Reregistration of gynaecologists in South Africa — the profession's opinion

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Objective. Testing of the profession's opinions and attitudes with regard to a possible reregistration system.

Methods. A questionnaire was sent to all the gynaecologists in South Africa to test their opinions and attitudes with regard to reregistration.

Results. After two mailings, 62,4% of the 603 gynaecologists had responded. Seventy per cent of the respondents were in private practice while 19% were in full-time academic positions. More than two-thirds (68%) of the respondents resided in a city, close to a medical school. Although 74% were in favour of the implementation of a reregistration system, only 56% were enthusiastic about it. Congress attendance and self-study programmes were the categories in which more than 85% of the respondents would be able to earn points. The general feeling was that such a system should be governed by the profession.

Conclusions. The profession was in favour of a system of reregistration, but great concern was expressed at the contents of such a programme and the manner in which it would be governed.

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As early as 1905, Sir William Osler remarked that medical undergraduates embarked upon a lifelong career as opposed to a 6-year course in medicine. Even Hippocrates stated that life is short, yet the science thereof is everlasting.[1] These statements only serve to accentuate the importance of continued education and training of qualified practitioners. Yet formal programmes of continuing medical education (CME) have only recently been instituted. In 1932, the Association of American Medical Colleges developed a formal CME training programme, which was only implemented 8 years later in 1940.[2] On completion of postgraduate studies, the practitioner had to pass an examination that then served as a type of quality guarantee. In order to maintain a certain degree or level of expertise, it became necessary for the practitioner periodically to undergo re-evaluation and recertification. In the USA, a voluntary recertification programme was initiated in 1973.[2]

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In 1990, The Royal Australian College of Obstetrics and Gynaecology made reregistration compulsory.[3,4] Over a 5-year period, practitioners have to earn a minimum number of credits in as many as five different fields. The different categories are: (*i*) attendance at congresses, symposia and development courses; (*ii*) tuition and instruction of students, nurses, etc.; (*iii*) research; (*iv*) auditing (compilation of practice statistics); and (*v*) completion of self-study programmes. This system was an immediate success and was soon implemented in neighbouring countries.

In the UK, a similar credit system was recently introduced. This was the result of a study investigating the activities of all British members and fellows of the Royal College of Obstetricians and Gynaecologists (RCOG). After careful analysis of the questionnaires, a programme was introduced whereby a practitioner had to earn a minimum of 200 credits over a 5-year period. Credits can be accumulated in the following fields: (*i*) hospital-based activities (e.g. formal tuition, clinical review meetings); (*ii*) RCOG-based activities (e.g. congresses, symposia, examination of postgraduate students); (*iii*) personally induced activities (e.g. publications, CME lectures, public addresses); and (*iv*) self-study (videos, telephone conferences, self-study programmes).

In South Africa, the idea of a reregistration programme has become increasingly popular. Both the SAMDC and the MASA have voiced their strong support for such a system. In view of the recent developments in Australia, the UK and South Africa, the South African Association of Obstetricians and Gynaecologists (SASOG) decided to test the opinions and attitudes of South African gynaecologists with regard to reregistration. This decision inevitably led to this study.

Methods

In September 1993, 603 questionnaires were posted to all gynaecologists registered with the SAMDC in South Africa. A second mailing 3 months later targeted 435 gynaecologists who had not responded to the first questionnaire. In this questionnaire volunteers were requested for a 12-month trial run of the proposed reregistration system. The trial run commenced in July 1994. Points can be accumulated in five different categories: (*i*) congress and symposium attendance; (*ii*) tuition and instruction; (*iii*) research; (*iv*) auditing; and (*v*) self-study programmes. The chi-square test was used in the analysis of parametric data and the Kruskal-Wallis test for non-parametric data.

Results

After two mailings, 376 gynaecologists (62,4%) returned their questionnaires. The percentage replies received from the nine health regions (according to the Department of National Health and Population Development) before the recent revision of provincial boundaries, was as follows: PWV — 57%, Northern Cape — 33%, Western Cape — 71%, Eastern Cape — 69%, Natal/KwaZulu — 62%, OFS — 62% Western Transvaal — 67%, Eastern Transvaal — 88% and Northern Transvaal — 78%.

If the replies to the first and second mailings are regarded as two separate groups, it is important to note that the respondents to the second mailing were significantly less enthusiastic about the implementation of a system of reregistration ($P = 0,00091$).

Of the 376 respondents who formed the basis of this study, 3% had qualified less than 1 year before, 19% 1 - 5 years before, 20% 6 - 10 years before, 16% 11 - 15 years before and 42% more than 15 years before. A summary of the nature of the participants' practices is given in Table I. More than two-thirds of the respondents (68%) resided in a city, close to a medical school; 19% lived within 200 km and 13% more than 200 km from the nearest medical school.

Table I. Nature of respondents' practices

Practice	No.	%
Private	139	38
Private + academic sessions	119	32
Full-time academic	69	19
Full-time non-academic	21	6
Sessions	4	1
Part-time private	4	1
Retired	6	1
Other	7	2
Total	369	100

The respondents were strongly in favour of reregistration: 74% were in favour of the proposed system, 14% were against the implementation of such a system while 12% remained in doubt ($N = 364$). The actual attitudes of the respondents were, however, less positive: 56% were enthusiastic, 28% remained neutral, 15% were negative and 1% was unsure ($N = 372$). Specialists practising full-time in academic hospitals expressed more enthusiasm for a reregistration system than their counterparts in private practice (69% v. 50%; $P = 0,02409$).

The number of categories in which respondents felt that they would actually be able to score points is given in Table II. An overwhelming majority felt able to earn points in at least three or more of the five possible categories. The majority of gynaecologists (58%) in full-time academic institutions would be able to score points in all five categories, while 50% of their counterparts in private practice felt they could obtain points in a maximum of three of the five categories ($P = 0,0000$). Private specialists undertaking certain sessions at academic hospitals were significantly better off than their colleagues in private practice only, since 50% of these specialists felt able to score points in at least four of the five possible categories ($P = 0,0000$).

Table II. Number of categories in which credits could be scored

Categories	Respondents	%
0	7	1
1	8	2
2	30	8
3	126	34
4	127	34
5	78	21
Total	376	100

The potential to earn points in each of the proposed categories is summarised in Table III. It seemed that congress attendance and self-study programmes were regarded as having the most point-scoring potential. Furthermore, practitioners living in cities near a medical school were in a

more favourable position than those practising more than 200 km from such a medical centre ($P = 0,0024$).

Table III. Credit scoring potential in each of five categories

Categories	Respondents potentially able to score credits (%)*
Congress and symposium attendance	94
Tuition and instruction	69
Research	33
Auditing (compilation of statistics)	77
Self-study	85

* Not mutually independent.

Seventy per cent of all the respondents were of the opinion that a professional association, such as SASOG, should be involved in the organisation and control of reregistration. The College of Medicine of South Africa was acceptable to 59% of the respondents, while only 36% favoured the SAMDC as governing body.

The majority of respondents (77%) were in favour of penalisation in the event of a practitioner's not scoring the minimum required points in the given time period. There was a general feeling (53%) that a 5-year cycle would suffice, although 27% were in favour of a 3-year cycle.

The trial to refine and test the effectiveness of the proposed system of reregistration commenced in July 1994 with 177 volunteers and will run for 12 months.

Discussion

'My local medical committee sent me here to say we want nothing to do with it. We're quite happy the way we are. Our patients are satisfied, we are satisfied and I don't see any point in the whole business.' These words reflect the attitude of many practitioners toward reregistration.[5] Even in our study, the same cynical attitude was evident in many of the comments passed concerning the various aspects of the proposed reregistration system. For example, a comment on congress attendance: 'These are ego trips for the academics and a jolly time for the rest.' With regard to research, responses included 'No money. No time. No equipment' and 'It is of no value at all. We want a balanced, clinically orientated doctor.' Apropos auditing, one practitioner asked: 'What's the use?', and in the case of the self-study category we received the following comment: 'I don't want to be examined like a student.'

If this reflects the attitude of a certain portion of our profession, why then are we even considering the implementation of reregistration? The main reasons are the achievement of excellence and the promotion and ensurance of quality in practice as a lifelong commitment to our patients.[1,8] We owe them that much. Problems encountered in medicine today include the unacceptably large variation between practitioners in the treatment of the same medical condition as well as the extremely high costs associated with certain methods of treatment. The important question is: how do we actually deal with these problems?

Auditing of medical practices and CME have, to date, been the most successful endeavours in improving the standard of medical expertise. Since the institution of a birth register in England in 1823, auditing has formed an integral part of obstetrics. The main objective of auditing is to collect data, analyse it and then apply the information to improve patient care. However, even auditing has its disadvantages, often highlighting only a certain aspect of the problem. Guidelines for clinical practice are often used in conjunction with auditing. This means that auditing is a method of determining whether a certain course of action, in the treatment of patients, is in keeping with the general directive.[7]

In the not-too-distant future, computers may be used to verify each practitioner's *modus operandi* by checking that patient details are effectively documented and that all necessary tests have been conducted.

The concept of CME has been widely accepted. However, the problem is the marketing of it in such a manner as to bring about a change in the practitioner's behaviour that will result in an improved standard of expertise. Just as examinations improve the standard of learning of undergraduate students, so reregistration aims to improve the efficacy of a CME programme. What would be the practical use of a system unless it resulted in higher levels of expertise?[1,8]

The results of our study indicate that South African gynaecologists favour reregistration, but demonstrate a slight hesitance in accepting the proposed system. Although the particulars of our proposed system are in accordance with those of similar systems implemented in Australia and the UK, it remains necessary to evaluate them critically. Will our proposed system motivate and stimulate practitioners to higher levels of expertise? Will it improve public perception and opinion of our profession? Will it measure up to the goals and expectations set by individuals?

These questions only accentuate the need for thorough planning before a system of reregistration can be introduced in this country. Furthermore, no single medical body, e.g. the South African College of Medicine or SASOG, has the expertise and power autocratically to govern and control a national reregistration programme. The MASA, with its knowledge and infrastructure, will therefore necessarily have to assist SASOG and other interested parties to facilitate the process.

From this study, we can conclude that although reregistration is deemed necessary, most gynaecologists find it a highly sensitive issue that must be tackled diplomatically. It would therefore be better to develop a system for the profession by the profession.

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REFERENCES

1. Purdie DW. Continuing medical education. *Br J Obstet Gynaecol* 1994; **101:** 281-283.
2. King RB. Challenges in recertification. *Surg Neurol* 1989; **32:** 403-407
3. Gabb R. How did they score points? *RACOG Bulletin* 1990; Aug: 13-14.
4. Gabb R. Recertification of specialists. *Med J Aust* 1991; **155:** 71-73.
5. Sencer J. Audit in general practice: where do we go from here? *Quality in Health Care* 1993; **2:** 183-188.
6. Kremer BK. Physician recertification and outcomes assessment. *Evaluation and the Health Professions* 1991; **14:** 187-200.
7. Kassirer JP. The quality of care and the quality of measuring it. *N Engl J Med* 1993; **329:** 1263-1264.
8. Hamilton-Fairley D. Audit in obstetrics and gynaecology. *Br J Obstet Gynaecol* 1994; **101:** 81-84.

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