Editorial

Specialist Registration in Occupational Therapy. Is it desirable? Should it be an option?

Kathy Holland, Nat Dip OT (Vona Du Toit College of OT), B (Hons) UP, M.Ed (Tertiary Education) UN.

Are we as Occupational Therapists (OTs) ready for specialists in our profession? I believe it is critical for the growth of our profession and a natural progression for the profession, just as Foto[1] did when writing from an American perspective. I have observed an 'informal' trend with individual therapists limiting their practice by choice, and becoming more knowledgeable and skilled in that aspect of occupational therapy that they choose to engage in. An interesting observation made by Welles (cited in Foto[1]) just over 50 years ago, was that: "In the last half century organised knowledge has moved forward so rapidly that it is no longer possible for one individual to be fully competent in even one branch of occupational therapy." But, on the other hand some might argue that a country like South Africa can ill afford specialist registration. From a purely medical perspective, it has been estimated that 56% of the health resources and 63% of doctors serve just 16% of the population, while the other 44% of the resources and 37% of doctors serve 84% of the people[2]. It is probable that a similar situation exists in OT. Can we therefore afford to go the specialization route that might deny a large group of people access to OT services because they either can't access them easily or afford them? In addition, if we believe that the focus and purpose of our profession is holistic intervention does specialisation not negate this?

We already have a number of professionals who essentially function as specialists, as they by choice, limit or confine their practice and then seek post-graduate education and Continuing Professional Development activities to assist them in sharpening their 'specialist' skills and knowledge. This habit has seen practitioners limit their practice to impairment categories (e.g. hands, psychiatry), age groups (e.g. paediatrics, geriatrics) or place of employment (e.g. school based OT, private practice, programme management)[2]. Much can also be made of the argument that we can only offer the highest quality of care when we are additionally qualified[2].

Perusal of Health Professions Council of South Africa (HPCSA) documentation[3] and Act 56 of 1974 as amended[4] identified the following: A **specialist** is a practitioner who has been registered as a specialist with their specific Board. This was achieved by submitting proof to the Board that, in addition to a defined number of years of service, s/he had obtained a specialist qualification accredited by the Board. Further, a practitioner could only be registered as a specialist in one speciality and no practitioner could practise in more than one speciality. Most importantly, a specialist practitioner had to confine her/his practice to that speciality in which s/he was registered.

In 2006 the HPCSA Board for Occupational Therapy, Medical Orthotics and Prosthetics and Arts Therapy (the Board) resolved to formally explore specialist registration[5]. A small task team representing the Board, the Occupational Therapy Association of SA (OTASA) and the Universities was appointed to prepare a submission in this regard. It was decided to survey the opinion of registered therapists, and to this end a draft proposal and questionnaire were developed and circulated to all registered therapists. The response rate was unfortunately very low (156 or 5.4% of registered therapists returned their questionnaire) and it was unclear at the time why more therapists did not respond. It however appeared that those who responded were therapists who either (1) already held (or were in the process of completing) a formal post-graduate qualification or some form of additional training (e.g. NDT or SCT) or (2) worked in private practice. These individual therapists possibly had most to gain from a proposal for a specialist register. The areas of Paediatrics, Hands and Upper Limbs and Work Practice/Vocational Rehabilitation were most frequently recorded as suggestions for speciality areas, and perhaps reflected their employment situation at the time. The Board then resolved to pursue speciality registration in these three areas, as it thought it prudent to initially propose a limited number of speciality areas/fields in order to avoid fragmentation, confusion and possible overlap of scopes of practice. Pate[6] noted that a professional group needed to agree on how specialisations were recognised if the profession wanted understanding and acceptance by the public. The Board acknowledged that speciality areas would not be limited to these three areas, and that other areas could be added at a later date. These three areas also interestingly enough mirrored the post-graduate qualifications on offer at a number of the educational institutions.

The following arguments support specialist registration[2,7].

Firstly, having specialist categories would be of value to the development of the profession as they would formally allow recognition of expertise within the different areas of practice. It would also regularise an already existing 'informal' development within the profession, and in this way increase our professional standing. Secondly, it would encourage the development of additional post-graduate education opportunities at Universities which would have positive spin-offs for the profession in terms of knowledge production. Finally, the users of our services would be afforded the opportunity to obtain 'specialist' intervention. It is however understood that such services come with additional cost implications.

On the other hand, a number of concerns have been raised[2,7] as follows:

One concern was that the needs of the country need to be factored in, as we needed to ensure that an equitable service was offered to the population at large. With this in mind, a ratio of 75% generalists to 25% specialists had previously been mooted[7] in an opinion paper requested by OTASA. This however needs further debate within professional fora like OTASA, the Forum for Occupational Therapists in the Public Sector and the Education sector. It is interesting to note that one of the roles of the Medical and Dental Professional Board is to determine, in consultation with the Department of Health, the required number of specialists in each discipline in order to meet the needs of the country. Secondly, a defined scope of practice (having to limit one's practice) could lead to a conflict of interest in terms of appointments in, for example, the Department of Health, Education and NGO's, especially where such employers could not offer the employee a 'specialist' position. The possibility of a practitioner wanting to change and/or expand his/her practice area also needed to be considered. Thirdly, there would be additional costs involved for the individual practitioner in terms of garnering the required post-graduate qualification and then registering as a specialist. Fourthly, concern has been voiced that specialists might also be predominantly urban-based[1] as is currently the situation in Medicine. Finally, Universities might feel pressurised to offer only those post-graduate course-work Masters programmes accredited by the Board for specialisation purposes.

The matter is far from settled, and much exploration of opinions, motivation for, and work in terms of what would be required legally still needs to be done. Three areas of specialisation have been identified after the survey conducted in 2007/8 with the understanding that other specialisation areas would be phased in over time. As a start, the Scope of Practice for each specialisation needs to be clarified and defined by the Board. It is important that a specialist register does not become a licence for practitioners to practice outside the Scope of the profession. The Board would also need to develop criteria to accredit post-graduate qualifications for this purpose and then ensure that an acceptable standard of post-graduate education was maintained. The current University educational programme

evaluation process whereby programmes are accredited does not include post-graduate offerings. The World Federation of Occupational Therapists also does not extend its influence to post-graduate education as its mandate is to 'oversee' undergraduate education[7]. The registration process, establishment of the registers, costs and regulatory rules would need to be determined by the Board, as well as the policy for dealing with contraventions in terms of working outside the defined Scopes of Practice. The final recommendation by the Board in terms of specialist registration would then be forwarded to the Council of the HPCSA for their deliberation. Once approval has been obtained at this level, the proposed HPCSA regulations would then be forwarded to the Department of Health for promulgation. Concurrently, the Board would need to lobby the various Public sector employing bodies, through the already established system of annual meetings, to create the necessary post structures that would support such specialist services. Universities would also need to develop and obtain the necessary approval for a range of post-graduate qualifications to cater for this initiative. Much work still needs to be done……

I have written this piece to provide some background to the matter, and hope that I have prompted you to consider the matter further or possibly for the first time. Do you have any additional comments, views, or thoughts on this matter? Comments, in the form of a letter to the editor would be most welcome. The newly appointed Board will continue with this initiative in 2010, so comments can also be directed to the Board Secretary. (The Board Manager, HPCSA Board for Occupational Therapy, Medical Orthotics and Prosthetics and Arts Therapy. P.O. Box 205. Pretoria 0001).

I wish to acknowledge the role of the task team members, the 2004 – 2009 Board and especially Mrs S Beukes in the development of the final proposal submitted to the Board in 2008.

References

1. Foto, M. Generalist versus Specialist Occupational Therapists. The American Journal of Occupational Therapy, 1996. 50(10):771-774
2. Hugo, Prof. Clinical Associate Training. Introduction presented during a seminar hosted by the Centre for Rural Health in co-operation with the College of Health Sciences. 2007. Cited in feedback from K Holland to the Board of Occupational Therapy, Medical Orthotics and Prosthetics and Arts Therapy. UKZN, Durban.
3. HPCSA. Medical and Dental Professions Board, Form 57 MED. HPCSA Executive Training Manual, point 1.16 page 211. HPCSA Form 19 Applications for Registration of an Additional Qualification.
4. South Africa. Act No. 56 of 1974. Regulations Relating to the Specialities and Sub-specialities in Medicine and Dentistry, No.R. 590. 29 June 2001.
5. Holland, K. Specialist Registration for Occupational Therapists. Official HPCSA Board correspondence. Item31/1/9. 3 April 2007 and 1 July 2008.
6. Pate, R. H. Certification of Specialties: Not if, but How. Journal of Counseling and Development. 1995. 74:181-184.
7. van der Reyden, D. Comment to the OTASA on the Establishment of Specialist Registers. Invited opinion and communication, 2005.
8. WFOT correspondence. Comment received from the WFOT secretariat by the Board. Private Communication, 2007. ❑

Author's address
Kathy Holland
Lecturer: Occupational Therapy, UKZN.
Dean's Assistant, Faculty of Health Sciences, University of Kwa Zulu Natal.
Member, HPCSA Board for Occupational Therapy, Medical Orthotics and Prosthetics and Arts Therapy, Jan 2004 – May 2009.
hollandk@ukzn.ac.za