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The true purpose of CPD: The MPS gets it right

Continuing professional development (CPD) was not always mandatory. Since an important characteristic of a profession is that its practitioners stay up to date, why should CPD requirements be set and enforced?

The notion of keeping up to date by the provision of continuing medical education (CME) started with the best of intentions, and many practitioners voluntarily attended refresher courses. It became rather more formal in the USA, starting with the family practitioners. Litigation in the USA is bigger than elsewhere in the world, and it was argued that if practitioners kept up to date by CME (later CPD) the incidence of litigation would fall substantially. This was unfortunately based on the wrong premise. Our own regulatory body, in keeping with the rest of the world, finds that it is not usually ignorance or incompetence that lands practitioners in trouble. Rather more important are other causes such as negligence, unsavoury practices (false certificates, incorrect billing, etc.) and practitioners being impaired (substance abuse, old age, etc.). Despite this the provision of CME became widespread and then mandatory in many disciplines and countries. This in turn spawned a whole lucrative industry of offerings that promised the required 'points', often wrapped up in luxury holidays on cruise ships or close to beaches or golf courses.

The South African Medical and Dental Board of the Health Professions Council (HPCSA) has done a good job of providing clear classifications of CPD activities and of the minimal annual requirements that have to be met in order to remain on the register. As stated, practitioners would in any event have kept up to date and the requirements are sufficiently modest for this not to be a hardship for most. However, these requirements do not do a good job in addressing the key causes of the likelihood of patients suing their doctors.

The Medical Protection Society (MPS) provides professional indemnity cover for doctors. In supporting doctors in this way their aim is to keep annual membership fees as low as possible, and they have a key interest in keeping doctors from getting sued by their patients and of keeping legal costs and settlements within reasonable bounds. The MPS has therefore developed an educational programme for doctors that will shortly be rolled out in South Africa (MPS Education and Risk Management 2009).

The programme is based on findings of the real causes of what motivates patients to sue. Firstly it has been established that only 2 - 3% of patients who experience negligence file some form of claim and that most claims are initiated by patients who have not experienced negligence. Secondly, 70% of litigation is because patients feel that they have been deserted or devalued, lacked information or been misunderstood. Negative communication behaviour by doctors increases litigious intent – even when there has been no adverse outcome. There is also no evidence that litigation history is directly linked to clinical competence.

High-risk doctors can be profiled, as less than 1% of doctors account for approximately 25% of claims. Furthermore, doctors who enrol in risk management seminars have significantly lower rates of litigation. By recognising that flawed communication and a few bad eggs are the main cause of litigation by patients, the MPS programme at last addresses an important reason for CPD. The trick will be to enrol doctors who most require it rather than the usual 'worried well'.

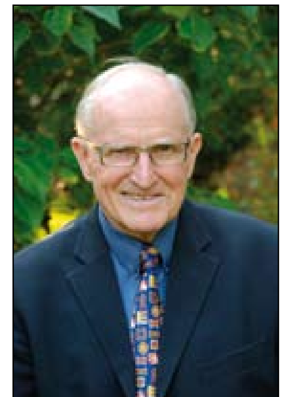
The HPCSA and editorial responsibilities

The SAMJ published the full letter from Advocate Mkize,[1] registrar of the HPCSA, despite its being more than 5 times the usual length for correspondence, to enable him to vent his full grievances against the editorial[2] that addressed concerns about the new structure and controls of the HPCSA. We were unaware of his other abuse of publication etiquette by also publishing his letter elsewhere – in the June 2009 *Medical Chronicle* ('Copyright: Material submitted for publication in the *South African Medical Journal* (*SAMJ*) is accepted provided it has not been published elsewhere').

The editor did not respond to his letter because there were so many misrepresentations of the editorial that it would have taken up too much space. Furthermore, we are happy for readers to arrive at their own opinions concerning such interchanges.

On a previous occasion Advocate Mkize, in a letter to SAMA, was highly critical of the editors for publishing on another matter that had a bearing on the HPCSA. However when the editors offered to publish his letter to air his views more widely, he refused to give permission.

The *SAMJ* will continue to publish material where there is sufficient evidence that it is true and that publication is in the public interest. As in this instance, we also provide the opportunity for dissent.



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1. Mkize B. HPCSA: A mess in the Health Department's pocket. *S Afr Med J* 2009; 99: 484-488.
2. Van Niekerk JPdeV. HPCSA: A mess in the Health Department's pocket. *S Afr Med J* 2009; 99: 203.