RURAL HEALTH ISSUES

The South African Academy of Family Practice's Rural Health Initiative (RHI) is proud to be able to bring you the following section of the journal, that will concentrate on issues pertaining to rural health in South Africa. We hope to provoke discussion on these issues and would encourage anyone interested in rural health to offer contributions to future issues.

RHI
RURAL HEALTH INITIATIVE

ORGANISING CPD FOR RURAL HOSPITALS

Many rural hospitals seem to struggle with organising CPD for themselves. Usually, this is not at the level of the practical process of getting accreditation for CPD meetings. That is a fairly simple process: the doctors in a hospital can get their professional development activities accredited for points in Category 2 (small group activities) by any CPD provider, such as the SA Academy of Family Practice/Primary Care as long as they have a structured programme for their education.

The issue rather seems to be a lack of imagination in terms of what can be done as part of CPD programmes, and, perhaps, even more fundamentally, a failure to see the value in such activities.

We all know we have to earn CPD points. Why is it worthwhile to do so within our hospitals, in place of attending organised meetings and conferences? Many reasons could be given, but I wish to suggest only two. Firstly, the learning that takes place in such an environment is much more likely to be useful, practical and applicable than the information (rather than learning) taken on board at meetings in the city. Secondly, it is a very important team-building exercise. Team functioning is a vital element in quality of health care delivery, and learning together as a team of doctors enhances this tremendously. Involving other members of the health care team in many of the activities can further help to develop a team spirit in the hospital.

What kind of meetings or activities can be conducted in order to gain CPD points? I will list some ideas that I have experience of and which have proved useful. This is not intended to be a comprehensive list but rather to stimulate thought and hopefully to inspire some hospitals to broaden their CPD activities, or even to start CPD programmes.

1. **Journal club.** This has tended to be the traditional activity, which can be done in a number of ways. For example, each doctor can be allocated a specific journal that s/he must present each month. Or, the presenter may choose (or be allocated) a topic and present a number of articles on the topic from different journals for discussion. Alternatively, the team can decide together that everyone will read certain articles and these are then discussed in terms of their usefulness and applicability.
2. **Evidence-based practice meeting.** In such a meeting, a topic is chosen arising from a question or problem encountered during ward rounds or consultations. The task of the presenter is to research the evidence around the issue and to present the findings to the group. The group can then discuss what guidelines should be adopted in their context on the basis of this evidence. For example, one can research and then discuss guidelines for the treatment of pneumonia in the hospital. (For a good summary of the evidence-based medicine process, see Pather M. "Continuing professional development" in Handbook of Family Medicine, ed. Bob Mash. Cape Town: Oxford University Press, 2000)
3. **Protocol meeting.** Here the team works together to develop a protocol for the hospital which everyone agrees on. Protocols that have been developed by external bodies should be discussed to get buy-in by all the doctors (otherwise they are ignored). Thus the team could establish a locally applicable protocol for the management of hypertension, within the framework of the Essential Drugs Programme Standard Treatment Guidelines, or establish a protocol for the use of antibiotics in Caesarean sections. One doctor can take responsibility for drawing up and presenting a first draft for discussion and development. Previously developed protocols should be reviewed periodically; it is thus useful to keep a file with accepted protocols, with dates, so that they can be reviewed. Such a file can then also be made available to newcomers to ensure there is conformity.
4. **Ward rounds.** These may take different forms, but the two that seem to work most successfully are the problem ward round, where the team go together to see particular patients that individual doctors in the hospital have questions about or are stuck with or simply want to show their colleagues for interest, and the admissions round, where the team together reviews all the admissions from the previous night as a way of learning. In each case, the patients are presented to the group by the admitting or ward doctor, with a designated colleague leading the discussion. An "office ward round" can also be held in which patients are presented in detail during a meeting and then discussed by the team, as a problem-solving exercise. (Routine ward rounds cannot be accredited; there must be an educational aspect.)
5. **Audit meetings.** Many different types of audit meetings are possible. The commonest type is the perinatal mortality meeting, which is essential for maintaining standards

in obstetric care. However the review of obstetric care does not have to be limited to perinatal mortality – one can also look at "near-misses", i.e. deliveries where things went wrong but the outcome was fortunately good, and perinatal morbidity, i.e. looking at children who are born prematurely, needed resuscitation, get sepsis, etc. Audit meetings can be conducted for any ward or section in the hospital. For instance, a paediatric ward mortality meeting can be a very helpful exercise to review care and protocols in the paediatrics ward. One can audit statistics in any ward such as the number of patients who stay longer than a week, the number of admissions without a clear diagnosis, the number of patients who died within 24 hours, etc; the important thing is not simply to look at the statistics but to review individual patient records which reflect the issue being discussed in order to address any problems. An audit of surgical procedures is also useful, analysing what procedures are done, for what indications and with what outcomes. Even clinics and other community services can be involved in these kinds of audits, e.g. looking at TB statistics for the hospital, or number of referrals from a particular clinic. For these kinds of meetings, it is important where possible to involve the relevant nursing staff in the process.

6. **Ward review.** Although audit is a often a form of ward review, it is useful from time to time to review aspects of a ward or unit's functioning, as distinct from individual patient care. Issues that may be discussed with respect to the ward concerned include, for example, equipment, physical environment, staffing, training, special investigations, timing of ward rounds, etc. The focus is on improving the quality of care, and requires research and reading by the facilitator to be of educational benefit.
7. **Quality improvement meetings.** These are held as part of an ongoing process of quality improvement, in which the team takes a particular issue, sets standards for practice, evaluates current practice, makes plans to implement changes, and then evaluates this. As noted, the process may arise out of a ward review. Thus the team may for example decide to look at the overuse of non-steroidal inflammatory agents in the hospital, or the whole issue of laboratory investigations.
8. **Information-sharing meetings.** This term covers a multitude of possibilities. I have a few in mind. One such meeting will be a report back from doctors who have attended a conference or course; it should be a requirement that any doctors should share the knowledge gained with their colleagues, especially if they have been given study leave or been supported in any way to attend that course. Another very useful kind of information-sharing meeting is to invite other members of the health care team to discuss their roles, what they can offer, what problems they are facing, and/or what kind of referrals they want – because we as doctors are often very ignorant of these. Thus, depending on who is available at the particular hospital, there may be sessions with the occupational therapist, physiotherapist, dentist, psychologist, social worker, laboratory technologist, pharmacist, radiographer, etc (all of whom can usefully be regular attendees at any of the CPD activities).
9. **Teaching meetings.** Any of the above may in fact be teaching meetings, with allied health professionals giving input to the doctors on their field of expertise, thus building the knowledge and skills of the team; e.g. input from the rehabilitation professionals on the recognition and management of disability in children, or from a psychologist on the management of anxiety and depression. In addition, I think here of visiting specialists who may be roped in to run a teaching meeting; e.g. a visiting paediatrician may give an update on the management of glomerulonephritis in children, or a family physician can do an overview of care for patients with chronic illness. The usefulness of this is the interaction and discussion, which ensures relevance and applicability. In provinces where the Red Cross Flying Doctor Service operates, this can easily be made a regular feature of the meetings timetable.
10. **Skills teaching sessions.** Doctors with specific practical skills can be given the opportunity to teach those to other colleagues. For example, how to do a Tru-cut biopsy, how to give an intra-articular injection, how to do an obstetric ultrasound, etc. This often happens informally on "see one, do one, teach one" basis, but can be structured to ensure that appropriate and adequate learning occurs.

A word of caution: it is advisable to separate quite clearly the CPD meetings from other business, planning, or handover meetings, and to be disciplined in keeping these distinctions clear, otherwise the time for CPD is easily taken up with administration rather than learning. A full hour is required to justify each CPD point awarded.

One doctor needs to take responsibility for running the small group, which means applying for accreditation, keeping the required attendance register for each session, allocating points to individuals on the basis of this, and issuing CPD certificates.

Other Boards within the Health Professions Council are introducing CPD requirements for their professional groups: dietetics has already done so, with optometry, medical technology, occupational therapy and psychology to follow shortly. This would increase opportunities for team-building by establishing programmes that are jointly accredited.

Doctors who have queries about the technicalities of CPD accreditation may contact the author or the Academy's CPD secretary, Mrs Lucille Pick (011-807 6605) (jblitz@med.up.ac.za)

I would be interested to hear about other innovative CPD activities which hospitals are running.

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