The design of a national Postgraduate Diploma in Family Medicine: Feedback to stakeholders

Introduction

This workshop was held at the City Lodge Hotel, OR Tambo International Airport on Friday 6th February 09h00-13h00.

The purpose of the workshop was to report back on the design of a national Postgraduate Diploma in Family Medicine and to get feedback from key stakeholders, before the Diploma is further developed and implemented.

This has been a collaborative process over a year as part of the project "Strengthening primary health care through primary care doctors and family physicians". This project is funded by the European Union in collaboration with the government of South Africa. The key objective from this project addressed in this workshop was "to build the capacity of primary care doctors to function in support of community-based primary care teams and to improve the quality of PHC services" and the activity that was funded was "designing, developing and implementing a national Diploma level training for existing primary care doctors, from either the private or public sector, to enable them to better support the ward-based primary care teams and to offer services commensurate with the government's PHC revitalisation programme."

The activity involved the following partners:

- Division of Family Medicine, Stellenbosch University
- Division of Family Medicine, University of Cape Town
- Department of Family Medicine, Free State University
- Department of Family Medicine, University of Witwatersrand
- Department of Family Medicine, University of Pretoria

- Department of Family Medicine, University of Limpopo (now Sefako Makgatho Health Sciences University)
- Department of Family Medicine, University of KwaZulu-Natal
- Department of Family Medicine, Walter Sisulu University
- SA Academy of Family Physicians
- College of Family Physicians

Over the last year the design process included the following steps:

- June 2014: A stakeholder consultation to define the roles and competencies expected of future primary care doctors in a revitalised system moving towards universal coverage under national health insurance. For a full report see: http://www.sun.ac.za/english/faculty/healthsciences/Family%20Medicine%20and%20Primary%20Care/Pages/National-Stakeholder-workshop.aspx
- September 2014: A meeting of the partners under the auspices of the SA Academy of Family Physicians Education and Training Committee to develop learning outcomes and educational design principles. http://www.sun.ac.za/english/faculty/healthsciences/Family%20Medicine%20and%20Primary%20Care/Pages/EuropeAid-Project-Outputs.aspx
- November 2014: A meeting of the partners who already have Diploma's to look at the implications for revising them in line with the new design.
- February 2015: A meeting of the partners to finalise the design and assist the partners who must submit applications for a new programme. http://www.sun.ac.za/english/faculty/healthsciences/Family%20Medicine%20and%20Primary%20Care/Pages/EuropeAid.aspx

In addition a national survey of self-reported learning needs of primary care doctors has been conducted and the results are about to be published in the SA Family Practice Journal http://www.tandfonline.com/doi/full/10.1080/20786190.2014.1002677#abstract.

Attendance

B Schweitzer, G. Bresick (University of Cape Town), B Mash, J Blitz, K von Pressentin, Z Malan (Stellenbosch University), S. Rangiah, M Naidoo, B. Gaede, L Campbell (University of Kwa Zulu Natal), J Chandia, P. Yogeswaran (Walter Sisulu University), N Mofolo, H Steinberg (University of the Free State), G Botha, K van den Berg (Pretoria University), S Mazaza(SAAFP), I Govender, G Ogunbanjo (Sefako Makgatho University) L Baldwin-Ragaven, R Cooke, E Reji, S Moosa (Witwatersrand University), N Mxenge, Z Dunn (Discovery Health) S Naude, J Dippenaar (Health Systems trust) G Makgoka (Foundation for Professional Development)

Feedback on the national survey of self-reported learning needs

Dr Zelra Malan presented the results of the national survey. The details of the survey are available in the podcast presentation (URL: http://fmhspod.sun.ac.za/Podcasts/FamilyMedicine.aspx?moid=13872) and in the published research article in the *SA Family Practice Journal*. The key recommendations from the survey for the design of the Diploma were:

- Primary care doctors differed in their learning needs, for example between those working in the public and private sectors, and the design should be flexible enough to adapt to prior learning and individual learning needs. An approach based on adult learning and self-directed learning therefore makes sense.
- Primary care doctors were aware of most of the selected guidelines (20/30), but very few were implemented in clinical practice (6/30). There is a need to increase skills in adoption and implementation of key guidelines.
- General practitioners (in the private sector) were less aware of the national guidelines used more commonly in the public sector such as the National Standard Treatment Guidelines based on the Essential Drug List, TB guidelines, Integrated Management of Childhood Illness, and guidelines related to Life Support (basic, trauma and cardiovascular).
- Primary care doctors were trained in all the listed skills and had performed most of them in the last year (70/85). General practitioners were less likely to have performed skills related to emergency care in children and adults, to have interpreted their own investigations such as x-rays or ECGs, to have certified a patient as dead or under the mental health care act, to have shared bad news or used a genogram.
- Primary care providers were most confident in their roles as competent clinicians, capacity builders and collaborators. They were less confident in their roles as critical thinkers, change agents and champions of community-orientated primary care.

Klaus von Pressentin, Zelra Malan, Bob Mash (EU project team), Gboyega Ogunbanjo (President SAAFP and CFP) and Richard Cooke (Wits)

Feedback on the design of the Diploma

Professor Bob Mash presented an overview of the design of the national Diploma. The podcast presentation is also available at http://fmhspod.sun.ac.za/Podcasts/FamilyMedicine.aspx?moid=13873 .

The design was based on the roles and competencies defined in the first workshop. These roles were developed in the context of a national priority to strengthen primary healthcare and for the primary care doctor to play an important and different role in the future system. The needs of society and the healthcare system were therefore considered when making sense of the future roles required of primary care doctors. The future system will need to utilise the expertise of all primary care doctors who are currently divided between the public and private sectors. The relationship of the design to national health policy and future directions is tackled further in the next section.

Six broad roles and competencies with associated learning outcomes were developed. These roles are shown below and the details given in the Appendix.

All the partners in the project have agreed to align their Diploma programmes with these national learning outcomes. For the four existing programmes at UCT, SU, KZN and UP this means revising the current curriculum and as long as the changes are <50% this can be tackled as an internal matter. For the four partners without programmes at FS, SMU WSU and Wits, they will submit applications to the Department of Higher Education, Council on Higher Education and SA Qualifications Authority to start the Diploma at their institutions.

The College of Family Physicians has also agreed to align its Diploma examination and criteria with the new learning outcomes. This should enable the Diploma to be offered at scale throughout the country to primary care doctors and with the same outcomes.

Approach to teaching

This will be a 2-year Diploma with a modularised curriculum (typically 4-6 modules) and a blended approach which will involve campus-based teaching, web-based teaching and work-place based learning. Where possible training will be integrated with other district based training such as the training of registrars. Overall the design will support adult self-directed learning. This means, for example, that the learners will identify the clinical areas in which they need to improve to reach the learning outcomes and focus on meeting their learning needs in these areas by using the resources provided in the programme.

Training sites

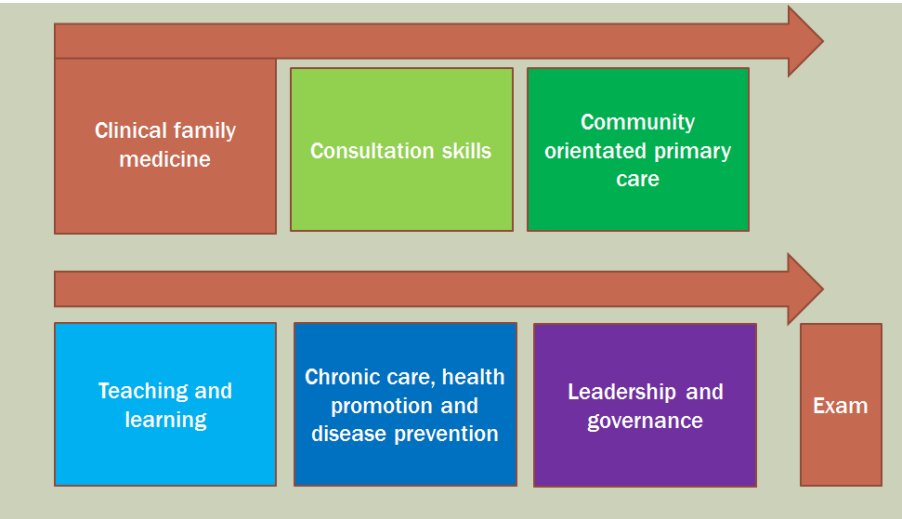
The design principle is to be inclusive and enable as many primary care doctors as possible to have access to the Diploma. The following broad criteria guide whether the doctor is working in a suitable setting for entry to the Diploma. The doctor should be:

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

Doctors working in district hospitals would usually meet these criteria as they would be performing outreach to the primary care platform, seeing ambulatory patients in the hospital and working as a generalist across all parts of the hospital, especially after-hours. Doctors working in clinics, health centres, and private general practice would of course meet these criteria. Therefore doctors can be in the public or private sector and study the Diploma in their practice.

Academic programme

A programme co-ordinator will be responsible for the programme at each training institution and will be assisted by other tutors from the department in the teaching of the modularised programme. Overall programmes should aim for 60-hours of contact time per year made up of face-to-face teaching on campus, peer learning in the workplace or virtual on-line synchronous contact. Assessment during the programme will focus on the modules and work-place based learning. The modular structure of one of the revised programmes is given as an illustration of what the Diploma might look like. Each programme will however meet the learning outcomes in their own unique way.



Work-place based learning and assessment

Learning in the work-place will be driven by peer learning and documented by means of a portfolio of learning. Peers might be family physicians, other doctors with the Diploma in Family Medicine, studying on the Diploma course, or experienced colleagues. The portfolio of learning would need to include:

- Evidence of self-directed learning by means of 6-monthly learning plans and reflection
- Evidence of learning by means of at least 10 observations per year of their performance in the work-place in relation to one of the key roles with feedback given on their capability and learning needs. Typically this would be observation of a consultation, clinical procedure or mentoring of others using standardised tools such as the Mini-CEX.
- Evidence of learning clinical skills by use of a logbook to reflect on their performance of key skills, competency and learning needs
- An annual assessment of the learning documented in the portfolio by the training institution

Final assessment

There should be one national exit examination for the country and this should ideally be offered by the College of Family Physicians. The portfolio should be a part of this assessment. There must be quality assurance of assessment, training for assessors and assessment must be aligned with teaching methods and learning outcomes

If the national exit examination is offered by the College of Family Physicians then the following should be considered:

- Entry to the exam should enable doctors to complete the Diploma within the 2-year period.
- Passing the College exam should not disadvantage completion of the university programme

- Successful candidates will receive a Higher Diploma from the College and become a member of the College as well as a Postgraduate Diploma from the university.
- University programmes should look at ways of incorporating the cost of the first sitting of the exam into the course fees

Quality assurance

Quality assurance for the Diploma will be ensured by the National Education and Training Committee of the SA Academy of Family Physicians which facilitates co-ordination and collaboration between programmes; as well as by the Colleges of Medicine who oversee the national examination. Each university has its own internal quality assurance processes for Diplomas and ultimately the programme co-ordinator and tutors will be responsible for the quality of modular content and teaching, work-place based learning (peer learning, portfolio of learning) and assessment.

Incentives and going to scale

If the universities all deliver on offering the Diploma in order to improve the capability of primary care doctors at a national scale and strengthen primary healthcare then stakeholders need to incentivise doctors to do the Diploma. This might mean:

- Incorporating the Diploma into the ongoing development and support of private GPs that contract with the public sector to work in the clinics
- Making the Diploma one of the accreditation criteria for doctors under NHI
- Making the Diploma a criteria for accelerated notch progression, bonuses or rank progression for MOs
- Making the Diploma a criteria for preferred status / accreditation by medical schemes
- Providing bursaries for Diploma students
- Allowing community service doctors to study the Diploma

Relationship of the Diploma to the re-engineering of primary healthcare

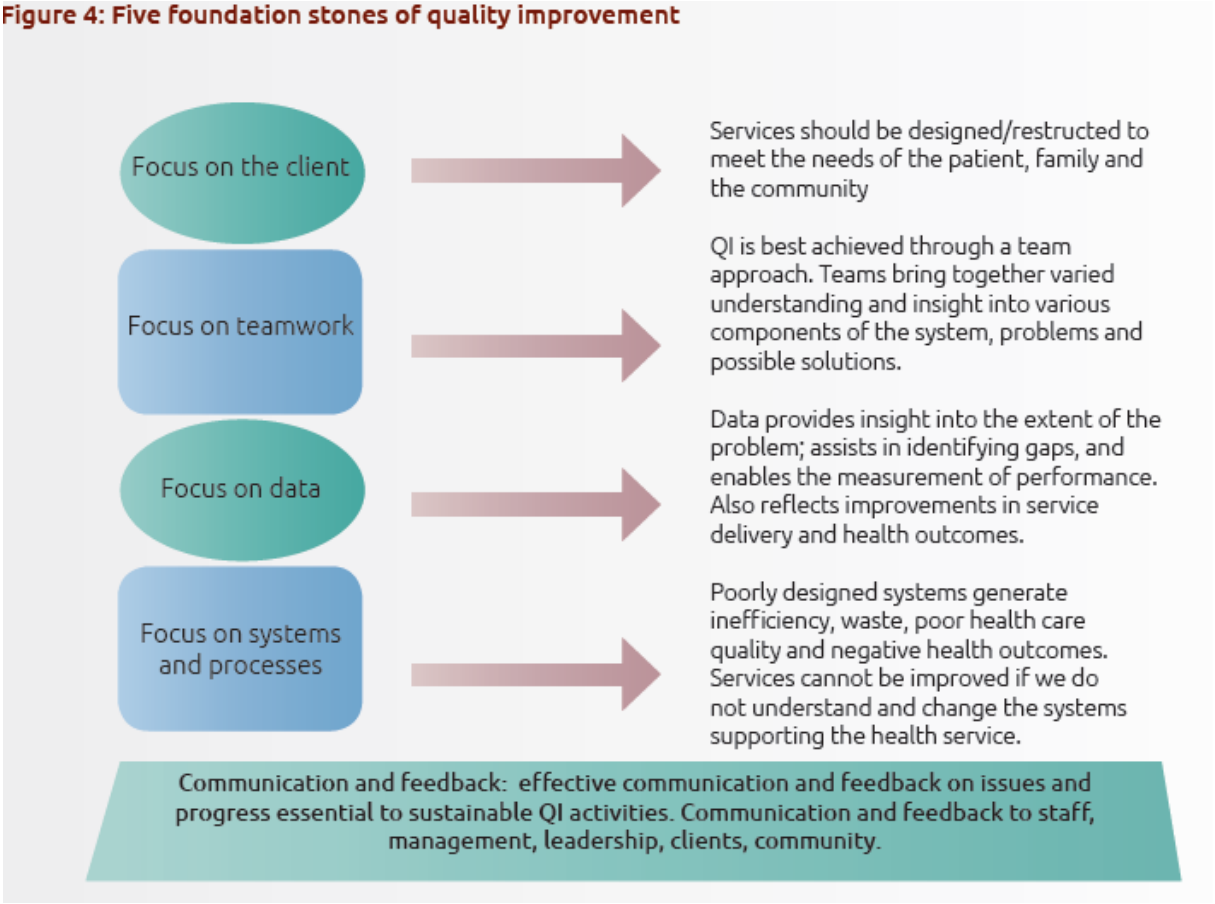
Dr Richard Cooke explored how the new national Diploma might articulate with the plans for the revitalisation of primary healthcare. His presentation is available as a podcast at http://fmhspod.sun.ac.za/Podcasts/FamilyMedicine.aspx?moid=13875 .

At a high level one can see a link between the new national Diploma and the implementation of national health insurance, improving the quality of health services and improving human resources for health. In the global picture the Diploma contributes

towards the suggested sustainable development goal of ensuring opportunities for lifelong learning.

There is a clear linkage between the five foundation stones of quality improvement (NDoH Quality Improvement Guide, 2012) and the six roles of the primary care doctor.

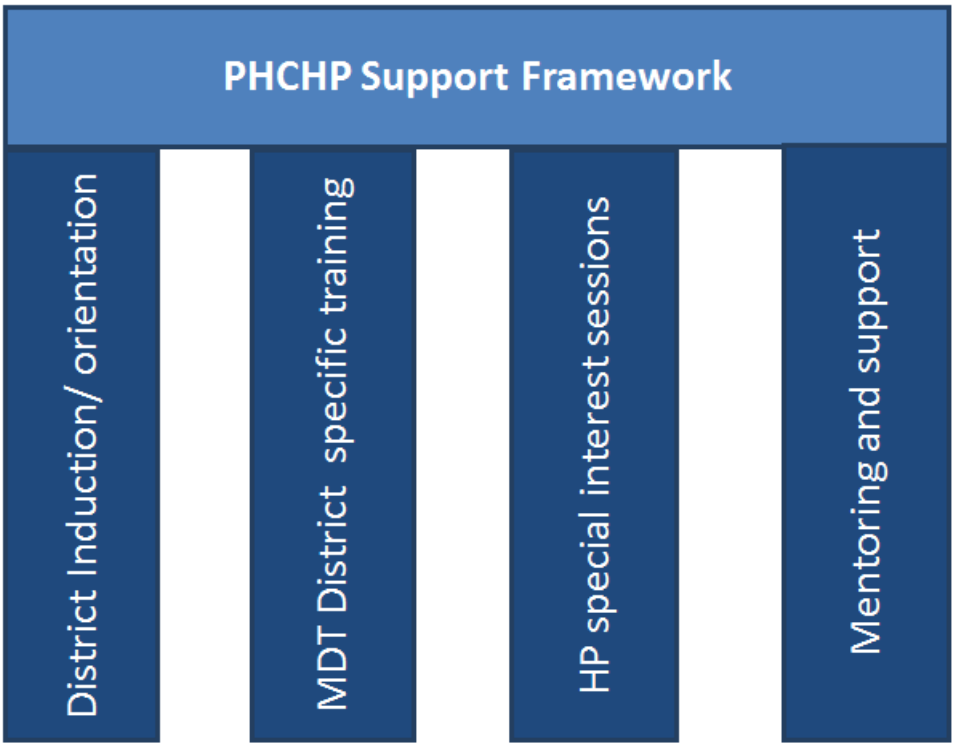
Figure 4: Five foundation stones of quality improvement



For example the competent clinician and community advocate focus on the patient, family and community; the collaborator and capability builder focuses on teamwork and effective communication; the critical thinker focuses in making sense of data and information; while the capability builder and change agent focuses on improving clinical processes and system performance. Primary care doctors who function in this way can assist with improving the quality of health services in line with the Office of Health Standards Compliance and the Ideal Clinic criteria. It should be noted that one of the Ideal Clinic criteria is the presence of a primary care doctor. This may also help with reducing the increase in medical-legal claims against the Department of Health.

The process of contracting general practitioners to offer sessions in the public sector has been implemented throughout the NHI pilot sites and recruitment is now being driven by the Foundation for Professional Development. Contracted GPs are expected to participate in an induction and orientation process and are offered training opportunities that align with the specific district's needs as well as continuing professional development activities. Ongoing mentoring and support is then required and together these four pillars are termed

the Primary Health Care Health Professionals Support Framework (PHCHP-SP) as illustrated below.



It is clear that the national Diploma can make a significant contribution to continuing professional development (pillar 3) and ongoing mentoring and support (pillar 4).

The District Clinical Specialist Teams were established to improve the maternal and child health outcomes within the districts. Doctors that have completed the Diploma would be natural allies in assisting the DCSTs to achieve their goals at the primary care level. The DCSTs could also contribute to the process of peer learning.

The role of the primary care doctor in relation to the school health services is not so clear.

The development of ward-based outreach teams (WBOTs) is expected to accelerate this year with the initiation of widespread training of community health workers. The piloting of WBOTs in the City of Tshwane suggests a clear role for the primary care doctor in helping such WBOTs to make sense of the information collected at a household level, planning appropriate responses and in on-going development of the team members. Primary care doctors who are better prepared for this role through the Diploma (critical thinker, community advocate, capability builder) would be invaluable to the success of these teams.

The Integrated Chronic Disease Management policy together with the integrated PC101 clinical guideline for management of adults is another important initiative. Successful implementation of this policy requires primary care doctors to assist clinically with more complicated patients, mentor and support clinical nurse practitioners, as well as to help improve the organisation of systems for chronic care. The roles of the primary care doctor as

competent clinician, capability builder, collaborator, change agent, and critical thinker are all intimately connected to the success of this policy.

In conclusion therefore the Diploma in Family Medicine can contribute to the development of the primary care doctor as an essential human resource who will also impact on the broader primary care team, while complementing a systematic approach to PHC re-engineering that ultimately will improve the quality of care for our patients and communities.

Feedback on the design by stakeholders

Once all of the above was presented, the participants at the workshop had the opportunity to affirm the design, raise concerns or make recommendations regarding the way forward. The following is a summary of their feedback.

The stakeholders affirmed the following aspects of the design:

- That the design is a collaborative process that aligns all programmes with a national set of learning outcomes and assessment
- That the design was based on research evidence and national guidelines
- That the process has clarified the roles of the primary care doctor
- That the learning outcomes are applicable and relevant
- That the design has the potential to go to scale, is very inclusive and includes both public and private sectors
- That the design includes important roles that were previously neglected
- That the design allows for flexibility and self-directed learning
- That the peer learning approach in the work-place develops local communities of learners and encourages the emergence of lifelong learning skills as well as learning organisations
- That the Diploma demonstrates the contribution of family medicine to the national priorities
- That the Diploma can contribute to the development of universal coverage and NHI

The stakeholders had the following concerns:

- Will the NDoH buy-in to supporting the Diploma, for example with suitable incentives
- Will the NDoHET, CHE, SAQA approve the new Diplomas
- More detail is needed on who and how the portfolio will be assessed
- More thought is needed to align the academic programmes with the college exam timeframe
- Will private GPs be willing to sacrifice some of their consulting time to meet their learning needs if this is needed
- Will public sector facilities be willing to assist private GPs to meet their learning needs if this is needed

- Will doctors be realistic about their learning needs and gaps
- Inter-professional teamwork should be a part of the learning process, is this viable in public and private clinical settings?
- Some concepts need more operationalizing, such as “leadership”
- What is the status of this Diploma vs. others such as the PG Diploma for nurses
- Is it Ok for people to get a Diploma from the College and the University
- How will this process continue once the EU funding ends
- Will the Departments have enough staff to support teaching on the Diploma
- How will other transitions in the private sector impact on the Diploma

The stakeholders made the following recommendations:

- Engage the medical schemes further about the Diploma (Discovery, Metropolitan Life and Medscheme)
- The Diploma should also be part of a career pathway in primary care
- The planning should be for large scale roll out and going to scale
- Consider a more central place for community-orientated primary care
- Plan research to evaluate the implementation of the Diploma
- The DOH should align the job description of the primary care doctor with the 6 roles outlined in the Diploma and take this on board in other policy – service alignment
- The DOH draft Performance Management Framework for PHC doctors should reflect the 6 roles outlined in the Diploma process – input needed from SAAFP
- The DOH should be supportive of their MOs enrolling in the Diploma
- Diploma should capacitate doctors to skilfully respond to system changes or challenges e.g. electronic data capturing /electronic health records
- Doctors should be able to study individual modules as short courses
- Strengthen collaboration between partners with Diplomas and those developing new Diplomas
- The Foundation for Professional Development should consider aligning their Diploma with the same set of learning outcomes and be a participant in the ongoing process
- An aggressive marketing strategy will be needed
- May need to look for further funding to support the process
- Ensure that there are incentives to complete the Diploma
- The Diploma programmes need ongoing co-ordination and collective quality assurance
- Quality improvement in service delivery (led by the DoH) necessarily adopts a programmatic, systems approach, but there needs to be more emphasis on the roles, competencies and behavioural attributes of the human resources – as this Diploma is seeking to address.
- Look for synergies with other disciplines such as clinical associates and nurses
- College Council must agree to further alignment of the national examination with the Diploma programmes

Appendix

Roles and competencies	Learning outcomes
Competent clinician ▪ The primary care doctor should be able to practice competently across the whole quadruple burden of disease ▪ 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.	• 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.
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.	• 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.	• 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.
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.	• 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.
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.	• 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.
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.	• 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	• 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
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.	• 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.