Design of a national Diploma in Family Medicine: Workshop with the Education and Training Committee of the SA Academy of Family Physicians

This workshop was held at the Alphen Hotel Conference Facility in Constantia, Cape Town on 18th and 19th September 2014.

1. Introduction

The purpose of this workshop was to develop a set of national learning outcomes for the proposed Diploma and to agree on a model for the delivery of such a Diploma at scale to primary care doctors in South Africa.

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
- The national learning outcomes for the training of family physicians at the level of a 4-year MMed degree with full time registrar training.

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

Dr Richard Cooke gave an overview of how the design of this Diploma dovetailed with Primary Health Care Health Professionals Support Framework (PHCHP SF) developed by the National DOH to assist GPs that contract to work in the public sector. The PHCHP-SF consists of 4 pillars:

- Induction and orientation – attend the workshop, provide with an electronic resource pack
- District specific training opportunities – join in with CPD offered by that district
- Special interest sessions – additional CPD activities around specific needs
- Mentoring and support

The Diploma could offer mentoring and support over a 2-year period and contribute to the last pillar of this framework.

A draft performance management framework focuses progressively on:

- Administrative compliance e.g. timesheets
- Clinical management e.g. providing quality care
- Quality improvement e.g. initiating quality improvement activities
- Clinical governance e.g. leadership of clinical governance activities

Quality improvement was seen as having five foundational stones:

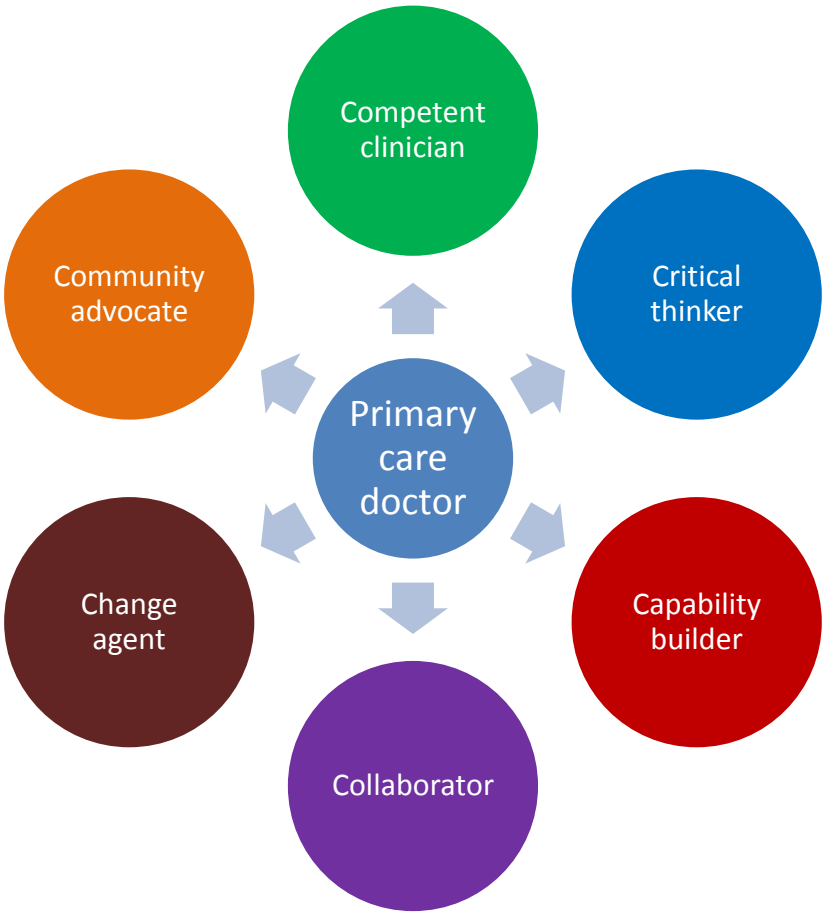
- Focus on the needs of / experience of the client
- Focus on a team approach to QI
- Focus on creating and reflecting on accurate and relevant data
- Focus on systems and processes, not just diseases
- Focus on communication and feedback to staff

2. Attendance

1. Bob Mash	Stellenbosch University
2. Zelra Malan	Stellenbosch University
3. Klaus von Pressentin	Stellenbosch University
4. Julia Blitz	Stellenbosch University
5. Richard Cooke	Primary Health Care Health Professionals Support Framework, NDOH
6. Graham Bresick	University of Cape Town
7. Beverley Schweitzer	University of Cape Town
8. Nathaniel Mofolo	Free State University
9. Hannes Steinberg	Free State University
10. Ian Couper	University of Witwatersrand
11. Laurel Baldwin-Ragaven	University of Witwatersrand
12. Gerard Botha	Pretoria University
13. Selma Smith	Pretoria University
14. Indiran Govender	University of Limpopo
15. Honey Mabuza	University of Limpopo
16. Mergan Naidoo	University of Kwa-Zulu Natal
17. Clive Rangiah	University of Kwa-Zulu Natal
18. Parimalaranie Yogeswaran	Walter Sisulu University
19. Jimmy Chandia	Walter Sisulu University
20. Jenny Morgan	Registrar representative

3. The roles and competencies required of primary care doctors

The overarching role of the primary care doctor is to be an **expert generalist**. The previous stakeholder workshop in June 2014 envisaged such an expert generalist as having the following roles to play in the future primary health care system. The six roles can be thought of as the 6 Cs as described below.



3.1 Competent clinician

The primary care doctor should be able to practice competently across the whole quadruple burden of disease (HIV/AIDS, TB, maternal and child care, non-communicable diseases, trauma and violence) and in terms of the morbidity profile of primary care in South Africa. This includes acute (emergency) care, chronic care and in some cases care provided in the midwife obstetric unit. In this respect they should be aware of the key national guidelines and be able to assist with their implementation in primary care.

They should have the clinical and procedural skills to fulfil this role in primary care.

They should be a role model for holistic patient-centred care with the accompanying communication and counselling skills.

They should be able to offer care to the more complicated patients that primary care nurses refer to them.

They should support continuity of care, integration of care and a family –orientated approach.

They should be able to offer or support appropriate health promotion and disease prevention activities in primary care.

3.2 Capability builder

The primary care doctor should be able to engage in learning conversations with other primary care providers to mentor them and build their capability.

They should be able to offer or support continuing professional development activities.

They should help to foster a culture of inter-professional learning in the work-place.

As part of a culture of learning they should attend to their own learning and development.

3.3 Critical thinker

The primary care doctor is one of the most highly educated/trained members of the primary care team and as such should be able to offer a level of critical thinking to the team that also sees the bigger picture.

They should be able to help the team analyse and interpret data or evidence that has been collected from the community, facility or derived from research projects.

They should be able to help the team with rational planning and action.

They should have IT and data management skills and the ability to make use of basic statistics.

3.4 Community advocate

The primary care doctor should exhibit a community-orientated mind-set that supports the ward-based outreach teams, understands the community's health needs and social determinants of health in the community and thinks about equity and the population at risk.

They should be able to perform home visits in the community when necessary.

3.5 Change agent

The primary care doctor should be a champion for improving quality of care and performance of the local health system in line with policy and guidelines.

They should be a role model for change – people need to see change in action.

They should know how to conduct a quality improvement cycle and partake in other clinical governance activities.

They should provide vision, leadership, innovation and critical thinking.

They may need to support some aspects of corporate governance.

They may need to assist with clinically related administration e.g. occupational health issues, medical record keeping, medico-legal forms

3.6 Collaborator

The primary care doctor should champion collaborative practice and teamwork.

The primary care doctor should use their credibility and authority to assist the team with solving problems across levels of care (referrals up and down) or within the community network of resources and organisations.

They should help develop a network of stakeholders and resources within the community.

4. Summary of results from the survey of self-reported learning needs

The aim of the survey was to identify the perceived learning needs of existing primary care doctors in the public and private sectors in terms of their awareness of key clinical guidelines, clinical skills and scope of practice

Ninety (90) general practitioners were included in the survey. GPs were selected from the pilot NHI districts as induction and orientation workshops were being held with GPs who were considering whether to contract with the local primary care services. These were GPs therefore located in the private sector, with an interest in working in the public sector and who would need to think about their learning needs in making this commitment. This process was led by Dr Richard Cooke on behalf of the National DOH. GPs were recruited more or less equally from Gauteng, Northern Cape, Free State, Limpopo, Mpumalanga, North West and Kwa-Zulu Natal.

Eighty (80) medical officers were included in the survey. MOs were selected from the provinces where the co-applicants to the EU funded project were located. MOs were identified via the family physicians linked to these departments. The sample was derived from the Western Cape (17%), Tshwane, Gauteng (14%), Kwa-Zulu Natal (22%), Limpopo (17%) and Free State (25%).

Respondents were asked to complete a questionnaire that had three sections:

- A list of the latest clinical guidelines used to guide practice across the whole burden of disease in South Africa. Respondents rated their level of awareness and engagement with the guidelines on a likert scale from 1 to 4.
- A list of clinical skills derived from the skills set defined for family physicians and relevant to ambulatory primary care practice in South Africa. Respondents were asked to rate their performance of these skills on a likert scale from 1 to 4.
- A list of activities representing the extended scope of practice envisaged for primary care doctors (i.e. see 6Cs above). Respondents were asked to rate their ability to perform these activities on a likert scale from 1 to 4.

The detailed results of the survey will be presented in an original research scientific article and published. The workshop participants considered the detailed results and reflected on their implications for the design of the Diploma. Key points derived from these reflections are summarised below.

Awareness of and engagement with guidelines:

- No guidelines scored more than 3.0.
- Overall there was low awareness (<2.0) of the more advanced guidelines on life support (e.g. ATLS, ACLS, PALS, ANLS), with GPs significantly less aware than the MOs.
- Overall there was low awareness of the guidelines for intra-partum and post-partum care (<2.0) and relatively lower scores for all the maternal care related guidelines. There were no significant differences between MOs and GPs. The need for intra-partum care would be limited to those primary care facilities with MOUs.
- Overall there was low awareness of the guidelines on managing patient complaints and facility supervision.
- Overall there was low awareness of the PC101 guidelines, which is not surprising given that they are relatively new in most areas and have previously been more targeted at nurses.
- GPs had low awareness of the TB guidelines and the Standard Treatment Guidelines
- GPs were significantly less aware of the Integrated Management of Childhood Illness guidelines compared to the MOs.

Clinical skills

- Clinical skills were mostly rated 2.5 and above by all respondents
- MOs appeared significantly more likely to perform skills related to emergency care for both adults and children, interpret investigations such as radiographs, and use the Road To Health Card in children.
- GPs were more likely to have injected the shoulder.

Scope of practice

- The majority of statements to assess the scope of practice were rated 2.5 and above by all respondents.
- Lower scores were obtained for community orientated care: helping CHWs to prioritise and respond appropriately to issues discovered during home visits, making sense of information on the population served by your practice and sharing with others in the PHC team.
- Lower scores were also obtained for aspects of clinical governance: leading a quality improvement cycle, leading a meeting to critically reflect on significant adverse events / death, critically appraising and making recommendations for the incorporation of new evidence into practice.

- GPs reported that they were significantly more confident with making sense of information on the population served by their practice and sharing it with the PHC team.

5. Creation of learning outcomes

Prof Julia Blitz reminded participants of how to create learning outcomes based on the roles and competencies defined earlier. Participants worked in small groups around specific roles and competencies to write high level outcomes (i.e. for the whole 2-year programme) and then peer reviewed each other's work. The final agreed outcomes are listed below.

5.1 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

5.2 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

5.3 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.

5.4 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

5.5 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

5.6 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)

6. A model for delivery of the Diploma programme

Prof Mash led the group in a discussion of the model needed to deliver the Diploma programme. There were a number of assumptions made in this discussion:

- The learning outcome developed above, along with the roles and competencies agreed on earlier, and which are aligned with the future needs of the primary care system, will guide the design of the Diploma.
- The model needs to offer training at scale (e.g. a minimum of 800 over 6-years, 20 per year per dept, 160 per year)
- Training will be offered via the university departments
- The duration of the Diploma will be 2-years (120 credits)
- The Diploma design, development, implementation and revision process will be co-ordinated between departments via the Education and Training Committee of the Academy.

People worked in small groups to discuss the teaching methods, approach to assessment, approach to training sites and trainers, as well as the need for strategic incentives and support. The different suggestions of each group were then collated and the viewpoint of the whole group obtained via a nominal group technique. The consensus of the whole group is presented below.

6.1 Teaching methods

The Diploma programme should offer teaching and training that is:

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

6.2 Assessment

The Diploma programme should offer an approach to assessment that is:

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

6.3 Training sites and trainers

The Diploma programme should offer an approach to training sites and trainers:

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

6.4 Strategic incentives and support

The following suggestions were made:

1. The DOH should assist by incorporating the Diploma into their PHCHP-SF for primary care doctors
2. The Diploma qualification should be a pre-requisite or 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. University should incentivise clinical trainers via recognition as lecturers, CPD and access to resources

6. Create bursaries for Diploma students
7. Open to COSMOs

7. The way forward

At the end of the workshop each University summarised its thinking in relation to the way forward.

7.1 Kwa-Zulu Natal

Not difficult to align their current diploma with new one. They will continue with current diploma as is, until the content of the new diploma has been finalized, then they will try to change <50% of current diploma and move forward (not such a huge step for them).

7.2 Stellenbosch University

Have an existing Diploma and are committed to revise this in line with the new learning outcomes (should be less than 50% of the curriculum). District based sites are available. Need to build better engagement with private sector.

7.3 University of Cape Town

Have an existing Diploma and revision should be less than 50%. They are also opening their Diploma to other PHC workers. More trainers needed, existing e-learning platform can be used, if student numbers sufficient they can get extra resources from university.

7.4 University of Pretoria

Have a Diploma, but it is out-dated and needs significant revision. Revisions may be more than 50% of curriculum necessitating a longer process of accreditation. Feel that the process is in the right direction and look for more guidance to help with the revision and still have several unanswered questions.

7.5 University of Witwatersrand

Do not have an existing Diploma and can see the value in having different exit points in family medicine training. They are trying to fill a post for PG co-ordinator. Need assistance from the collaboration to develop standardised modules, assessment and apply for accreditation. Could use experienced GPs and senior registrars as trainers, but finding trainers may be a challenge.

7.6 Free State University

Do not have an existing Diploma, but the local DOH have expressed a desire for such a degree. Have a newly accredited training platform which provides the opportunity for training, maybe even in Lesotho. Need support from the collaboration to develop the programme and get accreditation. Difficulties are low confidence in capacity to train, possible difficulty to do assessment, still not sure where newly trained doctors will fit into the bigger picture.

7.7 Walter Sisulu University

Do not have an existing Diploma and are interested in developing one, especially with the NHI pilot site of Oliver Tambo. However will need a lot of support to develop the programme and get accreditation as local capacity is very limited.

7.8 University of Limpopo

Do not have an existing Diploma and the immediate development of a new programme will be difficult until the de-merger that it currently happening at the university has occurred. The additional workload for the existing 15 family physicians to run a Diploma programme is also an issue. Accreditation of a new programme takes a long time and they will need to identify training sites.

7.9 Other matters

The summary of this workshop needs to be presented at the upcoming College Council to explore the response of the College to the learning outcomes and desire for a national exit examination.

We should aim to meet with the Foundation for Professional Development to see how these plans for a Diploma dovetail with their own plans for short courses aimed at primary care doctors.

The process will be taken forward in February in a workshop that will assist the four departments without Diploma's to prepare the application for accreditation. In the meantime the four departments with Diploma's will consider the needed revisions in more detail, the design of a portfolio and how they can assist the other Departments and each other with modules / standardised content.

This activity has been produced with the financial assistance of the European Union. The contents of this document are the sole responsibility of Stellenbosch University and can under no circumstances be regarded as reflecting the position of the European Union.