# Decentralised clinical training of health professionals will expand the training platform and enhance the competencies of graduates

The South African Association of Health Educationalists (SAAHE), at its 2017 National Conference in Potchefstroom, deliberated on the critical issue of the appropriate training of healthcare professionals in South Africa (SA) and resolved to continue and intensify its advocacy for distributed clinical training of healthcare professionals in the country. In its Consensus Statement,[1] SAAHE defines distributed training as the 'training of students outside the central academic hospitals' in district and other appropriate healthcare facilities embedded in the community, in which the students are immersed 'in the experience of social determinants of health, in understanding the continuum of comprehensive care and the role of context in health and illness, and in addressing the maldistribution of human resources for health'.

The development of decentralised training platforms as part of the education of health professionals in SA is being discussed in many forums, and the Consensus Statement has attracted wide interest from professional, academic and statutory bodies. Decentralised training has received the support of leaders of many universities around the world that offer medical and health professional training, who regard decentralised training as an essential component of the endeavour to increase graduate output and to improve outcome competencies for health professionals.[2]

In respect of undergraduate medical training in particular, decentralisation has become more urgent in the SA context owing to the growing numbers of senior medical students needing clinical training in the face of limited capacity at academic hospitals. The increase is due in part to the Nelson Mandela-Fidel Castro Collaboration students returning from Cuba, whose programme includes a period of training at SA medical schools, and in part to the increasing intake of students by SA medical schools at the instance of the Minister of Health. The large numbers of students involved have made medical schools uneasy, fearing that quality will be compromised for quantity, thus reflecting the dilemmas that have accompanied massification of higher education more generally.[3]

However, capacity and other logistics are not the only justification for distributed professional training. Experience from elsewhere in the world has shown that health professional training in non-academic hospital settings produces graduates who are better fit for purpose[2,4,5] and who are competent and confident to work in generalist settings in many healthcare systems throughout the world.[6,7] This is echoed in the report of the Lancet Commission on Health Professional Education for the 21st Century[8] and the World Health Organization guidelines on transforming health professional education.[2]

Various initiatives of decentralised training have been around in SA for some years, albeit on an *ad hoc* basis and driven by individual institutions with little national co-ordination. The Walter Sisulu medical school was founded on – and remains – a distributed training model. A number of other medical schools (including the University of the Witwatersrand, Pretoria University, the University of KwaZulu-Natal and Stellenbosch University) have for a long time undertaken a variety of initiatives to extend training into rural health facilities, and the envisaged new medical school at the Nelson Mandela Metropolitan University is intended to be wholly based on distributed training. Currently, the Stellenbosch University Collaborative Capacity Development through Engagement with Districts (SUCCEED) project is supporting a national process in developing models to shift clinical training from the metropolitan academic hospital centres to district hospital and community settings.[9]

This editorial seeks to add to the advocacy for a national consensus-based commitment to the adoption of a comprehensive, across-the-board policy on distributed clinical training for SA as envisaged in the SAAHE Consensus Statement. This will require the co-operation of all the principal stakeholders, among others the health sciences faculties, the professional accreditation agencies, and the departments of Health and of Higher Education. There will be a need for agreement on an appropriate core curriculum among medical schools and the Health Professions Council of South Africa, and a commitment on the part of the state to fund and equip rural training centres suitably.

Such a national consensus will require three paradigm shifts. The first is acceptance of the relocation of much of the training from the metropolitan academic hospitals to the district hospitals, primary care clinics and community settings. This shift is both a geographical one and a shift within the healthcare system, and needs to be paired with innovative modalities of knowledge transfer and greater use of information technology. This shift reflects trends in many a medical school throughout the world[10] in both developed countries and low- and middle-income countries.

The second is the reimagination of the healthcare system in terms of infrastructure and logistics upgrade to benefit training and facilitate the implementation of the National Health Insurance system. Community-embedded training invariably benefits local services. It enhances the quality of care for the affected communities and emphasises the inter-dependence of and mutual benefit to the healthcare system, universities and communities to develop appropriately trained graduates.[11]

The third shift is a change in educational philosophy towards generalism. Deeply embedded in the traditional curriculum common to most medical schools is the domination of specialism. The rotations are based on specialist disciplines that teach discipline-specific content in sequential 'blocks'. Medical training at central academic hospitals tends to be unduly specialty-biased, whereas the graduating doctor should rather be equipped and orientated to work with an undifferentiated patient population. Decentralisation calls for a rebalancing of curricular content and processes to reflect this reality and examine how the crucial contribution of the specialist can be meaningfully integrated.

Developing and sustaining decentralised training platforms offers major opportunities to make changes in health professional education that effectively not only respond to policy imperatives but develop high-quality, fit-for-purpose health professionals for the 21st century.

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