Journal of the Colleges of Medicine of South Africa
ISSN: (Online) 2960-110X

Developing a national clinical competency committee for family medicine training, South Africa

Authors:
Louis S. Jenkins[1,2,3]
Mergan Naidoo[3,4]
Kefilwe Hlabyago[3,5]
Dirk T. Hagemeister[3,6]
Neetha Erumeda[3,7]
Busisiwe Cawe[3,8]
Tasleem Ras[3,9]
Mulimisi Ramavhuya[3,10]
Owen Eales[3,11]

Affiliations:
[1]Division of Family and Emergency Medicine, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa

[2]PHC Directorate, Family, Community and Emergency Care, Faculty of Health Sciences, University of Cape Town, Cape Town, South Africa

[3]National Clinical Competency Committee, College of Family Physicians, Colleges of Medicine of South Africa, Cape town, South Africa

[4]Discipline of Family Medicine, School of Nursing and Public Health, College of Health Sciences, University of KwaZulu-Natal, Durban, South Africa

[5]Discipline of Family Medicine, Faculty of Health Sciences, Sefako Makgatho Health Sciences University, Ga-Rankuwa, South Africa

[6]Department of Family Medicine, Faculty of Health Sciences, University of the Free State, Bloemfontein, South Africa

Entrustable professional activities (EPAs) have been introduced into family medicine training programmes across South Africa (SA) as part of a competency-based medical education (CBME) framework. These EPAs provide a structured approach to assessing and developing the competencies required for independent practice in family medicine. Twenty-two EPAs, aligned with the scope of family medicine in SA, were identified and integrated into a national electronic portfolio of learning (ePOL), Scorion. This allows for continuous documentation, assessment, and feedback, supporting both registrars and supervisors in tracking progress. To ensure a robust assessment of competence and readiness for entrustment decisions, local and national clinical competency committees (CCCs) were established. Local CCCs operate within training institutions, comprising faculty teams that review registrar performance data from the ePOL to make entrustment decisions on specific EPAs. The national CCC, comprising of representatives from all nine family medicine departments in SA, provides oversight, ensures standardisation, and addresses inter-institutional variability in assessments.

Contribution: The implementation of EPAs and CCCs represents a significant advancement in family medicine education, fostering accountability, consistency, and transparency in assessment. Initial outcomes suggest improved alignment between training and workplace requirements, enhanced feedback quality, and better preparation for independent practice. Challenges remain, including ensuring faculty development, managing workloads, and fostering a culture of continuous quality improvement. Future steps include further refining the CCC framework, addressing implementation challenges and exploring the impact of these changes on registrar training and assessment.

Keywords: national; clinical competency committee; postgraduate; family medicine; training; assessment; South Africa.

Introduction

Clinical Competency Committees (CCCs) are decision-making entities that evaluate registrars' workplace-based performance against speciality-specific milestones. In the United States of America, CCCs were introduced in 2013 as part of the Accreditation Council for Graduate Medical Education (ACGME)'s competency-based framework.[1] Clinical Competency Committees should consist of at least three faculty members directly involved in the training programme, with at least some of the members being familiar with the registrars.[2] The CCC should be diverse in terms of academic rank, gender, race, programme role, professional focus, and professional background.[3] Other members may include an interprofessional colleague who works with registrars (e.g., nurse, social workers) or even a member of the public (to represent patients' perspectives).[4] The CCC should meet at least twice a year to review registrars' progress by scrutinising multiple aggregated assessments from

[7]Department of Family Medicine and Primary Care, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa

[8]Division of Family Medicine, Faculty of Health Sciences, Walter Sisulu University, Mthatha, South Africa

[9]Division of Family Medicine, Faculty of Health Sciences, University of Cape Town, Cape Town, South Africa

[10]Department of Family Medicine, Faculty of Health Sciences, University of Limpopo, Polokwane, South Africa

[11]Department of Family Medicine, Faculty of Health Sciences, University of Pretoria, Tshwane, South Africa

Corresponding author: Louis Jenkins, louis.jenkins@westerncape.gov.za

Dates: Received: 17 Jan. 2025 | Accepted: 14 Mar. 2025 | Published: 23 Apr. 2025

How to cite this article: Jenkins LS, Naidoo M, Hlabyago K, et al. Developing a national clinical competency committee for family medicine training, South Africa. J Coll Med S Afr. 2025;3(1), a179. https://doi.org/10.4102/jcmsa.v3i1.179

diverse perspectives of workplace-based clinical performance, to provide feedback to the training programme and registrars, to identify registrars in difficulty (which could be registrars struggling with personal, social, or professional issues), and to make recommendations regarding registrars' progression and entrustability with patient care tasks.[5]

Besides making summative decisions about entrustment and registrar progress and associated feedback, CCCs need to formulate remediation interventions and tailored training opportunities for registrars who require them, evaluate programme effectiveness and identify weaknesses in the curriculum or programme of assessment, and provide feedback to those overseeing the assessment programme on the focus and quality of workplace-based assessments (WPBAs).[6] Table 1 explains some of the pitfalls, misconceptions, and mitigating strategies for CCCs. The aim of this paper is to describe the process of creating a CCC for family medicine registrar training in SA.

Reflections on the national clinical competency committee process for family medicine in South Africa

South Africa has used WPBAs in many postgraduate clinical training programmes for some years.[7] The discipline of family medicine recently embarked on an entrustable professional activity (EPA)-based curriculum, with 22 nationally agreed EPAs.[8] The EPAs were agreed upon in an iterative national consensus process with all nine programmes in SA. The EPAs align with the national unit standards for family medicine training, which address the national health priorities in the country. The previous national portfolio of learning has been revised to capture WPBAs aggregated to various EPAs in the Scorion e-portfolio.[9] This led to the establishment of local CCCs (at the academic institutions) and a national CCC. After reviewing best practices in the literature, many of the nine postgraduate family medicine specialist training programmes in the country started having local CCC meetings.[10,11] One of the functions of the local university CCCs is to evaluate their registrars' portfolios of learning according to the multiple 'low stakes' entries of evidence and ad hoc entrustment decisions of workplace performance to enable a cumulative 'high-stakes' recommendation to proceed or not in their training. The local CCC also provides feedback to each registrar and the supervisors and to the training programme itself. This is an improvement towards reducing bias for or against a registrar, where previously, the head of department alone signed off on a registrar portfolio at the end of a training year.

The national CCC consists of nine members representing the nine training programmes. These members were opportunistically selected by each training programme, which nominated senior faculty who were actively involved in registrar training and WPBA. One of the functions of the national CCC is to review the portfolios of learning of final-year registrars who are applying to take the national exit exams, whether the candidates are eligible or not. The original College of Family Physicians regulations stipulated that a candidate needed three satisfactory portfolios of learning over three training years, the most recent of which should be within the last 3 years. More recently, these have been revised to stipulate that a candidate needs to have attained entrustability at level 4 (work safely under distant supervision) in most

TABLE 1: Clinical competency committee pitfalls, misconceptions, or limitations and mitigating strategies.

Potential CCC pitfalls, misconceptions, or limitations	Potential mitigating strategies
Pitfall: ignoring potential sources of bias in the CCC process	Ensure diversity of the CCC members (e.g., on issues of identity, speciality, phase of training, and non-physician members). Faculty and trainee development on the evidence that suggests a trainee merits entrustment or advancement. Structured procedures for reviewing and interpreting trainee performance information and generating decisions. Avoid having each member prepare for one trainee, precluding group deliberations. A standard approach to data presentation.
Pitfall: inadequate engagement of trainees in the process	Standardised process for engaging trainees, transparent to both CCC members and trainees. A priori clarity around what trainee data are to be used by the CCC in decision-making, including data on trustworthiness. The standard process for trainee self-assessments on the entrustable professional activities (EPAs) requires them to attest to their self-perceived readiness for entrustment. Trainees can also create the CCC form in the e-portfolio. Involvement of trainees in a portion of the CCC meeting to present their self-assessment. The standard process for post-CCC meeting feedback (written and oral) to the trainee, including CCC findings and decisions and any plans for follow-up.
Misconception: 'One size fits all'. CCCs will need to vary depending on the type of trainees they are assessing (e.g., where on the education – training – practice continuum the trainee is), the volume of trainees and of EPAs	Adjust meeting frequency to ensure the ability to discuss each trainee's progress on the EPAs (ensure time allotted matches the workload). Adjust the size of CCCs to ensure the engagement of all members. Adjust the number of CCCs to accommodate increased trainee volume (e.g., a programme with 4 trainees per year might have a single CCC, while an undergraduate student body of 250 students/year might require several CCCs).
Misconception: the CCC is only for struggling trainees.	Ensure discussion of all trainees at the same intervals and allow sufficient time to provide feedback on EPA-based decisions and progress to each trainee. (This does not mean that a CCC must review every trainee at every meeting.)
Limitation: CCCs are time-consuming.	Optimise administrative support, such as pre-meeting aggregation of data, intra-meeting notetaking, and postmeeting provision of written feedback. Develop a reward system for participation (such as counting towards promotion and tenure). Create term limits for committee membership, when possible, to share the time commitment across faculty.
Limitation: CCCs may be both an entrustment body and a promotion body simultaneously.	Ensure roles are clear a priori regarding the decision-making expectations for entrustment on EPAs and for advancement across phases of training. Identify potential conflicts of interest a priori and determine standard processes for conflict resolution.

Source: Adapted from Englander R, De Graaf J, Hauer KE, Jonker G, Schumacher DJ. Chapter 21: Clinical competency committees in an entrustable professional activity framework for curriculum and assessment. In: Ten Cate O, Burch VC, Chen HC, Chou FC, Hennus MP, editors. Entrustable professional activities and entrustment decision-making in health professions education. London: Ubiquity Press, 2024; pp. 249–258.

EPA, entrustable professional activities; CCC, clinical competency committee.

EPAs. The initial meeting in late 2023, during which 16 portfolios were evaluated, served to establish guidelines and work out the logistics of assessing registrars' portfolios across the country. Subsequently, there were two CCC meetings in 2024. The meetings were 3 h–4 h long, held online via Zoom©. The first CCC meeting in 2024 evaluated 15 registrar portfolios. The second CCC meeting evaluated 17 portfolios. The nine family medicine programme representatives on the CCC received access via a secure SharePoint® folder in the case of paper portfolios which were uploaded as portable document format (PDF) files or received access to the e-portfolios via a secure code after the individual registrars gave consent for their portfolios to be viewed by the members of the CCC. Each CCC member evaluated 1–2 portfolios from a different programme, one week prior to the national online CCC meeting. The portfolios were evaluated according to a pre-determined template to ensure a fair and reasonably standardised review process (Table 2). During the online national CCC meeting a week or two later, every member presented their critical evaluation of the 1–2 portfolios they reviewed. After review of all the data points of evidence in the portfolio, including the registrar reflections, narrative feedback from the various supervisors, and

TABLE 2: Local and national clinical competency committee template used to evaluate registrar portfolios.

	Name of candidate (portfolio owner)			
	Training year and interim or final (end of year) CCC assessment [Check if the registrar is doing a remedial year]			
	Complex/subdistrict of candidate			
	Name of CCC assessor (to be anonymised during feedback)			
	Access to portfolio (Scorion e-portfolio/PDF files/multiple files/links)			
1	Portfolio is completed during the year or mainly towards the end of the academic year.			
2	Selection of evidence submitted: Comment on diversity. Note which EPAs were selected for each learning plan (LP) and correlate with allocation reflections and supervisor allocation assessments. Review data points for these and other EPAs. Consider all learning events: Observations: DOPS, mini-CEXs, C-sections, anaesthetics, teaching skills, multi-source feedback (MSF), group educational meetings and entrustment-based discussions, skills logbooks, and course assignments. Also include patient safety incidents, mortality and morbidity meetings, continuous professional development certificates, community engagements, and other outside portfolios.			
3	Quality of registrar reflections [What, why, system thinking, What if…]			
4	Number of observers over the academic year (e.g., > 3)			
5	Amount of narrative feedback (scanty, average, sufficient) Indicate in which forms/areas			
6	Quality of feedback (detailed, done well, could be done better, action plan?) Indicate in which forms/areas/ EPAs			
7	Information from CCC member who knows the registrar. Professional work ethics, etc.			
8	Feedback to the registrar			
9	Feedback to the university programme			
10	Summative decision: Is the portfolio acceptable to proceed to next phase in training or to be evaluated by the national CCC for admission to the national exit exam? (yes/no)			
Review the registrar portfolio 'Dashboard' and note the number of data points and spread of entrustment level decisions for each EPA's data point. Complete the table below to assist the CCC in making a combined high-stakes entrustment decision in the portfolio interim/final CCC form. At least one data point should include an 'allocation supervisor assessment' entry for that EPA. The registrar's reflections, supervisors' feedback, and MSF entries must also be considered when making the overall 'thick' assessment.				
Nos.	**EPA titles**	**Number of data points in portfolio**	**Spread of entrustment level decisions for the EPA's data points**	**Overall entrustment level considering all data points or note 'insufficient evidence'**
1	Managing women and newborns in the peripartum period			
2	Managing pregnant women			
3	Managing women and babies in the postnatal period			
4	Managing children with undifferentiated and more specific problems			
5	Managing children requiring inpatient care and procedures			
6	Providing anaesthesia in the district hospital operating theatre			
7	Providing anaesthesia for minor procedures			
8	Managing adult and adolescent patients with chronic conditions			
9	Managing adult and adolescent patients with undifferentiated problems			
10	Managing patients with infectious diseases			
11	Managing adults with conditions that may require surgery or procedures			
12	Managing patients with mental health disorders			
13	Managing patients with emergency conditions			
14	Managing patients with forensic problems			
15	Managing adults and children with palliative care needs			
16	Managing care for older patients			
17	Managing patients with impairments and rehabilitation needs			
18	Supporting community-based health services			
19	Supporting and providing health promotion and disease prev. services			
20	Providing training and continuous professional development			
21	Leading a clinical team			
22	Leading clinical governance activities			

EPA, entrustable professional activities; CCC, clinical competency committee; DOPS, direct observation of procedural skills.

feedback from the CCC member in the committee who knew the registrar personally, the CCC concluded with a high-level recommendation that either the registrar was ready and competent to proceed to the national exit exams or needed more evidence of workplace experience before readiness for the exams could be recommended. The main challenges included a time commitment from each committee member and the difficulty of agreeing as a CCC on a decision when an insufficient registrar portfolio was reviewed. This was made easier since the CCC members knew each other and had developed a level of trust among each other, with all agreeing on the need to maintain high standards for the profession and ensure competent specialists for the public.

TABLE 3: Lessons learnt by all nine family medicine training programmes in South Africa.

Number	Key lessons learnt
1.	**Flexibility** The CCC remained aware of the organic nature of this new process and allowed for reasonable explanations where there seemed to be insufficient evidence of workplace-based learning and assessments. The CCC is following a developmental approach rather than a problem identification approach.[12] It is a learning process for the registrars and the local and national CCCs. Faculty development is essential.
2.	**Virtues** Emphasise confidentiality in the CCC, respect and fairness towards CCC members and the registrars while expecting high standards of WPBAs processes.
3.	**Seniority** The CCC representative must be a senior person (e.g., HOD, programme director, senior trainer) who knows their registrars. This representative will have the decisions and summary data for their candidates from the individual programmes' local CCCs.
4.	**Responsibility** Each member is expected to be involved in developing their local university departmental WPBA processes and their local CCC through faculty training to ensure supervisors understand their roles, are aware of their biases, and agree on WPBA processes.
5.	**Standardisation** Agree on which data points and how many data points per EPA in the portfolio are sufficient. For example, an end-of-allocation supervisor report carries more validity or weight than a logbook entry. The same template used by all local CCCs and the national CCC ensures fairness and consistency.
6.	**Structure** Have a structured format for the CCC meeting, with a few minutes of presenting the portfolio assessment by the member who reviewed and summarised the portfolio of a registrar from a different institution beforehand (according to the template), followed by a short CCC discussion, with input from the CCC member who knows the registrar, and a final decision by the CCC regarding progression or remediation.
7.	**Contextuality** The CCC is very aware of the various training contexts in the country with their challenges, and the CCC decision takes this and the registrar's personal health issues into account.
8.	**Feedback** The chairperson gives feedback to the College of Medicine of South Africa on the decisions of the CCC and gives feedback to the various programmes where there are uncertainties and learning points regarding incomplete evidence of training experience.
9.	**Grace** At this early stage, the CCC allows for a grace period for the registrar to clarify and provide evidence to the CCC within a short period (typically 1–2 weeks) after the CCC meeting if uncertainty exists in the assessment.
10.	**Roles** In the future, the terms of reference for the CCC will become very clear, with improved alignment between national and local CCCs, with acceptance by the National College of Family Physicians, and the national CCC chair will sign off on each registrar decision, which will be sent to the HOD of that programme.

Note: Please see full reference list of this article, Jenkins LS, Naidoo M, Hlabyago K, et al. Developing a national clinical competency committee for family medicine training, South Africa. J Coll Med S Afr. 2025;3(1), a179. https://doi.org/10.4102/jcmsa.v3i1.179, for more information.

CCC, clinical competency committee; HOD, head of department; WPBA, workplace-based assessment.

Lessons learnt

The lessons learnt during the first three national CCC meetings are summarised in Table 3.

Recommendations and conclusion

This is a mind shift for the discipline of family medicine and in postgraduate health education in SA. The formal inclusion of WPBA and assessing registrar portfolios via CCCs at institutional and national levels are expected to impact positively on the quality of registrar training in the country. Practical recommendations include aligning the local CCC processes with the national CCC process; the national CCC representative of a training programme knowing the registrars being discussed at the CCC; training programmes being receptive to the feedback from the CCCs; and just getting on and starting organically with CCC meetings. Future steps include further refining the CCC framework, addressing feasibility challenges in implementation, and exploring the impact of these changes on patient care and health system outcomes in SA. Lessons learnt could be helpful in other disciplines in the country and in similar contexts in Africa.

Acknowledgements

The authors express their sincere thanks to the colleagues who participated in the implementation of the national CCC.

Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

Authors' contributions

L.S.J. was responsible for conceptualising the article. L.S.J., M.N., D.T.H., N.E., B.C., and K.H. provided inputs to subsequent drafts. L.S.J., M.N., D.T.H., N.E., B.C., K.H., T.R., M.R., and O.E. scrutinised and approved the final manuscript.

Ethical considerations

This article followed all ethical standards for research without direct contact with human or animal subjects.

Funding information

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Data availability

The authors declare that all data that support this research article and findings are available in the article and its references.

Disclaimer

The views and opinions expressed in this article are those of the authors and are the product of professional research. It does not necessarily reflect the official policy or position of

any affiliated institution, funder, or agency or that of the publisher. The authors are responsible for this article's results, findings, and content.

References

1. Andolsek K, Padmore J, Hauer KE, Ekpenyong A, Edgar L, Holmboe E. Clinical competency committees: A guidebook for programs [homepage on the Internet]. Accreditation Council for Graduate Medical Education. [cited 2024 Dec 23]. Available from https://www.acgme.org/Portals/0/ACGMEClinicalCompetencyCommitteeGuidebook.pdf
2. Ekpenyong A, Padmore JS, Hauer KE. The purpose, structure, and process of clinical competency committees: Guidance for members and program directors. J Grad Med Educ. 2021;13(2s):45–50. https://doi.org/10.4300/JGME-D-20-00841.1
3. Hauer KE, Cate OT, Boscardin CK, et al. Ensuring resident competence: A narrative review of the literature on group decision making to inform the work of clinical competency committees. J Grad Med Educ. 2016;8(2):156–164. https://doi.org/10.4300/JGME-D-15-00144.1
4. Loo LK, Lee S, Acosta D. Maintaining the public trust in clinical competency committees-societal representatives. J Grad Med Educ. 2017;9(1):131–132. https://doi.org/10.4300/JGME-D-16-00533.1
5. Duitsman ME, Fluit CRMG, Van Alfen-van der Velden JAEM, et al. Design and evaluation of a clinical competency committee. Perspect Med Educ. 2019;8(1):1–8. https://doi.org/10.1007/s40037-018-0490-1
6. Englander R, De Graaf J, Hauer KE, Jonker G, Schumacher DJ. Chapter 21: Clinical competency committees in an entrustable professional activity framework for curriculum and assessment. In: Ten Cate O, Burch VC, Chen HC, Chou FC, Hennus MP, editors. Entrustable professional activities and entrustment decision-making in health professions education. London: Ubiquity Press, 2024; pp. 249–258.
7. Ras T, Jenkins L, Lazarus, C. et al. 'We just don't have the resources': Supervisor perspectives on introducing workplace-based assessments into medical specialist training in South Africa. BMC Med Educ. 2023;23:832. https://doi.org/10.1186/s12909-023-04840-x
8. Mash R, Jenkins L, Naidoo M. Development of entrustable professional activities for family medicine in South Africa. Afr J Prim Health Care Fam Med. 2024;16(1):a4483. https://doi.org/10.4102/phcfm.v16i1.4483
9. Jenkins L, Mash R, Naidoo M, Motsohi T. Developing an electronic portfolio of learning for family medicine training in South Africa. Afr J Prim Health Care Fam Med. 2024;16(1):a4525. https://doi.org/10.4102/phcfm.v16i1.4525
10. Kinnear B, Warm EJ, Hauer KE. Twelve tips to maximise the value of a clinical competency committee in postgraduate medical education. Med Teach. 2018;40(11):1110–1115. https://doi.org/10.1080/0142159X.2018.1474191
11. Al-Bualy R, Ekpenyong A, Holmboe E. Effective clinical competency committee meeting practices: Before, during, and after. Acad Med. 2023;98(11):1340. https://doi.org/10.1097/ACM.0000000000005123
12. Hauer KE, Chesluk B, Iobst W, et al. Reviewing residents' competence: A qualitative study of the role of clinical competency committees in performance assessment. Acad Med. 2015;90(8):1084–1092. https://doi.org/10.1097/ACM.0000000000000736