Letter to the Editor

Dear Sir

Thank you for the opportunity to respond to your guest editorial "A Family Medicine Renaissance in South Africa" published in this edition of the *Journal of SA Family Practice*, the official mouthpiece of the SA Academy of Family Practice/Primary Care.

Firstly, I agree that the discipline of family medicine is undergoing a major renaissance. There are departments of family medicine in all the health science faculties in South Africa, training under- and postgraduate students, with improved co-ordination facilitated by the recent formation of FaMEC (Family Medicine Education Consortium). Family physician posts in the public sector are filled with highly skilled family doctors. The Academy's vocation of the past 18 years is finally acknowledged by the proposed recertification system for 1999. What we are seeing now in our discipline is as a result of much more than the mainly negative influences you mention. I believe that family medicine is coming of age in South Africa today due to the sheer hard work of a few dedicated people in our discipline. Whilst there are threats and restraining forces at play, they are far outweighed by the opportunities afforded by the new developments.

Secondly, whilst I have experienced indifferent and unsympathetic attitudes towards family practice, I would certainly not describe the world as 'hostile' to family practice. Many of these attitudes are shaped by a lack of information about our discipline. These attitudes often change completely once family practice is put into context.

Lastly, I object to the word 'decay' being used with reference to the SA Academy of Family Practice/Primary care. The organisation has had its ups and downs over the years and has indeed had to overcome serious problems in the recent past. We acknowledge that, but we are certainly facing up to the challenge[1,2]. The rapid progress that our task teams on Continuing Professional Development and Information Technology have made in their short three month existence is a clear indication of the Academy's motivation, will, strength, and growth. Decay? Let the readers be the judge. The Academy has also supported the formation of a unitary academic body for family medicine since the inception of negotiations and should be given credit for the facilitative and leadership role that it fulfils in this process.

Thank you for your contribution to the Academy's' Journal. I am looking forward to many more of your "kokende potjies" in our Journal.

Yours sincerely
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CONTINUING PROFESSIONAL DEVELOPMENT

A Guide for Family Practitioners

Continuing Medical Education (CME) systems for medical practitioners are used internationally to keep doctors abreast of developments in their field and to improve the quality of care for patients. The obligatory CME systems in Canada, Australia and the USA are some of the best-known models. South Africa is introducing a system of obligatory Continuing Professional Development (CPD) in January 1999. All medical practitioners will be required to participate in CPD to ensure recertification by the Medical Council.

The shift from CME to CPD started in the early 1990s. There is a clear difference between CME, which traditionally focuses on knowledge update, and CPD, which embraces other spheres of activity, such as competence and performance, behaviour change models and managerial and organisational skills[1].

Educational activities should not be restricted to medical knowledge, as performance depends on other factors such as communication, management, preventive skills, scholarship and personal development[2]. Replacing and reorganising knowledge on the basis of experience is a superior learning method for improving clinical performance, as opposed to the unending accumulation of new data[3].

The professional development process should centre on the individual practitioner's needs within the wider context of the healthcare system. Conventional CME is no longer adequate to meet all the educational and career development needs of doctors in modern healthcare. CPD's additional dimensions should include strategies for personal coping and professional growth, career development, role adaptations, management ability, multi-disciplinary and multi-professional learning.

Opportunities for all doctors to reflect on their professional experience should be a regular part of practice[4]. This is affirmed in the proposal by the Interim National Medical and Dental Council of South Africa (INMDCSA) that CPD programmes should be doctor-initiated to achieve personal mastery[5].

The objectives of CPD in South Africa should include and ensure the following:

- the professional competence of practitioners in clinical practice;
- the continual improvement in the quality of patient care rendered by practitioners;
- the continued growth and development of practitioners;
- added value to the profession and its members;
- the promotion of high ethical standards for general/family practice[6].

CPD activities for general/family practice should be relevant to general/family practice and include topics such as the clinical, ethical, management, quality assurance or business spheres of practice. CPD should also address any topic in a holistic manner.

It is proposed that CPD programmes be organised under the auspices of, or be officially approved by, the professional organisation for general/family practice or a university Department of Family Medicine. CPD activities attended in other countries, if accredited by the national accreditation body of that country, may qualify for accreditation in South Africa after scrutiny by the South African body responsible for accreditation[6].

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The aim of this paper is to provide information to medical practitioners on the proposed system, to outline some of the international and historical perspectives around the development of the philosophy of CPD and to describe the South African Academy of Family Practice/Primary Care's (Academy) thinking on CPD and its implementation in South Africa. The intention is that this paper should assist Academy members to understand some of the concepts around CPD and demonstrate how they will be able to implement CPD policy either as a provider or as a participant.

The CPD system and activities

The following is a summary of the system and premises as proposed by the INMDCSA[7].

Every medical practitioner will be required to accumulate 250 points over a five-year cycle. However, the first cycle will run over six years in order to compensate for the inevitable teething problems of the new system, with the first re-registration at the end of 2004. A minimum of 25 points and a maximum of 75 points may be accumulated in any one year.

The emphasis is on a continuous process of point accumulation. Internationally, it appears that the standard time commitment for CPD is in the region of 50 hours per annum, as is proposed in the South African system. A minimum of 10 points in medical ethics will also be required from all practitioners in any five-year cycle.

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For recertification purposes one hour of approved CPD will equal one point. Council however states that the final responsibility rests with the accreditors to discount sub-optimal activities downward to an appropriate point allocation or time unit. Prior approval of all educational activities for certification must be obtained from Council. Practitioners will be required to submit documentation to the Professional Board annually regarding the status of their points.

The Professional Board will appoint accreditors who will have to approve and review activities according to guidelines provided by the Board. Accreditors will include Faculties of Health Sciences, the College of Medicine, professional bodies and associations, including the Academy. The new unitary academic body for Family Practice, the Interim College of Family Medicine, favours the use of an accreditation board, composed of all the role players in Family Practice, which will set the standards for CPD in the profession.

Categories of educational and developmental activities for the purpose of CPD are:

Category 1: Organisational activities, including formal learning opportunities such as conferences, workshops, refresher courses, lectures, departmental meetings etc.

Category 2: Small group activities, defined as informal learning opportunities where participants are actively involved, including journal clubs, small group discussions, teaching ward rounds etc.

Category 3: Individual activities including:

(a) self study activities evaluated by an approved provider e.g. journals, electronic or computerised material;
(b) individual learning e.g. individual skills training;
(c) research and publication in peer-reviewed/CPD journals;
(d) teaching and/or training of undergraduates, postgraduates and peers;
(e) presentation of paper/poster at a congress or lectures to peers;
(f) additional relevant qualifications;
(g) examinations for postgraduate qualifications; evaluation on behalf of a registering authority; assessments of theses or scripts;
(h) supervision of candidates for Master's or Doctoral qualifications.

Any relevant educational or developmental activity within the scope of CPD, which does not fall under the activities listed above, may be submitted for approval by the Medical and Dental Professional Board and, if approved, will be accredited for recertification purposes. A maximum of 80% of the points accumulated by any practitioner may be accumulated in any one of the specified three CPD categories over a five-year cycle. This is of particular relevance to rural family practitioners, who may find it easier to undertake individual activities, but who will have to accumulate at least 20% of their points in some other activity.

Practitioners may apply for deferment of CPD. This clause also provides for doctors who are overseas for more than twelve months and those registered for speciality/subspecialty training. However, all practitioners who are active clinically (even part-time) will be required to accumulate the full number of points over the five-year period.

Non-compliance with the requirements of the system of CPD will be dealt with in a fashion prescribed by the Professional Board and may include the following measures:

(a) granting the practitioner deferment for ONE extra year, on condition that the practitioner's next five year cycle will commence in the same year;
(b) requiring the practitioner to follow a remedial programme of continuing education and training as specified by the Board;
(c) requiring the practitioner to write an examination as determined by the Board;
(d) registering the practitioner in a category of registration which will provide for supervision regarded as appropriate by the Board;
(e) removing the practitioner's name from the relevant register.

It should be noted that the INMDC-SA has attempted to emphasise the developmental aspects of CPD and not any punitive aspect. At the time of writing (end November 1998) no implementation measures have been put into place.

The rest of this paper outlines proposals for CPD that will be put forward by the Academy.

CPD methodology

The contributions of CME, a major facilitator of change in practitioner behaviour, are undermined by difficulties in CME delivery. This is often unco-ordinated, disjointed, and driven by the largess of drug companies and the requests of (specialist) physicians. CME is also plagued by doubts about, and relatively little evidence for, its own effectiveness and efficacy. Current CME models tend to be disease-based and to be provided outside the context of individual practice. The effectiveness of lecture-based CME has been called into question both on the grounds of educational theory and the lack of evidence that it leads to improved clinical care[8,9].

There is a need to integrate learning with practice planning and performance, so that an accredited item of learning has a measurable effect on medical practice[9]. CME that is applicable to clinical practice not only has the greatest impact on improving patient outcomes but also offers physicians a greater sense of satisfaction. This goal cannot be reached without an accurate pre-assessment of educational needs, the development of a learning plan around these educational needs and post-course evaluations to determine impact on daily practice[10].

A programme should aim to ensure that all members thoroughly review the way they practise and commit to continuous improvement in the service they offer, through a combination of professional planning, active learning (CME) and medical audit. Quality assurance in CME is important to ensure that it does actually improve patient care[11]. Self-directed learning, based on the individual needs of GPs and their practice, is the key to effecting positive change and more physicians are finding that lifelong learning can be an attraction rather than a chore[10,12].

Problem-based learning is seen as the most effective CME

method, followed by feedback on performance and doctor reminders to reinforce learning combined with patient-education materials[2]. The problem-based learning approach can be used to make educational programmes more relevant to health needs if the selection of problems in a programme reflects the health care needs that doctors face.

It is also important that problem-based learning and other educational approaches should reflect the practice environment. This is the environment in which the health professional has to make decisions that take into account the resources of, and the constraints facing, individual patients and the community as a whole[13]. The harmful effects of passive forms of learning are now increasingly recognised[14]. The outcome approach to CME includes new adult learning methods such as practice-based small groups helped by a trained learning facilitator, discussing case material relevant to practice[10].

A strong and powerful national association of family medicine/primary care should organise CPD for primary care physicians. The need for ongoing education of health professionals should be concerned with good decision-making, principles of health economics, good clinical care related to costs, informing patients about care costs and resisting inappropriate demands[11]. Each discipline must ensure that the educational programmes that it organises are adapted to the specific needs of its members[15].

Individual family doctors should have control of their own learning. Increasing emphasis should be placed on this individual responsibility, encouraging members to be critical and reflective about what they do and how they incorporate new ideas and knowledge into their practices[16].

Each doctor can assess the educational value of an activity by applying the following criteria:

- assessment of learning needs before attending the activity;
- evaluation of learning afterwards, e.g. did you learn something new that was important?; did you verify some important information?;
- discuss the information with colleagues; did your attitude to this topic change in some way?;
- assess whether the new information is likely to have a beneficial impact on your practice;
- assess the quality and style of the presentation; did it enhance your ability to understand the content?

The role of pharmaceutical companies

The European Charter on CME states that CME cannot be organised and financed exclusively by the profession, but the profession should be able to guarantee the quality of CME and its independence[17]. There should therefore be an independent professional body at national level charged with assessing and guaranteeing both quality and independence. CME is an essential element of state-of-the-art medical practice. As such the necessary expenditure on CME must constitute a natural and mandatory element within the general expenditure on health care.

Many companies have worked co-operatively with CME planners in organised medicine to develop progressive educational activities (rather than relying on the company's marketing and promotion). The policies of both the Canadian Medical Association and the Pharmaceutical Manufacturers Association of Canada stipulate that responsibility for programme content and choice of speakers should rest with the CME programme organisers[18].

Many organisations have adopted and published guidelines defining the ethical relationships between drug companies and the medical profession, particularly in relation to CME. The common features of most guidelines are that CME organisers (not the drug industry or the funding source) should be responsible for the content and quality of the CME programme; that the funds should be given in the form of an unrestricted educational grant to the CME organisation and that financial arrangements and any possible conflict of interest will be disclosed[19].

The Academy strategy

It is the responsibility of the individual doctor to obtain and submit the necessary certificate to the Health Professions Council of South Africa. However, the Academy intends to examine ways of facilitating this record-keeping (paper or electronic) to assist members attending Academy-approved CPD activities.

For the purposes of CPD implementation, four levels need to be examined:

1. Health Professions Council of South Africa - delegation of responsibility for accrediting activities to accreditor body.
2. Accreditation body - accreditation of provider's activities
3. Provider - provides CPD activity for doctor
4. Doctor - tasks or obligations of doctors.

The accreditation body

The Academy proposes that some general principles need to be adhered to:

(a) The academic professional body for Family Medicine should be the only accreditor for Family Medicine activities.
(b) There must be national standardisation of family medicine CPD.
(c) There needs to be a central body for accreditation/administration of CPD for family medicine, which is managed as a self-funded (non-income-generating) business. The functions of this body should be performed by a formally-appointed, salaried chief censor, with formally-appointed regional censors in support. The administrative functions should include collation of annual returns from providers.
(d) Cognisance needs to be taken of the recommendations of a local representative (regional censor or his/her appointee) in accrediting activities. This local knowledge will be useful in terms of assessing quality of presenters and giving credibility to the activity and verification of family medicine input.
(e) A mechanism needs to be built into the system to measure and demonstrate the growth and development of the individual doctors.
(f) The activity must have scientific/clinical content with a direct bearing on patient care, on the delivery of patient care, or on the teaching, ethical, or social responsibilities of the family physician.

The provider

In order for "individual" activities to be accredited, the individual needs to have successfully completed a programme to indicate that he/she has gained the skills necessary for that activity. For example, reading journals requires successful completion of a course in critical appraisal skills. There needs to be "evidence" that an activity is needs-based (perceived, expressed, measured, etc.). This may be based on the individual's own needs, or may be based on data showing the needs of the profession in terms of learning new skills or upgrading management of common conditions. Points allocated to activities must be discounted if they do not meet the accrediting body's criteria.

Accreditation of an activity needs to be based on submission of an application form that should contain the following data:

- Requirements of HPCSA
- Plus motivating documentation:
  - Based on learning cycle - learning needs > objectives > method > evaluation
  - How attendance and participation will be monitored
  - Brief curriculum vitae of the presenters
  - Recommendation of a local representative of the accreditor body
  - Source of funding - to be used for planning, assessment of need for "checks"

Activities will be subject to "spot-checks" by the chief censor or his/her appointee. Sample surveys should be performed of doctors' evaluations of activities, in order to improve accreditation criteria and process.

Accreditation process

1. Obtain application forms from accrediting body's administra-

tion office (local or national office, website).
2. Complete forms and accompanying motivation data.
3. Submit one copy to the local office and one copy to the central/national office, with non-refundable administration fee.
4. Local representative adds recommendation or rejection (with reasons) of activity; one copy kept at regional office and other sent to central/national office.
5. Central/national office documents and stores all communications: receipt of application, allocation of CPD number, allotted number of points, attendance statistics, evaluation forms.
6. Certificate of accreditation sent to provider and includes warning of possible spot-checks, CPD number and number of points allocated.
7. Validated as "Academy-accredited programme".

Dissemination of information from provider to doctor

The Academy's website should be used to disseminate information about CPD and the activities that the Academy has accredited, such as updating of information on policy developments (HPCSA rules, Academy accreditation guidelines), advertising details of "Academy Approved Activities", etc. The *SA Family Practice Journal*, Academy newsletters, mailings to members and information provided at regular Academy meetings are all mechanisms to disseminate information. Other mechanisms for reaching potential new members and non-members need to be pursued.

Tasks and obligations of the doctor

Doctors need to move towards self-directed learning methods and will need to develop the skills necessary for this. The more that doctors can become involved in the process of development of CPD activities, the more likely it is that CPD activities will meet their assessed needs and, therefore, the more likely it is that CPD will achieve its stated aim of improving the quality of patient care.

Tasks for the Academy

The Academy should provide an administrative mechanism (paper or electronic) for consolidation of each member's attendance at Academy CPD activities. A portion of membership fees would need to be allocated to this and non-members would be charged a fee.

Suggestions for "new" activities to be provided by the Academy include:

- Critical journal reading;
- Implementing evidence-based practice;
- Audit cycle;
- Developing a practice profile;
- Development of learning portfolio;
- Approved activity database for members to access when determining how to meet their learning objectives.

Tenders should be put out for the development of these courses for the Academy.

For example, in New Zealand, before journal reading can be counted for CME, the journal appraisal module (which itself gains credits) must be successfully completed. Medical audit is becoming an integral part of general practice for both quality assurance and accountability. The College, in conjunction with groups of GPs around the country, has developed quality assurance packages containing audit protocols, as well as other information and tools to improve patient care. Groups applying for peer review registration must meet together for a minimum of 15 hours a year, must specify their goals and must have a means to evaluate them[12].

The Academy needs to find mechanisms to ensure that the Academy member's subscriptions to a large extent cover the costs of CPD activity attendance. It should also lobby the Department of Finance to request that CPD activities be tax-deductible (the INMDCSA also supports this principle) and the Department of Health to ensure that public service doctors be given time (other than vacation leave) to attend CPD activities.

Conclusion

The Academy is enthusiastic about the positive aspects of obligatory CPD. These include:

- the recognition of the continuing learning that most general practitioners do anyway;
- the standardisation of the programmes offered around the country;
- making programmes presented to family/general practitioners more relevant to their needs.

The CPD system affirms and reinforces what the Academy has been doing for more than 18 years.

However, there are also a number of problems with the envisaged system that need to be addressed. Which organisations will be allowed to accredit (approve) CPD activities and for whom, i.e. will specialists tell general practitioners what they need to know? Which sort of CPD activities would be best in terms of improving the quality of patient care? How will the costs to doctors of attending CPD be covered? The Academy is acutely aware of the financial implications of CPD and will endeavour to keep its members well served with appropriate CPD at as little extra cost as possible.

The Academy is working to ensure that family/general practitioners supervise CPD for family/general practitioners. As academy office-bearers, closely involved with the development of CPD, we look forward to helping our members to make CPD a worthwhile process; one that they enjoy, that develops their own professional skills and that improves the quality of patient care.

The authors, the Academy's National Chairman (Dr Marietjie de Villiers: mrdv@gerga.sun.ac.za) and the Chairman of the Academy's CPD Task Team (Dr Julia Blitz: africsky@pta.lia.net) welcome readers' comments on this discussion paper. ●

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