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PERSONAL VIEW

Rural hospital focus: students

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ABSTRACT

Rural and Remote Health is committed to the task of providing a freely accessible, international, peer-reviewed evidence base for rural and remote health practice. Inherent in this aim is a recognition of the universal nature of rural health issues that transcends both regional interests and local culture. While RRH is already publishing peer-reviewed material, the Editorial Board believes many articles of potential worth are largely inaccessible due to their primary publication in small-circulation, paper-based journals whose readership is geographically limited. In order to augment our already comprehensive, international evidence base, the RRH Editorial Board has decided to republish, with permission, selected articles from such journals. This will also give worthwhile small-circulation articles the wide audience only a web-based journal can offer. The RRH editorial team encourages journal users to nominate similar, suitable articles from their own world region.

This article, 'Rural hospital focus: Students', first appeared in South African Family Practice 2000; 23 (2), and is reproduced here in its original form, with kind permission of both publisher and author, prominent South African rural doctor, Professor Ian Couper. 'Rural hospital focus' was the title of the SAFP column which presented this article.

Attitudes of rural doctors (all doctors?) to students vary a great deal – some view them as unnecessary nuisances, others view them as necessary evils, and still others see them as missionaries bringing some city excitement to their faraway institutions. I suspect many of us have felt all of these at different times, depending on our mood, our workload, where the students come from and how they behave.

Few rural doctors would dispute the need to expose medical students to rural practice, as this is a vital way to attract staff in the future. Fear of the unknown and misconceptions about rural practice abound amongst students and are often constantly reinforced by registrars and consultants involved in student teaching, who themselves have negative attitudes based on the same factors. So we agree that students should go out to rural hospitals. But that is probably as much agreement as we will find – the details of when, how, for how long, how often etc, are areas of debate. And it is perhaps this lack of agreement that has led medical schools generally to be slow in sending students out to rural hospitals – though most claim to have some kind of rural exposure in their curriculum. This is despite the fact that international literature does show that a rural clerkship can have a positive impact on later practice decisions (though a relatively small one), and thus can be an important factor in the recruitment of rural doctors.

Where are the problems? I will not dwell on the issue of accommodation, because I have discussed this in a previous column; though this was not in terms of students, it applies to accommodation for students equally. One problem is timing: when should students be sent to rural hospitals? Sending students in their final year is often too late to make any difference (though of course it is better than not at all). On the other hand, when students are in their final year they can be more useful in the health service, making a positive contribution, rather than just being a drain, as well as learning more themselves. A number of rural hospitals will only accept students who are in their final year. Yet if we can expose students earlier, we may have more of an impact on their career decisions. The ideal, which only happens with a handful of students in this country at the moment, is for students to develop a relationship with a particular rural site early on in their training and to continue to visit the same site throughout, thus developing relationships and understanding along the way. This has been done very successfully in Australia, in various States, usually through the mechanism of Rural Student Clubs.

Another problem is the length of stay. Here I will stick my neck out and say that a 2 week block, as seen in some medical schools, is hopelessly inadequate. My aim when hosting such students has been to achieve no more than giving them a little insight into the functioning of a rural hospital and what rural health is about. Thus, when they are neurosurgical registrars in the urban academic complex and they receive patients from a rural hospital, they will have some understanding of the patient's and the referring doctor's context, which may influence their management plans. The extreme of this was a programme, planned by a paramedical department, which wanted to send students up to Manguzi for one day only (with the flying doctor service). I refused to accept them, not because I had anything against the individual students nor because I thought they would learn nothing, but rather because it seemed that the department saw it as a way out – they could claim they gave students rural exposure – and I was not prepared to let them off the hook. (No doubt they went elsewhere and the department has presented papers on their rural programme!)

What is the ideal length? As long as possible! I always feel that it takes a few weeks for someone to find their feet and begin to feel comfortable in a place, after which real learning can start. I always preferred not to accept any student who was coming for less than 4 weeks. In an exciting innovative programme in South Australia, students at Flinders University can elect to spend the entire final year in a rural area. Initially there was much reluctance, but this attitude changed when those students who had been on this programme performed amongst the best in their class.

The next question, for me, is what the students should do during their rural attachment. Obviously this depends on which department is sending them, for how long and with what objectives in mind. On the one hand, I would try to ensure exposure to as wide a range of activities associated with the rural health service as possible – including wards, OPD, clinics, mobile clinics, community programmes, home visits, local GPs, traditional healers, special programmes (e.g. TB or AIDS programmes etc). On the other hand, there are great advantages in letting students spend time in one

area in order to develop a deeper understanding of patients, and relationships with patients and staff. In resolving this, it is best to put the various options to the students, and let them decide on the programme that suits them best. Above all, though, my aim has always been to try to ensure that the students have a good time, so that when they leave, whatever they have learnt, the concept of rural practice will evoke a positive emotion in them.

Related to that is the area of supervision. Often students are left to the newest, youngest recruit for supervision. That has the advantages of enthusiasm and of greater similarity in age, and often doctors get very involved in the lives of their students, and vice versa. More senior doctors can offer insights and perspectives from years of experience, and are important role models. However, they are often tired of reaching out to the ever-changing medical staff and training new doctors, leaving them without energy for students. Ultimately the person who wants to do it should be the one doing it, wherever possible, and should ensure exposure of students to different staff members (not only doctors).

I have always had a dilemma when it comes to students from abroad. I recognise the value of exposure to health care in another country during a student's training. Yet, at the same time, I struggle with the knowledge that the overseas students are unlikely ever to return to work here (especially given the current position of the Department of Health), though there are certainly exceptions, and some of them just want to use our patients to gain practical experience, which is lacking in their own country. My negativity is not helped by some wealthy students from developed countries who come and go without much in the way of gratitude, certainly in terms of material offerings. At the same time, I have had extremely positive experiences with foreign students, who have brought ideas, energy, enthusiasm, and ongoing material support. Our approach at Manguzi was to accept students from abroad, for limited periods, at times when South African students were not expected.

A stay at a rural hospital can be a life-changing event for a student. My elective at Charles Johnson Memorial Hospital as a fifth year medical student certainly confirmed my future plans to make a contribution to rural practice. I believe that medical schools are becoming more open to sending their students out to rural areas, partly because of pressure from government. Rural doctors should work constructively with universities to ensure as much exposure as possible, in the most effective way.

Ian Couper
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Author's note

Since publication of the original text in *South African Family Practice*, the author has become aware that Flinders University Parallel Rural Community Curriculum (PRCC) medical students spend their entire third year (of a 4 year graduate-entry course) in a rural community, and not their final year as stated. At least one 6 week final-year placement is spent in a rural area.

