



We have tried to keep the paperwork down to a minimum otherwise 'management' tends to take over the service aspect of the project. There are no charges, but donations from individuals and organisations are received (at times with immense sighs of relief).

This year we have extended the project to provide a school and accommodation for AIDS orphans and abandoned children, further down the hillside. Alongside this is a health and nutrition rehabilitation unit that involves both mothers and pregnant women with training in mothercraft, child rearing and nutrition, and we are currently building another large rondavel in this outer circle, which will be a school for community health educators.

There is also a sacred place, a large thatched semi-rondavel situated on a cliff with awesome views over the umbrella acacias in the valleys below. In the mornings you can hear the doves cooing at the rising sun and in the evenings the calls of villagers on the other side of the valley. All patients and

ministers of different religions and beliefs use the place for services or personal prayer or meditation. The project is aimed at an integration of Western and Traditional healing methods within the wider vision of an 'African hospital'.

We run on a mixture of paid and voluntary staff of nursing sisters, teachers, traditional healers, faith healers, and visiting doctors. The small industries are starting to be profitable and we have now started a gardening service, which everyone joins in. Tree planting is a communal occasion and involves much discussion, planning and many opinions.

Our holistic ethos has been further enriched by a musician, who plays the flute and guitar and works at the school in the day and plays at the main rondavel in the evening and at the sacred place. He works in conjunction with a story teller (*izinganekwane*) in a programme of revival of African music, drama and story telling.

The Phumula project is an attempt to bring together all aspects of human life in the care of the sick of Africa.

MEDICAL EDUCATION

Continuing professional development — where are we now?

V I McCusker

CPD was discussed for decades within the professions. The concept gained focus and clarity when the College of Medicine of South Africa published proposals in 1994. The Medical Association investigated and propagated the concept and passed a consensus resolution at a Federal Council meeting stating that the Medical Council should be involved to achieve compliance by the more reluctant members.

Workshops were arranged by the Interim and Dental Council

including the Medical and Dental Schools, the College of Medicine, the Academy of Family Practice and the Medical and Dental Associations. The basic principles were defined and the requirement of 50 hours per year was accepted as being in keeping with international standards.

Different categories of activities were defined and it was agreed that no more than 80% of points could be obtained in a single category. It was felt that even for the most isolated doctors some interaction with their peers is essential, currently at least 10 hours per year. In keeping with international thinking, a minimum of 2 hours per year related to human rights and ethics are considered essential.

CPD is compulsory only for doctors in clinical practice. A separate registration category for non-clinical practice was proposed, but the regulations for this have yet to be published by the Department of Health. The annual subscription will be lower, as these are not the practitioners responsible for the high costs of professional conduct inquiries to the HPCSA.

Ivan McCusker, a general surgeon, practised in the private and public sectors. He served on the National Council of SAMA for two decades and has been president of three Branches and the Association of Surgeons. His involvement in CPD started as Chair of the SAMA Health Policy Committee and continues until the end of this year as Chair of the CPD Committee of the Medical and Dental Professions Board. He now farms in George.



When the points submitted for the year 2002 are reviewed, there will be doctors who are more than 100 points in arrears. They will be limited to supervised clinical practice until they have made up the deficit.

The CPD Committee tries, as far as possible, not to complicate the lives of compliant practitioners. Rather than to punish we would like to stimulate those who fall behind to participate and help improve the system.

Frequently asked questions

The CPD Committee, like the SAMJ, receives and answers many questions and comments.

It is alleged that the SAMJ and CME points often relate to obscure topics and are too easy and this excellent and easily available source of education (and points) is being subverted by those who collude to structure answers and even sell completed questionnaires. The content, relevance, difficulty of questions and time involved are regularly reviewed and discussed by the forum of accreditors. It would be an achievement to stop dishonest practice without curtailing those who comply and benefit. We may have been too sympathetic to the isolated doctors in allowing them to earn 80% of their points from an activity without peer group interaction.

Some providers have used an accreditation number to present recurrent activities where the content and quality of the presenters has eroded. These are curtailed when reported and confirmed and the details of these providers are circulated among accreditors.

International activities approved by an accreditor in this country are accepted. Verified activities and compliance with an acceptable programme in another country are under consideration. An 'honour system' where the activities of only some practitioners are verified and where the practitioner returns without such verification seems too tenuous.

Many practitioners retire and do not participate in CPD but wish to continue to diagnose and treat themselves, relatives and friends with impunity. These are the people who mean the most to you and surely deserve referral to a suitable doctor! International experience has demonstrated an unacceptable rate of unprofessional management under these circumstances. Professions are mentioned that retain the rights to practise even in very old age, relying on their illustrious records. Most of us would not fly with airline pilots under these circumstances.

It is interesting to learn from countries that do performance assessment of practitioners in their normal working environment that deficient compliance with CPD requirements is one of the most significant predictors of substandard practice profiles.

What you should do if you are more than 100 points in arrears and receive notice of restriction to supervised clinical practice:

If you are not in clinical practice: Reply that you await the establishment of the non-clinical register and would like to change your registration when this is available.

If you are in clinical practice: Make up your point deficit during the notice period and escape the restraints of supervised practice. Continue your further participation in CPD. Help us, the accreditors and the providers refine the system to make your involvement as beneficial as possible to you and ultimately to your patients.

Definition of 'clinical practice': Clinical practice means the management of individuals or groups and may include, but is not confined to, taking a history, performing an examination, ordering or performing tests or special investigations, making a diagnosis, and administering or prescribing medical or dental treatment.