Design of a national Diploma in Family Medicine: Workshop with the co-ordinators of existing programmes

This workshop was held at the Division of Family Medicine and Primary care on 11th November 2014.

1. Introduction

The purpose of the workshop was to look in more detail at the revisions required by the existing Diploma programmes to align themselves with the agreed national learning outcomes.

The workshop built on three pieces of previous work:

- A previous national stakeholder workshop in June 2014 which reached consensus on the future **roles and competencies** expected of primary care doctors. The summary of this workshop also gives the rationale and **background** to the Diploma in the light of the efforts to improve the quality of primary health care and to establish national health insurance.

- A survey to identify the self-reported **learning needs** of primary care doctors in the public and private sectors
- A previous workshop to design the Diploma, which agreed on **learning outcomes and core principles** for delivering the Diploma in September 2014.

This workshop was funded by the European Union as part of the project "Strengthening primary health care through primary care doctors and family physicians".

2. Attendance

1.	Bob Mash	Stellenbosch University
2.	Zelra Malan	Stellenbosch University
3.	Klaus von Pressentin	Stellenbosch University
4.	Julia Blitz	Stellenbosch University
5.	Graham Bresick	University of Cape Town
6.	Gerard Botha	Pretoria University
7.	Honey Mabuza	College of Family Physicians
8.	Clive Rangiah	University of Kwa-Zulu Natal

3. Learning outcomes

The learning outcomes which were used in the workshop to guide the revision process are listed below.

3.1 Competent clinician

1. Manage patients with undifferentiated problems in primary care
2. Respond effectively to the quadruple burden of disease
3. Provide ethical, legal, professional, and scientifically sound healthcare
4. Perform clinical (incl. communication, procedural) skills appropriate to level
5. Provide comprehensive, co-ordinated and continuing care (preventative, promotive, curative, rehabilitative, palliative)
6. Manage resources within the context of the multi-disciplinary team and the referral system towards optimal clinical care
7. Use evidence and guidelines to reflect on practice

3.2 Change agent

1. Facilitate a Quality Improvement Cycle with the PHC team on aspect(s) of clinical care, clinical performance, patient experience or COPC

2. Reflect on and develop his/her leadership capability in order to be a change agent for a specific facility or service
3. Use behaviour change counselling as it applies to patients and colleagues
4. Align professional values and behaviour as a role model for change
5. Conduct relevant aspects of corporate governance

3.3 Capability builder

1. Facilitate and support inter-professional learning activities.
2. Guide a primary health care provider / colleague to identify and address their own professional learning needs.
3. Reflect on their own professional learning needs, and design and implement an appropriate learning plan.

3.4 Critical thinker

1. Evaluate and assess the system and individual clinical processes within the team.
2. Teach and support the team to interpret and use health indicators from the local facility by:
    - Management of data capturing
    - Analysis using basic statistical methodology
3. Offer recommendations on adjusting and adapting the health service provision of the local team in the light of the national context

3.5 Community advocate

1. Support patients and communities in engaging with their health rights and responsibilities
2. Coordinate the holistic care of patients with healthcare providers and facilities in their community/geographic service area
3. Assess and respond to the social determinants of health within a particular community

3.6 Collaborator

1. Facilitate functional health teams
2. Facilitate cooperation amongst stakeholders (intra-sectoral/inter-sectoral) in addressing health needs and PHC indicators of patients and communities (community and system perspectives)

4. Evaluation of the current curricula

Each of the 4 training programmes at SU, UCT, UP and KZN presented an outline of how their programme is currently designed and delivered. The programme at KZN is still theoretical as they are awaiting final approval to implement it. The College also presented their current approach to the assessment of the Diploma. After each of these presentations questions were asked to clarify the information and to map the curricula on to the learning outcomes. A scale was used to make this rating from nothing (not addressed in current curriculum), + (minimal engagement), ++ (some outcomes addressed), +++ (all outcomes addressed). The results of this evaluation are presented in Table 1.

Current national regulations allow a change in a current curriculum of up to 50% without formal re-accreditation and approval of the programme.

Table 1: Evaluation of the alignment of curricula with the new learning outcomes

Outcomes	UP programme	UCT programme	SU programme	KZN programme	College exam
Competent clinician	++	+++	++	+++	+++
Change agent	+	+	++	++	
Capability builder	+			++	
Critical thinker	+	+	++	+	
Community advocate			+++	+	
Collaborator	+		++	+	+
Notes	Distance learning only using CDs and paper based. Work in primary care. 10-14 students.	Blended programme but mostly relies on weekly face to face meetings. Work in primary care. Are opening Diploma to nurses. 4 students.	Distance learning only via web with optional contact sessions. Work in primary care. 40 students.	Blended with 30% contact and 70% distance. Requirement for training sites and supervisors.	2-years of supervised in-service training. Supervisor as FP at training site. MCQ paper MEQ paper OSCE

The competent clinician is the one outcome that is addressed well by all programmes and the College examination. The SU programme did not have any explicit clinical material and

clinical topics were addressed indirectly when working on assignments from the modules. The UP programme had some gaps in its coverage of the burden of disease e.g. maternal and child health. The other learning outcomes are not adequately addressed in the existing programmes or in the College examination, particularly the areas of capability building, leadership and governance, and community advocate.

The group felt that the Diploma should not attempt to cover the whole clinical curriculum, but to enable students to evaluate their current knowledge, decision making and skills and to then focus in a more individualised way on the gaps over the 2-year period. For example this could mean a baseline assessment (e.g. MCQ, logbook) and reflection at the start of the programme, repeated after 1-year, with reflection and a learning plan (in portfolio). Resources such be made available (e.g. guidelines) or identified (e.g. local skills acquisition) to enable the learning plan to be achieved. This would then allow a deeper focus on the development of the other six learning outcomes, which is where the major transformation of mind-set and competency needs to occur.

Each programme reflected on the key changes that would be needed to align their curriculums or assessment with the national learning outcomes:

Stellenbosch University: Needs to incorporate more clinical material, incorporate the module on teaching and learning (capability builder) and leadership and governance (change agent). Reduce the emphasis on ethics and FOPC and bring this in to the Consultation module. Provide more contact time (face to face or synchronous on-line).

University of Cape Town: Need to broaden the focus of the Diploma curriculum from the consultation and clinical issues to include the learning outcomes which speak to a broader role in terms of the health services and systems (Community advocate, change agent, capability builder, and critical thinker).

Pretoria University: Need a major re-design of the current programme to align with the learning outcomes, change to a more blended approach to learning, utilise e-learning, and include the portfolio and national exam. Would be >50% change.

University of Kwa-Zulu Natal: Need to increase attention to COPC (community advocate) and maybe reduce or change the emphasis on the clinical material (competent clinician). Feedback was given that the current design looks too intense and comprehensive for a Diploma level training programme.

College of Family Physicians: Need to broaden the scope of the examination to include the other learning outcomes and change the published learning outcomes / curriculum to align with the national ones.

5. Training sites, trainers and the portfolio of learning

The group discussed the recommendations, listed below, from the previous workshop in the light of their experience of actually running Diploma programmes:

1. Site can be any public/private facility offering suitable Primary Care exposure
2. ETC should coordinate common criteria for sites/trainers but appointments/accreditation be with university
3. Anyone with FM qualification (Dip/MMed) could be accredited as trainer
4. There needs to be a short course for training of trainers

Clinical trainers

The group recognised that the existing pool of family physicians is small, the family physicians are not widely distributed throughout the country and those in the public sector are already full committed and stretched to training of medical students, interns and registrars. The intention behind the Diploma is to make it as widely available as possible to any primary care doctor that would be interested in it and also to offer training at scale for the country. Requiring that students on the Diploma programme be supervised directly by a family physician will become a major obstacle to achieving this goal and will not be practical.

The group therefore moved away from a requirement for an accredited trainer such as a Family Physician to verify training and replaced this requirement with that for a portfolio of learning which would be the responsibility of the student. The student would then identify and utilise all local expertise to assist them with their learning and to fulfil the requirements of the portfolio (such as observations of their clinical skills). Such local expertise could include a family physician, someone with the Diploma, another student on the Diploma programme or a suitable peer/colleague, in either the public or private sectors. In order to build the adult and self-directed learning skills required for this approach it was suggested that the Diploma programme starts with a focus on the capability builder learning outcomes (mentoring, teaching and learning).

The student would interact with more formally recognised teachers and trainers at the university via the e-learning platform (synchronous or asynchronous interaction) as well as at face-to-face contact sessions.

Training sites

The group considered what criteria should be used to decide if the student's workplace was acceptable for the Diploma. Again the group reminded themselves that the intention of the Diploma is to help re-orientate and up-skill large numbers of primary care doctors for the future healthcare system. The criteria therefore should be as inclusive as possible. The following criteria were suggested, that the student should be

- Consulting ambulatory patients
- Providing first contact medical care
- Working as a medical generalist

Ambulatory care implies that patients are mobile and return home after the consultation. First contact medical care implies that you are the first doctor to consult this patient after they enter the healthcare system, although they might have been seen first by another healthcare worker. 'Medical generalism is an approach to the delivery of healthcare that

routinely applies a broad and holistic perspective to the patient's problems. It involves: (a) seeing the person as a whole and in the context of his or her family and wider social environment; (b) using this perspective as part of the clinical method and therapeutic approach to all clinical encounters; (c) being able to deal with undifferentiated illness and the widest range of patients and conditions; (d) in the context of general practice, taking continuity of responsibility for people's care across many disease episodes and over time; (e) coordinating his or her care as needed across organisations within and between health and social care.'[1] These criteria would typically be met by a doctor working in a clinic, health centre, general practice or district hospital.

Portfolio of learning

The group considered what should be included in the portfolio of learning and concluded:

1. Introduction
2. Learning outcomes
3. Learning plans (Baseline and every 6-months)
4. Observations (10 per year, 1 of a mentoring/teaching/training activity)
5. Logbook (Core primary care skills, with some additional elective skills, assessed at baseline and every 6-months along with the learning plan)
6. Other courses, congresses, workshops, meetings (optional additional material)
7. Assessment of portfolio (at least annually)

6. Assessment

The group discussed the recommendations, listed below, from the previous workshop in the light of their experience of actually running Diploma programmes and the first College diploma examination held in October:

1. One national exit examination
2. Portfolio must be part of assessment
3. Clinical assessment should be decentralised
4. There must be quality assurance of assessment
5. There must be training for assessors
6. Assessment must be aligned with teaching methods and learning outcomes

The group discussed the principle of a national exit examination and concluded that the College had the best expertise and administrative support to offer such an examination. The examination by the College and the training by the Universities would need to be combined in such a way that both benefited from the collaboration i.e. students were not tempted to drop out of the university programme. Such collaboration would ensure that candidates for the College were well trained in terms of the learning outcomes and that all students in the country sat the same College examination. The group recommended that:

[1] Howe A. Medical Generalism: Why Expertise in Whole Person Medicine Matters. London: RCGP, 2012. http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/Medical- Generalism-Why_expertise_in_whole_person_medicine_matters.ashx (accessed 5 November 2013).

- Entry to the College exam should be based on the student having successfully completed the academic programme over the first 18-months and having a learning portfolio for 18-months of training.
- The academic programme should ensure that all modules can be completed prior to sitting the College clinical exam in October of the second year (this is to avoid people not completing the programme if they pass the examination).
- Students should be able to pass the Diploma within the 2-years by sitting the College examination in the August-October period of the second year. To stretch the Diploma to more than 2-years would not be fair for a qualification at this level.
- Successful candidates will get both qualifications a postgraduate diploma from the University and a higher diploma from the College. This is necessary to ensure the University receives its subsidy and the College gains Diplomate members.
- In this model the College examination could still focus more, although not entirely, on the competent clinician as the other learning outcomes would be adequately and more appropriately assessed by the Universities as reflected in the entry requirements. Clinical assessment would be centralised (not decentralised) and if numbers increase dramatically it might be necessary to examine the Diploma on a separate day(s).
- Attention should be given to the cost of the 1st sitting of the Diploma at the College (currently around R6000) being incorporated into the student fees at the university. In other words the cost that would normally be budgeted for the university to assess the candidate would be used to pay for the entry fee to the College exam.
- Attention should be given to incentives and bursaries to encourage primary care doctors to complete the Diploma.

7. Teaching methods

The group discussed the recommendations, listed below, from the previous workshop in the light of their experience of actually running Diploma programmes:

1. Integrated (of content, people, Dip+MMed) district based training across whole DHS platform
2. Blended distance (e-learning)/work place and campus-based learning
3. Has standardised core modules shared by all programmes: common content, and elective modules
4. Mentor supported reflective learning process

All of these principles would still stand, except for the creation of standardised core modules. Each programme will revise its existing curriculum and structure to align itself with the national learning outcomes, but to try and standardise the modules across existing programmes would be an unnecessary burden. The existing programmes would however be willing to share content and resources with each other or new programmes in the future.

8. Strategic incentives and support

The following suggestions were re-iterated:

1. The DOH should assist by incorporating the Diploma into their PHCHP-SF for primary care doctors
2. The Diploma qualification should be a recommendation for accrediting sites/doctors for NHI
3. The Diploma should enable accelerated notch progression for MOs who obtain it.
4. The Diploma should be a criteria in career (rank) progression for MOs
5. When possible Universities should incentivise clinical trainers via recognition as lecturers, CPD and access to resources
6. Create bursaries for Diploma students
7. Open to COSMOs

9. The way forward

In terms of the College of Family Physicians (Dr Mabuza):

- Dr Mabuza will discuss the recommendations of this workshop with Prof Ogunbanjo
- College Council members will be invited to the stakeholder meeting on 6th February 2015, City Lodge, Airport OR Tambo, Gauteng.
- The final design and implications for the College will be presented to the College Council at the May 2015 meeting for approval.

In terms of the Universities (Dr Botha, Dr Rangiah, Prof Blitz/Mash, Dr Bresick):

- Each co-ordinator to complete the mapping of their curriculum onto the new learning outcomes
- Each co-ordinator to discuss the principles of this document with their faculty (especially the section on assessment and the collaboration with the College).
- Each co-ordinator to complete the design for their revised Diploma programme
- Each co-ordinator to identify the developmental requirements to implement this design (what needs to be developed or acquired).
- Each co-ordinator to present the new design and needs for development to the Diploma workshop on 5th February 2015, City Lodge, Airport OR Tambo, Gauteng.

Planning for the workshop 5th February 2015, City Lodge, Airport OR Tambo, Gauteng (Dr Malan and Von Pressentin):

- Presentation of the new designs and development needs from UP, UCT, SU and KZN
- Presentation of the recommendations for the trainers, training sites, assessment, teaching methods and incentives.
- Discussion of the above

- Workshop the completion of the CHE form for new programmes which takes us through all the issues to consider. EU project to complete a sample form with help of Clive prior to the workshop.

Next workshop 5th and 6th February 2015, City Lodge, OR Tambo Airport, Gauteng

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