Dietitians' perceptions of the continuing professional development system in South Africa

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Abstract

Objective: To retrospectively evaluate the South African Continuing Professional Development (CPD) system (previous and current) for dietitians, by determining their perceptions of the system's implementation and participation in CPD activities.

Design: An observational descriptive study in the quantitative and qualitative research domains.

Methods: A national survey of 1 589 dietitians was conducted using a self-administered questionnaire, followed by 3 focus group discussions (FGD) with 19 Pretoria-based dietitians. In-depth interviews were also conducted with 6 CPD/Health Professions Council of South Africa (HPCSA) administrative personnel.

Results: Twenty per cent of dietitians responded to the survey. The CPD administration fee was unreasonable to 54.5% *(N = 156)* of dietitians and most FGD participants. CPD activities were expensive to 55% *(N=164)* of respondents while 29% *(N = 88)* of respondents, in agreement with the FGD participants, acknowledged the availability of variably priced activities. Statistically significant cost differences were determined across practice areas, qualifications and provinces. Lectures and seminars were activities most commonly participated in, followed by conferences and articles with multiple choice questions (MCQs) from peer reviewed literature. However, conferences ranked highest as the most preferred activity. Barriers to CPD activities included costs, geographical access, obtaining leave from work, family obligations and internet access. More dietitians were satisfied with the service quality at the CPD office and the Association for Dietetics in South Africa (ADSA) than with that provided by the HPCSA, but requested simpler correspondence from all these offices. In the current system, dietitians need to keep their own CPD records, but 51.7% *(N = 161)* preferred not to do so.

Conclusions: Addressing factors affecting CPD participation will contribute to the acceptability of the system by dietitians.

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Introduction

The short half life of nutrition information and a dynamic practice environment necessitate a continuous pursuit of knowledge by dietitians, to improve their professional abilities and provide optimal nutritional care to clients and the public.[1,2,3]

Continuing Professional Development (CPD) is recognised as a means to access current scientific information and to keep abreast of changes that affect the healthcare environment as well as to assist dietitians in growing within their individual practice area and to improve and prove their competence.[3, 4, 5, 6]

The learning achieved through CPD is still controversial since it cannot be assumed that the mere attendance of an activity results in a transfer of knowledge and in turn, changes in practice.[1,4] Despite several studies which acknowledge or criticise the benefits of CPD, it remains accepted as a measure of practitioner competence.[7,8,9]

While the responsibility of CPD lies with the individual, as does most learning, it is only a supportive process. A system is required to assess and document skills.[3] More than 10 years ago (1995) CPD was introduced to dietitians as a voluntary system. It was envisioned that through CPD, the values of the Association for Dietetics in South Africa (ADSA) would be upheld to portray the image of dietitians as credible, responsible and accountable for high standards of practice.[10] Six years later, though, CPD became obligatory for all health professionals.[11]

Since its inception, the CPD system has evolved substantially to improve user-friendliness and cost effectiveness.[12] The latest amendments however aimed to standardise CPD across all professional boards. In April 2006, a new system of personal CPD record keeping was introduced, replacing the CPD office responsible for administering dietitians' CPD points, in the previous system. Additional changes featured in the current system relate to the accumulation and awarding of points or Continuing Education Units (CEUs) and a reduced annual point requirement of 30.[11]

Any CPD support system requires evaluation to identify successes and pitfalls[7,13] and in South Africa (SA) no formal evaluation of the system was undertaken. This study, therefore, aimed to conduct an evaluation of the CPD system with specific objectives of determining i) dietitians' perceptions of how well the CPD system was implemented, ii) dietitians' perceptions about CPD activities and the barriers to participation, and iii) perspectives from the administrators of the CPD system, with a view to providing information on possible improvements which could be incorporated into the current system.

Methods

This was an observational descriptive study employing qualitative and quantitative research methodology, and was conducted in three phases, that is, a national survey and focus group discussions (FGD) with dietitians and in-depth interviews with CPD/HPCSA personnel.

The qualitative methods were included to expand and support the survey data by triangulation so as to enhance the usefulness of the findings.[7,14]

Instrumentation

Evaluation concepts guided the development of a conceptual framework and the design of provisional questionnaire items. Following revision of the questions, content and face validity were determined. Chronbach alpha values calculated for selected questionnaire items ranged between 0.65 and 0.98, demonstrating acceptable to excellent reliability. Prior to distribution, 10 dietitians, conveniently selected to represent the study population, pilot tested the questionnaire for clarity, comprehension and logistics.

The final instrument consisted of a 40 item self-administered questionnaire with 6 open-ended and 34 closed-ended questions in three sections:

Section 1: Seven demographic questions
Section 2: Thirteen questions regarding the administrative aspects of the CPD system
Section 3: Twenty questions regarding participation in CPD activities

Concerns and key issues, identified from the completed returned questionnaires, formed the basis of the FGD questioning route. The interview schedule centred on discussion points extracted from both questionnaire and FGDs.

Subjects

The CPD database listed 1 628 dietetic practitioners registered with the HPCSA. Dietitians involved in the questionnaire development, and one registrant without contact details were excluded, leaving 1608 dietitians as the survey's study population.

FGD dietitians were conveniently selected from the Pretoria area only, for logistical and financial reasons. Issues of bias were not considered to be influential, as FGDs were not the chief data collection tool, but were included to explore, in greater depth, issues already raised in the questionnaire. Six CPD personnel were purposively sampled for interviews based on their current or previous involvement in the CPD system. They represented the CPD Office, ADSA, the HPCSA and the Professional Board for Dietetics.

Data collection

During October/November 2005 the questionnaire was distributed with a consent form and a covering letter to all dietitians who qualified to participate in the study. The questionnaire was sent electronically to dietitians with email addresses (N = 1190), while those without (N = 418) were sent the same documents and a stamped self-addressed envelope via the post. Respondents with failed delivery email responses were also sent the questionnaire via the post. Nineteen posted questionnaires were returned due to invalid postal addresses. It was therefore assumed that 1 589 dietitians received the questionnaire (1 032 by email and 557 by post) and the invitation to participate in the survey. Reminder notices were sent out to improve the response rate.

The FGDs were facilitated by the researcher and executed from December 2005 to January 2006. Nineteen dietitians participated in three groups with five to eight participants per group. After the third group, a point of saturation was reached where no new information surfaced. The group comprised five females and one male, and represented the five practice areas in various employment positions. The discussions were recorded on a dictaphone and video camera.

The researcher conducted one of the in-depth interviews in person with a CPD/HPCSA personnel member while the rest were conducted telephonically during June and July 2006. Each in-depth interview lasted between 35 minutes to an hour.

Data analysis

The closed-ended questionnaire items were coded while the open-ended ones were categorised into similar response themes, prior to coding. Statistical analysis included descriptive statistics and determination of frequencies. Associations between specific demographic data and ordinal variables were determined using the ANOVA/F-test. The Kruskal-Wallis or Mann-Whitney test was used to confirm the ANOVA. Chi-square analysis was used for cross tabulations of selected nominal variables and demographic data. If $p < 0.05$, differences were considered significant. StatSoft Inc (2004) STATISTICA® version 7 www.statsoft.com was used for all analyses.

The in-depth interviews and FGD data were fully transcribed into written text. A process of themed analysis was used to group similar responses into common themes and perceptions.[15]

Results

A total of 318 questionnaires were returned, giving a response rate of 20%. One questionnaire, with pages missing was excluded from the analysis.

Description of Survey Respondents

The majority of respondents (98%; *N = 309*) were female (see Table I) with a mean age of 32.8 years (Standard Deviation [SD] 8.36). Most (60.8%; *N = 192*) had a bachelor's degree, while 39.2% (*N = 124*) of dietitians had obtained higher qualifications. The majority (73%; *N =230*) were employed full time, primarily in therapeutic nutrition (31.5%; *N = 91*). ADSA membership was maintained by 79.5% (N = 252). More than a third resided in Gauteng (35.6%; *N = 112*), while the minority of participants originated from the Northern Cape (2.2%; *N = 7*). Dietitians abroad (8.3%; *N = 26*) practised mainly in the United Kingdom, but also in the United States and Saudi Arabia.

Affordability of CPD

Administration fees

Survey respondents were almost equally divided in their view that the CPD administrative fee was either reasonable (45.3%; *N* = 130) or expensive (42.3%; *N* = 121). The remaining 12.4% (*N* = 36) were either unaware of the fees, preferred standardised costs across professions, or suggested that all fees that dietitians usually pay, be combined into one.

Table I: Demographic characteristics of respondents

Demographic variables of study respondents	N (%)	National register of dietitians (*N* = 1652) (HPCSA-2006)[17,18] (%)
Gender (*N* = 316)		
Female	309 (97.8)	96
Male	7 (2.2)	4
Highest qualification (*N* = 316)		
Bachelors/bachelors and postgraduate	192 (60.8)	
Diploma	88 (27.8)	
Honours	29 (9.2)	
Masters	7 (2.2)	
Doctorate		
Work status (*N* = 316)		
Employed, full time	230 (72.8)	
Employed, part time	44 (13.9)	
In community service	22 (7.0)	
Unemployed	10 (3.2)	
Other	10 (3.2)	
Major practice area (*N* = 289)		
Therapeutic/hospital	91 (31.5)	
Private practice	73 (25.3)	
Community Nutrition	20 (6.9)	
Education/academia	19 (6.6)	
Pharmaceutical industry	16 (5.5)	
Foodservice Management	15 (5.2)	
Nutritional consultant	14 (4.8)	
Food Industry	14 (4.8)	
Research	14 (4.8)	
Registered but not practicing Nutrition Information	7 (2.4) 6 (2.1)	
Residing province (*N* = 315)		
Gauteng	112(35.6)	35
Western Cape	71(22.5)	23
Kwazulu-Natal	27(8.6)	11
Abroad	26(8.3)	2
Eastern Cape	17(5.4)	4
Free State	17(5.4)	7
Limpopo	16(5.1)	7
Mpumalanga	14(4.4)	5
North West	8(4.2)	4
Northern Cape	7(2.2)	
ADSA membership (*N* = 316)		
Member	248 (78.2)	78
Non-member	68 (21.5)	

FGD participants displayed greater dissatisfaction with administration fees. One statement about the previous system was "*We are paying twice; first for the activity and then for the administration. The point of CPD is for knowledge and having attended the training and received the points, for them to be taken away for not paying, makes no sense.*"

In response to these comments, CPD personnel stated that, in the previous system, dietetics was the only profession for which an efficient system of managed points existed in the country. Therefore they considered the fees to be "reasonable" and "essential" to cover the CPD office costs for managing these points.

Activity costs

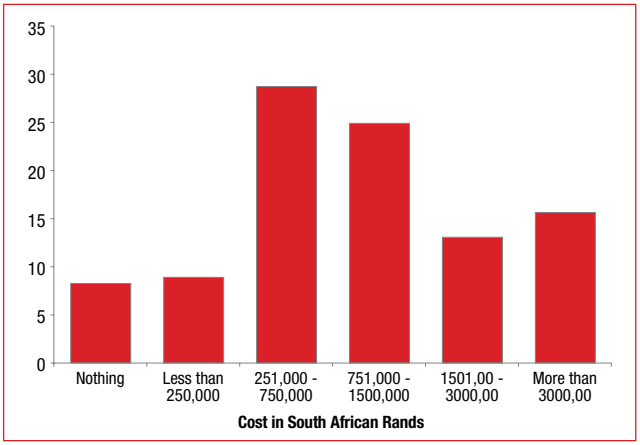
More respondents (55.2%; *N* = 164) perceived CPD activities to be costly while 15.2% (*N* = 45) felt the CPD activities were reasonably priced. Less than a third (29.6%; *N* = 88) stated that both costly and inexpensive activities were available to them.

Across all three FGDs, participants corroborated the survey findings, that activities in various price ranges were available. Conferences were highlighted for their all-round high cost and associated loss of earnings for private practising dietitians, while out of office. Suggestions included centrally located venues, more day events and negotiation of travel and accommodation packages. Two opposing views emerged, that is, "*compared to other professions our activities are not expensive,*" while another stated: "*everybody, even the doctors don't pay the amounts we do*". The majority agreed though, that small group activities organised by universities, ADSA, hospitals and sponsored company events were reasonably costed. However, participants felt that access to group activities remained a problem for dietitians based in rural areas.

CPD personnel agreed that both affordable and expensive CPD activities were available; however, conferences and congresses have always been a problem for dietitians without financial assistance. It was suggested that "*we need to work out how to accommodate all dietitians, possibly by taking this up with ADSA*".

In 2004, the majority of respondents (28.8%, *N* = 90) spent between R251.00 and R750.00 on CPD activities. For 8.3% (*N* = 26) there was reportedly no cost involved, while 9.0% (*N* = 28) spent less than R250.00. Only 15.7% (*N* = 49) spent more than R3000.00 annually on CPD activities (Figure 1).

Figure 1: Respondents' (N = 312) reported expenditure on CPD activities for the year 2004



Activity costs differed significantly across qualification levels (F-test, $p = 0.04$), practice areas (F-test, $p = 0.02$) and provinces (F-test, $p < 0.01$). Dietitians holding master and doctorate degrees spent more on CPD than those with honours and bachelors degrees. Dietitians in research showed the highest spending on CPD, followed by food industry dietitians and then those in education, with non-practising dietitians spending the least. Dietitians abroad spent most in rand, followed by dietitians from the Western Cape and Gauteng provinces. Dietitians in the Limpopo and Northern Cape provinces spent the lowest amount on CPD participation for 2004. CPD activity costs between ADSA members and non-ADSA members (F-test, $p = 0.07$) were not statistically significant.

The preponderance of respondents (60%; N = 173) reportedly carried the activity costs personally. A third (32.1%; N = 93) received partial assistance from an employer and/or sponsor and only 8.3% (N = 24) had all their activities completely paid for. Differences were statistically significant across practice areas (Chi-square test, p = 0.00) and provinces (Chi-square test, p = 0.005). In each practice area, the majority paid personally for CPD activities with the exception of dietitians in hospitals and academic institutions who received some financial help. Private practicing and non-practicing dietitians received the least financial assistance. Respondents based in research and community nutrition reportedly had almost all activities sponsored. Respondents from Mpumalanga and the Free State provinces received more partial financial assistance than other provinces, while North West respondents received the least financial assistance. Half the respondents from the Northern Cape paid for their own CPD activities, and half received complete sponsorships.

Type of CPD Activities

Respondents ranked lectures and seminars as the usual activity attended, followed closely by conferences, congresses and symposiums and then articles with MCQs from peer reviewed journals (see Table II). However, if given a choice, most dietitians preferred attending conferences more than lectures and seminars. Small discussion groups and journal clubs rated third as a preference, closely followed by the MCQ articles and then workshops.

Table II: Ranked CPD activities attended by respondents (*N = 315*)

CPD METHODS	Reported frequencies %
Attending lectures and seminars	22.7
Attending conferences, congresses and symposiums	22.2
Reading articles in journals and MCQs	21.4
Attending workshops	13.7
Reading internet articles and MCQs	8.2
Attending journal clubs or small discussion groups	6.2
Postgraduate studies	2.4
Interactive TV conference	1.4
Other	0.7
Presenting a paper, lecture	0.6
Writing articles	0.1

Financial factors were cited as the greatest constraint to participation in CPD. Travel distances and geographical access to activities also featured prominently, as did obtaining leave from work and family obligations (see Table III). Differences between the barriers to CPD were significant across provinces (p = 0.008). Financial constraints were the greatest barrier in all provinces and abroad. Unavailability of activities was most significant in Limpopo and Mpumalanga, and to a lesser extent in the Eastern Cape, Northern Cape and Free State. Obtaining leave from work was mainly a constraint in Gauteng, Kwa-Zulu Natal, Eastern Cape and abroad, in that order.

FGD findings across all three groups concurred with the survey results on issues of cost and geographical accessibility, hence the popularity of articles with MCQs from peer review journals which they stated "*reduces cost*", "*can be done at home, in your own time*" and

Table III: Barriers to participation in CPD *(N = 313)*

BARRIERS TO PARTICIPATION IN CPD	Reported frequencies (%)
Financial limitations	26.5
Distances too far to travel and few activities in my geographical area	18.6
Leave from work	14.0
Family obligations	9.4
Poor or no notification of events	8.1
Limited or no access to the internet	6.9
Topics not relevant to my field	6.2
No barriers to my participation	5.3
Uninteresting topics with little variety	2.2
Other	1.1
No transport	0.9
Disinterest in CPD activities	0.4
This is not applicable to me as I am not practicing as a dietitian	0.4

"*without leaving your practice*". There was general dissatisfaction at the lack of variety and usefulness of article topics and the "technical and tricky" multiple choice questions.

One interviewee responded by stating that articles used for CPD are limited for copyright and cost reasons. Moreover, "*it is the responsibility of the dietitian to show discretion in selecting topics and presenters*". Another suggested that technical questions are a consequence of CPD being administered mainly by academics. It was added that "*CPD is not an exam or study, but rather the take home message is of importance. Some hold the philosophy it is to 'up' the level of dietetics. It is not.*" They also admitted that earlier complaints about fewer rural events decreased when "*more journal and internet articles became available, and cross accreditation was introduced*". Restricted internet access might still limit free activities to some dietitians. Personnel also maintained that dietitians had been slow to update their contact details for event notification. According to CPD personnel dietitians would receive more CPD information as members of ADSA. "*through the journal, newsletters and emails*", that members receive.

Points status and record keeping

In 2004, 6.4% (N = 20) of respondents recalled earning less than 25 points while 23.8% (N = 74) had between 25 and 49 points for that particular year. Half (49.5%; N = 154) reportedly earned more than the 50 required points. A fifth (20.2%; N = 63) of all respondents either did not know or did not participate in CPD.

Most dietitians, 61.5% (N = 192) found ethics points difficult to achieve, while 23.1% (N = 72) obtained the 2 points required in the old system, with ease. A few (12.8%; N = 40) stated that it was still possible to achieve if they tried harder, while 2.6% (N = 8) responded with 'not applicable'. The most common reason given for difficulties in obtaining ethics points were insufficient opportunities available for the purpose (65%; N = 197), and according to others, ethics activities offered nothing new (18.8%; N = 57). A few (16.2%; N = 49) felt that there were sufficient such opportunities.

The majority (68.5%; N = 215) of dietitians stated that the lowered requirement of 30 CEUs in the new system was now more

reasonable and easier to achieve but 11% (*N* = 35) still found it high. The remaining 20.4%; (*N* = 64) found it low, did not care or were oblivious of the change.

With regards to the current system of personal records, the majority (51.7%; *N* = 161) of respondents preferred not to do so. Only 16.7% (*N* = 52) said they preferred to, while some did not mind either option (31.5%; *N* = 98).

CPD correspondence and communication

Correspondence

Correspondence from the CPD office was understood well by 42.6% (*N* = 133) when compared with 24.2% (*N* = 77) of respondents who understood such correspondence from the Professional Board for Dietetics or the HPCSA. Forty-three per cent (*N* = 134) of respondents found the CPD office's information complicated and lengthy, and therefore only scanned through it versus 60.4% (*N* = 191) who declared this about the HPCSA. Only 0.6% (*N* = 2) and 3.5% (*N* = 11) admitted never reading documentation from either the CPD office or the HPCSA respectively, while 25.5% (*N* = 80) did not receive regular correspondence from either office.

Two CPD administrative staff members acknowledged that it might be possible for some dietitians to feel uninformed because of "*correspondence with too many guidelines*".

Communication

Most dietitians (61.2%; *N* = 194) reportedly contacted the CPD office with queries, 13.9% (*N* = 44) contacted ADSA and 2.5% (*N* = 8) contacted the HPCSA. The remaining 22.4% (*N* = 71) were either unsure, would ask a colleague, or had the information at hand. Out of all the respondents who rated the service at these offices, more respondents were pleased with the contactable, friendly and helpful reception. The exception was the HPCSA which was perceived as being difficult to contact (see Table IV).

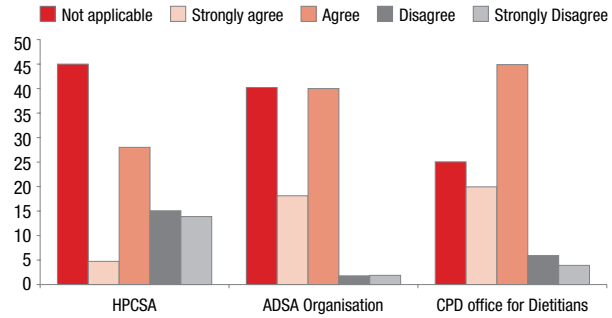
Table IV: Dietitians' responses (%) on the quality of service provided by the HPCSA, ADSA and the CPD office

Quality of service	HPCSA (N = 167)	ADSA (N = 187)	CPD office (N = 222)
	(%) Agree Disagree	*(%) Agree Disagree*	*(%) Agree Disagree*
FRIENDLY	78.4 21.6	95.2 4.8	91.4 8.6
HELPFUL	66.3 33.7	92.1 7.9	90.9 9.1
EASY TO CONTACT	39.3 60.7	78.8 21.2	71.1 28.9

Only 58% (*N* = 163) of respondents commented positively on the successful resolution of their queries at the HPCSA, compared with 61.9% (*N* = 179) and 79.2% (*N* = 232) whose queries were successfully resolved by ADSA and the CPD office respectively. At all three offices more respondents agreed that their problem and/or enquiry was efficiently handled, with appropriate feedback (see Figure 2).

Regarding the FGD, most participants recounted frustrating experiences when dealing with these offices. The HPCSA was

Figure 2: Respondents' (*N* = 293) views on efficient handling of queries and provision of feedback by the various offices



difficult to contact, while point summaries from the CPD office were often incorrect with insufficient time for follow-up.

The CPD officer stated being contactable at all times, handling up to 30 emails daily with queries typically about completion of forms or points reconciliation. They found that follow-up usually revealed missing 'DT' numbers or names omitted from the organisers' attendance lists. Consequently, "*dietitians had to be led by the hand*" to assist with the paperwork. The HPCSA call centre audit showed that more than 60% of calls were resolved within 24 hours, with most of the remainder being resolved within 48 hours.

General operation of the CPD system

Dietitians listed key strengths of the system as improved knowledge and patient care, and networking with colleagues. Their additional suggestions for improvements included greater focus on learning rather than point collection, a better system for those abroad and even electronic registration at events. Some wanted more enforcement for non-compliant individuals or incentives to be offered to those who attended CPD activities, while others did not like being "policed".

A few FGD participants were annoyed by the ongoing changes while some were uncertain or anxious about the current system.

The CPD personnel stated that "unfortunately, people on the Board are blamed for changes, which usually come from a central committee at the HPCSA".

They advised:

- "*View changes as improvements*"
- "*Read documentation*"
- "*Responsibly direct your career path*"
- "*The system is meant to update dietitians for best practice and patient care. We should emphasise this aspect and focus less on the system*"

Discussion

This study marked the first formal investigation of the CPD system for dietitians in South Africa. During the study, a transition to a new system for all health professionals was underway. Therefore, in terms of the findings, results apply to aspects of both the old and the new CPD system.

Although disappointingly low, the response rate was not unexpected of postal surveys.[16] A possible response bias is acknowledged, especially with regards to disinterest and negativity. Representivity

in this study aptly reflected the gender and provincial profiles of the profession, which, has important implications for generalising and drawing conclusions from the findings[17,18] (see Table I).

Financial factors were identified as the foremost barrier to participation in activities. Ideally, ADSA in collaboration with providers and organisers of events, and as a service to their members, should investigate ways to make activities such as conferences more affordable. Cost differences between provinces could be due to a combination of factors, namely, dietitians in provinces like Gauteng have more activities available to them and they tend to have a higher income than dietitians in other provinces. Dietitians from the Gauteng region would thus spend more money annually on CPD. This study found cost differences between ADSA members and non-members statistically non-significant, which is noteworthy since being an ADSA member usually entitles one to reduced registration costs. It is likely that ADSA members received greater notification of CPD events, attended more activities, and so paid more for CPD. In the new system, the reduced point requirements mean attendance of fewer activities which in turn, will impact favourably on the costs of CPD activities. It is anticipated that dietitians would have little difficulty in the future in achieving 30 CEUs, since the majority reportedly achieved more than the required 50 points in the old system. The change of role of the CPD office in the new system, from administrative and accreditor to accreditor only (individual responsible for own administration of CEUs) has eliminated the highly contentious administration fee. The HPCSA CPD committee has now finalised maximum accreditation fees for all professions. Professional boards are required to set fees for each profession. Participation in most activities will not require individual point application or payment of accreditation fees (except for some level 2 activities), since the service provider will provide the certificate and pay the required accreditation fee.

Apart from affordable CPD, other dietetic and health practitioners, locally and abroad,[19,20,21] also listed inconvenient times, family obligations, few opportunities in rural areas and poor notification as deterrents. Scheduling events away from city centres and timely notification should be addressed by the appropriate service providers familiar with the area, experts and available facilities. Family obligations also deserve due consideration, as the dietetics profession is presently a female dominated profession. For individuals affected by these factors, computer-based options and CPD reading activities would be a more viable option.

This study found peer reviewed journal articles with MCQs and, to a lesser extent, internet articles with MCQs, widely used to circumvent constraints of cost, geographic inaccessibility and inconvenience associated with conventional presentations. However, these were criticised for their lack of variety and usefulness. To improve its training value, providers should develop questions on the basis of improving performance, rather than focusing on technical issues. It is recommended that activities be translatable to professional duties, by incorporating principles of adult learning in their planning.[4] Conferences and large gatherings have been criticised for their minimal impact on knowledge and skill but were also seen to have advantages, for example, networking with colleagues and the opportunity to travel. Indeed, each method carries its own potential for the acquisition of knowledge, and a greater variety of activities on offer is more likely to meet the learning styles of individuals and suit their circumstances.[5] The literature predicts that conferences will remain popular but technology-based CPD will not be far behind, especially as more computers and internet access become available at home and in the workplace.[22]

Respondents requested a simple system, with easy rules and concise correspondence. It would appear that the CPD management is aware that much of the CPD documentation goes unread and even prior to the study, had noted that this was an administrative challenge.[23] It would also appear that the need for less confusing correspondence is not unique to dietitians. Practitioners that participated in the CPD pilot study for the current HPCSA CPD system reported poor understanding of their CPD guidelines and requested a short, simple brochure.[21] For the SA CPD system, effective correspondence will be imperative in facilitating a smooth transition to the new system while dietitians ought to make a concerted effort to read all CPD correspondence and provide up-to-date contact details so that they may receive information. In 2003, Pistorius stated with foresight that the "functionality of any system depends to a large extent on efficient communication. Optimal communication will not only solve many current CPD problems, but will also prevent many from occurring."[24]

The same report [24] also highlighted the problem of obtaining points for ethics, stating that doctors found ethics points difficult to achieve. The latter problem also emerged in this study. The current system awards ethics-related activities with 3 CEUs compared with other non-measurable presentations that receive only 1 CEU per hour.[11] The HPCSA feels strongly about incorporating ethics into the CPD system as part of their moral obligation to protect the public due to a disconcerting HPCSA report documenting sharp increases in public complaints against health professionals over the past few years. More than a third of complaints involved ethical issues of substandard service/treatment and consent or confidentiality transgressions, despite the compulsory ethics in the previous system.[25] It is recommended that consideration be given to fostering ethical practices amongst practitioners in the current CPD system. Indeed, each professional board should subscribe to a set of ethical principles, maintain such, and apply these standards to practice.[26] As of July 2007, the HPCSA has stipulated that per annum, five of the 30 mandatory points should be on human rights, ethics and medical law.[27] Unfortunately, many professionals commonly view ethics as a "stagnant topic".[26] However, technological advancements and changing work environments will necessitate updates in research ethics, ethical decision making and dealing with conflict in ethics.[28,29]

It is predicted that the greatest adjustment for dietitians in the current system will be maintaining personal CPD records. One would assume that this change would be welcome since access to points, incorrect summaries and the administration fees were major sources of frustration. Surprisingly though, the majority of respondents indicated that they preferred not to keep their own records. Nevertheless, minimal problems can be anticipated since the majority of respondents kept records anyway, for purposes of cross-checking with the CPD office.[30]

In the current CPD system, compliance will be checked through random audits. A voluntary audit already conducted by the HPCSA obtained 315 responses from dietitians and showed a compliancy rate of 92% among local dietitians, and only 1%, among dietitians abroad.[31] Respondents expressed opposing views on compliance. Some were concerned that there is little consequence for non-

compliant dietitians and without a test of knowledge, there is potential for abuse and dishonesty. On the other hand, some respondents detested the constant threat of deregistration and would prefer a system of encouraged (not forced) CPD participation. Since the current system will be based on trust, it is hoped that practitioners will participate in CPD activities in the pursuit of life-long learning rather than simply meeting the requirements set by the HPCSA.[11]

Encouragingly, the widely held view among respondents in this study was that CPD kept them informed and has provided opportunities to learn and network with colleagues. They stated also that CPD affords confidence in the work setting and sets a high standard of patient care. It is anticipated that dietitians would appreciate these effects to a greater extent in the current system, if all changes are viewed as improvements, and CPD is standardised for all professions.

Conclusion

The CPD system exists to ensure that scientific information is accessible to all dietitians, so that competent dietitians are available to all those clients requiring nutritional care. This can only occur if each individual takes responsibility for her/his learning and if a system exists that is supportive of learning and opportunity. Addressing concerns raised and recommendations made in this study will be helpful in striving towards a more user-friendly system that will be acceptable to all its participants.

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