.

Interns must be aware of their limitations, both in knowledge and skills, and not hesitate to seek advice from senior colleagues. Such referral is not a sign of weakness, but of maturity and is to the benefit of the patient.

Continuity of care is vital in a hospital situation. Appropriate hand-over of patients is essential.

Interns should avail themselves for formal teaching, as well as of the use of a library or reference books. Reading around patient problems will foster the habit of on-going medical education.

NOTE

The responsibility of registration with the Board as an intern, as a medical practitioner to perform community service and finally, as medical practitioner (independent practitioner) in terms of the *Health Professions Act, 1974*, rests with the individual. However, it should be noted that no person may undergo internship training, or perform community service in South Africa without having been so registered (see Annexures A, D and E).

14. EVALUATION AND REGISTRATION

Interns should have regular assessments during their training. They should be praised when deserving, and criticized and corrected when necessary.

During each rotation, an evaluation of the Intern's performance should be conducted (mid block as well as end of block, using the prescribed form for evaluation of intern rotations and experience, as per the Logbook for Interns (Form 139). This form has two components: A

section to be completed by the intern, and one by the Domain Supervisor. The latter should do so in conjunction with his or her colleagues. The assessment must be discussed with and signed by the intern. The form must also be signed by the Head of Department. This will facilitate the early recognition and correction of problems. A confidential counselling service, separate from the appraisal system, should be available.

At the end of the year, the CEO/Chief Medical Superintendent/Hospital Manager, together with the Heads of Departments, will certify whether an intern has satisfactorily completed his or her training by issuing the Intern Duty Certificate (see Annexure B), thus enabling the Board to register him or her as a medical practitioner to perform community service.

Should an intern have failed to satisfactorily complete part or the whole of his or her training, the Board may demand additional training before granting such registration (see Annexure C).

Interns are reminded that it is illegal for them to work in any form of practice outside accredited facilities.

During recent evaluations and inquiries pertaining to internship training, the various delegations, including the intern delegations, confirmed their awareness of the fact that interns were legally restricted to practising under supervision in facilities accredited by the Board for the purpose of internship training.

Despite the paragraphs above, it had become necessary to recommend to the Board that urgent steps be taken to advise all interns and medical practitioners that the employment of interns in any clinical practice outside accredited facilities was illegal and could lead to disciplinary action on the part of the Board against any intern who might engage in such practices, as well as against any medical practitioner who might be found to employ an intern as a *locum* or in any other fashion outside accredited facilities.

Accredited facilities should be aware that the Board could withdraw accreditation for internship training should it find that the facility was aware of interns performing locums.

NOTES

If so required, the Head of Department/Domain may add a specific addendum to the standard evaluation form referred to in paragraph 14.

In view of misconceptions in this regard, it must be stressed that the Criteria for Internship Training specified in paragraph 3 of Part I, and the Criteria for Delayed Registration (see Annexure C), still apply.

In the case where an Intern Duty Certificate was presigned and the intern subsequently willfully neglects to complete his or her internship training, a complaint will be lodged with the Board and disciplinary action may follow as a result thereof.

In view of the above, interns, Health Authorities and relevant hospitals are advised that community service in terms of Section 24A of the *Health Professions Act*, 1974, may only commence after successful completion of internship training and submission to the Board of a fully signed Intern Duty Certificate (Annexure B), which proves compliance with the said criteria.

15. LOGBOOK

The compulsory completion of the *Logbook for Interns* came into effect as from January 2002. Submission of the completed Logbook forms part of the prerequisites for registration as a medical practitioner to perform community service. The Intern Duty Certificate as well as the prescribed registration form is included in the Logbook. Every intern must ensure that he or she has a copy of the Logbook which is provided by the Board upon registration as an intern in medicine.

16. RESOLUTION OF CONFLICT

It does happen that conflicts arise as to the training and employment of interns. This may be due to the physical unsuitability of the facility, the terms of service, the trainers or the intern(s).

Most minor issues usually can be resolved through negotiation between the various parties. In this regard the Intern Curator plays a crucial role. The Evaluator(s) of Internship Training appointed by the Board may also help by drawing attention to deficiencies or by acting as independent facilitator(s).

Should serious problems regarding professional conduct arise; the Board will deal with such matters. This will consist of an investigation of the issues by means of a round-table discussion. The purpose of such inquiry is to verify alleged facts and to resolve the problems in a constructive manner. However, it should also be noted that the "ethical rules" (see Annexure E), and the professional conduct procedures of the Board, equally apply to interns as to medical practitioners.

Apart from the above, it needs to be remembered that interns are in the employ of the relevant Health Authority. As such, their conduct falls under the provisions of the *Public Service Code*. Disciplinary matters in terms of those provisions should be dealt with in accordance with the said *Code* or the *Labour Relations Act*. A copy of any warning letter addressed to an intern should, however, be sent to the Board for its notification.

17. PROCEDURE FOR DEALING WITH IMPAIRED / UNDERPERFORMING INTERNS

17.1 Impaired Intern due Health reasons

In October 1996 a Health Committee was established by the Interim Medical and Dental Council of South Africa as a Standing Committee in order to deal with impairment in students and practitioners registered in terms of the Act.

The expression "impaired" in terms of the Act "means a mental or physical condition, or the abuse of or dependence on chemical substances, which effects the competence attitude, judgement or performance of a student or another person registered in terms of this Act".

In principle, the procedures of the Health Committee in relation to individual impaired persons are confidential as in the case of a doctor/patient relationship. This principle has positive results in creating a relationship of trust between the Committee and the different stakeholders concerned.

It needs to be emphasised that management of stress in the study and practising of medicine and dentistry requires special attention at all levels, but especially in students, interns and young practitioners. Factors creating stress need to be identified urgently and addressed, where possible.

In view of the above, the importance of early identification of impairment in students must be stressed once again, as well as the important role and responsibility of Deans of Faculties or Heads of Schools of Medicine in this respect.

Please note that in terms of the Board's ethical rules (Annexure E), a registered person has a responsibility to report impaired colleagues to the Health Committee. Please also note that specific reference is made to students and interns.

17.2 Underperforming intern

This section deals with an intern who is underperforming due to –

- Lack of adequate knowledge
- Lack of commitment to work

Continuous assessment, mentorship and corrective measures by supervisors are the best way to address the situation. However the formal process to assess performance is the midblock evaluation and end of block evaluation.

Extension of training is the formal corrective step if continuous corrective supervision did not yield positive results. Indication of possible extension should be conveyed to the intern at midblock evaluation if the performance is not satisfactory in the first half of the rotation. Extension of training is recommended by the Clinical Head of the Domain at the end of the block. This has to be supported by the Clinical Management team of the Hospital.

The period of extension can be decided by the Clinical Management team in consultation with the clinical head of the domain for a period not exceeding the total duration of training in the specific domain.

Such a decision should be notified to the Internship Subcommittee of the HPCSA for ratification. If at the end of the maximum allowed period of extension in that domain the intern is still found to be underperforming, then the matter should be referred to the Internship Subcommittee for an appropriate decision.

In instances of misconduct disciplinary processes must be initiated as required by the public service regulations.

18. PROVINCIAL INTERN CO-ORDINATOR

INTRODUCTION

The need for a clearly identified co-ordinator of intern matters has been highlighted by the various problems experienced with internship training and related matters in some provinces.

The function of the Provincial Intern Co-ordinator is currently not clearly defined in terms of role and responsibilities. This results in problems being experienced at all levels and especially by interns. The need for a uniform consistent and readily identifiable Provincial Intern Co-ordinator is essential.

The primary role of a Provincial Intern Co-ordinator (PIC) would be to ensure that all matters relating to internship training, emanating both from the National Department of Health and the Board are transmitted accurately and timeously to all parties involved in internship training with special emphasis being placed on all training facilities, especially Hospital Managers, Intern Curators and Clinicians.

In addition to providing information, the PIC should on an on-going and programmed basis ensure that matters relating to internship training are complied with. This would include orientation and induction programmes, completion of evaluation forms, information to facilities on completion of Forms 10-A and 11-A so that there is both uniformity and adherence to a programme.

The mandate of the PIC extends to ensuring that support is provided to interns at training facilities. This includes having an updated list of Intern Curators as the visits of Evaluators of Internship Training are not necessary on an annual basis.

The PIC provides a valuable identifiable link between the National Department of Health, the Board, Evaluators of Internship Training, training facilities and academic institutions, where applicable.

The above is read in conjunction with the functions of the PIC which could be included in his or her job description.

The position of a Provincial Intern Co-ordinator (PIC) in each province should be clearly defined to ensure uniformity in the role and responsibilities of PIC's.

JOB PURPOSE

To provide an identified person in each province for liaison on internship matters between the National Department of Health, the Provincial Authorities, the Board, Schools of Medicine, and all facilities accredited for internship training.

JOB DIMENSIONS

The PIC should preferably be based in the Provincial Head Office to facilitate communication between the respective role players. The main functions will be advisory, supervisory, co-ordinating and facilitating of internship programmes at all levels. The position should be at a Medical Advisor level.

KEY RESPONSIBILITIES

Communication with the Board

The Board is to liaise directly with the PIC in respect of all information that requires to be disseminated to the Provincial Authorities and facilities. The PIC provides a clear channel of communication to ensure that all information from the Board, National Department, and the Provincial Head Office regarding internship matters reaches institutional managers. The PIC ensures that reports from training facilities to the Board are processed within a specified time frame.

Communication with the National Department of Health

The PIC is available to liaise directly with the National Co-ordinator. He or she represents the Provincial Authorities at the Subcommittee for Internship Training meetings and gives the necessary feedback. He or she relays information pertaining to internship matters, e.g. yearly schedule, allocations, etc. to the facility on a programmed basis.

Communication with the Provincial Authorities

The PIC acts as a liaison person between the National Department of Health and the Board. He or she provides communication pertaining to policy from the Provincial Authorities to facilities and follow-up on responses. There needs to be a dynamic two-way process. The PIC informs facilities of intern allocation changes.

Communication with accredited facilities

The PIC is to be available to provide information to training facilities on all matters relating to internship training and supervision. He or she informs the management of facilities and Intern Curators of visits by Evaluators of Internship Training and ensures that all relevant documentation is submitted in time. He or she is to be informed about problems relating to interns. The PIC ensures that facilities are updated on intern matters on a regular basis.

CO-ORDINATION

The PIC is the co-ordinator of accreditation visits/evaluations and must: Be informed by the Board of visits/evaluations. Inform facilities of proposed visits/evaluations. **Be present at visits/evaluations** and provide the Evaluators of Internship Training with information on provincial policy. Relay urgent problems and concerns of Evaluators of Internship Training to the Provincial Authorities. Liaise with facilities to ensure compliance with recommendations made by the Evaluators of Internship Training. Conduct *ad hoc* evaluations at training facilities where problems have been identified and discuss remedial measures/actions with Evaluators of Internship Training.

INFORMATION

To facilitate a provincial workshop of key role players on an annual basis in order to provide an update on internship training matters and to discuss concerns in respect of intern training and supervision. To provide information on allocation of interns to accredited facilities. To provide information in good time to expedite the annual registration of interns. This alleviates the problem of individual facilities requesting information from the Board, e.g. on registration fees, dates for submission, etc.

PROVINCIAL REPRESENTATIVE

To represent the Provincial Authorities at the National Department of Health and Subcommittee for Internship Training meetings so that there is continuity. The PIC should have the necessary delegated authority to make decisions.

CONTACT PERSON AT TRAINING FACILITIES

The PIC must be known to all facilities accredited for internship training in the province. He or she must be well informed to assist in all internship training matters as there may be a lack of or discrepancy in the information which the facility managers have. This situation is aggravated by the somewhat rapid turnover of managers and intern curators, some of whom take on the position by default.

PART II

GUIDELINES PERTAINING TO THE CONTENTS OF TRAINING PER DOMAIN

1. INTRODUCTION

GENERAL REMARKS

Part I of the Handbook described the aims and purposes of internship training, and the general guidelines as to how and where the training should take place.

Part II provides more specific guidelines about the objectives and criteria for each domain through which the intern may rotate. It is meant to be a guide and aid for both the trainers and trainees, recognising that patient profiles and health services may differ widely in different hospitals and clinics.

The overriding goal of the intern year(s) is to expose the trainee to a wide range of patients and common conditions to further develop his or her clinical skills. Internship training is a step in the process of professional development, and should not be seen as the completion of training as a medical practitioner.

EMPHASIS IN TRAINING

The emphasis in training should be on the core values and skills of:

- a. History taking.
- b. Examination.
- c. Clinical diagnosis.
- d. Appropriate and cost-effective investigations.
- e. Patient management.
- f. Need for referral and/or follow-up.

The importance of keeping case records and completing official documents cannot be over-emphasised, both for patient care and for medico-legal purposes.

ROTATION THROUGH SPECIFIC DOMAINS

The purpose of interns rotating through specific domains is to ensure adequate exposure to and training in that domain. It allows trainers to impart to trainees the knowledge, skills and attitudes of that particular aspect of medical practice. Continuity of training is essential, and blocks should not be broken up. It is recognised that night duties may entail cross-over, but during the day the intern should remain in his or her domain.

SUPERVISION

Because of the importance of supervision and adequate training, the Board will expect for interns to be trained by practitioners with the following qualifications and experience, namely:

- a. A full-time specialist; or
- b. A part-time specialist consultant providing at least ten (10) hours of on-site service per week; or –
- c. full-time medical officer with a diploma in that domain; or

- d. full-time medical officer with at least THREE (3) years' post internship training experience in that domain.

Access to a trainer should be available twenty-four (24) hours per day. Interns must be supported by at least one medical officer or registrar on the hospital premises.

JOB DESCRIPTIONS

Each hospital and domain must specify what is expected of the intern in terms of –

- a. in-patient responsibilities
- b. out-patient duties
- c. casualty department cover
- d. night and weekend duties
- e. administrative duties

EDUCATIONAL OBJECTIVES

Each facility and domain must specify what educational aids and opportunities are available to interns. These would include all or some of the following:

- a. Standard management protocols for common conditions.
- b. The Standard Treatment Guidelines and Essential Drugs List (provided by the National Department of Health).
- c. A checklist of conditions which interns are expected to encounter and/or learn about.
- d. A checklist of skills to be acquired and procedures to be observed. (Such a list will depend on the diseases seen at the specific site, and the investigation and management will depend on the facilities available.)
- e. Departmental meetings.
- f. Presentations by interns.
- g. Journal clubs.
- h. Medical audit meetings.
- i. Courses towards acquiring diplomas.

NOTE

Hospitals should make it possible for all trainees to do an ATLS course.

EVALUATION

The evaluation of both the training programme and the progress of the intern should be taken extremely serious. Evaluation should be on-going. There should be an interim assessment halfway through a rotation to institute any correctional steps that may be required. A formal evaluation, using Form 139 (included in the Logbook), should be completed by each individual intern during his/her rotation (midblock) as well as at the end of the rotation. Domains may also decide to include the following in their formal evaluation of trainees, namely:–

- a. A completed checklist;
- b. A more specific evaluation form.

NOTE

Interns who have failed to satisfactorily complete part or the whole of their training, may at the discretion of the Board be required to undergo additional training.

2. GUIDELINES: DOMAIN OF GENERAL MEDICINE
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The following guidelines **should be read in conjunction with the introduction to Part II.** As stated there, **the emphasis should be on exposure to and management of common conditions under appropriate supervision.**

GENERAL MEDICAL CONDITIONS

- a. Cardiology.
- b. Pulmonology.
- c. Endocrinology and diabetes mellitus.
- e. Gastroenterology and Hepatology.
- f. Rheumatology.
- g. Neurology.
- h. Geriatrics.
- i. Nephrology.
- j. Infectious diseases.
- k. Dermatology.

ADULT MEDICAL EMERGENCIES

This list, which is not exhaustive, is provided in a problem-orientated fashion. Many of these problems will present themselves during routine ward intakes and trainees should make every effort to learn not only an approach to and the therapy of these problems, but to acquire the technical skills required for their management.

- a. Severe chest pain.
- b. Acute severe dyspnoea.
- c. Syncope.
- d. Cardiovascular collapse, including cases of shock, cardiac arrest and CPR.
- e. Coma.
- f. Convulsions.
- g. Acute confusional states.
- h. Severe abdominal pain.
- i. Major bleeding and severe chronic anaemia.
- j. Toxic and metabolic emergencies.

ESSENTIAL SKILLS

- a. Technique of proper sputum collection.
- b. X-rays, peak flow measurement and ECG – interpretation of common and abnormal findings.
- c. Venepuncture and venous cannulation for drip infusions. Venesection.
- d. Bladder catheterisation, urinalysis and microscopy.
- e. Rectal examination, including proctoscopy and rectal biopsy.
- f. Lymph node biopsy, including despatch for both microscopy and culture. This latter procedure should only be done in theatre under supervision.
- g. Lumbar puncture.
- h. Pleural and peritoneal paracentesis.
- i. Bone marrow aspiration.
- j. Joint aspiration.
- k. Placement of thoracic drainage tubes.
- l. Nasogastric intubation.
- m. Skin biopsy and appropriate removal of skin lesions.

3 GUIDELINES: DOMAIN OF GENERAL SURGERY (INCLUDING SURGICAL TRAUMA)

The following guidelines **should be read in conjunction with the introduction to Part II.** As stated there, **the emphasis should be on exposure to and management of common conditions under appropriate supervision.**

It is important that interns receive adequate training with supervision in trauma which plays an ever-increasing role in health care in South Africa. Whether this is done in association with Orthopaedics or General Surgery or a Trauma/Casualty Department will depend on the situation at each hospital.

SPECIFIC OBJECTIVES

- a. To understand the importance of the pre-hospital phase and the communication with paramedical personnel.
- b. To understand the "Chain of Survival".
- c. To observe the correct immobilization of an injured patient.
- d. To learn how to prepare for receiving a medical emergency.
- e. To understand the concept of triage during mass casualties.
- f. To understand the importance of the mechanism of injury and to search for injuries based on the mechanism of injury.
- g. To witness and assist with resuscitation:
- h. To understand the concept the primary and secondary surveys.
- i. To learn the essential special investigations required for trauma patients.
- j. To learn how to move and transport trauma patients.
- k. To learn the importance of continued monitoring of an injured patient, also when referred to the X-ray Department, etc.
- l. To learn how to accurately document findings and to consider medico-legal issues.
- m. To understand the concept of organ protection and the prevention of secondary injuries.

GENERAL SURGICAL CONDITIONS

- a. Soft tissue infections, tumours.
- b. Gastroenterology and hepatobiliary conditions.
- c. Vascular conditions.
- d. Breast conditions.
- e. Surgical endocrine conditions.
- f. Pre and post-operative assessment and care.

ADULT SURGICAL EMERGENCIES

Assessment, resuscitation and management of the following:

- a. Upper and lower GIT bleeding.
- b. Acute surgical abdomen.
- c. Traumatized patient, including preparation of theatre.
- d. Peripheral vascular emergencies.

ESSENTIAL SKILLS

Diagnostic

- a. Rectal examination, including proctoscopy and rectal biopsy.
- b. Assistance at upper and lower GI endoscopy.

- c. Excision of minor skin and subcutaneous lesions.
- d. Fine needle aspiration – cytology and needle core biopsy of soft tissue lesions.
- e. Venepuncture and venous cannulation for intravenous infusions.
- f. Technique of endotracheal intubation, insertion of central venous lines, intercostal drains, bladder catheterisation.
- g. The technique of cardiopulmonary resuscitation. It is strongly advised that all trainees should do an ATLS course or an abridged version of it.
- h. Minor surgical procedures like suturing of wounds, drainage of abscesses, peri-anal fistulectomy, etc.
- i. Diagnostic skills for the traumatized abdomen including ultrasound and/or diagnostic peritoneal lavage.

Therapeutic

- a. Exposure to debridement.
- b. Suture of wounds.
- c. ATLS (Advanced Trauma Life Support) should be used as a guideline for training.

4 GUIDELINES: DOMAIN OF OBSTETRICS AND GYNAECOLOGY

The following guidelines **should be read in conjunction with the introduction to Part II**. As stated there, **the emphasis should be on exposure to and management of common conditions under appropriate supervision**.

SPECIFIC OBJECTIVES

OBSTETRICS

- a. To become competent in the management of antenatal care, labour, delivery, postnatal care and the early identification of potential risk factors including prevention of the fetal hypoxia.
- b. To become competent in neonatal care of the infant (emergency and routine) including advice about and supervision of exclusive breastfeeding.
- c. Understanding of community-based midwife obstetric units and postnatal clinics.
- d. Empathetic understanding of antenatal, intra-partum and postnatal care of HIV positive mothers and their infants.
- e. Understanding of ultrasonograms (both in Obstetrics and Gynaecology) as well as cardiotocographs and partograms.
- f. Attendance at maternal/infant mortality meetings in order to appreciate the prevention of these catastrophes, their early diagnosis and effective treatment.
- g. To become competent in the Essential Steps to Manage Obstetric Emergencies.

GYNAECOLOGY

- a. Prevention, diagnosis and management of common gynaecological problems.
- b. Operative and post-operative care of gynaecological patients.
- c. Counselling and treatment of HIV patients and their families.
- d. Comprehensive understanding of contraception (counselling, methods and dangers).
- e. Understanding of the prevention, early diagnosis and treatment of gynaecological malignancy.
- f. Empathetic understanding of human sexuality, marital life, fertility and infertility.
- g. Proficiency in vaginal examinations (Gynaecological and Obstetric), speculum and rectal examinations.

PROCEDURES PERFORMED/WITNESSED

OBSTETRICS

- a. External cephalic version and amniocentesis.
- b. Induction of labour (normal and surgical).
- c. Normal vaginal delivery, episiotomy and its repair.
- d. Abnormal vaginal delivery (twins, breech, forceps, vacuum extraction, prolapsed cord, impacted shoulders, postpartum haemorrhage, repair of third degree tear, manual removal of placenta).
- e. Caesarean section and the management of inversion of the uterus.
- f. Emergency management of eclampsia and fetal distress.
- g. Postpartum sterilisation (mini-laparotomy).
- h. Examination of the neonate, Apgar rating, clearing of airways and endotracheal intubation.

GYNAECOLOGY

- a. Ectocervical, endocervical and endometrial sampling for exfoliative cytology.
- b. Colposcopy, cone biopsy and LLETZ procedure.
- c. Laser coagulation of cervix, vagina and vulva.
- d. Laparoscopic procedure (especially lap sterilisation).
- e. Insertion of an intra-uterine contraceptive device (IUCD).
- f. Hysteroscopy and colpopuncture.
- g. Marsupialisation incision of a Bartholin's cyst or abscess and a vulval haematoma.
- h. Evacuation of uterus.
- i. Laparotomy for ectopic pregnancy.
- j. Hysterectomy (abdominal and vaginal).
- k. Clinical staging and management of pelvic inflammatory disease and carcinoma of the cervix.
- l. Wet smear microscopy of urine and vaginal discharge.
- m. To become aware of the many ethical problems facing the Obstetrician/Gynaecologist.

5 GUIDELINES: DOMAIN OF PAEDIATRICS AND CHILD HEALTH

The following guidelines **should be read in conjunction with the introduction to Part II**. As stated there, **the emphasis should be on exposure to and management of common conditions under appropriate supervision**.

EDUCATIONAL OBJECTIVES

- a. Three hours teaching per week.
- b. One presentation to a departmental meeting per two-month cycle.
- c. Exposure to the range of conditions in the paediatric and neonatal wards.
- d. Exposure to the range of conditions presenting in the out-patient department.
- e. Exposure to paediatric emergencies (respiratory, cardiac, gastrointestinal, renal, neurological, haematological, endocrine/metabolic, infectious).
- f. Awareness of the role of community health clinics.
- g. Exposure to autopsies, and responsibility for competently completing the death certificate.
- h. Knowledge of the requirements regarding notification of a disease, and responsibility for competently notifying cases which are being managed by the Intern.
- i. Attendance at mortality and morbidity meetings and an understanding of health statistics, particularly as they relate to the particular hospital/facility.

- j. Exposure to one or more subspecialty clinics (where such clinics are a feature of the particular hospital/facility).

SPECIFIC TOPICS TO BE COVERED DURING TEACHING AND/OR PRESENTATIONS

- a. Low birth weight in first and third world communities.
- b. Congenital infections with emphasis on HIV and syphilis.
- c. Prevention and management of birth asphyxia.
- d. Infant mortality patterns in first and third world communities.
- e. The expanded programme of immunisation.
- f. Use of the Road to Health Card.
- g. Infant feeding in first and third world communities, and nutritional rehabilitation for malnutrition.
- h. In addition, and according to the case mix of the particular hospitals/facility, teaching should cover common paediatric problems (cardiac, respiratory, renal, neurological, haematological, gastrointestinal, endocrine, metabolic, infectious, neoplastic, etc).

SPECIFIC PROCEDURES TO BE PERFORMED/SKILLS TO BE ACQUIRED

- a. Blood pressure measurement in neonates and infants.
- b. Growth monitoring in neonates, infants and children, and use of the Road to Health Card.
- c. Developmental assessment.
- d. Taking and interpretation of ECGs.
- e. Interpretation of skull, chest and abdominal X-rays.
- f. Interpretation of sideward urine tests.
- g. Interpretation of standard laboratory reports (haematology, biochemistry).
- h. Fluid and electrolyte balance (intravenous therapy and oral rehydration therapy).
- i. Venipuncture, IV line insertion and intra-osseous infusion.
- j. Neonatal resuscitation.
- k. Paediatric resuscitation.
- l. Competent admission and discharge assessments of patients and recording thereof in bed letters.
- m. Competent letters of referral to other health professionals or agencies.
- n. Prescribing according to the national EDL (Essential Drugs List) for children.
- o. Lung function.
- p. Allergy testing.

CLINICAL PROTOCOLS

Clinical areas should have standard operating procedure protocols for conditions regularly admitted to the hospital/facility at both in and out-patient levels.

In-patients

Examples include: –

- a. Treatment of severe malnutrition.
- b. Community acquired pneumonia.
- c. Treatment of HIV - infected infants and children.
- d. Cardiac failure.
- e. Gastroenteritis with dehydration.
- f. Diabetic ketoacidosis.
- g. Nephritis and nephrosis.
- h. Bacterial meningitis.
- i. Asthma.

Out-patients

Examples include:

- a. Failure to thrive.
- b. The un-immunised infant.
- c. Developmental delay.
- d. Tonsillitis.
- e. Otitis media.
- f. Constipation.
- g. Infectious diseases.
- h. Fever.
- i. Anaemia.
- j. Jaundice.

Casualty

Examples include:

- a. Drowning.
- b. Near-miss SIDS.
- c. Convulsions and coma.
- d. Epilepsy.
- e. Hypoglycaemia.

LOGBOOKS AND CLINICAL RECORDS

The following must be entered into a logbook at monthly intervals and verified by the trainer:

- a. The total number of paediatric admissions to the paediatric wards.
- b. The five most common conditions (with number of admissions for each of the five).
- c. The total number of children attending the general out-patient area per week.
- d. The five most common conditions/problems encountered in the out-patients area for the time period (with number of encounters for each of the five).
- e. Conditions listed above for which no clinical/protocols were available.
- f. Listed procedures which were not performed during the period under review.
- g. Number of days on which no teaching took place.
- h. Topics formally presented to the department.
- i. Autopsies witnessed (diagnosis and causes of death) and number of death certificates completed.
- j. Notifiable conditions seen and number of cases notified to the health authorities.

6 GUIDELINES: DOMAIN OF FAMILY MEDICINE/PRIMARY CARE

The following guidelines **should be read in conjunction with the introduction to Part II. As stated there, the emphasis should be exposure to and management of undifferentiated conditions under appropriate supervision.**

GENERAL

The domain of Family Medicine/Primary Care provides the intern the opportunity to manage undifferentiated conditions, chronic disease, palliative care, clinical forensic medicine and to integrate the experience, knowledge and skills gained in all other domains. Experience of working in a health care team will be provided. Opportunities for collaboration with other primary health care workers such as nurses, allied health professionals must be created.

Colleagues working in specialities at secondary and tertiary levels of care will provide support and assist towards capacity-building.

The specific rotation through the domain of Family Medicine/Primary Care should be jointly decided on by each accredited facility based on its resources, but in accordance with the Guidelines.

The three (3) month rotation in the domain of Family Medicine/Primary Care, should be completed as a single rotation.

SPECIFIC OBJECTIVES

During the rotation in Family Medicine/Primary Care the interns are expected to:

- a. Gain competence in the management of health problems in patients at the level of the patient's first contact with the health care system, both with regards to emergencies and health problems.
- b. Develop a holistic (comprehensive) and patient-centered approach to patient care.
- c. Develop effective communication skills.
- d. Develop the skill of using every patient contact as an opportunity to promote a healthy lifestyle and practice preventive medicine.
- e. Become aware of their own limitations as medical practitioners and the appropriate use of consultation with other health care providers.
- f. Form the habit of continuing professional development as a means to maintain and improve their professional skills throughout their careers.
- g. Learn a cost effective approach in the utilization of all health care resources, such as prescribing, the utilization of special investigations, and referral to secondary and tertiary levels of care.
- h. Develop sensitivity for ethical issues, cultural differences in-patient care, and learn how to apply the principles of medical ethics in every day medical practice.
- i. Develop skills and competencies that are necessary to function at district hospital and district level health care services.
- j. Develop skills and competencies to manage mental health problems at generalist level.
- k. Develop skills and competence in management of chronic diseases, clinical forensic medicine and palliative care.
- l. Develop skills in practice management which include clinical record keeping, human resource and personnel management.

EXPOSURE AND RESPONSIBILITIES

The domain of Family Medicine/Primary Care should be the entry point into the health care system where interns should be exposed to first contact patient-care of both routine ambulatory care and emergencies, combined with responsibilities for patients in wards under their care.

The programme should show evidence of a continuum of training from ambulatory care in the community clinics, community health care centres and district hospitals (i.e. inclusive of and not only restricted to OPD and Casualty Departments).

Interns should have the opportunity to perform relevant side-room tests and investigations with respect to their level of care and service ("Norms and Standards for District hospitals" Department of Health, Pretoria, 2002.). They should also be able to perform (minor) surgical procedures.

Every effort must be made to ensure personal follow-up of patients previously seen by the intern to provide continuity of care to patients, and for the intern to learn to form professional relationships with patients that last over an extended period of time.

Interns must work together with other health care providers such as nurses, physiotherapists, social workers, dietitians, etc., in the care of their patients, in order to learn the team approach to health problems in primary care practice.

Interns must have the opportunity to refer patients to health care providers in medical specialties, as well as receive patients back after consultations with specialists.

TRAINING SITES

Family Medicine/Primary Care may be conducted in any health care facility with first patient contact where in and/or out patient services are offered. Suitable facilities are:

- a. District hospitals.
- b. Community health centers (day hospitals).
- c. Participating private practices.
- d. Hospitals with a regional and district component (OPD, casualty, beds and CHC) can be considered.
- e. Departments of Family Medicine/Primary Care.

MINIMUM FACILITIES

Minimum facilities for internship training should include the following:

- a. A consulting room with adequate privacy.
- b. Ophthalmoscope and ENT diagnostic instruments.
- c. Gynaecological examination instruments, including Papanicolou smear equipment.
- d. On site side room laboratory (e.g. urine testing, pregnancy testing, malaria testing, Hb, blood glucose, etc.)
- e. Emergency and resuscitation equipment and drugs.
- f. Access to basic pathology laboratory tests and diagnostic radiology.
- g. Minor procedure room (abscesses, dressings, biopsies).
- h. Inpatient facilities pertaining to investigations and diagnostic procedures as per norms and standards in "Norms and Standards for Districts hospitals" Department of Health, Pretoria, 2002.

KNOWLEDGE AND SKILLS

The intern should acquire at least the following knowledge and skills:

Diagnosis and appropriate management of undifferentiated conditions in an out-patient/ambulatory care facility. The range of the conditions will be dictated by the morbidity profile of the community where the health care facility is situated.

The diagnosis and appropriate management of undifferentiated diseases related to lifestyle, such as tuberculosis, AIDS and HIV-infection, hypertension, diabetes, stress disorders, headaches, backache and depression.

The diagnosis and management of undifferentiated conditions that are amenable to short duration surgery under local anaesthesia such as the following: Suturing of lacerations; finger/hand injuries; excision of subcutaneous lumps; removal of foreign bodies (ear, nose, cornea); aspiration and injection of joints (knee, wrist, ankle, shoulder); reduction of paraphimosis /dorsal slit; excision cautery /cryotherapy of skin lesions; etc.

The appropriate generalist management of all emergencies; resuscitation of patients in shock; the stabilisation and transport of the severely ill patient.

The appropriate intervention in family crises e.g. domestic violence; disability; death; substance abuse; infertility; abortion; divorce.

The appropriate clinical forensic medicine skills for managing e.g. rape; inter-personal violence; drunken driving.

Appropriate skills in palliative care.

Rational prescribing habits: A thorough knowledge of the drugs on the Primary Health Care Essential Drug List used by the facility, their indications, contra-indications important drug interactions and cost implications.

A sensitivity to cultural differences with respect to illness experience and its influence on the causation of disease, healing and compliance with medical interventions.

An awareness and understanding of the total spectrum of health care resources in the community, and an approach to the optimal use of these resources for the health of the community and individual patient care.

Knowledge and skills to render appropriate inpatient care at generalist level.

Knowledge and skills to render appropriate mental health care at generalist level.

SUPERVISION

Supervision should be provided by a Family Physician or a general medical practitioner with at least three years' post-internship experience in this general practice domain, who must be accessible twenty-four (24) hours a day.

EVALUATION

Ongoing evaluation by the supervisor should take the form of direct observation of consultations, patient record reviews, and case discussions.

A checklist of required skills should be provided to the intern for determining what specific skills need to be acquired and documented during the Family Medicine/Primary Care rotation.

At the end of the rotation both intern and supervisor must complete, discuss and sign the general assessment form.

7

GUIDELINES: DOMAIN OF PSYCHIATRY

The domain of Psychiatry will facilitate the experience of the integration of the management of psychiatric disorders at primary care level within a health team. The specific rotation through Psychiatry should be decided on by each accredited facility based on its resources, but in accordance with the Guidelines.

DURATION OF PLACEMENT

The period of placement should be of one (1) month duration.

FACILITIES REQUIRED

The placement and exposure to psychiatric practice must be such that a full range of disorders is managed at the various levels of severity, under supervision. The facilities utilised should have referral to specific psychiatric services within the complex. There should be facilities for outpatient treatment, follow-up and evaluations as part of the community psychiatric services team. A minimum of twenty (20) general beds should be available. These facilities may be in a general or specialist psychiatric hospital. There should be the same standard of clinical care as in other disciplines and the full range of special investigations must be available.

SUPERVISION/HUMAN RESOURCES REQUIRED

There must be definite time allocated for supervision of the work undertaken. The grade of experience of the supervisor must be that of a specialist psychiatrist or a medical officer or mental health care practitioner with at least three (3) years post internship experience in the field of Mental Health.

SUPPORT

There should be consistent and immediate access to support in the form of a registrar or medical officer.

JOB DESCRIPTION

This should be completed and provided by each complex in view of local differences and services available. The duties to be included are to be specified in relation to the site and lines of authority.

The responsibilities of the intern should be designated to include in-patient and out-patient care. Attendance at psychiatric community clinics, where available, should be included if based at a psychiatric facility. Emergency duties and after hour duties, under supervision, must form part of the experience. Duties in relation to report writing and record keeping must be monitored and evaluated.

OBJECTIVES

The aim of the postgraduate experience is to provide the intern with the capability to effectively manage common clinical problems of mental health.

- a. There must be allocation of teaching time in the form of case presentations/ward rounds, tutorials and attendance at departmental meetings.
- b. There must also be exposure to common conditions and the range of adult disorders in clinical and emergency settings, as well as the rehabilitative role of community clinic duties.
- c. A familiarity with the workings of the Mental Health Care Act and other legislation and the ethical principles relevant to Mental Health must be achieved.
- d. There could be an exposure to subspecialties such as child, forensic and old age mental health, where applicable, in the clinical setting.
- e. During the placement, there should be experience and exposure to emergency and crises situations, as well as the psychosocial rehabilitation processes in the multi-professional team functioning where ever possible.

SPECIFIC SKILLS AND COMPETENCE TO BE ACQUIRED

Skills in psychiatric evaluation, management and counselling should be achieved. The bio-psychosocial approach, seeing the patient as a person in a holistic fashion within the various contexts, is embraced.

Exposure to cognitive-behavioural therapy, anxiety/stress management programmes or substance abuse programmes is suggested.

Specific skills and confidence in the management and evaluation of violent/dangerous patients and suicidal risk assessment should be achieved.

CLINICAL PROTOCOLS

There should be standard protocols available in all areas which reflect the standard to be followed. These have been formulated by the Mental Health Directorate of the Department of Health. Familiarity with the utilisation to include the following protocols:

- a. Admission criteria and procedures in terms of the Mental Health Care Act.
- b. Management of the violent or dangerous patient.
- c. Medication in the patient with chronic Schizophrenia.
- d. Management of alcohol or drug withdrawal.
- e. Investigations at first presentation/admission of psychiatric patient.
- f. Management of Mood Disorders.
- g. Management of Anxiety Disorders.

ASSESSMENT AND EVALUATION

A record should be kept of the experiences of the intern by the use of log-books of clinical cases managed. This should aim to record the numbers of and categories of admissions clerked, presented, outpatients seen, reviews of cases, certification process, journal club, lectures, ward rounds attended, etc.

Objective evaluation forms to be completed during and again after the placement with the opportunity of feedback on progress to the intern at set intervals.

KNOWLEDGE

A basic knowledge of general mental health, as expected at MBChB level, must be supplemented during the placement to include:-

- a. Diagnostic criteria (DSM), adults and common childhood disorders.
- b. Therapeutic management and investigations.
- c. Preventative and rehabilitative interventions.
- d. Psychopharmacology.
- e. Aetiology.
- f. Human development.
- g. Interviewing skills.
- h. Cultural issues.

PROFESSIONAL THINKING, ATTITUDE AND ETHICAL STANDARDS

An awareness of transference/counter-transference reaction should be aroused. There should be an opportunity in supervision for feedback by the intern on progress and feelings and to develop a sensitivity to ethical standards and appropriate attitudes to psychiatric patients and their management.

8

GUIDELINES: DOMAIN OF ANAESTHESIOLOGY

GENERAL

Trainees who undergo the two-month Anaesthesiology rotation will have to accept that this has been designated to learn the basic skills of anaesthesia. These trainees would, however, have gained significant benefits from the introductory course by acquiring the skills

and competencies outlined below. They will be able to utilise these in many other fields of medicine, including Emergency Medicine and Critical Care.

OBJECTIVES

During the two month anaesthesia training period, intern training will focus on the following interlinked aspects (objectives) of peri-operative management:

- a. Knowledge and understanding of basic anaesthesia.
- b. Knowledge and understanding of basic resuscitation.
- c. Recognition of factors playing a role in peri-operative risk.
- d. In addition to the above, there are three critical skills that the intern needs to attain during the anaesthesia training period:
- e. Skills in obstetric anaesthesia. The causes of anaesthesia related maternal death emanating from the Confidential Enquiry into Maternal Deaths include failed intubation, aspiration of gastric contents, high spinal anaesthesia, and hypotension during spinal anaesthesia, with ninety percent (90 %) of these deaths considered to be preventable. These causes of death emphasize the need for the intern to develop a safe, competent approach to the obstetric patient requiring anaesthesia care.
- f. Management of the trauma patient or patient suffering hemorrhage. Developing good basic skills, as outlined in the guidelines below, will facilitate management of these patients.
- g. Cardiopulmonary resuscitation. The intern needs to develop knowledge and skills of CPR. It is a prerequisite for completion of the form that the intern demonstrate competence in CPR during the anaesthesia training period.
- h. Completion of the two month rotation enables the intern to provide an anaesthetic service under supervision. It does not constitute adequate training for the provision of independent anaesthetic practice.

PREREQUISITES FOR TRAINING

- a. Adequate equipment: Theatres and recovery rooms to be equipped according to the standards recommended by the latest SASA Guidelines to Anaesthetic Practice.
- b. Adequate supervision: Constant supervision of the intern is of critical importance. The most acceptable form of "adequate" supervision is the presence of a specialist Anaesthesiologist or a registrar in anaesthesiology. In the absence of a specialist, the supervisor should preferably possess the Diploma in Anaesthesia of the Colleges of Medicine of South Africa, or at a minimum, have three (3) years full-time experience of administering anaesthesia as a medical officer. Irrespective of the qualification, the constant presence of the senior physician on a one-to-one basis, is strongly recommended.

CORE SKILLS AND KNOWLEDGE

Pre-operative evaluation of the patient:

- a. Emphasis should be placed on eliciting airway, respiratory and cardiovascular symptoms and signs.
- b. Other medical or surgical problems that may complicate anaesthesia must be identified pre-operatively.
- c. Evaluation of the airway.
- d. Previous anaesthesia related problems.
- e. Drugs currently and previously being taken.
- f. Family history, especially of malignant hyperthermia or porphyria.
- g. Appropriate use of pre-operative side-room and special investigations.

The pre-operative evaluation should result in the following:

- a. The ASA pre-operative classification of the patient. After two months interns should be able to electively manage ASA 1 (normal healthy patients) and ASA 2 patients (patients having mild systemic disease under good control) only.
- b. A written summary of the main problems.
- c. Evaluation of whether the patient in optimal condition pre-operatively. The anaesthetist must consider whether (further) pre-operative resuscitation or optimization is in the best interests of the patient.
- d. An anaesthesia plan needs to be formulated.
- e. Pre-medication should be prescribed if indicated.

Preparation for anaesthesia:

Theatre preparation should include:

- a. Machine and breathing circuit check. This includes:
 - i. Presence of self inflating resuscitation device (Ambubag or equivalent device).
 - ii. Suction apparatus.
- b. Checking for the presence of emergency drugs.
- c. Availability of a functional defibrillator. The practitioner must be comfortable with the use and checking of a defibrillator.
- d. Equipment for airway management.
- e. Anaesthesia drugs.
- f. Patient preparation should include placement of intravenous cannulae.
- g. Monitoring needs to be instituted before induction of anaesthesia:
 - i. The most essential monitor is the vigilant presence of an anaesthesiologist at all times during surgery.
 - ii. Minimum monitoring: the use of oximetry and availability of capnography, non-invasive blood pressure, ECG are considered mandatory, while the facility for temperature monitoring should be available.
 - iii. Minimum monitoring includes continuous monitoring of the inspired oxygen partial pressure.

Maintenance of physiological homeostasis.

The intern needs to understand the deleterious effects of anaesthesia on the airway, respiratory and cardiovascular systems.

The intern needs to understand both the need for, and how to, maintain physiological homeostasis while anaesthesia is being administered.

Airway management

Airway maintenance basic:

- a. Application of basic airway maneuvers (jaw thrust, chin lift)
- b. Simple airway devices (oropharyngeal airways)
- c. The use of supraglottic devices (Laryngeal mask airway).

Endotracheal intubation

- a. Equipment and drugs needed.
- b. Attainment of the sniffing position.
- c. Correct use of the rigid laryngoscope.
- d. Use of introducer.
- e. Confirmation of endotracheal tube position, use and value of the capnograph.

- f. Management of failed intubation and ventilation. A simple approach such as the “DAMIT” airway algorithm (reference) is strongly encouraged. (This algorithm incorporates three steps:

Step 1 – basic airway maneuvers and devices followed by a single laryngoscopy attempt if ventilation is still difficult.

Step 2 – use of a supraglottic airway (e.g. LMA or iLMA) to facilitate ventilation (and possibly intubation).

Step 3 – infraglottic airway access.)

- g. Safe extubation of patients.

Airway protection from aspiration of gastric contents.

- a. “Nil per os” guidelines.
- b. Pre-operative recognition of the (potentially) full stomach.
- c. Actions to prevent aspiration before anaesthesia commences.
- d. Correct management of rapid sequence intubation. Attention must be specifically paid to the following:
 - i. Prior airway evaluation.
 - ii. Correct pre-oxygenation technique.
 - iii. Correct application of cricoid pressure.
 - iv. Correct sequence and dosage of induction agent and succinylcholine.
- e. Confirmation of endotracheal intubation.
- f. Management of failed intubation.
- g. Basic management should aspiration occur.

Maintenance of respiration (ventilation)

- a. Spontaneous respiration with mask supplemented with an oropharyngeal airway if needed, or with the use of a supraglottic airway.
- b. Take over ventilation manually if spontaneous respiration has been abolished or becomes inadequate.
- c. Use of a basic anaesthesia ventilator.
- d. Availability of, and use of a self inflating resuscitation device (Ambu bag or equivalent), especially in case anaesthesia machine failure.

Hypoxia

Basic understanding of the causes and management of hypoxia.

Basic understanding of oxygen therapy.

Equipment for support of airway and respiration

- a. Airway equipment (facemasks, oropharyngeal airways, laryngoscopes, supraglottic devices, endotracheal tubes, introducers).
- b. Understanding and check of anaesthesia machine.
- c. Understanding of assembly, limitations, advantages and fresh gas flow required in the following anaesthesia breathing circuits:
- d. Circle system.
- e. Ayres T piece.
- f. Magill system - dangers and appropriate use only in spontaneously breathing patients.
- g. Cardiovascular system
- h. Pre-load:
- i. Pre-operative recognition of the four degrees of hypovolemia
- j. Fluid resuscitation – volumes needed, different types of fluid including the use of colloids

- k. Placement of intravenous cannulae.

Oxygen delivery

Importance of adequate hemoglobin concentration.

Blood transfusion – indications and complications.

Importance of an adequate cardiac output. Determinants of cardiac output.

Hypotension

- a. An approach to the etiology of hypotension.
- b. A balanced approach to the treatment of hypotension using fluids, vasopressor and inotropes.
- c. Availability of vasopressors – knowledge of how to dilute these drugs and use in severe hypotension.
- d. Anaphylaxis – diagnosis and management.

Cardiopulmonary resuscitation (CPR)

It is a pre-requisite for certifying competence in anaesthesia that the intern demonstrate both knowledge of and practical competence in basic and advanced CPR. Three alternate routes to certification of competence in CPR are available: Ideally, this should take place in a laboratory type setting where mannequins are available. Alternatively, a question and answer session by the anaesthesia supervisor can be held with the intern. A current valid ACLS certification is also an acceptable way to fulfill this requirement.

Anaesthesia drug pharmacology

- a. Induction agents.
- b. Inhalation anaesthesia agents and nitrous oxide.
- c. Muscle relaxants:
- d. Depolarizers – Succinylcholine
- e. Non-depolarizers
- f. Reversal of non-depolarizers
- g. Opioids – intra-operative and post-operative use
- h. Non-opioid analgesics – paracetamol – non-steroidal anti-inflammatory drugs.
- i. The concepts of balanced anaesthesia including the synergistic and addictive interactions between various drugs.

SPECIFIC INTRA-OPERATIVE PROBLEMS

The obstetric patient

The physiological changes of pregnancy that affect anaesthesia management, especially airway, respiratory system, cardiovascular system, aorta-caval compression. The safe performance of a subarachnoid (spinal) anaesthetic for the obstetric patient (drugs, dose, spinal needles, safe levels of injection, prevention and management of hypotension) is considered a core competency for interns rotating through anaesthesia. In this regard, it is essential that the interns possess a detailed knowledge of the following article on management of spinal anaesthesia for caesarean section: Prevention and treatment of cardiovascular instability during spinal anaesthesia for caesarean section. R A Dyer, C C Rout, A M Kruger, et al. SAMJ March 2004, Vol 94, No. 3 (available free on "Pubmed"). The causes of anaesthesia related maternal death emanating from the Confidential Enquiry into Maternal Deaths. Pre-eclampsia and anaesthesia.

Regional anaesthesia

- a. Spinal (subarachnoid) anaesthesia – see above.

- b. Pharmacology of local anesthesia agents. Safe dosages, complications, how to avoid accidental intravascular injection, correct use and abuse of added vasoconstrictors with local anaesthetics.
- c. Peripheral nerve blocks – knowledge of the following is useful – infiltration techniques, digital nerve blocks, Bier's block.

The trauma patient, hypovolemic shock and emergency anaesthesia

Recognition and management of problems with the airway, respiration, hypovolemia, hypotension, anemia, head injury and the injured cervical spine.

Choice of anaesthesia agents in hypovolemic shock.

Paediatric anaesthesia

- a. Airway management of the child.
- b. Pediatric fluid management.
- c. Basics of pediatric anaesthesia.

Essential administrative functions of anaesthetics

- a. Consent.
- b. Maintenance of a contemporaneous anaesthesia record.
- c. Post-operative instructions.

Post-operative management

- a. An approach to delayed awakening from anaesthesia.
- b. Written post-operative instructions.
- c. When can the patient be left in the care of a nurse.
- d. Post-operative complications (airway, breathing, circulation) that need to be watched for –
 - i. Opioids – uses, advantages, dangers, correct dosing and intervals, endpoints of therapy.
 - ii. Non-opioid analgesia – uses, limitations, complications, contra-indications.
- e. Use of simple regional techniques and infiltration of local anaesthetics for post-operative analgesia.

Assessment/evaluation

A detailed logbook of all anaesthetics administered, including the name, age and hospital number of the patient, nature and date of surgical procedure and drugs used, is to be kept by each intern. All entries are to be signed by the trainer on an on-going basis. The Logbook will assist in ensuring that interns are adequately exposed to all aspects of anaesthesia. The Logbook in addition to a general section, will contain specified sections to ensure exposure to areas of anesthesia which are considered essential to the training process (e.g. caesarean sections, D & C procedures, emergency surgery and paediatric anaesthesia). CPR competence must be assessed.

9	GUIDELINES: DOMAIN OF ORTHOPAEDICS/ORTHOPAEDIC TRAUMA
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The following guidelines **should be read in conjunction with the introduction to Part II. As stated there, the emphasis should be on exposure to and management of common conditions under appropriate supervision.**

It is important that interns receive adequate training with supervision in trauma which plays an ever-increasing role in health care in South Africa. Whether this is done in association with Orthopaedics or General Surgery or a Trauma/Casualty Department will depend on the situation at each hospital.

OBJECTIVES OF A TWO-MONTH ROTATION

The objective of this training period is to expose the doctor in training to the diagnosis and management of musculoskeletal diseases and trauma. He or she must be able to obtain and record the relevant information in a systematic manner, identify the problem(s) of trauma management and make decisions on the level of management. He or she should have the knowledge and ability to foresee and diagnose possible complications, and should know the steps to be taken to prevent and/or treat these complications.

The trainee should develop the skills to treat less complex fractures, dislocations and soft tissue injuries, and should be able to resuscitate, splint, manipulate and reduce fractures and dislocations, apply Plaster of Paris (POP) casts to the limbs and apply both skeletal and skin traction, where applicable. He or she should be able to perform minor operations, where indicated, on trauma patients.

SPECIFIC OBJECTIVES

- a. Primary management of dislocations of the shoulder, elbow, hip and knee, wrist, hand, ankle, foot and toes.
- b. Recognition of joint injuries, including intra-articular fractures and ligament disruptions. Closed methods of treatment, where applicable.
- c. Recognition of and closed methods of treatment for the common metaphysical and diaphysial fractures in adults and children.
- d. Diagnosis of tendon injury and nerve injury to the upper and lower limbs.
- e. Diagnosis and emergency treatment of spinal injuries and pelvic injuries.
- f. Recognition and management of open fractures (Gustilo plus Anderson classification), with primary debridement of open wounds.
- g. Management of finger tip injuries and traumatic amputation of digits.
- h. The trainee should be taught the basic skills necessary to evaluate Roentgen plates of trauma patients, and should know whether the views are adequate for diagnostic purposes under the circumstances.
- i. In addition to the above, it is recommended that trainees attend out-patient sessions where cold orthopaedic conditions are seen, and become familiar with the management of non-traumatic back pain, arthritis of joints, infection of bone and joint, and screen procedures for systemic disease which manifests itself with musculoskeletal signs and symptoms, for example metastatic disease to bone, osteoporosis and neoplasms of the musculoskeletal system.

ESSENTIAL SKILLS

- a. Techniques of closed manipulation of fractures.
- b. Application of U-Slab for fractures of the humerus.
- c. Application of above elbow and forearm POP casts, including fracture of the wrist.
- d. Application of long leg and below knee POP casts, with and without walking heels.
- e. Application of skin traction to the lower limb and use of traction, with and without a Thomas splint. Gallows traction included.
- f. Application of skin traction to the upper limb – Dunlop traction.
- g. Application of an external fixator for open fractures and monitoring of pin tract sepsis.
- h. Regional and local anaesthetic techniques used in the treatment of fractures, e.g. Biers block, ring block to fingers and toes.

- i. Application of aluminum splints for phalangeal fractures.
- j. Debridement and lavage of compound fractures.
- k. Diagnosis of acute bone and joint sepsis.

NOTE

It is recommended that trainees do the ATLS course which is vital in the successful management of orthopaedic trauma.
