

# Reregistration of gynaecologists in South Africa — results of a 1-year trial run

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**Objective.** Evaluation of an Australian system of reregistration with recommendations for a possible future South African system.

**Design.** Cohort descriptive study.

**Setting.** Gynaecologists from both private and full-time academic practices.

**Participants.** One hundred and eighty volunteers participated for a period of 1 year.

**Intervention.** Each participant had to obtain a minimum of 25 points and an additional subminimum in at least two of the following practice-related categories: audit, continuing medical education (CME), self-study and research or tuition.

**Outcome measures.** Compliance with the rules of the system and participants' comments.

**Results.** Ten of the 180 volunteers withdrew from the study. Only 42% of the remaining 170 participants returned their logbooks and a mere 32% their self-study questionnaires. The majority were in favour of self-study programmes or CME as future methods of reregistration.

**Conclusion.** A future system of reregistration must be based on self-study programmes and a well-structured and relevant CME curriculum.

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The quality of medical services rendered depends largely on the integrity of the medical practitioner and his ability to keep in touch with new developments. Difficulty experienced in objective evaluation of medical practices resulted in the implementation of audit systems and continuing medical education programmes (CME) for all practitioners. It was thought that with these programmes quality care could be ensured. It was later realised, however, that because a control mechanism was lacking, the development and implementation of a variety of reregistration systems had taken place. Auditing of medical practice and CME in conjunction with reregistration therefore forms the basis of ensuring quality medical care.<sup>1,2</sup>

The past decade has seen the growth and development of reregistration. The Royal Australian College of Obstetrics and Gynaecology (RACOG) created a strong precedent with the implementation of their voluntary reregistration system in 1990.<sup>3</sup> Gynaecologists were expected to obtain a specified number of points within a certain time period in order to maintain their registration status. Points could be earned by participation in self-study programmes, auditing of medical practices, CME, tuition or research. This system was soon adopted by neighbouring countries, and even in the UK a modified format of the Australian system was implemented.

In 1993 the South African Society of Obstetricians and Gynaecologists (SASOG), being aware of these developments, sent a questionnaire on reregistration and its implementation to gynaecologists across the country. The results were published in 1995.<sup>4</sup> The majority of gynaecologists, although in favour of such a reregistration system, expressed concern about the exact nature and format thereof. Subsequently volunteers were invited to participate in a trial aimed at developing a system of reregistration well-suited to our specific needs and requirements. The proposed system, implemented for a period of 1 year, was based primarily on the Australian system whereby volunteers were expected to obtain a minimum of 25 points within the year.

The aim of this publication is therefore to present the results of this trial and to offer suggestions based on these results for future reference.

## Materials and methods

The 180 gynaecologists who voluntarily participated in this trial each received two logbooks (one per 6-month period) and two modules containing self-study material. Each self-study module included a questionnaire to be completed and returned to SASOG.

Points could be earned in any of the following categories as set out in each logbook: quality control (auditing of practice or departmental statistics); tuition or research (which included publications, congress presentations and lectures); CME (attendance of congresses, symposia, workshops and academic meetings) and self-study programmes.

Each practitioner was expected to obtain a minimum of 25 points within the 1-year period, with the point system based on 1 point for every hour spent at lectures, completion of self-study exercises or determining practice statistics. A specific subminimum was also set for each reregistration category and adapted to suit the different practice categories (academic or full-time and private, with or without sessions).

To qualify for reregistration the practitioner therefore not only had to obtain the minimum 25 points, but also the required subminimum in at least two of the practice-orientated categories discussed below.

The four reregistration categories and the allotted point system were implemented as follows:

1. **Quality control.** Each practitioner was expected to complete a monthly statistics form for both obstetric and gynaecological cases. By returning these forms to SASOG,

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the practitioner earned 2 points per 6-month period. If the total number of hours spent obtaining these statistics was indicated, it was also taken into consideration. Full-time academic gynaecologists were expected to earn a subminimum of 2 points and private practitioners a subminimum of 6 points.

2. *Tuition and research.* Depending on the type of publication, each practitioner could earn up to 10 points. The author of a letter in a non-subsidised journal could earn 1 point and the first author of an article in a subsidised journal 10 points. Congress presentations earned the practitioner 8 points as speaker and 3 points as co-author. Undergraduate lectures were worth 2 and postgraduate lectures 3 points each. Full-time academic gynaecologists were expected to obtain a subminimum of 16 points and private practitioners a subminimum of 9 points.

3. *CME.* The total number of hours spent (1 point per hour) in attending congresses, workshops, symposia or academic meetings was determined for the entire 12-month period. The required subminimum for academic gynaecologists was 4 points and, for private practitioners, 7 points.

4. *Self-study programmes.* Self-study material was sent in the form of two sets of RACOG continuing education modules together with a multiple-choice questionnaire for each; these were to be completed and returned to SASOG. Each completed questionnaire was worth 5 points, which were awarded irrespective of the number of incorrect answers. The time spent completing the self-study material earned the individual additional points.

The final analysis was based on that proportion of subjects able to attain the 25-point minimum total. The ability of participants to attain the required subminimum within each category, the distribution of points and the comments made by participants also form part of the final analysis.

## Results

Of the original 180 volunteers (80% in private practice and 20% full-time) 10 withdrew from the study. Only 73 (43%) of the remaining 170 volunteers returned their logbooks and of these, 51% returned only one logbook. Of those participants who returned either one or both of their logbooks, 80% were in private practice and the remainder in academic or hospital practice.

A total of 55 (32%) participants returned their completed questionnaires, but only 36% of them returned both questionnaires. The logbooks were satisfactorily completed, with nobody returning the self-study exercises only.

A mere 5% (7 of the 73 volunteers) failed to reach the set minimum of 25 points. Two of these participants, however, did succeed in obtaining the required subminimum in at least two of the reregistration categories. Furthermore, these particular participants returned only 6 months' data. Of the 66 volunteers able to attain the 25-point minimum total, 50% did so within 6 months, returning only 6 months' data. The median number of points obtained was 58 (minimum 12 and maximum 338.) The performance in each individual category of those volunteers who earned a total of 25 points or more is set out in Table I.

**Table I. Point distribution of 66 respondents able to attain the 25-point minimum total**

Category	Participants		Points earned		% attaining required sub-minimum
	No.	%	Median	Range	
Audit	63	95	10	2 - 63	94
CME	61	92	25	2 - 89	85
Self-study	52	79	9	4 - 22	79
Tuition and research	52	79	19	1 - 322	56

Comments and subsequent deductions made include:

1. *Logbook.* It was not 'user friendly'.

2. *Audit.* Where practice statistics were already computerised, minimal time was required to search for the necessary information and fewer points were therefore earned. This was seen as a form of discrimination against those who were already well organised. This system came in for much criticism.

3. *CME.* Responses varied widely. For one particular congress, the points claimed varied from 4 to 31, the maximum certainly being far greater than the number of hours allotted to actual lectures! Certain practitioners also claimed to spend at least 4 hours per week reading journal articles. Unfortunately this cannot be verified in any way.

4. *Self-study.* This was well accepted, and gave the best results.

5. *Tuition and research.* The actual nature of the lectures and publications for which the practitioner could earn points was a cause of great uncertainty. For example, certain practitioners felt that the hours spent tutoring students in a clinic should count as 'in-service' training and therefore earn them points, while rural practitioners especially felt this to be discriminatory.

## Discussion

Despite the initial enthusiasm of the volunteers, the overall response was somewhat disappointing, with only 25% of participants returning both logbooks and both questionnaires as stipulated. A tight work schedule and the knowledge that participation was not compulsory were certainly major contributing factors.

The system, as implemented, proved an enormous administrative burden, and gave rise to many practical problems. Can the system be implemented in such a way as to provide each practitioner with an equal chance of earning points? How can the system ensure the participation of every gynaecologist? What is to be done with non-respondents? What is to be done about those who do not obtain the required subminimum? Will the implementation of such a system truly effect an increased knowledge in participants and will this increase be of practical consequence?

The pros and cons of each category are summarised in Table II. The RACOG has recently implemented an examination system which provides every practitioner with an equal chance of retaining registration status. The fact that this examination is in 'open-book' format compels the practitioner to study the material set before him and practically eliminates dishonesty.

**Table II. Pros and cons of individual categories**

Categories	Pros	Cons
Audit	Compels participants to organise statistics and implement a self-audit system	Invites criticism; no form of verification possible
Courses and congresses	Courses and congresses are registered at a central point	No control as to actual attendance of lectures
Self-study	Each person has an equal chance of earning points; requires minimal administration	Preparation of study material
Tuition and research	Excellent methods of self-development	Variety of possible activities makes adequate control problematic

This study has certainly taught us what not to do. Tuition, research and auditing are not appropriate methods of *earning points in a reregistration system*. CME, on the other hand, holds vast potential, but the actual attendance of lectures by practitioners at congresses, symposia or workshops is difficult to verify. The fact that practitioners have to register may, however, serve as a certain measure of control. If one assumes that the average practitioner attends 60% of all lectures, the total number of points earned for *congress attendance can possibly be estimated as 60% of the total number of hours of the academic programme*.

Self-study programmes were well-received and gave the best results. There are currently a variety of CME journals available in South Africa. Articles from these journals, together with a multiple-choice questionnaire, can effectively be utilised as self-study material. Points can be earned either by returning the questionnaire or by determining the number of correct answers.

In conclusion, we would like to add that the success of any reregistration system will depend entirely on its being made compulsory for all practitioners. We suggest the implementation of a system whereby points are awarded for the completion of self-study exercises. The attendance of *specific courses or workshops may be considered as a second means of earning points*. Finally, the Health Professional Council of South Africa has to make reregistration obligatory and has to be responsible for the penalisation of individuals who do not obtain the required subminimum.

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