

**CONTINUING PROFESSIONAL DEVELOPMENT
IN MEDICINE - THE INHERENT VALUES OF
THE SYSTEM FOR QUALITY ASSURANCE IN
HEALTH CARE**

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DECLARATION

I the undersigned hereby declare that the work contained in this thesis is my own original work and has not previously in its entirety or in part been submitted at any university for a degree.

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1. Summary

The practice of medicine has always been a big area of interest as a profession. The focus ranges depending on issues at hand – it may be on the educational, training, humanistic, economic, professional ethics and legal aspects.

One area of medicine that is under the spotlight around the world is that of the maintenance of clinical competency, followed very closely and almost linked to professional ethics. This study follows the introduction of a system of Continuing Professional Development (hereinafter also referred to as CPD), in South Africa and an overview of how it has been introduced in a few other countries. The main areas of focus being the extrication of inherent values of CPD, relating this aspect to quality improvement in medical health care.

The medical profession as well as most of the interested parties, has different perspectives regarding the fact that the system is regulated through legislation. There is also the doubt whether the CPD system will be effective in achieving the goals that it has been set to achieve. Although a system of Continuing Medical Education has been a tradition in all countries, which implies that the CPD system is not totally new as far as the educational principles are concerned, the values accruable need to be exploited. It is the possible success of this kind of evaluations that may foster more understanding of the inherent values in this CPD system.

Opsomming

Beroepsgewys het die praktyk van geneeskunde nog altyd groot belangstelling gelok. Die fokus verskuif na gelang van die onderwerpe ter sprake. Dit wissel van opvoedkunde, opleiding, humanisme, ekonomie, en professionele etiek tot regsaspekte.

Dwarsoor die wêreld word daar gefokus op die handhawing van kliniese vaardighede, gevolg deur professionele etiek wat ook daarin verweef is. Hierdie studie bespreek die instelling van 'n stelsel van Voortgesette Professionele Ontwikkeling (hierna verwys na as VPO) in Suid-Afrika asook oorsig oor die wyse waarop dit in 'n paar ander lande ingestel is. Die klem lê op die inherente waardes met betrekking tot die verbetering gehalte in mediese gesondheidsorg.

Die mediese beroep, asook meeste van die belangegroepe het verskillende opvattinge oor die feit dat die stelsel deur wetgewing gereguleer word. Daar is ook twyfel of die VPO-stelsel in sy vooropgestelde doelwitte sal slaag. Wat die opvoedkundige beginsels betref, is die VPO-stelsel nie totaal en al nuut nie. Alhoewel VPO in ander lande tradisie is, is dit nodig om die totstandkoming van waardes te ontgin. Die moontlike sukses van hierdie tipe van evaluasies mag dalk beter begrip ten opsigte van die inherente waardes in die VPO-stelsel bevorder.

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2. CHAPTER 1: INTRODUCTION AND ORIENTATION

The Health Professions Council of South Africa (HPCSA), through its Medical and Dental Board, has introduced by legislation, a compulsory system of Continuing Professional Development (CPD) for the Medical and Dental professions from the 1st of January 1999. In terms of this CPD legislation all doctors and dentists, in active clinical practice and registered with the HPCSA, have to participate in the regulated CPD system on a rolling yearly cycle. In terms of this policy they have to accumulate 50 CPD points per year.

There has been over a few years already, a debate in this direction in terms of the merits and demerits of the introduction of a system of mandatory, regulated Continuing Medical Education (CME) that would be a requirement for continued registration with the Health Professions Council. One of the reasons for this policy decision was the alarming number of the public's complaints regarding a perceived low level of clinical competence due to unacceptable conduct displayed by some doctors.

The HPCSA has a statutory obligation to regulate the professional standards and quality of medical as well as health care. CPD was therefore introduced to improve the standards of clinical competence.

2.1 Definition of CPD

There are many ways of defining CPD. One definition is generic to all professionals and has been defined by Madden and Mitchell as:

'The maintenance and enhancement of knowledge, expertise and competence of professionals throughout their careers according to a plan formulated with regard to the needs of the professional, the employer, the professions and society.'

The broad definition of CPD recognizes that there are various elements that are fundamental to the professional's effective and efficient application of his responsibilities. The expertise, knowledge and competence have to be continuously displayed in the

professional work and ethical conduct. There is a wide range of relevant learning areas that go beyond the clinical subjects, from medical education management to ethics of medical practice.

Although Continuing Medical Education has been a tradition, undertaken voluntarily and unsystematically, it has never been regulated or engendered as part of the medical career. There is an increasing realization of the importance of consolidating CME with Continuing Professional Development system and the challenge of engendering a culture of lifelong learning in all service industries worldwide.

This thesis seeks to highlight the values inherent in the Continuing Professional Development (CPD) system – which can be viewed to be reinforcement of the traditional Continuing Medical Education (CME). There is a trend in this direction in many countries but the situation depends on the level of development of the CME/CPD system in each country. The values studied hereby are then assessed in terms of whether the introduction of CPD will be of value-related benefit to medical services and the health care system.

Thus the CPD system is being used as one mechanism of improving the skills and competencies as well as professional values in the medical and dental professions. There is presently a debate within the health sector statutory and employing bodies towards introducing a similar system for the other professions in health care.

2.2 The Health Professions Council of South Africa's purpose

The dual role of many Professional Bodies such as the HPCSA – that of a 'trade union' for their members and also a regulator and watchdog of professional standards – is a huge responsibility. On the one hand, as the professional bodies assume accountability for regulating the standards of competence in the profession, they have to be seen to be doing something about it. Therefore CPD regulations have gradually become incorporated as part of a more complex and expensive regulatory system. On the other hand, this is interpreted as highly bureaucratic by the professionals whilst the other interested parties including the public, are pleased to see some regulation and focus on professional standards.

The challenge to the medical profession is to be seen to be meeting the raised expectation of improved competence and efficiency. The dilemma of the HPCSA is striking a balance between satisfying the needs of other stakeholders and protecting the interest of doctors, its members. Is the CPD system a solution?

In the ideal situation, true professionals should not really need any encouragement – let alone enforcement, to keep up to date. This leads to three intriguing questions about professional bodies and the evolving approach to CPD:

- Is a CPD policy or legislation really necessary?
- Is the kind of CPD system currently operated in the medical profession effective?
- If a policy is necessary, but systems are ineffective, what should be put in place?

These and other questions will be elaborated upon with a view to highlight the difficulties of entrenching an idealistic value system in a 'reality' oriented environment.

2.3 Envisaged impact on medical services and health care system

The historical legacy of Apartheid policies introduced by the racially oppressive National Party Government permeated all sectors of the South African society. In the Health Care sector this system resulted in quality disparities in health services rendered to the white minority as compared to black/indigent majority citizens. This resulted in two different health care systems in one country. The one servicing a minority population of mainly white citizens is of good quality standards, run through in the private economic sector and expensive. The other one is servicing the majority population of mainly black citizens, is of poor quality standards and run through the public economic sector or Government. This situation led to the development of a health care system fraught with inequities, dehumanizing practices and racially biased focus on human value systems.

The new Democratic Government, is attempting to redress these inequities, hence the South African health care system is undergoing transformational changes in terms of the New Health Reforms. The principal tenets of these reforms are the provision of accessible,

equitable and quality health services to all sectors of society. CPD, in so far as it focuses on the health professional's standards of clinical competence, can be seen as part of this agenda.

Parallel to these Reforms there has been extensive changes in medical education in alignment with the changing approaches to health care. The undergraduate medical curriculum in many medical schools is at various stages of review and redesign. Continuing Medical Education is also changing in approach and aims to produce a holistically oriented medical practitioner, hence the reference to Continuing Professional Development. There is also an emphasis to rekindle the caring ethos in health services, coupled with a new focus on ethics in the medical profession, this aspect is included as a special '*ethics*'-category in the CPD regulations and guidelines.

The envisaged impact of CPD on behavioral change and the provision of quality health care by clinically active medical practitioners are the root aims of the CPD policy decisions all over the world. Highlighting the values of the system can, hopefully, help foster the enthusiasm of those otherwise despondent doctors, who have feelings of coercion into this system by the authorities for perceived bureaucratic and regulatory purposes.

2.4 Value perspectives

The implementation of policies such as the one on Continuing Professional Development implies a decision that was taken based on prior identification of some value aspects that underpin it and some evaluation of the benefit to society.

The values of a society are the key to its management of developments in medical science and technology as well as in other disciplines. Values shape the questions that are asked, the research done, the answers that are sought and the policies that get implemented. It is important for participants and stake holders of CPD to understand the relationship and interaction between science, technology and the society, and the role human values play in changing situations. In fact, human values may make more of an impact in the area of science and technology than in any other discipline.

Apart from the general medical knowledge, effective CPD must enlighten the professional to the value aspects of updating their knowledge in their chosen career discipline. Medicine is a noble profession, characterized by a caring ethos and a superior value to human life and health.

A lot of research still needs to be done in the area of Continuing Professional Development. The literature is starting to accumulate in the last few years, because the policy approach is new for most countries focusing on possible introduction of compulsory CPD.

This thesis is divided in to 6 chapters, focusing on certain topics ranging from the philosophical, academic through to an intensely practical outlay of the CPD system situation and experiences. Chapter 1 focuses on the definition and outline of the CPD system. Chapter 2 mainly looks at the problem that the new CPD system wishes to address. Chapter 3 discusses what happens in the field of continued medical education internationally. Chapter 4 is a detailed outline of the current South African CPD system, involving, amongst others, all the practical aspects. In chapter 5, the value basis of the new system is discussed critically. Chapter 6 forms the conclusion.

3. CHAPTER 2: PROBLEM STATEMENT

The introduction of a policy of compulsory Continuing Professional Development in the medical profession has been causing unhappiness to the targeted professionals since its inception. At best this has been described by those subjected as an inconvenience, and at worst as a time consuming and bureaucratic system.

The Health Professions Council of South Africa introduced CPD to perpetuate, amongst other values, the spirit of inquiry and continuous learning in the medical and dental professions. The ultimate and expected result would be the maintenance and improvement of clinical competence. This would hopefully impact positively on the maintenance and improvement of quality in health care and medical services. The problem stems from the fact that this system is being enforced by legislation and regulated through a monitoring system. Additional problems arise from the difficulties of administering a very complex system within a stressful professional medical practice environment.

Medical education and training is a continuous learning activity, from undergraduate through post-graduate level and, therefore, in actual practice. This situation is enforced by the fact that medicine and health are dynamic systems. The rapid changes and new developments in knowledge, technology and economic systems create a demand for the continued update of education and skills development. The rising public awareness of consumerism and the public's focus on quality services also put pressure on the medical profession to keep abreast of developments.

This fast-changing situation necessitates that the medical profession finds mechanisms of achieving continuous learning and development. There are many interactive processes, formal and informal, that constitute the education, training, learning and development of the medical professional. All the learning processes involved in the medical career development are interdependent and are based on three aspects:

- Theoretical learning – the undergraduate curriculum is based on incremental accumulation of theoretical knowledge.

- Practical and experiential self-study – the introduction and encouragement of a spirit of inquiry and analysis through health related research.
- Continuous learning – keeping up with the changes in knowledge content and management, understanding the principles and strategies for implementation of new health care policies.

3.1 Background to the problem situation

It would seem that the new Continuing Professional Development system is being introduced without any focus on value gains for the medical profession as well as the health system. This is because in the introductory phase the value aspect was not emphasized. What was highlighted is the need to improve clinical competence, in response to public complaints. There are many arguments for and against the effectiveness of entrenching the ethical values with ‘forced’ introduction of a system of this nature.

There are differences of views regarding the value aspects of introducing a regulated and compulsory system of Continuing Medical Education in the form of the newly legislated CPD program. This situation has prevailed over the passing decade, and ever since the debate started, in South Africa as well as in other countries.

The compulsory CPD system is being applied to a profession that has particular inherent values – the question is whether this new system will, and how it will enhance those values. As the values are noticed as a result of observation of a certain behavioral pattern over a period of time, the impact of the CPD system on the exercise and improvement of certain behavior patterns – indicating certain values being held – will be realized over a time period.

3.2 Values

There is a need for attempts to analyze the prevailing health care situation and highlight the role of CPD in the formation of values in medicine. The perception of some values accruable in any activity is a strong driver for compliance and even improvement of performance in that activity. At ‘face value’ it seems as if the system is about the accumulation of CPD credit points, whereas raised levels of knowledge and clinical skills development seem to be the obvious areas of envisaged gain in this new CPD system.

There are other values embedded in a humanist health care system that can be highlighted, such as compassion, caring as well as an enduring patient advocacy, that are accruable through the CPD system.

Continuous Professional Development has also been defined as “...an educational and developmental process that reflects a commitment by professionals to life-long learning”, (adapted from the Royal Australasian College of General Practitioners). It therefore consists of educational activities to maintain, develop or increase the knowledge, skills and competence of a doctor. It also aims to improve the relationships that a doctor uses in providing services to the public, patients and the profession.

The content of CPD includes that element of knowledge and skills generally recognized and accepted by the profession to exist within the basic medical sciences, the discipline of clinical medicine, professional ethics and the provision of quality health services to the public. The CPD system therefore emphasizes focus on all these areas to broaden the scope of knowledge and skills to a holistically oriented medical practitioner.

The definitive value aspects were not expatiated to the recipients at implementation of the system. Hence the doctors focus on the discipline of clinical medicine, or CME as they have always known it, unappreciative of being policed. The values accruable from this system, if implementation becomes effective, would benefit all parties interested in good quality health services. It is by the explication of the CPD policies and principles that value aspects can be appreciated.

To be able to follow the pointers to certain values or principles that govern certain behavior, these have to be identified and articulated. There also has to be a mechanism of delineating the emerging behavioral systems that relate to certain values, especially in the caring professions, as those that relate to bringing about quality in health care.

The humanistic values that can be identified as inherent in the medical profession will include the following:

Knowledge; Caring; Compassion; Responsibility; Empathy; Respect; Autonomy; Commitment; Competence; Advocacy; Selflessness; Altruism; Confidentiality; Spirit of inquiry; Life-long learning; Professionalism.

One may argue as to whose values the above are in the first place. My argument stems from the analysis of medicine as a noble profession. The expectation of society from a medical professional is built on these value attributes. What medical training, experience, practice and service produce is evaluated by society against these values. Even the historical analysis of the perceptions on the changing professional behavior of the medical practitioner is also given in the human value perspective.

3.3 Professional image and perceptions

The image of the medical profession has gradually changed over the years. There is a perception of a profession that shows less and less of the *beneficence* principles identified above. Is this due to changed economic and social systems, resulting in doctors practicing in increasingly commercialized and anti-social, unethical and non-caring environments? Or is this a simple example of a profession engulfed within a sea of unethical practices and lowered morals in all sectors of our society? The simple answer could be yes to both these questions. The differentiating issue is that all people know what is right and wrong, ignorance of the law (or the consequences of wrong doing) is no excuse, and we all have a right to make choices as well as a duty to take responsibility for our actions. Over and above that, the medical profession is one governed by high moral standards, humanistic values and ethics.

The breakdown in the moral fibre of our South African society is serious, and the national debate on ethics in health care and medicine could not have come at a better time. The public's confidence in the medical profession has decreased and is affected by what people see as a decline in the ethical behavior of doctors. The erosion of professionalism and good ethical behavior leads to poor patient care. Commercialization of medical health care has drastically changed the patients' and doctors' perception of what medicine should really be: an honorable profession whose goals are to keep people healthy and free of suffering.

The economic aspects of providing a health service make it *unpleasant* to live without making *some* profit. It then becomes a judgement call to medical / health professionals to measure and settle for a *certain level of unpleasantness* of life and *just enough* profit. There are relatively non-caring lifestyle perceptions on which doctors are judged, as a profession interested in personal wealth more than the humanistic values of their professional careers. The complicating problem is the economic and social dynamics, experienced in the South African and other economies. The outline of this situation can be described as:

- The pressures of change which are affecting all professionals in this half-decade such as economic uncertainty; accountability; quality; maintenance of competence; moves towards flexible working; and information technology.

- As economic uncertainty intensifies, there is an increasing emphasis on the role of professionals in the country's wealth creation and on finding effective ways to manage the professional workforce for the benefit of the whole economy. The Health Care Industry budget is equivalent to about 8% of the GDP and it is a fact that many critical financial decisions in health care are either made or influenced by medical practitioners. Specific to the South African society, the government has already thrown the gauntlet onto all professions for joint strategies that will improve the South African economy in the face of emigration of highly skilled professionals – commonly referred to as the 'brain drain', globalization and the evolving knowledge economy.

It becomes arguable therefore, that CPD should also include resource management as a specific learning area for the medical professionals.

3.4 Can changed values reverse the negative professional image?

The Health Professions Council of South Africa, as a custodian of professional ethics in health care, has taken the situation of declining ethics seriously, and recently released a Draft Statement on Perverse Incentives. A Multi-Professional Peer Review Committee was set up to draft a policy that will guide the professionals in their dealings with many challenges in the health industry, especially those of a financial nature that may cloud their

decision making regarding patient care. The policy states that the Forum of Statutory Councils holds the view that a health care professional should at all times act in the interest of the patient and place the clinical needs of the patient paramount. (HPCSA, Policy Statement on Perverse Incentives, 1999)

We can question, at this stage, the medical undergraduate education and training, leading up to the unsatisfactory practice and observed behavior. As a graduate of the South African system, I can attest to the ills of the medical education and training system as experienced and received in commentary and ongoing debates. Firstly, the medical undergraduate curriculum does not put any substantive emphasis on the fundamental ethical values of medicine as a noble profession. The focus on these aspects in health care provided by the doctors is therefore not appreciated. The desire to cure overrides the compassion to care and help the patient heal.

The second untoward effect is the focus on independent decision making that can be detrimental to a good doctor-patient relationship. This is because team approach to clinical management is referred to only theoretically. Even so, the doctor gives the orders and the rest of the health team is expected to cooperate. Poor listening skills and paternalism have been part of criticisms leveled at doctors. Of course this situation is an impediment to learning from every clinical situation, if only the learning could also be confirmation of existing knowledge.

Thirdly, an added perception is that of a tradition of inappropriate protection and professional support by the HPCSA and sometimes the Government, to doctors who are practicing unethically at worst, and unprofessionally at best or when put mildly. This gives a negative public impression of a conspiracy to protect the interests of the doctors and creates distrust when complaints regarding unprofessional conduct and unethical practice are lodged at the Health Professions Council.

Fourthly, there has been another legacy of the Apartheid system, the South African 'world view' of superiority and self-reliance backed by 'first world' education and training for the white privileged communities. This satisfied the SA Government and the white minority as a mechanism to counter international sanctions. This 'world view' served as a descriptor for the set of fundamental beliefs, attitudes and assumptions that became habitually part of the

privileged individual, community and culture. Professions, as part of this society, were thus not used to regulatory mechanisms to uphold standards. Compulsory CPD as a regulatory policy would not be easily welcomed.

The country is therefore reeling from the impact of a system that fostered autonomy of the educated, self-accountability and a racial superiority attitude. The environment of the poorer African neighboring states as well as the disadvantaged South African indigent communities posed no challenge. An overdrive in advanced education, scientific and technological training led to a utopia of unquestionable authority and world class competitiveness. Therefore there was no appreciable need to focus on continuous improvement once acceptable standards were achieved. The Apartheid system probably upheld this self-serving system that entrenched a false sense of affirmation, self-actualization and the feelings of security to ensue internal stability and support amongst its own. Can a forced system of improvement and policed participation undo this mindset? Or is this questioning the profession's integrity and limiting their professional autonomy?

3.5 Professional autonomy, knowledge and the interest of society

CPD is meant to balance the interest of medical professionals and those of a health seeking society. This is the view of the HPCSA as the authority body. The professionals regard themselves as knowledgeable, qualified and obliged to exercise their professional autonomy in health care decisions. The patient's interests might be, at the same time, influenced by non-health aspects in deciding on certain health-seeking behavior, a lot of this relating to the social and economic situation of the patient.

An autonomous person is expected to act on his/her judgement with reason, through reflection and calculation. The problem comes when misunderstandings regarding the service arise between the professional and the recipient of the service. This situation has unfortunately been occurring increasingly, prompting the medical profession to do some introspection and focus on standardizing medical professional service. Up came the CPD system, the main goal being to improve clinical competence.

Knowledge is a function of human interest and power. The inter-relatedness of knowledge and power stems from the notion that where there is power there is knowledge and vice versa. The notion that to function normally in modern society (or to be controlled?) one has to be literate/educated/knowledgeable is in itself a controlling mechanism, as this also implies being amenable to regulation.

The impact of the CPD system in reversing the present situation is therefore a subject of healthy debate. It will be the realization of positive and beneficial value systems, observed and assigned to the impact of the CPD system on the medical profession, that the negative perceptions become reversed to a positive image.

It is important that focus is also put on the positive as well as negative forces that influence the participation of doctors in this system.

3.6 Factors contributing to the doctors' perceptions

a) The perception of coercion as a disincentive to learning

“Continuing Medical Education died when CPD was born!” (The Royal College of Physicians of London Journal, June 1999) This statement was published in an article of a medical publication. It seemingly implied that medical professional life without the CPD system was a blissful existence.

The negative view towards the Continuing Professional Development system stems from a misunderstanding of the conceptual meaning of CPD in contrast to CME. The CPD system incorporates and broadens CME. Whilst continuing medical education was narrowly focussed on traditional didactic processes, continuing professional development includes interactive, experiential, change-related and dynamic principles and processes of education, learning and professional development.

The enforcement by statutory legislation creates a negative perception of coercion due to the apparent need to ensure participation of the profession through legislation. By

implication this gives a sense of perceived untrustworthiness on the part of the profession's commitment to improving the situation. The actual reason for the profession to self-regulate continuing learning is as a result of real problems regarding the bad professional image that has been identified. These mainly pertain to poor levels of clinical competency, less skill and deteriorating regard held for professional ethics.

b) Other options to improve the perceived situation of poor clinical competence are not explored

There are many reasons for the perception of poor clinical competence. These range from basic personality traits, inadequate education and training programs and apparent low levels of individuals' interest in the chosen profession. The indifference of many medical doctors employed in the public health sector is also due to perceived non-appreciation of effort they put into the work involved in rendering quality services, within financially constrained and unfavourable work conditions, with poor remuneration packages and inadequate incentive mechanisms.

c) The negative impact of financial cost implications

The participation in CPD entails paying nominal administrative costs for the facilitation processes. The CPD providers pay some money to become registered. Many courses, congresses, conferences and skills training activities have cost implications for registration and travelling. Absence from work in the private sector implies also paying for a 'locum tenens', the medical practitioner who will continue the work of the one attending the CPD activity.

Sometimes the costs are carried by a supportive commercial organization in the health industry. The Pharmaceutical Industry has played an invaluable role in this area for CME support to the medical profession over many decades. The regulated environment does pose some restrictive measures on this aspect as well, in terms of putting norms and standards for commercial support to CPD. This implies that the custodians of the CPD system need to find mechanisms that will ensure minimum cost, or subsidized cost effective programs.

d) Time constraints as counter-productive

The medical profession already has constraints of time in their day-to-day work schedules. To put additional time demands for compulsory participation in the CPD system creates more strain on the professionals to allocate time and focus.

This situation poses a danger of possible neglect of the medical health services whilst medical professionals have to attend certain activities be able to accumulate CPD credits. This poses a challenge on the medical professions statutory and employing bodies to come up with supportive strategies that help facilitation and planning for implementation of the CPD regulatory policies as well as taking care of service provision.

e) CPD teaching and learning credits are no guarantee to improved skills and competence

The best medical student in the academic environment does not necessarily become the best professional service provider. There are other characteristics that make up for good professional behavior and best practice even with successful participation in CPD system. These relate to the professional values subscribed to by the person involved that raise the level of enthusiasm, courage and motivation to assume and consistently practice value-driven medicine.

Subscribing to quality enhancing values entrenches the beliefs in learning and executing those behaviors that lead to the realization of the specific value system. The professional skills and competencies in medicine require constant, self-directed and initiated, perpetual spirit of inquiry.

f) A perception of intended 'de-specialization' as leading to poor quality standards

The CPD system, to the extent that it tends to broaden the scope of educational focus for the professional development aspects, implies that medical practitioners must include areas outside

their specialties and sub-specialties and participate in general practice and even non-clinical CPD programs. This perceived 'lack of focus' leads to the misconception of the creation of a 'jack of all trades and master of none' practitioner.

The reality of the situation is that the silo mentality of specialization might lead to a very narrowly focussed practitioner, oblivious of the rapid changes and broad progressive developments in health care. This has the potential of negatively affecting patient care as the decisions taken by the doctor might be academic and detrimental to the realistic and changing health needs of society as well as being out of synchrony with the new health system reform policies.

These factors notwithstanding, the medical profession does appreciate the need for a strong focus on standards and the role played by the authorities. For the practitioners, the stake holders directly involved are the individual, the professional bodies, the employer and providers.

For the individuals, it is imperative that they both maintain their current level of competence and also keep up-to-date with changes. In broad terms there are three common reasons for professionals to engage in CPD; these are to:

- Update themselves in new knowledge
- Train themselves for additional roles demanded of them
- Improve personal effectiveness (Vaughan 1991)

For professional bodies 'managing' CPD logically means creating a CPD scheme and underpinning this with some support; it may also entail monitoring compliance, although this may be contentious. For the employer CPD should be linked to the performance review system to enhance the professional's competence as the employer has a responsibility to provide professional service. Therefore this should entail integrating job-required competence and efficiency with the standards safeguarded by the professional body.

The idea that a provider is always needed may not be favourable to those who regard CPD as an opportunity for the individual to take ownership of their own learning. Nevertheless, for the moment at least, course provision is likely to be the mainstay of CPD.

Of the other stakeholders the government has a largely hands-off position, taking the view that CPD should be self-financed. Of the remaining stakeholders the position of the clients/patients can be implicitly addressed as beneficiaries of CPD and the managers should support professionals in their CPD.

There are some key issues pertinent for debate on the CPD system policy and principles of implementation. Some of these have been highlighted as:

- Monitoring participation in CPD – is it possible? Is it desirable?
- How standards are enforced – should they be? Is it possible?
- Participating in CPD – is a mandatory system effective? Who ‘owns’ CPD?
- The role of employers and how CPD relates to employer Human Resource Development practices (Are learners supported?)
- Maintenance of CPD during career break
- How and to what extent is CPD recorded?
- How can self-employed practitioners maintain their CPD?
- Sources of information about CPD - What counts as CPD?
- Who should provide CPD and how should the standards of provision be monitored? (Sandra Clyne, 1995)

Because of the questions raised above there are strong arguments in support of the view that other options of improving the situation could achieve the same or even better outcomes in terms of improving clinical competence and professionalism. Focus on these problem areas in selecting, training and educating prospective medical professionals, monitoring and rewarding progressive voluntary professional development as well as offering continuous support to the medical practitioners becomes important. This could indeed enhance the values associated with high levels of professional competence.

4. CHAPTER 3: INTERNATIONAL PERSPECTIVE

South Africa has only recently introduced a mandatory CPD system for the medical profession whilst some countries have done so ranging from two to six years ago.

The South African CPD system has been adapted from the experiences of the CME developments in the United Kingdom, Australasia, Canada and the United States. Continued focus and study of these systems has helped in the development and will still help in the appraisal and continuous improvement of the South African system.

The literature search provided a glimpse into other countries' perspectives, which has been gleaned from documentation on the introductory policies, formative processes and consolidation phases of the respective CME/CPD systems.

4.1 The United Kingdom CME/CPD system

The fourteen medical specialist bodies (Royal Colleges) in the UK fulfill the accreditation function in the Continuing Medical Education (CME) system. The traditional CME system is being broadened to embrace CPD principles and the General Medical Council is responsible for the introduction of re-certification as a form of regulation. This implies that the CME/CPD will in essence be 'mandatory' once the revalidation and re-certification process is complete and all the details are worked out.

Each Royal College (RC) independently sets its own criteria for CME/CPD in their specialist discipline. They coordinate the accreditation of particular courses and CME/CPD activities. Most of them work with consultants in their specialties to have the courses accredited. The Royal College of General Practitioners has a different scheme of funding and organization for GP specific CME.

The CME/CPD providers choose among their respective disciplines where to apply for accreditation. The physicians participate voluntarily in compliance with the policy requirement of the specialist colleges that they are registered with. The physicians need to gain 50 credits (1 credit = 1 hour) yearly. The recording is done individually on a CME diary and annual returns are collected and collated into a database by the responsible Royal College.

Colleges maintain a register and award certificates at five-year intervals. Compliance by clinically active physicians has always

been at about 77% and there has been general acceptance regarding the necessity of monitored CME.

The involvement of all the role players in strategic links for the further development of the CME/CPD system is agreed to by all concerned parties. These are the Academy of Royal Colleges, Department of Health, Specialist Societies, General Medical Council, British Medical Association, Post-Graduate Deans, British Association of Medical Managers, the Standards Committee as well as all other Colleges in the UK via their Directors of CME.

This implies undertaking to set up a system of a planned, validated and evaluated CME/CPD for physicians' individual clinical and professional development as well as the improvement of quality in health services. There is also need to develop competent IT computer systems for the administration, monitoring and evaluation of a mandatory CME/CPD system. Collaboration with employing bodies has also been highlighted, to ensure appropriate planning and resource allocation for CME/CPD participation by all registered physicians (including time allowances), focussing on the improvement of health services.

The General Medical Council, as the statutory body for the medical profession, supports the development of standardized CME / CPD.

The Ministry and National Department of Health, has the main interest in the facilitation of CME/CPD for the improvement of quality in health care services. The Board of Medical Education of the BMA focuses on the representation of the professional needs of the physicians, the development of standards for appropriate participation and improvement of the integrity of the CME/CPD system.

There is overall agreement on the need to develop a good CME/CPD system for the whole of the medical and health care system. The involvement of strategic partners in further developments has been welcomed as critical by all role players as it can foster beneficial cooperation. The London Joint Centre for Education in Medicine has published a report for the Chief Medical Officer's review of the CPD in practice entitled 'The effectiveness of Continuing Professional Development.'

4.2 The American System

The medical practitioners in the United States of America have to participate in CME/CPD activities to remain registered with licensing and employing bodies. The system is well developed, drawing on the experiences over the last six years, yet still being improved.

The American CME/CPD accreditation and provision has a joint collaborative governance system comprised of mainly four bodies that have clearly defined complementary roles in the Continuing Medical Education system. This body is called the Accreditation Council for Continuing Medical Education (ACCME), comprised of the American Medical Association, the Pharmaceutical Manufacturing Association, the Food and Drug Administration and academic representatives.

The ACCME's role is the identification, development, and promotion of standards for quality continuing medical education (CME), utilized by physicians in their maintenance of competence and incorporation of new knowledge, to improve quality medical care for patients and their communities. This role is fulfilled through a voluntary self-regulated system for accrediting CME providers and a peer-review process responsive to changes in medical education and the health care delivery system.

The major purposes of accreditation are to ensure quality and integrity of the accredited courses/programs and providers. This is done through establishing criteria for evaluation of educational programs and their activities, assessing whether accredited organizations meet and maintain the required standards, promoting organizational self-assessment and improvement and recognizing excellence.

The American Medical Association represents the medical professional needs and views on the system. It also plays a big role in the development and maintenance of medical education ethics and standards. The American Medical Association monitors the participation of the registered medical practitioners for the CME/CPD system. This is facilitated through a Physician's Recognition Award system, a certification program focussing on monitoring the participation of individual medical practitioners. It also gives input to ethical standards and criteria for commercial support of CME/CPD programs.

The Food and Drug Administration represents Government policy issues and addresses the health care industry's support to CPD.

It participates in the approval, regulation and recognition for compliance to the ethical standards and educational criteria, of participant organizations in the CME / CPD system. The main area of action is the formulation of guidelines and standards.

The Pharmaceutical Manufacturers Association represents the Pharmaceutical industry, which has a long history of supportive participation in CME. It mainly participates in the development and maintenance of standards for commercial support of CME / CPD providers, physicians and programs.

The ACCME is thus the main body that accredits and monitors CME/CPD provision. The system provides for accreditation of CPD-provider organizations, periodic review and appraisal, as well as applying disciplinary measures on non-compliance. There are well-developed criteria for accreditation and standards for CME provision that are recognized by all role players. The ACCME has developed very stringent policies and criteria for the commercial support of CME/CPD. This has a positive effect on the respected ethical values and the integrity of the American CME/CPD system.

The American system benefits from a working partnership with a CME/CPD provider support organization, known as the 'Alliance for CME', which facilitates the adoption and maintenance of uniform standards for CME provision. The working relationship between this organization and the CME/CPD leadership bodies assists in the coordination of the provision and application for accreditation. The Alliance runs training workshops for the providers, disseminating updated information on the principles and procedures, as well as the ethical, legal, commercial and educational aspects of the CME/CPD system.

4.3 The Canadian CME/CPD System

Canada has a system of CME/CPD that is equivalent and reciprocal to the ACCME (American) system. The CME credits are equally recognized across the two countries.

Although the Canadian CME system is complementary to the American system there is an area of excellence that can be copied by other systems. This is called the MOCOMP® competence-monitoring programme. It is built on the principle that self-managed education helps the practitioner learn how to plan, implement, monitor and evaluate CME/CPD in order to achieve professional goals. The concept falls within the ambit of Evidence-Based Medicine and operates as a computerized CPD personal diary.

This computer program is accessible through the Internet, operates on a voluntary individual and group basis, generates annual CPD-linked personal profiles and can be 'piloted' and evaluated to promote self-directed lifelong learning. It has added benefits like the production of updated professional Curriculum Vitae incorporating CPD credits for individual doctors.

4.4 Australasian CPD System

The CME system in Australasia is organized in a system similar to the United Kingdom structurally as well as functionally. The Royal Colleges are semi-independent and have their own accreditation and monitoring systems.

There is a good adaptable and valuable programme called "MOPS" – Maintenance of Professional Standards Programme. The programme has been developed by the Royal Australasian College of Physicians and The Australian College of Paediatricians and implemented in 1994. It ensures that consultant physicians and paediatricians are involved in a range of ongoing educational activities that maintain clinical standards and help them to continue to provide patient care of the highest quality.

The programme recognises participation in Continuing Medical Education, Quality Assurance, Teaching and Research over a five year cycle. The requirements are for the eligible fellows to submit annual report of CME activities. The 5 year cycle requires 500 credit points accumulated in either Practice Quality Review or minimum of 50 / maximum 250 to be earned in Quality Assurance, Practice-related CME or Teaching and Research. Successful

participation in the program results in a Certificate of Completion of the MOPS Programme.

4.5 Prospects for the future

The American CME/CPD system is the most developed and enjoys leadership worldwide. Many countries have modeled their systems on the ACCME approach. The system is developing further into a well-coordinated and effective educational tool. Maintenance of health care standards and physician competence are the main pillars of further development.

In the United States of America, as a leading country on CME/CPD, consideration is given to the development of international standards for education, professional development and clinical competence in the medical profession.

4.6 Lessons for South Africa

The alignment of the development of policy and setting of principles to the world leaders in CME/CPD systems has opened avenues for learning and adapting our system based on world standards. The development of a CPD system in South Africa is critical for the improvement of quality in health care.

- *Consolidating the introduction of CPD in the medical profession.*

The introduction of the CPD system in the medical profession caused panic and confusion. There is agreement though, that provision of CPD should be standardized to improve on quality and the integrity of the system.

All areas of practice of medical professionals need to be taken into account. There are many courses on management of health services that are run with no standards in place. SAMA proposes the accreditation of non-clinical, management and administrative courses that are health care specific, drawing on the principles and policies of the CPD system, with appropriate standards and criteria for accreditation.

The doctors have accepted the introduction of the system. There needs to be communication on the main principles and procedures of the CPD system. A mechanism of getting the views/concerns as well as addressing the needs of doctors and other role players should be embarked upon through surveys and responsive

publications. The financial and time expenditure, as an indirect impact of CPD on the quality of health care services, should also be considered in cooperation with then employing bodies.

- *CPD for other health professions.*

The American system is replicated through many professionals, driven by their respective statutory councils. The medical profession has a leadership role to play in the health care system. The CPD system will avail opportunities for all the leading organisations as well as the Health Professions Council to evaluate the impact on the quality of healthcare services through improved clinical competence.

The health services stand to benefit from the introduction of a parallel system for other health professions involved in the health care team. This would entail the involvement of the leadership of the relevant health professions in the development of norms and standards.

The CPD system focuses on education and clinical skill development for the medical profession. Doctors can only participate within and as part of a system of health services. Appraisal and quality evaluation of the health services can then include the assessment of the impact of CPD on improvement of services.

Re-certification of medical practitioners on proven compliance with CPD requirements would be carried out by the Medical and Dental Board of the HPCSA. This would be a regulatory measure for continued registration with the Council.

All role players need to participate in the evaluation programs that will assess the outcomes of the CPD system with regard to impact on clinical competence.

The South African health system reforms environment facilitates the acceptance of new systems of improvement. The New Health Reforms highlight humanitarian service values, principles and policies like quality assurance, service excellence, equitable access and continuous improvement.

4.7 Emerging international CPD trends

- *CPD as a business*

There is a growing trend of non-health organizations that are presenting educational activities on behalf of the health sector as a business. The technical aspects of educational product presentation, coordination and administration are the core business of many educational institutes.

The critical value analysis has to be the evaluation of courses for ethics, professionalism and the focus on the policy and principles of the CPD system.

- *Enforcement versus self regulation – an apparent conflict*

The difficulty of self-regulation in the profession is a world phenomenon. This is partly due to an age-old assumption of a profession of noble values and a tradition of non-control. The additional factors are due to the commercialization of health care.

Many countries are opting for regulated systems of CPD to ensure participation in CPD. But beyond just participation the crux of the matter lies at behavioral modification to the desired outcomes. There is no guarantee that forced CPD will lead to improved quality of health care. This aspect depends on other variables and timing of the evaluation.

- *Information Technology systems a sine-qua-non*

Due to the administration intensive processes of the CPD system the IT system has to be utilized. The importance of compatible soft-ware systems is essential for ease of

coordination within and between the different role players – professional councils, accreditors, providers and the participants.

CPD opens a challenge to the individual practitioners regarding the use of Information Technology (IT). Some accredited CPD courses are accessible via the Internet and the computer literate practitioner can benefit from all educational information and activities. CPD points can be accumulated through participation in international educational activities through electronic and digital communication media.

The information technological evolution involves applying one's broad-based medical education to understand new conceptual models, adjusting to new paradigm shifts, and analyzing the vast diversity of information available to us. However, to use the Web effectively requires the ability to organize, prioritize, analyze, and understand the vast range of information available.

This exciting world is not, however, without challenges. Materials on the Web are frequently inaccurate, partial, or disorganized; it is usually difficult to find exactly what one needs and to measure the value of what one finds. Also, the rapid expansion of information gained does not translate directly to knowledge, but needs a good measure of critical analysis. The combination of information, experience, understanding and judgement yields knowledge. Thus the information explosion has made the acquisition of data more convenient, and, in many cases more extensive, but it has not rendered the quest for knowledge a simpler task.

- *Possible integration of different medical disciplines' CPD programs*

Effective learning from CPD courses requires the development of critical consciousness and critical judgement, with emphasis on inter-relatedness of clinical subjects, the breadth of courses, concern with values, reflection and stress on 'wholeness' of medicine. Many CPD activities are interesting to attend, from all clinical disciplines. In this way there is gradual integration of traditionally separate disciplines to around topics of common interest.

The open and flexible approach of CPD might allow for practitioners to gain knowledge and experience in their own clinical disciplines as well as other areas of interest. This could improve the team and negotiation skills because they then learn and work with practitioners from other disciplines. But some may not have this extended interest and want to concentrate in their own specialty or clinical discipline.

- ***The super-profession image of the medical profession put to question***

The medical profession, as the traditionally exclusive and non-regulated profession, had assumed a status of a 'super-profession', unquestioned on its professional ethics, values and responsibilities for ongoing development. The introduction of compulsory CPD indicated that this image has been put to question and found wanting.

The system is transparent in the sense that all stake holders and the public have access to information on the non-participation of doctors – which has a bearing on their 'trusted' competency, and can influence the end result.

- ***Knowledge, authority and clinical autonomy***

Education and knowledge have been justified traditionally, though not exclusively, by the notion of freeing people from the authority of others – be it state, institutionalized oppression or any other forms of authority.

The attitudes of many members of the South African medical profession may also have been affected by the legacy of Apartheid. For many whites who lived in the Apartheid South Africa, raised in privileged petty bourgeois situations, learning came with the baby bottle before even going to primary school! Knowledge was the rule of existence and a privilege, although the irony was the selectivity in certain doctrines/teachings (or truths?), that they were prohibited to question or learn from. The untoward effect of this was the self-assurance it gave to the learned to the exclusion of any possibility to learn from other systems or be forced to learn in certain ways.

Many medical practitioners believe that their knowledge is adequate and the clinical autonomy should be guaranteed. The unquestionable knowledge implies that no authority may force different behavior as the professional is an authority in his/her own right. Clinical independence and autonomy may well be valuable areas of gain in the medical profession as the respect would hopefully come with the recognition of good CPD outcomes and values.

- *Lifelong learning*

CPD is entrenching lifelong learning in the profession. Even if it would be scrapped after the first cycle, a culture of continuing education and development will hopefully carry on. The aim of medical education is to cultivate in each professional generation the physical, intellectual and moral faculties necessary for the general and gradual improvement of the professional service and practitioners.

The 'saw-sharpening' revival that CPD brings, in the context of the fast evolving and evolutionary knowledge age needs a mind alive with curiosity. With enhanced ability to act on that motive, the practitioners are equipped for lifelong self-renewal.

- *Honesty – an antidote for the need of policing?*

An autonomous knowledgeable person is expected to act on his/her judgements with reason, through reflection, calculation and decision making, so as to organize and govern behavior. It is with observation of unbecoming behavior, evidence of incompetence and questionable motives that the integrity of the person or system is questioned.

In the non-compulsory systems there is assumed trustworthiness on the part of the doctors to monitor their own private CPD activities and studies for accreditation. The system presupposes that the profession is honest and therefore puts an obligation upon the doctors to realize their professional integrity and honesty as is expected of them.

The reality is that many doctors do not follow the expectation of lifelong learning, neither in the expected way anyway, or the unprofessional conduct and evidence of poor clinical competency implies the impact of other variables.

4.8 Some possible gains attributable to the CPD system

This is an area of further research that needs more focus as the CPD system becomes properly implemented. The evaluation methods may be difficult because of many variables impacting on possible gains and the timing of outcomes' assessments.

The CPD system is an opportunity to broaden the knowledge base of individuals as well as teams of medical professionals. The wide variety of accredited CPD activities and programmes offer knowledge that is updated and focused on the improvement of clinical capability of doctors. The individual learning CPD categories encourage learning from specific relevant publications and other CPD programme materials.

The CPD courses also offer education and training in various skills on psychological, physical and technological procedures that broaden the skills base of the doctors. The opportunity of sharing and imparting of skill between colleagues encourages formal and informal learning.

CPD is a mechanism of ensuring local delivery of high quality clinical services by the health professional body, reinforced by a new statutory duty of participating in lifelong programmes of learning and local delivery of professional self-regulated education and skills training. This is expected to spread to other health professions as the CPD system's gains and experiences are consolidated and integrated into the career and working life of the medical practitioner.

Investment in the CPD system fosters education and training of doctors in work related cost-effective mechanisms of delivering high quality health care as well as improving their orientation to health promotion and disease prevention. This broader CPD approach will result in the development of economically conscious doctors who are good advocates of cost control and quality assurance as part of the broad agenda of the health system.

5. CHAPTER 4: SITUATION ANALYSIS – THE MEDICAL CPD SYSTEM

5.1 The CPD system in South Africa: context

Legislation: The Health Professions Council of South Africa, published the Continuing Professional Development regulations, in terms of section 26 of the Health Professions Act, 1974 (Act No. 56 of 1974) in the Government Gazette of 27 November 1998. (HPCSA circular 3/14/7/16 – Introduction of CPD/Approval of Accreditors of CPD activities)

In terms of this Act, all South African registered medical and dental practitioners who are clinically active have to engage in the CPD system as from 1 January 1999. These regulations have been published and distributed to all members of the medical profession, with guidelines on the requirements and provisions for compliance. If the doctors cannot participate they can apply for deferment for stipulated periods. Certain categories are exempt from the system – retired, registrars, interns and doctors who are not registered as independent practitioners.

There are other policies relevant to human resource development which have been recently introduced for all employing bodies in South Africa. The goal is to ensure quality services, personal and organizational capacity, aligned with planned economic development. These act as complementary policy requirements regarding the skills development, job related training and focussed growth of the human capital.

The South African Government, through the Office of the State President, published in the Government Gazette of 2 November 1998, the Skills Development Act, 1998 (Act No. 97 of 1998). In terms of this Act - “All employing bodies have to provide an institutional framework to devise and implement national, sector and workplace strategies to develop and improve the skills of the South African workforce; to integrate those strategies within the National Qualifications Framework as contemplated in the South African Qualifications Authority Act, 1995; to provide for learnerships that lead to recognised occupational qualifications; to provide for the financing of skills development by means of a levy-grant scheme and a National Skills Fund; to provide for and regulate employment services; and to provide for matters connected

therewith”(– Government Gazette 2 November 1998. Vol. 401 No 19420).

Aligned with the Skills Development Act, the South African Qualifications Authority Act, 1995 (Act No. 58 of 1995), legislates the establishment of a National Qualifications Authority to oversee the purposeful and regulated education and training of the work force.

These policies facilitate the establishment of acceptable values for the social service systems, professionals, workforce and the recipient society. They serve to:

- a) use the workplace as an active learning environment
- b) improve the productivity and the competitiveness of employees
- c) improve the delivery of quality social services
- d) assist employers to find qualified employees who also get improved employment prospects
- e) ensure the quality of education and training in and for the workplace

The systematic introduction of such human resource development policies facilitates the adherence of the medical profession to the legislative policy approach to enforce continuing professional development. This is to ensure the upkeep of professional and educational leadership, as the other non-professional workers develop competitive work related education and skills.

5.2 CPD in comparison to CME

Continuing Medical Education started as a voluntary activity engaged into by a few doctors as far back as the middle of the eighteenth century. The activity was used to share and impart knowledge mainly from senior to junior doctors. Participation in CME had an effect of self-assurance to the doctor as a conscientious and learned practitioner. It was also used as an opportunity for doctors to socialize and for developing communication networks in their working environments.

CME focussed on theoretical and applied knowledge, passed on through the traditional teaching method of giving lectures or making

presentations whilst the audience listens passively and often asleep. There were doctors who would attend CME for reasons quite different from acquiring knowledge. One of these was the fact that the Pharmaceutical Companies' involvement and support was almost guaranteed. This entailed sponsorship with respect to the organization of the meeting, supplying the refreshments, rewarding the speaker and free samples of medical products and medical or health care devices.

It was therefore apparently not necessarily focussed on enhancing the values of medical education as highlighted previously. There was a realization of a need for another system of CME that achieves the education goal whilst it enhances the values inherent in medical professional development.

One can argue that although the old CME system was not regulated, it had very good aspects of organisational development as outlined below:

- Medical specialist groups were formed around and ran educational conferences, lectures and seminars for specialists and general practitioners.
- Special interest groups were formed on various areas of clinical medicine such as Anxiety/Depression, Obesity and Aviation Medicine.
- Some organisations formed with special focus on Clinical Research, Public Health and Managed Health Care. Some organisations focused on Medical Law and Ethics, indeed developing into independent institutions that also involve non-medical professionals sharing the same interest and expertise.
- CME even had focus on social aspects. The Balint Groups, named after Michael Balint, a famous medical practitioner, were specifically formed to focus on "difficult" patients where doctors shared personal emotions and dilemmas triggered by encounters with some characters of patients.

As can be appreciated, and in line with adult education, the old CME was voluntary, relaxed and driven by professional interest. The caring ethos was also evident by the way practitioners grouped themselves and focused on their practice. It could well be, then that resentment that the doctors expressed about the new CPD system was because of a perception that they are being treated like undergraduate students, forced to learn regardless of their professional or career interest.

5.3 The new approach to CME

The focus of CPD is a changed approach to traditional CME to service-focussed learning. The core principles of accreditation require that CPD programmes and activities should be:

- Purposeful and patient centred
- Participation should be ensured – fully involving the individual and other relevant stakeholders
- Targeted at identified educational need
- Educationally effective
- Part of a wider organizational development plan in support of local and national service objectives
- Focussed on the development needs of clinical teams, across traditional professional service boundaries
- Designed to build on previous knowledge, skills and experience
- Designed to enhance the skills of interpreting and applying knowledge based on research and development (Madden and Mitchell, 1993).

Innovative practices incorporating some form of CPD already exists in many health facilities and organizations. In many cases it is an integral part of strategies for improving staff recruitment and retention. In many organizations, appraisal and personal development planning are well established practices, also for non-medical staff. However, for many organizations this approach will still be more of an aspiration than practicable. A multi-disciplinary team based approach to CPD is a challenge for innovation to facilitate learning across traditional professional and service boundaries.

Work based learning is supposed to play an important part in CPD. Successful partnerships at local and national level will be essential for the development of innovative approaches to work based learning. As CPD programmes need to meet local service needs as well as the personal and professional development needs of individuals, CPD programmes can and should be managed by local employers. This can be achieved through partnerships with relevant education providers, professional associations and regulatory bodies.

Monitoring participation or compliance is a challenge to the custodians of CPD in the profession. The HPCSA has a big role to play in ensuring that true compliance as opposed to complacency is achieved.

“Critical to the success of CPD are personal motivation, commitment and support from professional organizations.” (Jones and Robinson; *Journal of Management Development*, 1997) This analysis raises other important aspects that align continuous learning to the working life of individuals, such as that:

- Career and personal development opportunities provided by companies for the professional must match their individual aspirations either in performance related pay or self-development opportunities.
- To ensure the involvement and commitment of such a workforce, the organization has to shift the emphasis of its human resource policies towards facilitating the personal development of each individual, giving them more control over their individual destinies, development and working methods – as true professionals.

5.4 Pressures on the role of the medical professional

Apart from playing an authoritative role in the management of illnesses of the patient, the doctor had unlimited autonomy regarding his/her own continuous learning. Gradually this role has been apparently eroded by other forces in the health care environment. This perception creates discomfort because doctors feel a loss of control and clinical autonomy. Some of these have been highlighted in a publication by Sandra Clyne (1995) and are represented in the following table.

Traditional View	New Expectations
Self-director, supervisor and motivator	Governed by Professional statutory body and government
A guardian of his own standards, expecting reasonable and guaranteed remuneration	Consumerism, quality service focus, inter-practitioner competition
Productive with own job responsibility	Performance targets, appraisals are enforced by other party

The challenge of fostering ownership of CPD by the professionals may be indeed achieved through a strong promotion of personal development mechanisms, assisted by the professional organization and employers.

5.5 Focus on a Personal Development Plan (PDP)

Norman Jones and Gordon Robinson, in the Journal of Management Development (1997), acknowledge the fact that CPD needs are unique to each individual and it is for each individual to decide what CPD should be undertaken, how and when. The first step is to make a realistic and critical appreciation of strengths and deficiencies in performance, for the present job and foreseeable future roles. A Personal Development Plan should then be prepared.

If adopted for CPD in the medical field, the Personal Development Plan should include objectives, priorities and time-scale – taking care of the work environment or institution’s job requirements and objectives, the professional organization’s requirements, personal interests and career opportunities. The PDP should be reviewed at regular intervals and CPD related action taken to secure its objectives must be recorded.

The bone of contention stems for the effectiveness of monitoring in view of difficulties and cheating possibilities as opposed to placing the onus on the professionalism of the practitioners to monitor themselves. There is no full-proof system in all the countries that have embarked on compulsory CPD and monitoring is not emphasized.

Nevertheless, there are two systems that can be employed:

- a) Questionnaire: Designed to identify the number of hours of CPD being undertaken; the means by which it is undertaken; the preferred mode; difficulties experienced; choice of topics
- b) Scrutiny of CPD Records/Logbook: Calling in of a number of PDPs/CPD Logbooks from a sample of practitioners selected at random.

Some advantages and disadvantages:

Questionnaire	Scrutiny of CPD Records
More of an 'information' scheme	More of a 'policing' scheme
Less opportunity to detect and pursue 'unsatisfactory' cases	Opportunity to pursue 'unsatisfactory' cases
Can get many respondents	Tends to prohibit large numbers
Less resource needed to process	Labour-intensive to scrutinize
Information about difficulties	No information
No information about CPD plans and records	Insight into PDPs and Logbooks
Little or no proof if CPD being carried out	Reasonable proof that CPD is being carried out
Facility for suggestions of topics of interest, etc.	No information about topics of interest.

The tone and style of approach is important because the practitioners will interpret this as a bureaucratic practice whilst the authorities and the public would like to see some tough stance taken by the profession. Therefore the credibility of the monitoring organization becomes important.

The development of personal qualities is also essential as part of career development. CPD is not new. What is new is the greater

importance and urgency and the need to have a determined and systematic approach to it.

Professionals are adult learners and as such they are voluntary learners (Madden and Mitchell, 1993). Not only does this mean that they learn best when the content of learning is relevant and has direct application to practice, but also that the process of learning must fit self-directed and self-motivated autonomous individuals. Adults learn by building upon existing experience and so the process of education or training should be practice- and problem-oriented and facilitative rather than didactic (Madden and Mitchell, 1993: 54).

CPD must take into account, and indeed drive and be driven by, the significant changes facing the profession in the next decade. Research suggests (Watkins *et al.*, 1992) that technological, social, economic, political and cultural developments are likely to affect work practice for professionals.

5.6 Consequences of non-compliance

Ideally the consequences of non-compliance to CPD should be understood taking into consideration the situations described in this situation analysis.

Punishment or sanction and fostering discipline to non-compliant practitioners is in itself entrenching the domination of authoritative institutions. This is an expression of power over the subjects who have no choice but have to comply. Nevertheless, the regulations have stipulated requirements

In the event of a practitioner not complying with the requirements of the CPD system, the Health Professions Council may impose any one or more of the following conditions:

- Granting the practitioner deferment for **one** extra year, on condition that such practitioner's next five-year cycle will commence in that same year.
- Requiring the practitioner to follow a remedial programme continuing education and training as specified by Council.

- Requiring the practitioner to write an examination as determined by Council.
- Registering the practitioner in a category of registration that will provide for supervision regarded as appropriate by Council.
- Erasing the practitioner's name from the relevant register of medical practitioners or dentists.(CPD Guidelines for medical practitioners and dentists, HPCSA 1999)

5.7 Deferment

Practitioners may apply for deferment of CPD and Council will review such applications individually on the basis of reasons acceptable to Council. Deferment will not be granted to practitioners who are retired, not practicing due to ill health, or medical/dental administrators. The Medical and Dental Professional Board is establishing a separate register for these categories. (HPCSA CPD Guidelines for medical practitioners and dentists, 1999)

Deferment, as it is stated in the Guidelines referred to above, may be granted for a maximum period of two years. Any practitioner wishing to re-enter the system after deferment which exceeds five years, will have to complete a period of supervised practice as determined by Council in his/her clinical area, where after his/her normal two-year cycle will recommence.

The HPCSA has taken responsibility to complement its role in the introduction of CPD legislation – with regulations, resources allocated, an obligatory policy since 1999 and recognition of a range of activities. There has not been any substantial effort to guide other role players in supporting the practitioners, except recommending that employers especially the government should support CPD participation.

The learning needs of practitioners will differ according to where they are employed, their role, and the stage of their career. Jones and Gordon (Journal of Management Development, 1997) state that in order to meet these requirements the content of CPD should cover:

- Updating and broadening of technical knowledge and skill

- Developing skills used by the professional such as communication, interpersonal, information technology and negotiation skills
- Preparation for changing professional roles, e.g. developing managerial, financial and management skills.
- Development of professional specialist expertise

5.8 CPD and the quality assurance agenda

The introduction of CPD is the culmination of progressive debates over the last decade in support of high quality health services, initiated in the medical profession. A qualitative definition of CPD is that of a process of lifelong learning for all individuals and groups which meets the needs of patients, delivers health outcomes and healthcare priorities of the health system, and enables professionals to expand and fulfil their potential.

From personal observation of the ongoing debates on CPD, it seems that all the relevant stakeholders welcome the HPCSA's introduction of lifelong learning and Continuing Professional Development, with strong support for the principle that lifelong learning should be designed to meet service needs as well as individual needs and aspirations.

CPD marks the beginning of a process – developing a culture of lifelong learning is a long-term goal. However, developing a self-regulatory and professionally managed approach to CPD is an important step towards building a learning environment in every health organization, to support lifelong learning and enable excellence in clinical care.

It is for all parts of the Health Service – in an increasingly competitive labour market, health services employers must recognize the value of appropriately managed CPD programmes in attracting, motivating and retaining high calibre professionals, managers and other healthcare staff.

Partnerships between regulatory bodies, academic institutions, professional organisations and employers will be essential for promoting effective CPD frameworks.

5.9 Aiming for a first class service

A first class service would be set out as a package of proposals to support the delivery of consistent and higher quality care to patients. The main elements of the service are:

- Arrangements for setting clear national quality standards, through a national CPD accreditation forum aligned to a forum for health service excellence. This should involve all the health professions and related services.
- Mechanisms for ensuring the delivery of high quality CPD programmes supported by the value principle of self-regulation. Monitoring should be aligned with mentoring and support throughout the medical and health professions.
- Effective systems of monitoring the satisfactory participation of doctors, performance evaluations aligned to a national survey of patient and user experience. Globalization necessitates a focus on world-class standards and being conscious of the diversities between countries.

CPD should be focussed on the needs of the patients and should help individuals and teams deliver the health outcomes and healthcare priorities of the health system. There should be a partnership between the individual and the organisation on CPD. Its focus should be the delivery of quality health services as well as meeting individual career aspirations and learning needs. All opportunities should be taken for patients and patient groups to give input to the CPD-aligned service evaluations.

Lifelong learning is an investment in quality for the health system. The health system must keep pace with a fast changing world – with medical advance, new technologies and new approaches to delivering high quality health care. Greater public awareness of these advances has rightly created increased expectations of what the health system can offer.

CPD programmes need to meet the learning needs of individuals in order to inspire public confidence in their skill but, more importantly, CPD also needs to meet the wider quality service development needs of the national health system. Every health

organisation and facility needs to develop a locally managed, systematic approach to CPD, built on a long-term vision guided by the published regulations.

It is for local employers to decide on the level of investment they need to make in CPD along with other key human resource development strategies, including security and the development of family friendly policies. (Journal of Management Development, 1997)

5.10 CPD policy implementation

Structural and functional arrangements

The Health Professions Council of South Africa devolved the powers of accreditation provisionally, to eighteen medical professional bodies, under the aegis of the Medical and Dental Professional Board. (memo 3/14/7/16 of Medical and Dental Professional Board) These were the fourteen faculties of medicine and dentistry of the ten health science training institutions, the College of Medicine of South Africa, the SA Medical Association, the SA Dental Association and the South African Academy of Family Practice.

All these bodies had to apply for the 'Accreditor' status and this would be achieved if certain provisions were made. The credential requirements are to ensure authority, capacity and sustainability for the appropriate participation of the organization in the implementation of the CPD system.

The overall quality improvement framework in the health services must integrate CPD in a coherent organizational approach. The service oriented CPD system requires a continuous approach focussed on four main areas of operation.

5.11 Assessment of individual and organisational needs

Appraisal is the corner stone of assessing the CPD needs for each individual. Appraisal should be a supportive process of reflection about an individual's learning needs. Developing appraisal skills should be a priority for every health organisation. Team appraisal may also be appropriate in some circumstances and may be helpful in agreeing on the development needs of a service team.

CPD should be incorporated in Personal Development Plans for all professionals in private and public services. Professionals may need managerial assistance in the development of the plans, which might be a simple written record or a more detailed paper based on an electronic planner.

Individuals should be encouraged to think creatively about the range of work based learning activities they might be able to pursue as part of their CPD-aligned Personal Development Plan. Application for CPD accreditation can be done through the employer or the organisation's structural arrangement. A permanent record should be kept of all learning activities undertaken so that these can be reviewed and evaluated at a later stage.

5.12 Evaluation

CPD programmes are mostly reviewed annually. This may take place in a number of ways – either through one-to-one discussion with a senior colleague, within a team if this is appropriate, or possibly through a peer review activity. Improvement to patient care resulting from the CPD-related learning activities are of prime importance. Every opportunity should be taken to involve patients in evaluating the outcomes of learning activities and setting goals for future CPD activities.

The regulations have criteria and guidelines for approval of CPD activities, scrutinizing them with regard to:

- Administrative issues – organisational arrangements, record-keeping, registration and certification
- Educational issues – programme format, presenters, learning objectives and evaluation
- Content – relevance of topics and quality standards
- Ethical issues – product promotion, exclusivity in participant invitation, and commercialization

5.13 The involvement of the Pharmaceutical Industry

The purpose of Continuing Professional Development is to enhance the doctor's ability to care for patients. It is the responsibility of the accredited sponsor/provider of a CPD activity to ensure that the activity is designed primarily for that purpose. The medical profession recognises the contribution that the pharmaceutical industry has made to CME / CPD over the years

Accredited sponsors often receive financial and other support from commercial organisations. Such support can contribute significantly to the quality of CPD activities. There are guidelines that can be used to describe appropriate behavior if accredited sponsors in planning, designing, implementing, and evaluating CPD activities, including those for which commercial support is received.

5.14 The overall approach of the medical profession

The Pharmaceutical Industry has a valuable role to play in CPD. Funding of international collaboration (exchange of scholars), and access to SA accredited international CPD activities can be a synergistic approach. Support to medical/health ethics education is an important area that enhances organisational integrity within the health industry. Unethical behaviour on the part of the pharmaceutical industry, and sometimes in collusion with the medical practitioners, has been a problem. This needs to be corrected following a set of guidelines for commercial support of CPD (Guidelines for Commercial Support of CPD, Medical Education and Communications, Ciba-Geigy Corporation, 1990)

The ultimate decision regarding funding arrangements for CPD activities must be the responsibility of the accredited Provider. The Health Professions Council and government have left the financial burden to the practitioners and this is part of the unhappiness within the profession. The support of the pharmaceutical industry has therefore met a very important need.

All funds from a commercial source should be in the form of a commercial grant made payable to the accredited Provider for the support of the programme. The terms of the grant must be set forth in a written agreement. No other funds should be paid to faculty, programme director, or others involved in the supported programme. All support associated with an educational activity must be made

under the direction of and with the full knowledge and approval of the accredited Provider.

Payment of reasonable honoraria and reimbursement of out-of-pocket expenses for faculty is customary and proper. Commercial support must be acknowledged in printed announcements and brochures, however reference must not be made to specific products. Following the CPD activity, and upon request, the accredited provider must be prepared to report to each commercial supporter, information concerning the expenditure of funds each has provided.

A CPD Provider may authorize a commercial supporter to disseminate information about a CPD activity to the medical community. However, the content of such material must always be explicitly approved by, but necessarily prepared by, the accredited provider. It must always identify the educational activity as produced by the accredited Provider.

In connection with an educational activity, it is not permissible to use funds originating from a commercial source to pay travel, lodging, registration fees, honoraria or personal expenses for non-faculty attendees. Subsidies for hospitality should not be provided outside modest meals or social events that are held as part of the activity.

Scholarships or other special funding to permit medical students, registrars or consultants to attend selected educational conferences may be provided, as long as the selection of students, registrars or consultants who will receive the funds is made either by an academic or training institution, or by the accredited provider with the full concurrence of the academic or training institution.

5.15 CPD – Educational guidelines and practices

The following set of guidelines has been published by the Ceiba-Geigy Corporation (Industry Collaboration Task Force on CME: Uniform Guidelines for Accrediting Agencies of CME, United States 1990)

A. Needs assessment

An accredited Provider should systematically identify the CPD needs of the prospective participants and use that information in planning CPD activities.

B. Objectives

The accredited Provider should, for each CPD activity, develop objectives based on identified educational needs.

C. Educational design

1. Objectives influence design

An accredited Provider should use the objectives designed for an educational activity to select the content and design the educational method for that activity.

2. Basic design requirements for CPD activities

In designing CPD educational activities, the accredited provider must assure that the activities have the following characteristics:

- They must be free of bias against any product
- They must be designed and produced so that content and educational methods are ultimately determined by the accredited provider
- If the activities are concerned with commercial products, they must present objective information about them based on scientific methods generally accepted in the medical profession

3. Independence of accredited Providers

The design and production of CPD educational activities should be the ultimate responsibility of the accredited provider. Commercial supporters of such activities should not control the planning, content or execution of the activity. To

ensure compliance the following requirements must be adhered to by commercial supporters:

a. Help with the preparation of educational material

The content of slides and reference materials must remain the ultimate responsibility of the provider. This responsibility may not be shared with the faculty of the accredited provider. The provider may ask a commercial supporter to help with the preparation of conference-related educational materials, but these shall not specifically promote the proprietary interests of the commercial supporter.

b. Assistance with educational planning

The accredited provider must maintain responsibility for and control over the selection of content, schedule, faculty, attendees and educational methods and materials in all of its CPD activities.

An accredited provider may obtain information that will assist in planning and producing an educational activity from any outside source, whether commercial or not. However, acceptance by a provider of advice or services concerning speakers, invitees, or other educational programme component, including content, should not be among the conditions of providing support by a commercial organisation.

c. Distribution of advertising

No commercial promotional material should be displayed or distributed in the same room on or immediately before, during, or immediately after an accredited educational activity.

Representatives of commercial supporters may attend an educational activity but may not engage in sales activities while in the room where the activity takes place.

d. Exhibits

When commercial exhibits are part of the overall programme, arrangements for these must not influence

educational planning or interfere with the presentation of CPD activities. Exhibit placement must not be a condition of support for a CPD activity.

e. Proprietary names of products

While the use of proprietary names of products is permissible during educational activities, generic names should be used by the faculty whenever possible. Moreover, it is the responsibility of the provider to ensure that presentations give a balanced view of diagnostic, therapeutic, or appliance options. If proprietary names are used, those of several companies that make relevant products must be used rather than only those of the single company.

D. Evaluation

The role of professional bodies is not only about safeguarding standards but also about continuing competence and questions of policy and practices.

The initial qualification gives the professional practitioner the start, CPD accords the power to choose and change direction. The initial training gives the ability to practice, whilst there is some experience gained. The picture can change and what is needed is conscious learning from a variety of sources – hence the demand for both structured and unstructured learning experiences which constitute the most effective approaches to CPD.

An accredited provider should evaluate the effectiveness of its overall continuing professional development programme as well as its individual educational activities and use this information in its CPD planning. This can be done by using evaluation questionnaires given to the participants to evaluate the educational relevance, the appropriateness of the format and anticipated impact on the approach to clinical practice.

There needs to be specific evaluation for educational activities regarding information on clinical trials as this introduces the element of marketing drug products.

Communicating results of Scientific Research

Objective, rigorous scientific research conducted by commercial companies is an essential part of the process of developing new pharmaceutical or other medical products or devices. It is highly desirable that direct reports of such research be communicated to the medical community.

An offer by a commercial supporter to provide a presentation reporting the results of a scientific research should be accompanied by a detailed outline of the presentation, which should be used by the provider to confirm the scientific objectivity of the presentation. Such information must conform to the generally accepted standards of experimental design, data collection and analysis.

Disclosure

An accredited provider should have a policy requiring disclosure of the existence of any significant financial interest or other relationship a CPD faculty member or the provider has with the manufacturer(s) of any commercial product(s) discussed in an educational activity. All certified CPD activities should conform to this policy.

Such faculty or provider relationship with commercial supporters should be disclosed to participants prior to educational activities in brief statements in conference materials such as brochures, syllabi, exhibits, poster sessions and also in post-meeting publications.

In the case of a regularly scheduled event, such as grand rounds, disclosure should be made by the moderator of the activity, after consultation with the faculty member or a representative of the provider. Written documentation that disclosure information was given to participants should be entered in the file for that activity.

Off-Label use of Products

When off-label use of a commercial product, or an investigational use not yet approved, is discussed during an

educational activity, the provider should require the speaker to disclose that the product is not labeled for the use under discussion or that the product is still investigational. Discussions of such uses should focus on those that have been the subject of objective investigation.

Activities that are repeated many times

An accredited provider that offers educational activities that repeat essentially the same information each time they are given, must demonstrate that every iteration of that activity meets all of these guidelines.

The use by an accredited provider of educational activities or materials prepared by organisations other than the accredited sponsor.

When an accredited provider offers an educational activity based on concepts or materials prepared by an outside organisation, that activity must adhere to these guidelines in all respects, especially in regard to the provisions concerning the independence of the provider in planning, delivering, and evaluating all of its educational activities offered for CPD credit points.

5.16 General Concerns

The Ceiba-Geigy Corporation, by producing the Guidelines referred to above, has tried to ensure ethical behaviour regarding involvement of pharmaceutical companies in CPD. This does not necessarily imply that there is compliance with these Guidelines. Some concerns have been raised on some of the criteria and guidelines – some pharmaceutical companies complaining that they are too rigid, and some medical professionals complaining that these can limit the support of the pharmaceutical industry. This is important for CPD Accreditors, accredited Providers and the HPCSA to have as ongoing debate that will help modify the criteria and guidelines for the improvement of the CPD system. This also will depend on the experiences of the CPD activity providers and participants.

The custodianship of any CPD related Guideline documentation similar to the Ceiba-Geigy, and continuous review of the guidelines

should be a joint collaborative forum of stakeholders focussing on CPD related ethics and values. This is because there will always be an element of vested interest in the investment of resources by industrial bodies. The HPCSA published its 'Criteria and Guidelines for the approval of CPD activities', outlined below, to assist applicants for accreditation as Provider put together CPD programmes. These will also undergo continuous modifications to meet the needs for quality medical practice and the health care situation.

The professional role of accredited organisations

The major role of professional organisations is to examine the policies and processes that affect the professional and career development of the members. Giving input and cooperation with other role players has to be done in a constructive and proactive way.

The CPD system, by virtue of its participatory design, has cost implications on the doctor both in terms of time and finances. In addition to policy, process and impact evaluation, the medical professional and academic organisations have to exercise the role of monitoring the quality and integrity of CPD programmes in the most cost-effective manner for the medical profession. Because resources are limited, the role of the participating organisations is to assist individual doctors, groups and organisations in the planning and prioritisation of CPD activities. This has to be done with the aim of facilitating the doctor's lifelong learning at minimum cost and maximum value.

The first cycle of the CPD system has been full of intrigue and apprehension as the profession assimilates the new reality into its systems. The accrediting and providing organisations have to facilitate effective communication on the structural and process issues to the medical profession across all levels of organisation and practice. The HPCSA CPD Guidelines for medical practitioners and dentists outline the point system and categories of activities as will be explained below.

5.17 The point system and allocation of points

The basic premise of the point allocation for activities in the following categories of educational and developmental activities for CPD purposes is that ONE hour equals ONE point, although the eventual onus and responsibility rests with the Accreditors of CPD Activities to discount sub-optimal activities downwards to an appropriate points allocation per time unit. The required amount is 50 hours of CPD activity or 50 points per year.

Not more than 80 percent of the points accumulated by any practitioner, may be accumulated in any one of the specified three CPD categories over a five year cycle. A minimum of 10 points in medical ethics shall be required from all practitioners in each five year cycle.

Any relevant educational or developmental activity in relation to the scope of CPD, which does not fall under the activities listed, may be submitted to an Accreditor of CPD Activities for a recommendation to and approval by the Medical and Dental Professional Board and, if agreed to, shall be accredited for CPD purposes.

Category 1: Organisational activities

Attendance of accredited (formal) learning opportunities

These activities include, but are not restricted to the following: Conferences; Congresses; Workshops; Lectures; Seminars; Refresher courses or Departmental meetings

Category 2: Small group activities

Participation in accredited (non-formal) learning opportunities

- 1 additional point per hour for presenting as per category 3.d.
- These activities include, but are not restricted to the following: Teaching ward rounds; Journal clubs; Small group discussions

Category 3: Individual activities

a. *Self-study*

These activities Include, but are not restricted to the following: Studying of journals, electronic or computerised material

b. *Individual learning*

These activities include, but are not restricted to the following:
Skills training such as Endoscopy; Short-term study at university departments, etc.

Prior approval will have to be obtained and attendance will have to be verified

c. *Research and publication in peer reviewed/CPD journals*

1st author: 15 points; Co-author: 5 points

d. *Teaching or training (undergraduate and/or postgraduate students and/or peers)*

e. *Speaker at departmental meeting(s)*

f. *Paper/poster presentations/lectures to peers*

Short papers (< 20 minutes); congress papers/posters:5 points

Long papers (> 20 minutes);invited lectures, keynote addresses:
10 points

g. *Relevant additional qualifications obtained*

Completed Diplomas

6 month Diploma: 10 points

1 year Diploma: 20 points

2 year Diploma: 40 points

Completed Masters or Doctoral degrees: 50 points

These points are in addition to any points obtained during the study period

h. *Examinations/Evaluations/Assessments*

These activities include, but are not restricted by the following:
Undergraduate and postgraduate examinations; Evaluation undertaken on behalf of registering authority; Assessment of theses or scripts

i. *Supervision of Degrees (Masters/Doctoral students (thesis or dissertation))*

Promotor/mentor/study leader for Masters or Doctoral qualifications

•15 points per graduate per year

5.18 Administration

The uniform management and evaluation standards of the CPD accreditation and provision processes should be developed and coordinated by the Health Professions Council through consensus with all role players on the basis of national criteria.

However, the necessary systems have to be put in place to maintain the integrity of CPD, and to promote professional ethics and education without undue commercial incentives. The areas for development of guidelines, norms and standards are accreditation, provision, quality monitoring and administration.

As confusion on capabilities of the structural and functional arrangements wanes it gives way to the realization of the gains accruable in a regulated professional education and development system. The critical one of these gains is the intended improvement in the quality of care for the patients. Although apparently secondary, the gain in professional competency and leading edge knowledge increases self-confidence in the doctor and bodes well for a respectable public image in the profession.

The majority of the Accreditor and Provider organisations are well established bodies in the medical profession. They therefore have political, professional and organisational responsibility for the facilitation and smooth introduction of the CPD system. This entails interfacing with the Specialists, Special Interest Groups, academic organisational groups and other interested bodies for the purposes of content appraisal for the CPD programmes and activities. This necessitates the establishment of CPD Committees to oversee the maintenance of integrity in the system.

The operational facilitation and management rests with a dedicated unit within the organisation's administration. The CPD facilitation and process development undertaken at the unit is resource intensive in terms of personnel, time and Information Technology infrastructure.

This situation can only be rectified through the development and enforcement of comprehensive policies regarding the Accreditation and Provision of CPD activities. This philosophy should be spread

to include support for the individuals and groups that engage in the CPD system as Providers.

CPD provider organizations' role

There need to be proactive involvement in the development of national norms and standards for CPD accreditation and provision.

The development of a comprehensive and accessible data base and facilitation of its utilization for collaborative initiatives can enhance smoother implementation of CPD.

For the support of the practitioners professional bodies should undertake to encourage the exploration, facilitation and development of accessible and user-friendly technologies for application of CPD programmes in multi-media communication vehicles.

Assuring cost-effective participation by all registered medical practitioners in valuable and relevant CPD activities is a role of the Health Professions Council.

Feedback and continuous improvement

The introduction the South African CPD system has had negative connotations in the minds of many doctors. The associated terms are: compulsory CME, bureaucracy, point scoring, dull lectures, stupid questionnaires, money making and characteristic lack of confidence in effectiveness. Ongoing assessment of the educational and developmental value of the CPD system must be done in consultation with the recipients.

It is the responsibility of all the parties involved as Accreditors and Providers of CPD to engage in processes of continuous evaluation of the gains to health care brought about by the introduction of the system. The tools used should be carefully chosen to allow for the free flow of commentary and views.

Open channel communication on all the programmes should be part of the delivery infrastructure. This should be for inquiries, criticism as well as active searching for suggestions for improvement.

Development of working relationships between CPD Accreditors, Providers and the HPCSA

The developmental implementation difficulties of the CPD system have necessitated a lot of interaction between the different role players. The Accreditors, Providers and the HPCSA share similar experiences regarding administrative, management and provision of the service.

The CPD system requires a lot of communication amongst all involved because of the variable activities, different responsibilities of the role players and the newness of the phenomenon.

The recording and reporting of the practitioners' accumulated CPD points is a personal responsibility. The CPD policy requirement stipulates that points gained in a calendar year must be reported to the Council yearly, and that the Council will keep a record of accumulated points and the give regular feedback on the CPD status of individual practitioners.

Accreditation of non-clinical CPD courses

Although the primary goal for the introduction of CPD in the medical profession is improvement of clinical competence, there is clear recognition of the broader aspects of Professional Development, incorporating non-clinical areas of learning which indirectly lead to the achievement of clinical outcomes.

There is accumulative evidence that:

- The introduction of the Continuing Professional Development in the medical profession has raised the importance of recognizing the involvement of doctors in managerial and administrative services and the void in the present CPD system's policy and standards.
- Doctors are increasingly interested in the financial/resource implications of providing quality health care
- There is a need to have a CPD mechanism that caters for the doctors and other health professionals involved in these services

– instead of being driven to seek educational qualification in general management, administration and leadership courses.

- Medical Professionals move between clinical and non-clinical work environments and systems and are involved in overlapping and more complex health service provision situations.
- There is evident positive interest and benefit for the health care system in addressing the educational and training needs to cater for this phenomenon.
- The Health System needs the maintenance of professional competence in all aspects of health care services.
- There are many CPD accredited courses on management and administration of health (and other) services whilst there are no accreditation criteria or standards.

5.19 Professional and health system considerations

It would be critical for the Health Professions Council of South Africa to interact with the relevant role-players in developing standards and norms for the accreditation of health care specific/oriented management and other non-clinical CPD courses. The reasoning behind this is that there are elements within health care that are peculiar to health, and experience informs that these areas need to be measured differently. The main goal would be to see the resources and knowledge already developed with the CPD system used to benefit the health care system.

There is a strong belief that accreditation of management courses in health will improve the quality of health as a significant number of professionals like doctors, nurses and pharmacists are increasingly playing a management role in the public health sector.

A model of research should be developed that would incorporate expertise in epidemiology and public health to provide a broader understanding of various diseases in society. Efforts to develop health care systems should begin with a solid core of primary and emergency care, and consider the needs of society's most frail humans. The doctors must also be oriented in economics, the

humanities, organization of health care to meet the contemporary health care systems.

The non-clinical CPD programmes need to be allocated points according to uniform criteria and standards. There is extra learning accumulated through preparation to give lectures and planning for a CPD activity offering and materials. Non-academic doctors should be encouraged to undertake these activities focussing on their practical situations. The incentive and reward for medical practitioners engaging in this activity is through the provision for additional CPD points for faculty and resources participants.

As the situation is dynamic and changing fast in medicine and health systems, the needs for more education and development of skills and capacity in the non-clinical aspects might change. This should be reflected in the CPD point allocation as areward for more medical practitioners engaging in the non-clinical areas.

CPD Providers

Medical practitioners have been involved in organising CME activities throughout history. Many individual doctors have the personal interest and skill in facilitating learning, research and debate regarding their clinical areas of practice and medicine in general. These are the people who are now registering for CPD Provider status. The value of their accreditation lies in their practical involvement and acute awareness of the situation.

The majority participants are medical associations and societies, specialist groups, special interest groups and a variety of professional groupings. There are also medical faculties of universities and other educational bodies, the research institutes and clinical service organisations such as pathologists, that provide a variety of CPD activities in all the categories.

Many pharmaceutical companies have participated in CME as supporters. The business of CME cannot be separated from other managerial functions like pharmaceutical research and development. The relationships that have been built over the years as well as the experience in CME make the pharmaceutical industry a credible player as sponsors and supporters of CPD activities

The health technology is also becoming increasingly involved in CPD activities although mostly relating to skills development for the use of their technologies. It is vital that the doctors and health personnel that use the medical devices and other equipment items in the health care system are educated and appropriately skilled. CPD educational activities are relevant for quality assurance in the increasingly technology intensive health care services, especially for the protection of the patients on which it is used.

Public health facilities such as the hospitals and clinics are ideal facilities for learning and skills training. The CPD educational activities have enormous value for undergraduate and post-graduate training and continuing development. The resultant gain in quality health care services is also of great value to the health system.

Private health companies / clinical facilities, in which the opportunities for learning and education are endless because of more availability of state-of-the art and world class resources and highly trained and experienced personnel are accessible. Adherence to the set national standards for CPD is crucial in this economic sector as the tendency might be to focus on top class services that are not available for the majority of the people.

Participants

In any private CPD activity, the individual may act as a lecturer, resource person, part of faculty, author, as coordinator / organizer of a group and participating in international CME program. The small group CPD activities are mainly focussed on the clinical area of interest, are run as mainly regular programmes such as Journal Clubs.

In large groups CPD activities are lumped together into conferences, seminars and workshops. This is a very convenient opportunity of focussing dedicated time to CPD in well organized environment and programmes.

International Reciprocity

The need has been expressed for CPD programmes and activities to be recognized nationally and across the world. This would facilitate the recognition of clinical competency of doctors as they move away from local to distant work areas.

The reciprocity can be achieved through the establishment of national and international guidelines and standards for the CPD systems to correlate.

Recipients of the CPD gains – quality values for society

Families, communities and patient groupings gain from the credibility, improved quality of the health services, that are also more oriented to primary health care, health promotion and disease prevention.

Health services in private and public facilities that utilize health communication media educational programs, health promotion literature and publications can all gain from the CPD system. There can be a quality assurance element if CPD can be integrated in the improvement of services, as well as knowledge transfer between professionals, other workers and the public. The views of other health practitioners, health service managers and patients should also be included.

Improvement of the doctor-patient relationship is possible if CPD is done this way, and if public awareness is raised, the caring image of the profession will add value to the services.

5.20 CPD with reference to the S.A. health system

The South African government's White Paper on the Health System emphasizes the following three principles on education and training of health personnel:

- Education and training programmes should be aimed at recruiting and developing personnel who are competent to respond appropriately to the health needs of the people they serve.
- Particular emphasis should be placed on training personnel for the provision of effective primary health care
- New policies and strategies for human resource development should address priority education and training needs. (ref : National Department of Health's White Paper for the transformation of the Health System in South Africa, 1997)

The implementation strategies for this policy focus on specific areas that are relevant to the CPD system. These are:

- a. Training appropriate to the level of care: this refers to the ability of health professionals to deliver approved health service packages at various levels of health care should be developed.
- b. Co-ordination of training refers to the large number of health personnel educational programmes offered by a variety of institutions that should be coordinated and, if necessary, rationalised.
- c. Career path development and continuing education specifically addresses the development of career paths and continuing education for all health professionals that should be promoted. The system of visiting consultants should be structured in such a way that specialist categories function as educators at the primary health care level.
- d. It would seem from the literature search that re-certification for competency and safe practice of health professionals should be the responsibility of the health professional councils or their successors in title. The question of involving other relevant structures of civil society needs to be debated.

5.21 Ongoing developments

Ongoing discussions on the CPD system's developmental dynamics have led to the formation of a SA National Accreditors' Forum. The initial consensus for this body was to have an informal structure with a view to formalize it as and when necessary with inclusiveness and representation of all the accrediting bodies ensured. The main goal of this body is the development of national norms and standards for the CPD system.

Several organisations and institutions were designated by the HPCSA as accreditors and CPD activities have been implemented since January 1999. This has happened without the existence of any standards or norms thus resulting in a state of confusion not only with accreditors but also within the affected professions. Developmental problems included some fraudulent behaviour like selling of CPD points, financial exploitation for accreditation and blackmail of commercial supporters who were coerced for the

financial support of CPD activities in return for the purchase of their products.

This Accreditors Forum would serve as a structural fortification of the CPD system, facilitating coordination, monitoring and evaluation of the CPD accreditation processes in collaboration with all role players and the HPCSA.

The South African Medical Association also produced a discussion document on a concept similar to that of the Accreditation Forum, referring to a South African Accreditation Council on CPD (NACPD). The purpose of the NACPD would be to promote, develop and encourage the development of principles, policies and standards for continuing professional development. The other need is to relate continuing professional development to health and patient care. Guidance of the accrediting bodies in the application of these principles, policies and standards when assessing CPD applications also needs specific focus. This Forum would deal with all other matters that relate to the advancement of the CPD system for South Africa and act as an Appellate body for any providers who may feel to have been unfairly treated by an accrediting body (SAMA Discussion Document on NACPD, July 1999)

Proposed functions of the NACPD

- a. To clarify the definition of the critical elements of the system and the intergration of the components
- b. To set standards and norms for continuing professional development.
- c. To review and assess developments in CPD and relate these to patient care through evaluation methods.
- d. To recommend and initiate studies for improving the organisation and processes of CPD.
- e. To recommend to accrediting bodies mechanisms for monitoring compliance by the providers of CPD activities.
- f. To develop a monitoring mechanism to maintain and improve the NACPD's oversight on Accreditors in order to ensure their continued effectiveness, fairness and reliability in assessing CPD applications.

- g. To review periodically its role in CPD and ensure that its policies and actions remain responsive to professional and public needs.
- h. To decide on the criteria for eligibility of CPD activities undertaken abroad for reciprocity in South Africa.
- i. To act as a clearing house for accreditation of intricate or complicated activities – “difficult situations.
- j. To encourage the utilization of Information Technological Systems – compatibility and system integration to be looked at as mechanisms that will foster close cooperation between Accreditors and the HPCSA (SAMA Discussion Document on NACPD, July 1999)

It is very important to make a differentiation between non-professional educational needs like personal financial planning versus professional educational needs like practice management for practitioners interested in providing a better service to patients. Practice management in this instance would include financial planning for the practice.

The NACPD would be constituted under the auspices of the Health Professions Council of South Africa and be accountable through this body to the health professions. Membership of this council would be drawn from the health professions plus representatives of the Department of Health. The Pharmaceutical Industry representatives, as CME-support will need to be somehow accommodated.

5.22 Guidelines for commercial support of CPD (adapted from the American Accreditation Council for CME, 1997)

1. *Statement of Purpose:*

The programme is for scientific and educational purposes only and will not promote the sponsor's products directly or indirectly.

2. *Selection of presenters and content:*

The provider is responsible for the selection of presenters, choice of programme and constitution of its content. The sponsor will not direct the content of the programme.

3. *Promotional activities:*

There will be no emphasis or direction of the content by the sponsor or its agents. No promotional activities or product advertisements will be permitted in the same room where the activity is conducted.

4. *Credibility of information:*

Should it be unavoidable to refer to a particular product, the provider will ensure that data regarding the product is objectively selected and presented, with favourable and unfavourable information and prevailing information on alternative products and/or treatments.

5. *Limitations on data:*

The provider will ensure as far as possible that there is meaningful disclosure of limitations on data e.g. ongoing research, preliminary data or unsupported opinion etc.

6. *Use of Contributed Funds:*

These should be in the form of an educational grant to the Provider. All other support associated with the activity e.g. brochures, slides and so on must be distributed with the full knowledge and approval of the Provider. No other funds besides the educational grant will be paid to the provider, programme director or anyone involved with the CPD activity.

7. *Attendance:*

Participants will attend the CPD activities at own cost and will not solicit commercial financial support for this purpose.

No commercial entity will be coerced or forced to supporting any Accrediting organisation or institution, Provider or participant(s) financially or otherwise. It is unethical for any commercial entity to request support for its products in exchange for its support of CPD programs. This amounts to a perverse incentive.

With reference to the South African situation, this seemingly highly stringent and over-regulated control system might be unfavorable for developing countries that still need a lot of support from the health industry. A healthy balance in the standards may have to be negotiated to accommodate the needs of both parties.

5.23 Monitoring and evaluating effectiveness of the CPD policy

The current system of accumulating a set quota of CPD points over a set period of time is questionable in terms of its effectiveness in actually delivering the intended results. Could this be the HPCSA's desire is to increase the degree of certainty that the public will receive the high quality service it expects if practitioners are forced to engage in CPD?

Then two related problems emerge:

- How can we ensure compliance of practitioners to CPD?
- How can we ensure relevance of CPD to clinical services – so that the public gets quality service?

The CPD participation questionnaire and CPD record reviews may shed some light in these aspects (Sandra Clyne, 1995). Creativity, planning and resource commitment to this purpose is critical for any measurable achievement of good evaluation.

Challenges for compliance and quality of CPD courses

Reporting of CPD requires annual submission of records to the Council as the practitioner's responsibility. This is an added responsibility for some very busy practitioners, and the documents can be lost in the postal system.

There are no standards for accreditation. There are good courses that are not accredited, rubberstamping by some accreditors, of some poor quality courses due to the inadequate intellectual resources, price differentials that are unrelated to quality and no on-site inspections at running courses or conferences.

Sanctions are imposed to practitioners that do not comply with the CPD policy. These range from suspension from independent practice to withdrawal of the doctor's license to practice, punishment for non-compliance with difficult policing gives an impression of a Council with no "teeth", no infrastructure set for monitoring and even offering the necessary support and advice.

Attendance of irrelevant courses is very common. Some practitioners have difficulty of access to relevant ones whilst there is easier access to irrelevant ones. Therefore practitioners focus on meeting the annual CPD points quota, spreading to more than one category and getting the minimum of the compulsory ethics points.

There is no focus on quality services for the patients – the practitioner's work situation might be different from the personal interest CPD category, there might be an under-resourced work environment and untenable circumstances to provide a quality service. Therefore the patients might get a service from someone who has a different focus and orientation.

Reliance on the professional conscience of the doctors cannot be relied upon as they were unhappy with the introduction of this system in the first place. It would seem that some authoritative recognition, career-related advancement or status accorded to CPD compliance – sought voluntarily for various reasons – would be more effective. The unfortunate reality is that this kind of system can only evolve over time and is dependent on other dynamics of the health system.

There are five elements in training/competence that are directly observable as part of CPD gains: These are:

- technical skills – the ability to perform tasks required for professional duties
- technical knowledge - knowing the facts and information required for the job or expected by patients
- interpersonal skills – the ability to deal with others in the line of duty so that clinical care objectives are met.
- Commercial skills – the skills required to influence the management of financial and other resources.

The success of CPD depends on the realization by the professional of the importance of these element in career development.

The operation of the CPD system based on points or hours of course attendance tends to encourage practitioners to attend technical knowledge-based courses, often to the exclusion of all else, when, as we realize, the real need is shifting away from knowledge-based towards skills-based training.

A CPD system should recognize that in order to serve the needs of the patients effectively, the CPD needs of the practitioner will change in line with the different mix of skills which are demanded as his/her career advances. Therefore it should support and encourage the CPD direction taken by the practitioner, fulfilling the learning needs that are in turn dictated by the patients.

A not uncommon example can be demonstrated through a concept called Hughes' Theory of Least Irrelevance (Clyne, Sandra 1995 – Perspectives on CPD in practice). It goes like this:

Dr H – the busy practitioner – sits on his desk for a short break. In walks the secretary with a cup of strong coffee and some mail. 'Oh my goodness!' says the busy practitioner, 'I haven't done any CPD this year yet.' He takes a slurp of his coffee and looks through the CPD courses' section of a medical publication, 'My lady, book me on the GP Update, Allergy Symposium and the Insect Bites course and that should sort the problem for another year'. The secretary points out that these are the same three courses the doctor has been on for the past three years and it might be sensible for her to book them in advance in future.

Hughes' theory of least irrelevance 'states' that the busy practitioner will select from any given range of CPD courses those courses that sound the least irrelevant to his work. As a result, although there is no focus on his specific CPD requirements/needs, the benefits to his patients and his professional development are minimal. The question therefore remains; 'How helpful are CPD requirements when expressed in terms of points per year?' The answer for me conjures visions of many doctor horses being led to the CPD waters and drinking a few drops, if any, at any given time. Maybe it should be: 'You can take a doctor to the CPD course, but you can't make him think!'

The irony of the situation is that the good practitioner finds relevant courses and, without thinking about CPD points quotas, attends and learns anyway. The bad practitioner manipulates his way through the system, attends the bare minimum and does not even learn. The majority are found in the middle of this spectrum and probably include Dr H. and 'hopefully' are not a danger to their patients.

6. CHAPTER 5: CPD VALUES, EDUCATION AND QUALITY

The common good of every profession demands a functioning educational system in order to ensure the professional competence, caring ethos and professional values. The South African CPD system has a unique element with special reference to values: All participation must include ten CPD points over a 5 years cycle accumulated in ethics – a special category. This implies that in the assessment of the root problem, the lack of a focus on ethics was identified and a solution had to be incorporated.

The formulation of sustainable policies is the desire of many social service systems development mechanisms. To be sustainable a policy should be aligned to the value systems of the intended target population. This study attempts to explicate the values that are inherent in the Continuing Professional Development system as mechanism to facilitate a quality assurance policy. These values are identifiable in the areas of knowledge, skills, quality of care and professional integrity.

Professional learners define their own territory of intellectual inquiry while benefiting from the groundwork laid over the years in each of the traditional disciplines. The role of CPD in the formation of values in medicine is very important. Highlighting these values can enhance the enthusiasm of medical practitioners to embrace the new CPD system and encourage developmental strategies for the professional authorities.

Some definitions of CPD bring out the societal values that CPD fosters. A definition commonly accepted is one adopted by the inter-professional CPD in the UK Construction Group which puts CPD as: 'The systematic maintenance, improvement and broadening of knowledge and skill and the development of personal qualities necessary for the execution of professional and technical duties throughout the practitioner's working life.'

A further definition is provided by Cyril Houle (1980): 'The ways in which professionals try, throughout their active lives of service, to refresh their own knowledge and ability and build a sense of collective responsibility to society'. This definition stretches the responsibility of professionals beyond their professional

development and recognizes that professionals have a special responsibility and, by implication, a particular status in society.

Welsh and Woodward (1989) consider that the 'key issue is *competence*' and it is by CPD that individual professional competence is maintained and approved. The culture of lifelong learning will be inculcated more successfully as the CPD activity forms part of the professional career development of every medical practitioner.

Other health professions will also be able to see the beneficial values embedded in the medical CPD system. If all health professions can follow suite, this can lead to the improvement of total quality in health care services.

6.1 Values and the practice of medicine

Since the early ages some philosophical questions have been asked about the practice of medicine: Is medicine an art or science? Is it a humanistic enterprise with a scientific component, or is it a scientific enterprise with a humanistic component? Although there seems to be no definite answers to these old questions, logic says that it is a humanistic, scientific and artistic enterprise. There appears to be though, general affirmation of the necessity that any strong vision of the goals of medicine must incorporate the art of human judgement in the face of uncertainty, a core of humanistic and moral values, and the findings of careful science.

Science informs and shapes our worldview; technology is developed and used according to the choices a society makes. Science, technology and society should be viewed in a mutually interactive context, enriched by a historical perspective and shaped by a wide-ranging multi-faceted dialogue among all members of society. Science, then, is ultimately reflective of some of our innermost values. Its quality is therefore dependant upon rational discourse and a respect for social diversity. CPD has to incorporate these aspects in broadening the approach to health care.

A medicine that seeks, simultaneously, to be honourable, temperate, affordable, sustainable and equitable must reflect constantly on its goals. The bureaucratic, organisational, political and economic

means of achieving those goals should not be allowed to overshadow the enduring, and often troublesomely difficult, questions of ends and purposes. Science teaches a kind of intellectual humility and cautiousness that must be a condition of wisdom, and certainly is an important check for people disposed to accept only their own authority.

6.2 The CPD system's value aspects for the medical profession

The value aspects that are explicated through the analysis of CPD principles can be exploited further to facilitate the understanding of the professional gains accruable in upholding them.

Moving continuing medical education from historic traditions of the 'old world' is very important. One of these was that of education by humiliation. A doctor would be expected to know what they should know, learning was thought to be complete at the end of training, uncertainty was discouraged and ignorance was avoided, especially at the post-graduate level. (Journal of the Royal College of Physicians of London Vol.28 No.2 March/April 1994)

In the 'new world' the most important thing is to know what you don't know, uncertainty is acceptable, learning is lifelong and it is about knowing how to find out what you don't know. The challenge posed by the compulsory CPD system is entrenching a continuous learning behavior in a conservative profession that has its own traditional culture and values.

- Spirit of inquiry

From the undergraduate to postgraduate levels of training, as well as in the continuing career, the medical professional has to inquire, from clinical evidence and from established science, in order to get to the diagnosis and treatment of disease and the maintenance of health. Without the enduring spirit of inquiry, which is backbone of CPD, the art and science of medicine loses the depth added by the broad and holistic approach to solutions.

- Professionalism

The caring professions focus on humanistic values that are at the core of the professional service. As one of the earliest established noble professions medicine has to take leadership in upholding professional principles. The resultant high regard in which society holds the medical profession stimulates a reciprocal approach to practice.

- Continuity of care and the Doctor – Patient rapport

The two values are linked because the one – continuity of care, facilitates the other – the development of doctor-patient rapport.

There are expectations from the patients and the health system that the patient gets to be treated by the same doctor at all consultations. This also enables ease of diagnosis and follow-up on treatment modalities.

- Confidentiality and patient advocacy

Respect for the patient is a cornerstone in the practice of medicine and health care as well as the establishment of a relationship based on trust. Information management is critical both for confidentiality and the exercise of advocacy, which roles in turn increase the trust endowed upon the doctor.

- Focus on quality

“First impressions last”. This expression cannot be more appropriate in the medical profession. It is in the look, the feel and experience of the encounter with the medical doctor and his/her environment that determine the assessment of quality of care. There is also a positive outcome relationship with cost-effectiveness that is associated with quality services.

- Personal integrity

Humanitarianism, collegial respect and service reliability foster the development and maintenance of integrity of the profession within society. The CPD system will hopefully raise the integrity

with which the profession is held by society. This can only be realised through acknowledgement by society of the quality of care gains associated with medical practice.

- Ethical standards

The maintenance of ethical standards is more critical than ever. Economic, social and scientific pressures on medicine in the late twentieth century are forcing policymakers throughout the world to attempt medical and health care reform. These efforts can fail, or not reach their full potential, unless a new light is turned on the values at the core of medicine.

- Honesty and transparency

The value of the truth and openness to society increases the trust and confidence that is put on the profession. Because the practice of medicine entails utilisation of unknown and 'privileged' scientific information, it is important that clear and understandable messages are relayed to the patients. The other challenge is the extensive development of the computerised Information Technology systems with the resultant exposure of scientific information to an increasingly aware society.

- Service and partnership relationships

The service aspect of the profession implies a certain measure of obedience that the doctor has to show towards the patient and the health system. This is also a two-way process. The conditions of service under which the doctor works influence his/her commitment and enthusiasm, whilst feedback from the patients and society also affects the service rendered. Therefore there are partnership relationships between the doctor and the health system and society.

- Evaluation

Self-regulation in the medical profession assures that a mechanism of evaluation is in place. The CPD system can only get better as it is based on regular evaluation of the accredited

programmes and activities. The ultimate values accruable in the system will also have to be assessed from an evaluative approach.

6.3 Educational values – The CPD way

As has been described previously, CPD is supposed to have additional educational value than CME was perceived to have. The enforcement through legislation is apparently supposed to foster guaranteed learning, which is supposed to guarantee improved quality in medical health services – is this desirable? Nevertheless, the following aspects might be the assumptions made in motivating for the introduction of CPD.

a. A commitment

When a doctor makes a life-long commitment to serving others through the profession of medicine, he or she must also make a life-long commitment to continuous learning.

Medical knowledge, science, and technology advance so quickly and so dramatically that it is impossible to offer competent medical care without ongoing medical education.

b. A professional code of conduct

As a medical professional the doctor is expected to follow a certain code of conduct: a doctor shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

c. Integrated continuing medical education

Education is the foundation for survival and independence in all social service and professional life systems. One of the greatest challenges doctors face is how to integrate ongoing education into

daily life already filled with other equally important professional and personal commitments. Doctors who want to realise the goals articulated by Manning and DeBakey in their book “Medicine, Preserving the Passion” must attend to their personal as well as their professional needs.

d. Self-directed learning

Medical professionals must be self-directed and look for learning opportunities in every dimension of their practices. This means reflecting on the patient care they provide; determining precisely what they need and want to learn; choosing the learning activities which will most effectively help them reach their learning goals; and finding the time and place for the experience.

e. Self regulation

The CPD system is regulated through a statutory body and a legislative Act. This is a legal regulation that forces doctors to participate in any of the stipulated CPD programme categories. The regulated environment also removes the free volition to engage but introduces an obligation, record keeping and evaluation of learning processes. It also enhances the integrity of the profession as it is seen to be self-regulating without the involvement of Government or other controlling mechanism.

f. Evaluation

As the CPD focuses on the achievement of learning goals, continuous evaluation of the accredited activities / programmes is the only way this can be verified. There are set mechanisms to evaluate whether the CPD programme has satisfied the learning needs of the participants.

Practice evaluation is equally important in assessing the quality of the medical service. There are readily available resources to assist doctors in meaningful reflection on patient care. Many specialty societies offer “self-assessment” activities; “practice profiling” and peer review systems. Other organisations offer assistance in “personalised” education using a variety of methods to determine a

doctor's learning needs and then designing a "tailor-made" educational programme around them.

6.4 Quality Health Care values

In health care quality is usually understood in the context of "clinical quality" and an implicit distinction is drawn between managerial and clinical activity. In other organisations quality improvement is often linked to the concept that quality should be a characteristic of the whole organisation.

The recent directives to develop clinical audit will go some way in addressing these divisions. Also, the onus of meeting the recently launched Patient' Charter initiatives has provided yet another separate focus for quality improvement within health facilities.

Policy developments for the national health care services, as stipulated in the White Paper on the Transformation of the health system in South Africa, promote quality services with emphasis on primary health care. The CPD system therefore, and in order to be relevant to the medical and dental practitioners' work environment, has to integrate all these initiatives into its accreditation principles and criteria.

7. CHAPTER 6: CONCLUSIONS

7.1 The Global Picture

The medical profession is subject to influence by social developmental trends and pressures. Profound changes are taking place globally and locally. They can be seen in a globalisation of economic systems, in the rapid development of science and technology, in the age structure and mobility of populations, and the emergence of an information and technology-based society.(Ref. Adult Basic Education & Training Journal Vol.1 No.2, 1997)

The world is also experiencing major changes in patterns of work and employment, a growing ecological crisis, and tensions between social groups based on culture, ethnicity, gender roles, religion and income. These trends are reflected in the health status, health seeking behavior and general planning and rationalising difficulties for expenditure in health care.

The CPD system has to integrate these realities in the programme content and evaluation of learning. Innovation and creativity in the structuring of the CPD activities and programmes is a challenge to the CPD Providers, Accreditors and participants to give collective input and suggestions on relevance. A CPD policy plays a necessary role in reinforcing the credibility of a professional body like the HPCSA, if it is to sustain its dual role of guidance to the professionals and regulator of standards.

The current form of CPD, based on quotas of points or hours attended, is not effective in ensuring that the practitioners obtain CPD points in courses relevant to their service needs. A much better system would be one that focuses on the assessment of learning

needs, the development of CPD plans and the monitoring of compliance with those plans.

Challenges to the CPD system

- Quality assurance in health care is at the core of the origins of the CPD system. Awareness and commitment to an effective CPD system of integrity and high quality standards for the improvement of the health care service is the challenge to the medical profession.
- Lifelong learning should come naturally in all medical practitioners but not necessarily for the accumulation of CPD credit points and keeping their names on the HPCSA register.
- The CPD system, as a common requirement, puts a challenge to the medical professional organisations for developing harmonious working relationships without undue competition.
- The improvement of the public image should be judged by the responses, comments and praises of the larger society towards the medical profession. The high regard in which children regard taking up a career in medicine, the respect from other professions, and more importantly the satisfaction of the patient communities will be the ultimate determinants of success.

Learning as an intention

Life-long learning is indeed central to the concept of Continuing Professional Development. The health sector is looking at improving the quality of its services in response to emerging consumerism and demand of value for money from the patients.

The CPD policy and its appropriate implementation point to a definite potential to boost the quality of health care services. The

challenge is at getting health professionals to engage in lifelong learning for the continuous improvement of the system.

The CPD system will achieve the goal of continuous learning being an integral part of medical practice. It is the appropriate utilization of the learned knowledge that will expose the professional values espoused through the observed behavior of the medical profession.

- *Evidence based CPD*

There is a need for an evidence base to support implied health service benefit of the Continuing Professional Development system. Therefore the CPD system needs formative, ongoing and summative evaluation to keep it relevant, educationally valuable and achieving its intended goals. This is essential for the justification of targeting limited resources and informing developmental strategies.

Society needs tools like the CPD system for strengthening all the developmental and support programs in service provision. Values can be powerful driving forces that foster compliance and pride in any systematic program. Because values are embedded in everyday actions and reactions, they need to be highlighted to help society base policy development and successful implementation.

7.2 Practicability

CPD is work that is not designed as an economic venture or an adjunct to wage earning capacity per se. However, if one recognizes that pervasive change requires a lifelong learning capacity and an ability to see the interrelated phenomena, CPD may, in the long run, be the most practical/economic career investment, as well as an investment in the individuals good professional life.

The work situation warrants special attention because the CPD system has financial and time implications. These issues present additional difficulties to management if no planning is undertaken. The following set of criteria should guide local health organisations as they establish a systematic approach to CPD. As highlighted by Norman Jones and Gordon Robinson in the *Journal of Management Development* (1997), local arrangements for CPD in the work environment should:

- be very closely linked to local organisational governance plans
- be supported by a clear infrastructure, with explicit lines of accountability
- have a multi-disciplinary remit
- provide the local mechanisms for ensuring that affected staff integrate CPD in personal development plans
- incorporate effective processes for identifying the education and development needs of individuals and service teams
- focus on local service objectives and priorities within the health improvement programme
- promote the understanding and use of up-to-date knowledge by linking together CPD, clinical audit and research and development activities
- be open and transparent in their working and reporting arrangements, following consultation with relevant staff
- actively promote equal opportunity for CPD, regardless of professional background, level of seniority or achievement, amongst full time and part time staff alike
- ensure that CPD programmes meet professional and educational standards and are flexible enough to accommodate different learning styles and preferences
- be appropriately linked and compatible with the CPD requirements of the regulatory body and health authorities, underpinned by the standards set by the relevant professional bodies

- support those tasked with leading CPD and address their specific development needs (Norman Jones and Gordon Robinson - Journal of Management Development, 1997)

Supportive strategies

Society (the medical community) not only continues to exist *by* transmission, *by* communication, but it may be fairly said to exist *in* transmission, *in* communication. The aims, beliefs, aspirations and knowledge are what binds a community, what constitutes it, and communication ensures participation into the public, shared forms of life.

Continuous communication and encouragement of the participant and all role-players is very important. The feedback on the quality of the services, improved professional image and the unquestionable integrity of the system must be consistently given to the profession and society.

Local library and IT strategies should provide mechanisms for CPD related information dissemination as well as equal access for all staff groups to the learning resources which support work based CPD. All the role players in CPD should contribute to the support of CPD participants.

The CPD Accreditors should be the link between the providers of CPD programmes and the HPCSA. Close collaboration on the evaluation of the implementation strategies of CPD should be undertaken continuously. The aim should be to modify and improve on the accreditation policies and procedures and enable smooth provision of CPD.

The accredited CPD Providers are the closest contact to the doctors who participate in CPD programmes. A coordinated approach to the evaluation of the achievement of the goals of the CPD system, in terms of meeting the learning requirements as well as improving the quality of care, should be an ongoing activity.

7.3 The future

The future almost certainly holds more structured, more data-based, more outcome-related CPD, and a growing understanding of the nature and context of medical practitioner learning and change. As this occurs, the concept of individual physician responsibility for professional, lifelong learning, integrating to practice, will surely be strengthened.

CPD has an ever-increasing role to play because of the rapid increase in scientific knowledge: more than 600,000 articles are published each year in the medical literature. The ability of today's doctor to remain knowledgeable, competent, and compassionate is challenged both by the sheer magnitude of all that is there to know and by the increasingly coercive and unfriendly environment in which many doctors work.

Research is the bedrock on which progress takes place, both research in science to prepare doctors for change, and research in education to foster innovative learning. CPD has an important role to play, but CPD practice and persons must have and a sound body of ethics on which to base their work. These must include the value of learning, the quality of scholarship, the importance of libraries and collections, support for humane and friendly learning environment, resistance to corruption of education by marketing forces, and a cantering of CPD around patient care.

Success as a doctor depends more than ever on a combination of technical knowledge, managerial skills, commercial awareness, and personal effectiveness. Initial education focuses on the first aspect and CPD continues to build up a portfolio of competencies focusing on the latter areas. Above all, doctors increasingly have to work in multi-disciplinary teams, which require communication and team-working skills.

CPD is high on the agenda of all authority bodies in the health professions. Sustained professional competence requires attention to CPD by both doctors and their employers, supported by professional and academic institutions.

The focus should move from just identifying the need for CPD to increasing the commitment and demand for CPD, and to providing support so that effective action is taken. However, important issues such as recognition of CPD, effective mechanisms for monitoring

and measurement, quality control and international standards need to be examined. These will surely provide opportunities for much debate and possibly more effective initiatives.

Doctors must be encouraged to view CPD as an investment in their future. It can be, on one hand, a mechanism for helping doctors to respond positively to change. As part of a change process it must be a bit ambitious and allow for innovation. On the other hand, CPD can be a mechanism for providing evidence of continued professional competence. They must own CPD and adapt it to their own needs and opportunities.

CPD must be a central force to ensure that doctors provide leadership in the facilities they work in. the challenge is to establish strategies for CPD which motivate doctors to continually improve their competence and their contribution to health service performance.

7.4 A positive outlook

What can CPD help with? It can provide opportunities for practitioners to:

- consider their current and future career and development needs
- formulate a personal development plan and take ownership
- broaden their learning and professional aspirations
- improve their capability in the management of change

What can be learnt through the current experience of CPD?

- CPD is about people, achieving through learning, training, education, and about improving quality standards and services.
- Ownership is important, as is commitment by the employers
- Results have to be earned; there are no measurable benefits overnight or without the investment of time and money.
- Implementation needs to be applied sensitively, systematically and convincingly.

- Individuals need mentors, coaches and records of progress from their professional associations.

An effective CPD system may be appreciated if seen as:

- a system well supported by legislation
- proactive and supportive professional bodies
- employers interested and supportive of CPD
- a wide variety of CPD provision
- motivated practitioners

These elements may be adapted to other professions and many contexts. There is no specific model, however, for the most effective CPD management model. The degree of success in the CPD system depends on a number of factors that will differ from profession to profession and from country to country. Whatever the prevailing regime, in order to progress, individual professions must adapt themselves to changes.

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