

Reflecting on Practice in Rural South Africa: A Research and Writing Journey

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Disclosure of Potential Conflicts of Interest

I DO NOT have an affiliation (financial or otherwise) with a pharmaceutical, medical device or communications organization.

Aim

- ▶ A journey
- ▶ To
 - Encourage you
 - Inspire you
 - Challenge you
 - Inform you
 - Help you reflect
- ▶ **NOT ABOUT ME**



My practice journey

- ▶ Student years
 - Student clinics
 - Making a difference
 - Charles Johnson Memorial Hospital
 - I know something
 - Gelukspan Community Hospital
 - Passion and purpose
- ▶ Internship/house officer
 - Livingstone and Dora Nginza Hospitals, Port Elizabeth
 - Getting away from the academic health complex

My practice journey

- ▶ A year in Paraguay
 - Being rather than doing
 - Understanding a community
- ▶ Manguzi Hospital 1990–1999:

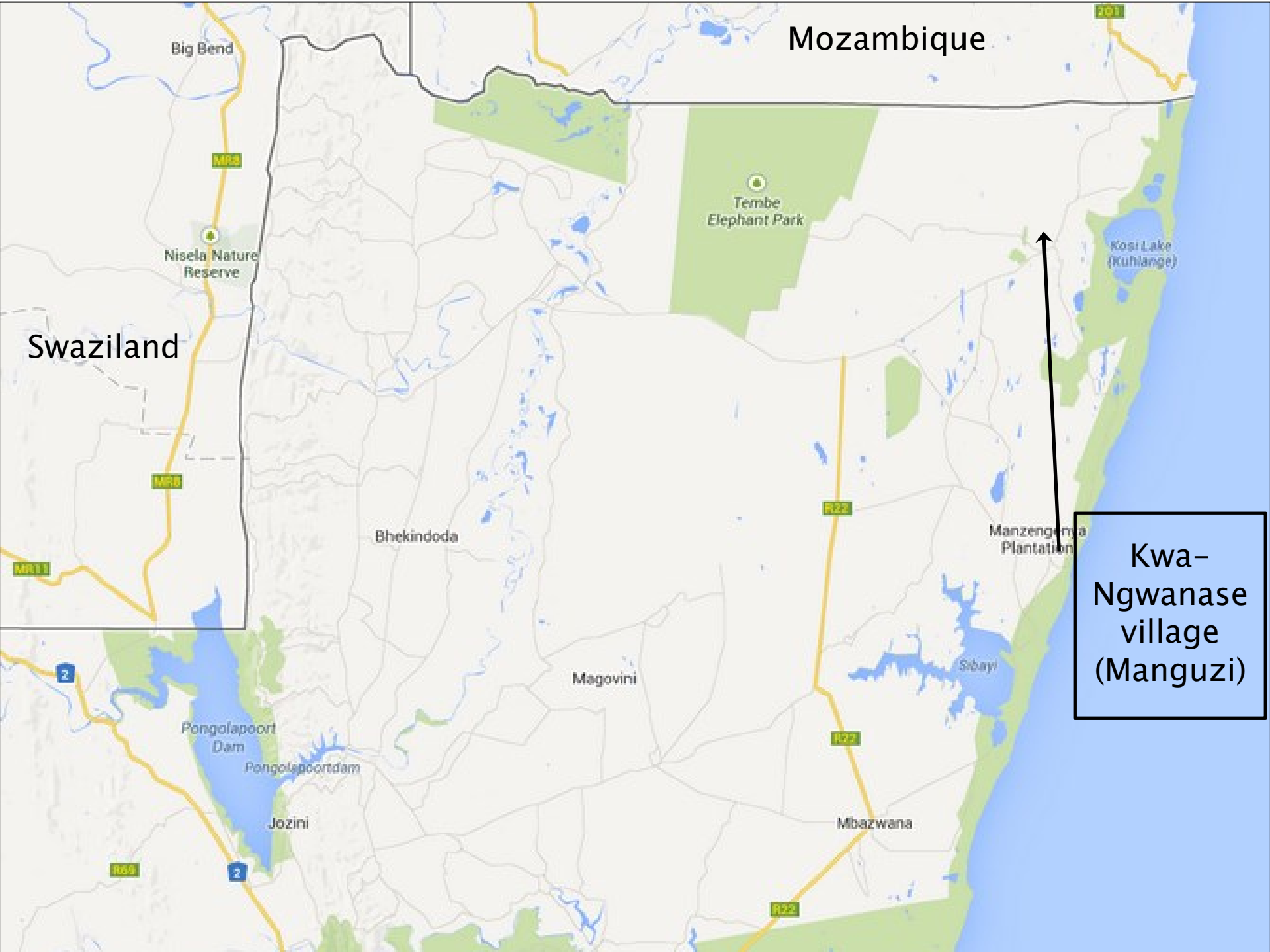


Namibia

Botswana

Swaziland

South Africa



Mozambique

Swaziland

Kwa-Ngwanase village (Manguzi)

My practice journey

- ▶ A year in Paraguay
 - Being rather than doing
 - Understanding a community
- ▶ Manguzi Hospital 1990–1999:
Community doctor – “Alternative service” –
medical superintendent
 - Community oriented primary care
 - Family medicine training: learning through reflection
- ▶ Monash Centre for Rural Health 1998
 - Vision for a possible future

My practice journey

- ▶ Medical University of South Africa (Medunsa)/Family physician, North West Province 2000–2002





Namibia

Botswana

Swaziland

Lesotho

South Africa



My practice journey

- ▶ Medical University of South Africa (Medunsa)/Family physician, North West Province 2000–2002
 - District-based care
 - Academic role
- ▶ Wits Chair of Rural Health/Director, North West Province
 - The big picture

Starting the journey

- ▶ Writing background
 - Not always academic!

Baby show with a difference



ABOVE LEFT: Three lucky winners of the Manguzi Hospital Baby Show with their wonderful prizes

ABOVE: The nursing staff dance and sing about health issues



LEFT: Some of the many participants of the Manguzi Hospital Baby Show

A remote hospital in northern Natal holds a very special baby competition each year

by DR I COUPER
photographs by DR I COUPER

A MOST newsworthy event took place recently at Manguzi, a small ex-mission hospital on the

150 entries.

"After traditional singing and dancing with health messages, each mother begins by showing her child's Road To Health Card, and is given a score according to how well the child is gaining weight and whether she's been fully immunised. Those without their clinic cards start with a handicap in the competition.

"Mothers are then questioned, by members of the hospital staff, on different facets of basic health knowledge

prizes issued. Competition is fierce – last year's winner scored 43 points out of a possible 46! Every participant gets something, starting with small food hampers and progressively increasing in range, until the winners walk off with more prizes than they can carry – hampers of different foods and nursery products, tea sets, walking rings and shopping vouchers.

"The day not only provides excitement and rewards for hardworking, rural mothers, but also emphasises the

Starting the journey

- ▶ Writing background
 - Not always academic!
- ▶ Writing as reflection
 - Donald Schon: The Reflective Practitioner
- ▶ Research as reflection
 - A simple step

I WAS JUST RUBBING STICKS TOGETHER FOR FUN
- I DIDN'T REALIZE I WAS DOING BASIC RESEARCH.



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Bla

Why research?

- ▶ Personality
- ▶ Investigative mind
- ▶ Quality improvement
- ▶ Academic progress
- ▶ Emotional reasons
 - Anger?!
 - “Can do”



My friends, as a result of our experimentation, we have just lost a dear and valued colleague....

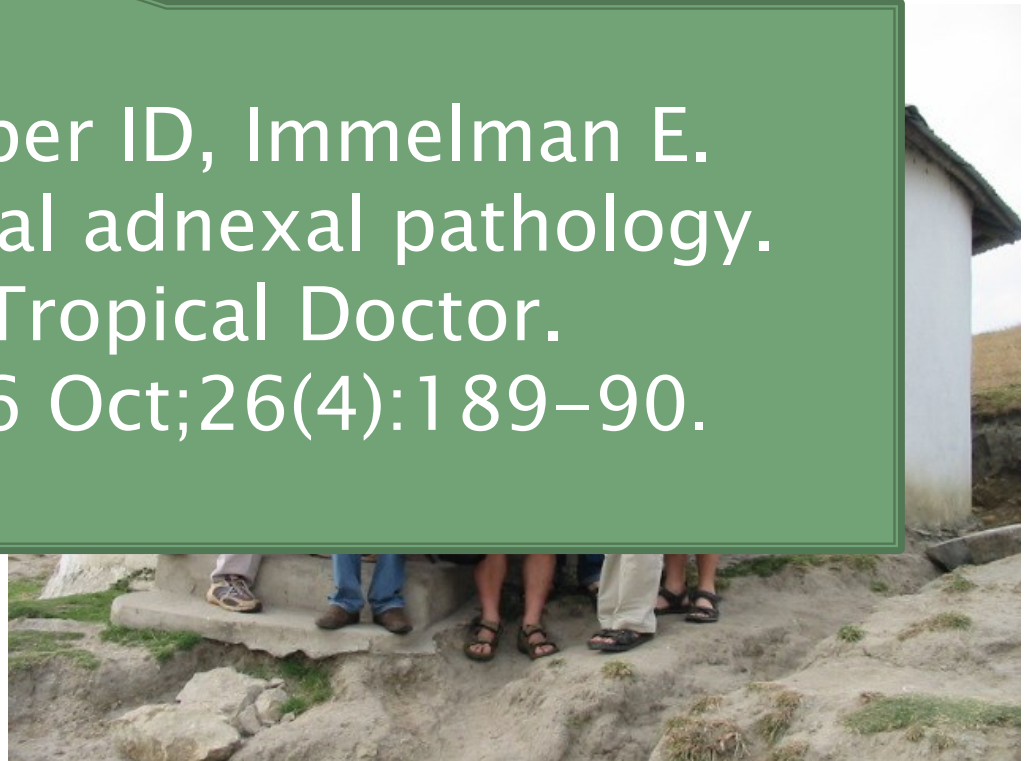
On the other hand, we have just gained a publication.



Reflections on rural practice

► Patients

Couper ID, Immelman E.
Bilateral adnexal pathology.
Tropical Doctor.
1996 Oct;26(4):189-90.



Reflections on rural practice

REFLECTION

The Impotence of Being Important – Reflections on Leadership

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ABSTRACT

An observed doctor-patient encounter, in which impotence and importance were confused, led me to a reflection on leadership. A sense of importance can be destructive in leadership, leading to failure to perform, or impotence. Understanding the dangers of self-importance, I am challenged to ensure that I regularly reflect on my leadership style.

Ann Fam Med 2007;5:261-262. DOI: 10.1370/afm.664.

Reflections on rural practice

Original Research

What interventions do South African qualified doctors think will retain them in rural hospitals of the Limpopo province of South Africa?

Submitted: 6 April 2006

Revised: 18 June 2006

Published: 6 September 2006

Full text: [View a printable version.](#)

Author(s) : [Kotzee TJ](#), [Couper ID](#).



Theunis Kotzee



Ian Couper

Citation: Kotzee TJ, Couper ID. What interventions do South African qualified doctors think will retain them in rural hospitals of the Limpopo province of South Africa? *Rural and Remote Health* 6 (online), 2006: 581. Available from: <http://www.rrh.org.au>

Reflections on rural practice

Original Research

Management of district hospitals - exploring success

Submitted: 2 May 2005
Revised: 31 August 2005
Published: 6 October 2005

Full text: [View a printable version.](#)

Author(s) : [Couper ID](#), Hugo JFM.



Ian Couper



Jannie Hugo

Citation: Couper ID, Hugo JFM. Management of district hospitals - exploring success. *Rural and Remote Health* 5 (online), 2005: 433. Available from: <http://www.rrh.org.au>

Building consensus on key priorities for rural health care in South Africa using the Delphi technique

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Background: South Africa is currently undergoing major health system restructuring in an attempt to improve health outcomes and reduce inequities in access. Such inequities exist between private and public health care and within the public health system itself. Experience shows that rural health care can be disadvantaged in policy formulation despite good intentions. The objective of this study was to identify the major challenges and priority interventions for rural health care provision in South Africa thereby contributing to pro-rural health policy dialogue.

Methods: The Delphi technique was used to develop consensus on a list of statements that was generated through interviews and literature review. A panel of rural health practitioners and other stakeholders was asked to indicate their level of agreement with these statements and to rank the top challenges in and interventions required for rural health care.

Results: Response rates ranged from 83% in the first round ($n = 44$) to 64% in the final round ($n = 34$). The top five priorities were aligned to three of the WHO health system building blocks: human resources for health (HRH), governance, and finance. Specifically, the panel identified a need to focus on recruitment and support of rural health professionals, the employment of managers with sufficient and appropriate skills, a rural-friendly national HRH plan, and equitable funding formulae.

Conclusion: Specific policies and strategies are required to address the greatest rural health care challenges and to ensure improved access to quality health care in rural South Africa. In addition, a change in organisational climate and a concerted effort to make a career in rural health appealing to health care workers and adequate funding for rural health care provision are essential.

Keywords: rural health; priorities; challenges; Delphi technique; health systems; leadership; management

Acronym

- ▶ Abbreviated Coded Rendition Of Name Yielding Meaning
- ▶ Army Confusion Regarding Obvious Nonsense You Make-up
- ▶ A Concise Representation Of Nomenclature Yielding Mnemonics
- ▶ Alphabetic Confusion Registering Odd Names in Your Memory
- ▶ Annoyingly Cryptic Reference Or Name You Make

Research acronym

- ▶ Reflecting and
- ▶ Showcasing
- ▶ Everyday
- ▶ Activities in
- ▶ Rural
- ▶ Health
- ▶ Care

Research acronym

- ▶ **R**eflecting and
- ▶ **S**howcasing
- ▶ **E**veryday
- ▶ **A**ctivities in
- ▶ **R**ural
- ▶ **C**are
- ▶ **H**health

Research acronym

- ▶ Reflecting and
- ▶ Showcasing
- ▶ Everyday
- ▶ Activities in
- ▶ Rural
- ▶ Health
- ▶ Care

Just ask ...

- ▶ Why?
- ▶ Why not?
- ▶ Why here
- ▶ Why now?
- ▶ What else?
- ▶ Can I/we do better?
- ▶ Is there an answer?
- ▶ Is the answer appropriate?



THE CLINICAL PROCESS!

A day in the life ...

- ▶ Morning meeting
- ▶ Ward rounds
- ▶ Outpatient/clinic consulting
- ▶ Theatre
- ▶ Teaching/supervision
- ▶ Community meeting
- ▶ After hours call



"ALL YOUR FOCUS GROUPS SAY
THE WHISKERS HAVE TO GO."

PERSONAL VIEW

Seeking quality: some experiences in South Africa

ID Couper

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Submitted: 28 January 2004; Revised: 25 March 2004; Published: 15 April 2004

Couper ID

Seeking quality: some experiences in South Africa

Rural and Remote Health 4 (online), 2004: no 271

Available from: <http://rrh.deakin.edu.au>

The role of clinic visits: perceptions of doctors

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Keywords: clinic visits, primary care, perceptions, doctors, team work, clinic nurses

Abstract

Background: The aim of this study was to ascertain what doctors perceive to be their role in visiting district clinics.

Methods: Individual and focus group interviews were conducted with hospital doctors of different seniority and with doctors who work solely in the clinics.

Results: A range of important themes emerged from the interviews, relating to the intended function of the clinics and their resources, the operationalisation of doctors' visits, the varied roles that doctors play in clinics and the importance of teamwork and support. Doctors working full time in the clinics shared a more positive view.

Conclusions: There is a need for clear consensus policy and guidelines on the role of the doctor in primary care clinics, the involvement of the doctor in the management of clinics, structuring doctors' visits to ensure continuity, facilitating transport for doctors, and ensuring that dedicated doctors are available to visit clinics, to support community service doctors visiting the clinics and to train clinic nurses.
(SA Fam Pract 2005;47(8): 60-65)

Ward rounds



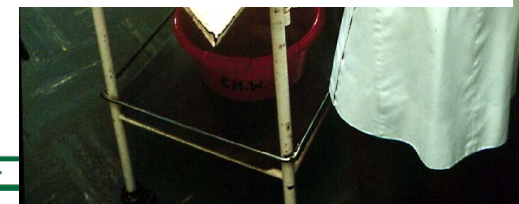
CASE REPORT

CONGENITAL MALARIA IN SOUTH AFRICA — A REPORT OF FOUR CASES

N F Moran, I D Couper

Congenital malaria is defined as malaria acquired directly from the mother, either *in utero* or during delivery.^{1,2} The mode of transmission is assumed to be transplacental, but there is as yet no clear evidence to explain the exact mechanism.^{3,4} There seems to have been little investigation into the condition in South Africa. Its incidence is unknown,⁴ and national guidelines⁵ give no recommendation about screening for, diagnosing or treating the condition. We report on four cases diagnosed in rural KwaZulu-Natal hospitals in 1996, and suggest that congenital malaria may be not uncommon in South Africa's malarious zones. We discuss management and emphasise the need for clinicians to be aware of the condition so that the diagnosis is not missed.

Moran NF, Couper ID. Congenital Malaria in South Africa: A Report of Four Cases. *S Afr Med J.* 1999; 89(9):943-6



Ward rounds

- ▶ Morbidity and mortality reviews





PERSONAL VIEW

WHAT DO WE DO ABOUT MISTAKES?

Ian Couper

'You just bury your mistakes.' How many times have we as medical practitioners heard this double entendre? Usually we laugh somewhat uncomfortably and change the subject. We do not often stop to reflect on the truth of it.

Truth? Yes, there is some literal truth, but certainly much truth at the figurative level. The medical profession prefers to hide, cover up or deny its mistakes. We avoid facing them.

Why is this so? Is it because we believe we do not make mistakes? Error is a normal part of human behaviour, and there is even a typology of human error.¹ It seems we are able to quote this fact in the oft-repeated saying 'to err is human', but we do not really like admitting that in our profession. Somehow we have accepted the god-like infallibility that patients often expect of us, and practise in denial of the reality. If we expect perfection, it is humiliating to make a mistake.² We know very well the percentage error of most laboratory tests, and make allowances for this in our decision-making, but somehow expect ourselves to function at an even greater level of accuracy than machines. Alternatively we negate the whole concept of error by viewing decision-making in medicine as a 'grey area', where nothing is certain.

Another reason for not facing mistakes is that we are not taught to do so in our medical education — or rather we are taught not to do so. Instead of using errors as positive tools for learning, most teachers prefer to brush mistakes aside or to cast blame on someone else — more often than not a junior colleague, a nurse, or 'the system'. As Alberti stated in the *British Medical Journal*, 'we are deeply immersed in a blame culture'.³ As a result of this, doctors-in-training develop a way of dealing with mistakes in which they protect themselves through the processes of distancing and denial.⁴

Having completed schooling in Port Elizabeth, Ian Couper did undergraduate studies at Wits University. After a year in Paraguay doing community health work, he worked for 9 years at Mangoch Hospital in northern KwaZulu-Natal, initially as a conscientious objector to military conscription, and subsequently as medical superintendent. During that time he completed the MFamMed course through MEDUNSA, and spent 6 months in Australia as a senior lecturer at the Monash University Centre for Rural Health. Since 2000, he has worked in the North West Province west of the MEDUNSA Department of Family Medicine and Primary Health Care.

Furthermore, it is not in the culture of the medical profession to face mistakes. When Dr David Hilfiker raised the issue of facing mistakes in the *New England Journal of Medicine* in 1984,⁵ senior members of the profession lambasted him for being incompetent and criticised the journal for publishing such unscientific opinions.⁶ When an article that I wrote, in 1996, about errors I had made,⁷ was shared in a journal club meeting by a colleague as a way of creating awareness of the issue, the response of the specialists in the meeting was to proclaim how this kind of incompetence would not have occurred in their units! If nobody is sharing mistakes, it reinforces the concept either that mistakes do not happen or that the consequences of talking about them are terrible. Yet it is only when doctors acknowledge their mistakes that they can really change and avoid these mistakes in the future.⁸

THE CURRENT SITUATION

We do not know what the frequency of medical error or adverse outcomes is because this is difficult to measure, but medical error has received increasing attention in recent years. A conference was held in the USA on the subject last year (Sandra Gilbert — personal communication), and the *British Medical Journal* has published a number of editorials and reviews on the issue over the past year.¹⁴⁻¹⁶ A few attempts to quantify medical error have been made. Vincent *et al.*¹⁷ found that almost 11% of 1 000 patients in acute hospital beds had experienced an 'adverse event'. Mizrahi,¹⁸ looking at internists-in-training in the USA, found that half of the new interns made a serious patient error in their first 2 months. Roughly 100 000 Americans a year die from preventable errors in hospitals.¹⁹ It is argued that the more closely we examine patient care, the more error we find.²⁰ No studies appear to have evaluated error in primary care, or even in community hospitals. I know of no attempt to quantify medical error in South Africa.

A wide variety of types of error have been studied. These include errors of omission (failure to act) or commission (incorrect action).²¹ The range of error described in the literature includes prescribing problems, diagnostic mistakes, adverse events in surgery and anaesthetics, misinterpretation of special investigations, etc. No specialty investigated thus far has been immune to error.

Mistakes have been examined in terms of their impact; a few studies have included emotional impact. We know that doctors do have difficulty dealing with their mistakes. Newerman⁸ describes the emotional impact of mistakes on family physicians; everyone experiences emotional distress after making a mistake but they are afraid to admit it for fear of humiliation. Hilfiker⁸ argues that the potential consequences of the mistakes we make as doctors are so overwhelming it is very difficult to deal with them in a psychologically healthy fashion.



Outpatient/clinic consulting

▶ Clinical research



Outpatient/clinic consulting

Cent Afr J Med. 1997 Aug;43(8):219–22.

Causes of death in a rural hospital in South Africa.

Couper I, Walker AR.



Outpatient/clinic consulting



Trans R Soc Trop Med Hyg. 2001 Mar–Apr;95(2):
211–6.

The effect of different anthelmintic treatment regimens combined with iron supplementation on the nutritional status of schoolchildren in KwaZulu-Natal, South Africa: a randomized controlled trial.

[Taylor M](#), [Jinabhai CC](#), [Couper I](#), [Kleinschmidt I](#), [Jogessar VB](#).

(A good example of COPC)



The quality and relationship of referral and reply letters

The effect of introducing a pro forma letter

I. D. Couper, R. J. Henbest

Objective. An intervention study was conducted to assess the effect of a pro forma letter on the quality of referral letters from general practitioners at a rural hospital in KwaZulu-Natal, and on the quality and rate of replies received.

Method. 254 referral letters and 111 replies were evaluated.

Results. The quality of referral letters improved after the introduction of the pro forma letter, but the quality of replies did not. The reply rate (43.5%) did not change, and the quality of replies showed a low correlation with the quality of referral letters, indicating that improvements in the quality of referral letters will not necessarily bring about improvements in the quality of replies. Instead, the reply rate was found to be influenced mainly by the hospital to which the patient was referred. Replies were also observed to function poorly as a means of continuing medical education.

Conclusion. Pro forma letters improve the quality of referral letters, but on their own do not improve the rate and quality of replies. Personal contact between referring doctors and consultants would seem to be an important factor in respect of the letter.

S Afr Med J 1996; 86: 1540-1542.

A fully functioning referral system is an important part of the support required for effective primary health care.¹ Letters between the practitioners involved are an essential ingredient of this system.

Consultants in referral hospitals complain about the poor quality or absence of referral letters; this is the subject of numerous journal articles.^{2,3} The intervention most commonly advocated to improve the quality of referral letters has been that of a pro forma referral letter,^{4,5} although no study on the effect thereof could be found.

General practitioners, however, complain about the poor standard of responses they receive from referral hospitals and the lack of reply letters. Various studies have shown that the response rate is often low,^{6,7} with the implication that

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Couper ID, Henbest RJ. The quality and relationship of referral and reply letters: The effect of introducing a pro forma letter. S Afr Med J; 1996, 86(12):1540-1542.



Outpatient/clinic consulting



Further reflections on chronic illness care

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Abstract

There are seven key principles in the care of patients with chronic illnesses which are fundamental in offering an appropriate service and adequate care for these patients. These are the principles that should underlie the setting up and management of any primary health care service endeavouring to treat patients with chronic illness. They determine how one understands the care of such patients and how to organise a service or practice. These principles are discussed in this article and will provide both the right mindset and the right organisational approach for effective chronic illness care.

SA Fam Pract 2007;49(4): 4-10



Teaching consultation skills using juggling as a metaphor

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Abstract

The consultation is a complex and important skill in medical practice. This article describes how a metaphor model of the consultation is used to train consultation skills. The metaphor is a juggler using 3 balls representing three continuous processes namely facilitation, clinical reasoning and collaboration in the consultation. Facilitation enables the practitioner to help the patient uncover his or her story. Clinical reasoning is the process of making an assessment through reasoning, history taking and physical examination while collaboration is the process of involving the patient in the understanding of the problem and the solution through a mutual plan. Negotiation is used when there is disagreement between the practitioner and the patient. The successful integration of these processes lead to a functional patient-centred consultation. The training first focuses on the training of the individual processes and then its integration. Training takes place through seminars including role plays and fish bowl sessions.

SA Fam Pract 2006;48(5): 5-7)

Outpatient/clinic consulting



The shared consultation: a necessity in primary care clinics?

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Keywords: consultation; primary health care; patient-centred care; doctor-nurse relations; nurse practitioners

Abstract

SA Fam Pract 2010;52(2): 223-226

The shared consultation is a concept that differs from shared decision making and shared care. It involves two or more health professionals in the consultation of a patient during the same illness episode. Commonly, the health professionals are a primary-care doctor and a clinical nurse practitioner. On the basis of clinical experience, a number of models of the relationship in such situations are described, viz the consultant, the master-servant, the teacher-pupil and the teamwork models. Issues of communication within the consultation, the patient as a person, continuity of care, and clarification of roles and responsibilities are highlighted. More investigation is required to explore this further.

Peer reviewed. (Submitted: 2009-09-10, Accepted: 2009-11-18). © SAAFP

The role of the visiting doctor in primary care clinics



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Keywords: Primary health care, role, medical practitioners, district health

Abstract

The concept of doctors visiting clinics to support primary health care is well established but the role that these doctors should play is not clear, and varies from area to area.

As an approach to understanding the possible roles of visiting doctors in order to assist District Management Teams to produce job descriptions for such doctors, groups of clinic nurses in 2 districts in North West Province (Odi and Brits) were interviewed in focus groups. The question posed was, "What do you think about the role of the visiting doctor at your clinic?"

From the analysis, which was validated by participants from the groups, a number of key themes emerged. Many **BENEFITS** were identified which indicate that the role of the visiting doctor is a valuable one; benefits were attributed to patients, clinic staff, the clinic as a whole, the hospital and the service. However, there are also **NEGATIVE EFFECTS**, which arose as side effects of doctors' visits, mainly centred around issues of relationship with staff and patients, and sub-standard medical practice, which serve as a warning to all those involved. **RELATIONSHIPS** were identified as a central issue, which determines whether the visiting doctor's role is a negative or positive one. A number of **CONSTRAINTS AND CHALLENGES** emerged which need to be addressed, by doctors, nurses and, especially, District Management Teams, as these are thought to be critical for the development of the service.

Across all the themes there emerged a series of **CONTRASTS** which on the one hand highlight the potential for improved health care where the visiting doctor's role is clearly understood and the doctor is functioning optimally, but on the other hand show the potential for harm and discouragement where the doctors' visits do not serve their purpose.

Recommendations to optimise the role of the visiting doctor, which emerged from the groups, included the involvement of administrators to address some of the constraints, orientation and training of doctors, developing respect as a basis for teamwork, and ensuring networking and co-ordination. (*SA Fam Pract 2003;45(6):*_____)



Theatre

▶ Procedures



Theatre



Building consensus on clinical procedural skills for South African family medicine training using the Delphi technique

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SA Fam Pract 2006;48(10):14

Teaching/supervision

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The consultation: a juggler's art

Jannie Hugo and Ian Couper

Keywords: consultation skills,
international, teaching



Hugo J, Couper I. The consultation: a juggler's art. *Education for Primary Care* 2005; 16 (5): 597–604

Teaching/supervision

How do doctors learn the spoken language of their patients?

Colin Pfaff, Ian Couper

Background. In South Africa, many doctors consult across both a language and cultural barrier. If patients are to receive effective care, ways need to be found to bridge this communication barrier.

Methods. Qualitative individual interviews were conducted with seven doctors who had successfully learned the language of their patients, to determine their experiences and how they had succeeded.

Results. All seven doctors used a combination of methods to learn the language. Listening was found to be very important, as was being prepared to take a risk or appear to be foolish.

The doctors found that it was important to try out the newly learned language on patients and additionally stressed that learning the language was also learning a culture. The importance of motivation in language learning, the value of being immersed in the language one is trying to learn, and the role of prior experience in language learning, were commonly mentioned. The doctors deeply valued the improved rapport and deeper relationships with patients that resulted from their language learning efforts.

S Afr Med J 2009; 99: 520-522.



PROJECT REPORT

The Neonatal Resuscitation Training Project in Rural South Africa

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Couper ID, Thurley JD, Hugo JF

The Neonatal Resuscitation Training Project in Rural South Africa

Rural and Remote Health 5: 459. (Online), 2005

Available from: <http://rrh.deakin.edu.au>

Teaching/supervision



Rural and Remote Health

MEDLINE listed  ARHEN
FRAME

The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy
ISSN 1445-6354

ORIGINAL RESEARCH

Rural longitudinal integrated clerkships: lessons from two programs on different continents

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Submitted: 15 November 2010; Revised: 1 March 2011; Published: 17 March 2011

Couper I, Worley PS, Strasser R

Rural longitudinal integrated clerkships: lessons from two programs on different continents

Rural and Remote Health 11: 1665. (Online), 2011



Community meeting

- ▶ Evaluation of community projects

Curationis. 1997 Jul;20(2):41–2.

Health education: a baby show as an evaluation tool.

Couper ID.

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AIDS: Views of Rural High School Students as expressed in an Essay Competition

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Abstract

An essay competition for high school students in the Manguzi sub-district of KwaZuluNatal, with the topic "AIDS: What can we do?" provided an opportunity to gain insights into students' understanding of the disease. The 668 entries were scrutinised and the expressed ideas of the students were grouped into a number of themes, which included the meaning of AIDS, transmission and

prevention of AIDS, the reason for and threat of AIDS, and possible solutions to the problem of AIDS. Although students demonstrated good awareness of the issues around HIV/AIDS, they also expressed much confusion and misunderstanding, together with a desire for more information. The concepts expressed by students can help to inform educational programmes in high schools.

SA Fam Pract 2001;23(4): 10-13



ORIGINAL RESEARCH

Suicide and attempted suicide: the Rehoboth experience

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Suicide and attempted suicide: the Rehoboth experience

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New directions

- ▶ As my roles have changed, reflection has continued ...

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ABSTRACT

Introduction: Chronic illnesses are a significant burden to the health services in South Africa. There is a specific national health plan whereby chronically ill patients who are acceptably controlled should be managed at clinic level. The perception has emerged that the management of primary care has not been optimal in the Southern District of the North West Province. This provided the motivation to initiate this research, namely consideration of chronic patient care at clinics in the North West Province of South Africa.

Methods: A cross-sectional descriptive study was carried out at four randomly selected clinics covering four sub-districts in the Southern District (North West Province). This was done using charts and registers at the clinics. Inclusion criteria were patients older than 15, and presenting with the following chronic illnesses: asthma/chronic obstructive airways disease (COAD), hypertension, diabetes and epilepsy. The major focus areas were the regular assessment of the patients, the level of control of the illness and the use of the Essential Drugs List and Standard Treatment Guidelines (EDL/STG).

Results: In the cases of all the chronic illnesses it was found that regular assessments were poorly done, with asthma (peak flow measurements) being the most poorly done. Control was generally less than 50% for all the illnesses, although the EDL was followed fairly well by the personnel at the clinics.

Discussion and conclusion: In the light of the burden of chronic illness the results give cause for great concern about the quality of care for chronically ill patients, and reasons were sought for some of the poor results. A subsequent decision was taken to carry out comprehensive quality improvement projects on each of the illnesses over the following five years.

INTRODUCTION

After 1994 the Department of Health reconfigured the country's health services to include free clinic services and free access to health for pregnant women and children under six years.¹ The government integrated primary care in the so-called super-urban approach to patient care.²

The down referral from the district hospitals to the community resources was also mapped out in the National Health Plan, and chronically ill patients who were not experiencing complications or needing specialised treatment were to be down-referred to their nearest clinics and health centres, where the visiting doctor would reassess them, six months and the clinic sister would supply monthly medication as well as carry out basic screening tests.³

In this area there is a very large number of patients who are chronically ill. This was confirmed in a report to the National Directorate of Chronic Illness and Rehabilitation in July 2006. Annual statistics for 2005/2006 from the Southern District confirm this.⁴

It has been suggested that the care of chronically ill people is often not optimal at clinics and that they then incorrectly access hospitals after-hours, in particular, in efforts to access what they perceive to be better care.

Diabetes (NIDDM)

In South Africa, an estimated two to three million people are affected with diabetes mellitus (DM), more than one million of whom are undiagnosed. During the period 1990-2000 an increase of 50% in the prevalence of diabetes was reported in Africa, mostly due to a change of lifestyle and an increase in obesity.⁴

Hypertension (HT) is a common co-morbidity to DM in South Africa and contributes significantly to morbidity in diabetes.^{5,6} It is therefore very important to optimise the care of diabetic and hypertensive patients and to persist in the maintenance of care at the highest standard. The bulk of this care rests on the primary care system, and in particular the care provided by clinics.

Hypertension

Hypertension has been targeted as a priority disease by the Reconstruction and Development Program⁷ as well as by the National Department of Health.⁸ Recently, in Limpopo Province, a high prevalence of hypertension with poor levels of control was found amongst adults, as reported by the Demographic and Health Survey (2005).⁹ In Sub-Saharan Africa, in 2004, the prevalence was estimated at 10-20 million out of 650 million people.¹⁰

Asthma

A world map showing the prevalence of asthma, taken from the GINA Burden of Asthma report (2007)¹¹ is shown in Figure 1. In this map, South Africa lies within the orange area (7-20% prevalence) and, according to the GINA report, has a proportion of 0.1% asthmatics in the population.

African Journal of Primary Health Care & Family Medicine Article #6



New directions

Key issues in clinic functioning – a case study of two clinics

I D Couper, J F M Hugo, J M Tumbo, B M Harvey, N H Maletle

Objective. The aim of this research was to understand key issues in the functioning of two different primary care clinics serving the same community, in order to learn more about clinic management.

Design. An in-depth case study was conducted. A range of qualitative information was collected at both clinics. Data collected in the two clinics were compared, to gain an understanding of the important issues.

Setting. Data were collected in a government and an NGO clinic in North West province.

Subjects. This report presents the findings from patient and staff satisfaction surveys and in-depth individual interviews with senior staff.

Results. Key findings included the following: (i) there are attitudinal differences between the staff at the two clinics; (ii) the patients appreciate the services of both clinics, though they

view them differently; (iii) clinic A provides a wider range of services to more people more often; (iv) clinic B presents a picture of quality of care, related to the environment and approach of staff; (v) waiting time is not as important as how patients are treated; (vi) medications are a crucial factor, in the minds of staff and patients; and (vii) a supportive, empowering organisational culture is needed to encourage staff to deliver better care to their patients. The management of the clinic is part of this culture.

Conclusions. This research provides lessons regarding key issues in clinic functioning which can make a major difference to the way services are experienced. A respectful and caring approach to patients, and an organisational culture which supports and enables staff, can achieve much of this without any additional resources.

S Afr Med J 2007; 97: 124-129.

The involvement of private general practitioners in visiting primary healthcare clinics



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Abstract

Background

The primary healthcare system was adopted as the vehicle of healthcare delivery and a means of reaching the larger part of the population in South Africa in 1994. One of the strategies employed in providing a comprehensive service is the incorporation of visits to clinics by doctors in support of other members of the primary healthcare team, particularly nurses. A successful collaboration at this level brings benefit to everyone involved, particularly patients. Clear expectations and a confusion of roles leads to lack of teamwork, thus it is important to have clearly established models for such involvement.

Doctors working in district hospitals mostly visit clinics, but their workload, staff shortages and transport often interfere with these visits. As a form of private-public partnership, local GPs are sometimes contracted to visit the clinics. Very little is known about this practice and problems are reported, including the perception that GPs do not spend as much time in the clinics as they are paid for. Understanding the practice better may provide answers on how to improve the quality of primary care in the district health system. The aim of this study was to describe the experiences of local GPs visiting public clinics regularly over a long period of time.

Methods

A case study was undertaken in the Odi district of the North West Province in three primary care clinics visited by GPs. The experiences of the doctors, clinic nurses, district managers and patients regarding the GP's visits were elicited through in-depth interviews. Details of the visits with regard to patient numbers, lengths of the visits, remuneration and preferences were also sought. The data were analysed using different methods to highlight important themes.

Results

The visits by the GPs to the clinics were viewed as beneficial by the patients and clinic staff. The GPs were often preferred to government doctors because of their skills, patience and availability. The visits were also seen as a gesture of patriotism by the GPs. There were constraints, such as a shortage of medicines and equipment, which reduce the success of these visits.

Conclusion

The involvement of GPs in primary care clinics is beneficial and desirable. It enhances equity in terms of access to services. Addressing the constraints can optimise the public-private partnership at this level.

The consequences upon patient care of moving Brits Hospital: A case study

C A Pfaff, I D Couper

Background. In 2001, North West Province took the decision to increase bed capacity at Brits Hospital from 66 beds to 267 beds. After careful consideration of costs and an assessment of available land, it was decided to demolish the existing hospital and rebuild the new hospital on the same site. It was planned that during this time clinical services would be moved to a temporary makeshift hospital and to primary health care clinics. This case study documents the consequences of this decision to move services to the makeshift hospital and how these challenges were dealt with.

Methods. A cross-sectional descriptive study was undertaken. Ten key members of staff at management and service delivery level, in the hospital and the district, were interviewed. Key documents, reports, correspondence, hospital statistics and minutes of meetings related to the move were analysed.

Results. The plan had several unforeseen consequences with serious effects on patient care. Maternity services were particularly affected. Maternity beds decreased from 30 beds in the former hospital to 4 beds in the makeshift hospital. As numbers of deliveries did not greatly decrease, this resulted in severe overcrowding, making monitoring and care difficult. Perinatal mortality rates doubled after the move. An increase in maternal deaths was noted. The lack of inpatient ward space resulted in severe overcrowding in Casualty. The lack of X-ray facilities necessitated patients being referred to a facility 72 km away, which often caused a delay of 3 days before management was completed. After-hours X-rays were done in a private facility, adding to unforeseen costs. Although the

initial plan was for the makeshift hospital to stabilise and refer most patients, referral routes were not agreed upon or put in writing, and no extra transportation resources were allocated. The pharmacy had insufficient space for storage of medication. In spite of all these issues, relationships and capacity at clinics were strengthened, but not sufficiently to meet the need.

Discussion. Hospital revitalisation requires detailed planning so that services are not disrupted. Several case studies have highlighted the planning necessary when services are to be moved temporarily. Makeshift hospitals have been used when renovating or building hospitals. During war or disasters, plans have been made to decant patients from one facility to another. From the Brits case study, it would appear that not enough detailed planning for the move was done initially. This observation includes failure to appreciate the interrelatedness of systems and the practicality of the proposal, and to budget for the move and not just the new structure.

Conclusion. The current service offered at the makeshift hospital at Brits is not adequate and has resulted in poor patient care. It is the result of a planning process that did not examine the consequences of the move, both logistic and financial, in adequate detail. Committed hospital staff have tried their best to offer good care in difficult circumstances.

S Afr Med J 2010; 100: 109-112.



New directions

- ▶ Health systems & services
- ▶ Human resources

New directions

Influences on the choice of health professionals to practise in rural areas

I D Couper, J F M Hugo, H Conradie, K Mfenyana, Members of the Collaboration for Health Equity through Education and Research (CHEER)

Background. Training health care professionals (HCPs) to work in rural areas is a challenge for educationalists. This study aimed to understand how HCPs choose to work in rural areas and how education influences this.

Methods. Qualitative individual interviews were conducted with 15 HCPs working in rural areas in SA.

Results. Themes identified included personal, facilitating, contextual, staying and reinforcing factors. Personal attributes of the HCPs, namely rural origin and /or their value system, determine consideration of rural practice. The decision to 'go rural' is facilitated by exposure to rural practice during training, an understanding of rural needs and exposure to rural role models.

Once practising in a rural area, the context and nature of work and the environment influence the decision to remain,

supported by the role of family and friends, ongoing training and development, and the style of health service management. Personal motivation is reinforced by a positive relationship with the community, and by being an advocate and role model for the local community. Educational factors were often felt to work against the decision to practise in rural areas.

Discussion. The results show the complexity of the interaction between a large number of factors working together to make HCPs choose to go and stay in rural areas. Factors other than educational ones seem more important. A comprehensive approach is needed to attract and retain HCPs in rural areas. Issues for educationalists to address include helping rural-origin students to connect with their own values and communities.

S Afr Med J 2007; 97: 1082-1086.

REVIEW ARTICLE

A critical review of interventions to redress the inequitable distribution of healthcare professionals to rural and remote areas

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Developing a new mid-level health worker: lessons from South Africa's experience with clinical associates

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Background: Mid-level medical workers play an important role in health systems and hold great potential for addressing the human resource shortage, especially in low- and middle-income countries. South Africa began the production of its first mid-level medical workers – known as clinical associates – in small numbers in 2008.

Objective: We describe the way in which scopes of practice and course design were negotiated and assess progress during the early years. We derive lessons for other countries wishing to introduce new types of mid-level worker.

Methods: We conducted a rapid assessment in 2010 consisting of a review of 19 documents and 11 semi-structured interviews with a variety of stakeholders. A thematic analysis was performed.

Results: Central to the success of the clinical associate training programme was a clear definition and understanding of the interests of various stakeholders. Stakeholder sensitivities were taken into account in the conceptualisation of the role and scope of practice of the clinical associate. This was achieved by dealing with quality of care concerns through service-based training and doctor supervision, and using a national curriculum framework to set uniform standards.

Conclusions: This new mid-level medical worker can contribute to the quality of district hospital care and address human resource shortages. However, a number of significant challenges lie ahead. To sustain and expand on early achievements, clinical associates must be produced in greater numbers and the required funding, training capacity, public sector posts, and supervision must be made available. Retaining the new cadre will depend on the public system becoming an employer of choice. Nonetheless, the South African experience yields positive lessons that could be of use to other countries contemplating similar initiatives.

Keywords: *mid-level medical workers; human resource policy and production; district hospitals; South Africa; policy analysis*

New directions

Rural-origin health science students at South African universities

J M Tumbo, I D Couper, J F M Hugo

Background. Rural areas in all countries suffer from a shortage of health care professionals. In South Africa, the shortage is particularly marked; some rural areas have a doctor-to-population ratio of 5.5:100 000. Similar patterns apply to other health professionals. Increasing the proportion of rural-origin students in faculties of health sciences has been shown to be one way of addressing such shortages, as the students are more likely to work in rural areas after graduating.

Objective. To determine the proportion of rural-origin students at all medical schools in South Africa.

Design. A retrospective descriptive study was conducted in 2003. Lists of undergraduate students admitted from 1999 to 2002 for medicine, dentistry, physiotherapy and occupational therapy were obtained from 9 health science faculties. Origins of students were classified as city, town and rural by means of postal codes. The proportion of rural-origin students was

determined and compared with the percentage of rural people in South Africa (46.3%).

Results. Of the 7 358 students, 4 341 (59%) were from cities, 1 107 (15%) from towns and 1 910 (26%) from rural areas. The proportion of rural-origin students in the different courses nationally were: medicine – 27.4%, physiotherapy – 22.4%, occupational therapy – 26.7%, and dentistry – 24.8%.

Conclusion. The proportion of rural-origin students in South Africa was considerably lower than the national rural population ratio. Strategies are needed to increase the number of rural-origin students in universities via preferential admission to alleviate the shortage of health professionals in rural areas.

S Afr Med J 2009; 99: 54-56.

Meeting the challenges of training more medical students: lessons from Flinders University's distributed medical education program

Ian D Couper and Paul S Worley

ABSTRACT

Objective: To use data from an evaluation of the Flinders University Parallel Rural Community Curriculum (PRCC) to inform four immediate challenges facing medical education in Australia as medical student numbers increase.

Design, setting and participants: Thematic analysis of data obtained from focus groups with medical students undertaking the PRCC, a year-long undergraduate clinical curriculum based in rural general practice; and individual interviews with key faculty members, clinicians, health service managers and community representatives from 13 rural general practices and one urban tertiary teaching hospital in South Australia. Data were collected in 2006 and re-analysed for this study in January 2009.

Main outcome measures: Participants' views grouped around the themes of the four identified challenges: how to expand the venues for clinical training without compromising the quality of clinical education; how to encourage graduates to practise in under-served rural, remote and outer metropolitan regions; how to engage in a sustainable way with teaching in the private sector; and how to reverse the current decline in altruism and humanism in medical students during medical school.

Results: Participants' views supported the PRCC approach as a solution to the challenges facing Australian medical education. The enabling capacity of the PRCC's longitudinal integrated approach to clinical attachments was revealed as a key factor that was common to each of the four themes.

Conclusions: The continuity provided by longitudinal integrated clinical attachments enables an expansion of clinical training sites, including into primary care and the private sector. This approach to clinical training also enables students to develop the skills and personal qualities required to practise in areas of need.

Medical education in Australia is undergoing a time of unprecedented change and challenge. In large part, this has been brought about by an acknowledgement that Australia needs to train more doctors to meet the present and future demands on our health services.¹ The Australian Government has responded by increasing the numbers of medical students at existing medical schools and by creating new medical schools across the country.²

While this increase in student numbers may be a welcome break in the drought for under-served regions in Australia, providing the students with a high-quality clinical education presents significant challenges to universities and health services. It is likely to be impossible to meet this demand by merely scaling up the existing clinical training venues. New venues are needed at both undergraduate and postgraduate levels, including an increased role for the private and ambulatory care sectors.

It is also important to ensure that these new graduates will practise in the areas in which they are most needed. Thus, there is likely to be an even greater role for rural,

Exposure to primary healthcare for medical students: experiences of final-year medical students

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Keywords: primary health care; skills; practice; medical students

Abstract

SA Fam Pract 2010;52(5):467-470

Introduction: Recognising the importance of primary healthcare in the achievement of the 1997 White Paper for the Transformation of the Health System and the Millennium Development Goals, the Faculty of Health Sciences of the University of the Witwatersrand introduced an integrated primary care (IPC) block. In a six-week final year preceptorship, medical students are placed in primary healthcare centres in rural and underserved areas. This article describes the experiences of medical students during their six weeks in the IPC block.

Methods: The study was qualitative, based on data collected from the logbooks completed by the students during the IPC rotation. A total of 192 students were placed in 10 health centres in the North West and Gauteng provinces in the 2006 academic year. These centres included district hospitals, clinics and NGO community health centres.

Results: The students reported that the practical experience enhanced their skills in handling patients in primary care settings. They developed an appreciation of primary healthcare as a holistic approach to healthcare. The students attained increased levels of confidence in handling undifferentiated patients, and became more aware of community health needs and problems in health service delivery.

Conclusions: Exposure to the IPC block provided a valuable experience for final-year students, as it is critical for orienting students to the importance of primary healthcare, which is essential for the realisation of targets identified in the national health policy.

New directions

Educational factors that influence the urban-rural distribution of health professionals in South Africa: A case-control study

S J Reid, I D Couper, J Volmink

Setting. The influence of undergraduate and postgraduate training on health professionals' career choices in favour of rural and under-served communities has not been clearly demonstrated in resource-constrained settings.

Objectives. This study aimed to evaluate the influence of educational factors on the choice of rural or urban sites of practice of health professionals in South Africa.

Methods. Responses to a questionnaire on undergraduate and postgraduate educational experiences by 174 medical practitioners in rural public practice were compared with those from 142 urban public hospital doctors. Outcomes measured included specific undergraduate and postgraduate educational experiences, and non-educational factors such as family and community influences that were likely to affect the choice of the site of practice.

Results. Compared with urban doctors, rural respondents were significantly less experienced, more likely to be black, and felt

significantly more accountable to the community that they served. They were more than twice as likely as the urban group to have been exposed to rural situations during their undergraduate training, and were also five times more likely than urban respondents to state that exposure to rural practice as an undergraduate had influenced their choice of where they practise. Urban respondents were significantly more attracted to working where they do by professional development and postgraduate education opportunities and family factors than the rural group.

Conclusions. Evidence is provided that rural exposure influences the choice of practice site by health professionals in a developing country context, but the precise curricular elements that have the most effect deserve further research.

S Afr Med J 2011; 101: 29-33.

New directions

- ▶ Health systems & services
- ▶ Human resources
- ▶ Educational issues
- ▶ Leadership

New directions



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CONFERENCE REPORT

Transforming rural health systems through clinical academic leadership: lessons from South Africa

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Transforming rural health systems through clinical academic leadership: lessons from South Africa
Rural and Remote Health 13: 2618. (Online) 2013

Available: <http://www.rrh.org.au>



Less successful projects ...

- ▶ Water research
- ▶ Kellogg project
- ▶ Neonatal resuscitation evaluation
- ▶ Telephonic referral



What facilitates research?

(in the clinical context)

- ▶ Academic environment
- ▶ Supportive group
- ▶ Peers
- ▶ Mentors
- ▶ Management understanding



Remember ...

- ▶ Reflecting and
- ▶ Showcasing
- ▶ Everyday
- ▶ Activities in
- ▶ Rural
- ▶ Health
- ▶ Care

Remember ...

- ▶ Reflecting and
- ▶ Showcasing
- ▶ Everyday
- ▶ Activities in
- ▶ REAL
- ▶ Health
- ▶ Care



STICK YOUR NECK OUT!

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Wits Centre for Rural Health

<http://web.wits.ac.za/Academic/Health/Entities/RuralHealth/>

Writing an article

for publication in a scientific journal

Ian Couper

Director: Wits Centre for Rural Health

Editor: African Section, *Rural and Remote Health*

Writing is difficult!


- Not what we are trained to do!

MEDICAL ALPHABET

A B C D E




F G H I J




K L M N O



P Q R S T



U V W X Y



Z



VIA 9GAG.COM

Reasons to publish

Advance science/ improve health outcomes

Disseminate results of your (hard) work

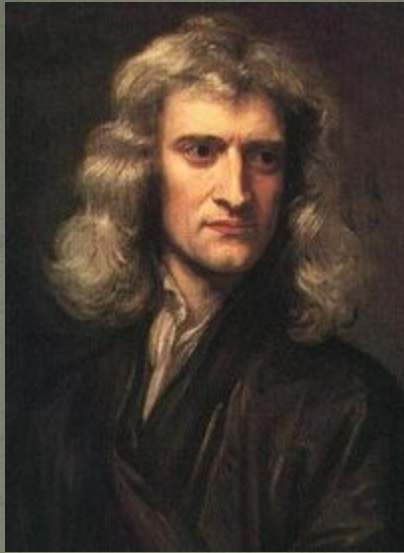
Enhance your status/track record/reputation

Improve chances for promotion/research grants

Promote your hospital/service/project

Unethical not to publish research?





Isaac Newton
(1643–1727)

“Isaac Newton was famously reluctant to publish, and when he did, to put his name to the work.”

Drummond Rennie



Yuri Timofeevich Struchkov (1926-1995)

Crystallographer

Yuri Struchkov published one paper every 3.9 days for 10 years

Drummond Rennie

He had only one hand!



Some how to's

Perspectives from an editor

With acknowledgments to
Prof Pierre de Villiers
Editor: SA Family Practice Journal

Manuscript must be “readable”

**Structure
IMRD**

**Flow of the
(scientific)
story**

**Minimise
repetition
(space)**

**Balance
information
vs brevity**

**Good
English!**



Structure - IMRD

Introduction –
provide context and
tell readers why your
study is important

Discussion – the
implications of your
work, conclusions and
recommendations.

Methods – describe
what you did, so that
others may be able to
reproduce your work

Results – present
them to be easily
understood. Balance
of tables/fig & text



Literature review “essentials”

Focused on the topic of your study

Based on **good search** – Google Scholar; Pubmed

Use most **recent** sources (last 5 years)

Organise in appropriate **themes**

- What is known on the topic?
- What are the gaps related to your study?

What will your study aim to **contribute**?

Choose your journal carefully



Focus & Scope of journal



Status of journal: Impact factor
(ISI/Scopus)



DoHET subsidy (ISI, SA list)



Indexing (Medline, EMBASE etc)



Availability on internet



Open Access vs. Toll Access



Cost – author side publication fees



Use the author guidelines

Metadata (author, info, abstract)



Formatting



Length, word count, tables, figures



Style and system of referencing



Correct submission (paper, online)



Uniform requirements (ICMJE) – www.icmje.org

Mention ethical issues



Measures taken to obtain consent, protect confidentiality



Ethical approval obtained



Possible conflicts of interest: e.g. funding or other sources of support



Get language assistance

- Spelling, grammar, syntax and clarity
 - Co-authors
 - Other colleagues
 - English teachers, lecturers
 - Language experts

Respond appropriately to the peer review report

- Response time (3-6 m)
- Be polite and appreciative
- Respond to each suggestion in a table attached to your new draft
- Say what you changed and what not and give reasons
- Make all changes in tracking or different text colour

Look carefully at the proofs

- Short response time (days)!
- Last chance to pick up mistakes
- Only minor changes allowed
- Your ultimate responsibility (+ editor)

Note

- Different types of article
 - Original research
 - Wide range of research types
 - Scientific letters (NB Easier than opinion pieces)
 - Case reports
 - Project reports
 - Systematic reviews
 - Etc
- Learn by reviewing
 - Good reviewers needed! (Learning process)
- Partner with experienced authors

ICMJE rules for authorship

All 3 must be met:

1. **Substantial contribution** to conception and design, OR analysis of data; and to
2. **Drafting** the article OR **revising** it critically for important intellectual content,
3. **Final approval** for version to be published

Don'ts

Send your research report as is for publication – wrong format!

**Send your small survey to the N Engl J Med.
(Be humble and realistic)**

Send your article to more than one journal at the same time and withdraw suddenly when one accepts



Don'ts

Wait 5 years to publish, and not update your references

Attack the peer-reviewers in your response, be obstructive, protective

Re-write the article in the proofing stage (costly)



DON'T

**.... give up if at first rejected:
try another journal**

Remember ...

Editors need authors more
than authors need editors

Richard Smith
Editor, BMJ

Questions?

Ian.couper@wits.ac.za