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Présenté par le Dr HOLM

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Memorandum concerning development of continuing medical education (CME)/ continuous professional development (CPD) in Europe

Summary points

- Doctors are autonomous and independent with an ethical obligation to practice according to accepted ethical standards which include a continuing endeavour to develop knowledge, skills and attitudes in response to patients' needs.

- The strongest motivating factor for continuous life-long learning is the will and desire to maintain professional quality through a process of continuous professional development (CPD) which includes all the activities undertaken to improve areas of competencies (medical, managerial, social, personal) necessary to meet the needs of the patients served.

- The trust of the public rests on the assumption that doctors adhere to contemporary standards of professional quality. The profession must be able to apply peer pressure and policing for those who fail to meet these standards. Procedures applied should be publicly known and secure a fair process.

- A well functioning occupational health service for doctors is an important element in preventing low quality practice.

- The professional is fully responsible for his clinical actions irrespective of employment status (employed or self-employed), but cannot be made accountable for system failures, either nationally or locally, beyond his or her control.

- The professional must at any time pursue what he or she thinks is in the best interest of the patient. As a consequence, drawing on various types of knowledge and experience, deliberate diversions from guidelines and protocols will occur from time to time, and are part of professional practice.

- Doctors are in general capable of identifying their learning needs, but should take advantage of both peer-assessments (whenever feasible) and methods of self-appraisal.In the end, it is the privilege and the responsibility of the professional to plan and carry out CPD-activities considered to meet her or his needs.

- There is hardly any evidence to support introduction of mandatory measures (e.g. certain amounts of CME) as a means to maintain competence. On the other hand, professionals should share willingly the strategies they apply to keep abreast, and employers have a special responsibility to facilitate their staff's CPD (e.g. proper funding, learning facilities and protected time)

- Doctors have an obligation to engage in learning activities in order to facilitate the enhancement of competence of peers as well as other members of the health care team as part of their leadership. Doctors should seek personal competencies to enable them to lead organisational change and learning and to search for new competencies to develop quality of health care.

- Professionals should familiarise themselves with methods of continuous quality improvement (CQI); i.e. document the standard of their care, unravel areas of needed improvement, define learning needs and run the improvement circle.

- CQI should be an integral part of medical curricula at all levels of training.

- Successful implementation of CQI in health care requires the full involvement and leadership of doctors who acknowledge that effective healthcare is based on teambuilding and –performance.

Introduction.

Studies undertaken by the CP (CP 97/072 Rev 1) and the UEMS indicate that more and more European countries are adopting various systems of mandatory requirements of defined periods of activity in CME/CPD for qualified doctors including, in some countries re-certification, contrary to the CP Charter on CME (Declaration of Dublin 1998, revised Funchal 1993 (CP 93/26)), which emphasised that such activity must be voluntary.
Medicine, being a profession, implies that doctors are autonomous, self-regulatory and independent in their practice. Ideally the public places its trust in the profession and relies on the profession's ability to render a service which is in the best interest of the public it serves.
Doctors and their professional organisations are supposed to practice according to generally accepted ethical standards (professional codes) which are widely publicised and to which doctors are held accountable.
The trust of the public rests on the assumption that the profession has mechanisms in place that are able to identify and remedy any practice which falls below accepted standards. Such mechanisms may be organised by public authorities (e.g. the authority responsible for keeping the Register of those licensed to practice) in co-operation with the professional organisations, whose members are the only ones capable of evaluating the quality of the practice of their peers. A transparent system, well known to both the profession and the public, should maintain high standards of medical practice and retain public trust.
Many doctors feel that their profession today is under siege. The reasons given are their experience of increased bureaucratisation and regulation of medical practice initiated not only by the authorities but, sometimes, by initiatives taken by the profession itself to regulate the practice of their members. Regulation of practice may affect clinical decision making and autonomy in unprecedented ways, as for instance the limitations on diagnostic procedures and therapies experienced in many health maintenance organisations (HMOs).

Likewise, aspects of evidence-based medicine (EBM), and the fast growing numbers of medical guidelines and protocols are, by many doctors, perceived as straightjackets rather than helpful support for clinical decision-making. In many countries, these negative trends are reinforced by the increased tension between the legal system and the medical profession. Many doctors feel that EBM and guidelines are being perverted by lawyers in order to establish negligence cases.

Increasingly, all social security systems in the various member states are attempting to restrict the rate of increase in health care budgets. These measures are often described as “value for money” or cost-effectiveness”. Many doctors, however, see this as, either restrictions on care in one form or another (rationing), or attempts at increased volume (number of cases) at reduced cost by cutting corners, i.e. less than optimal care.

Continuous Professional Development (CPD)

Continuous professional development (CPD) is the mechanism by which the trained physician regularly reviews and updates knowledge and skills to meet the needs of his/her patients. CPD includes the continuous acquisition of new knowledge, skills and attitudes. There is no sharp division between continuing medical education (CME) and CPD as CME during the last decade has gradually come to include topics beyond the traditional medical subject-oriented issues. Using the term CPD acknowledges the multifaceted competencies needed to practise high quality medicine, including medical, managerial, social, and personal areas of competencies. Although subject-oriented knowledge and skills, traditionally included in CME, is the core of medical practice, changes of practice and knowledge during a lifetime are influenced by a number of factors of which the context of practice, with the characteristics of the population served, plays a pivotal role.
CPD takes account of medicine as an art and acknowledges professional competence integrating technical scientific and rational aspects of medicine with the personal experience from everyday practice. This renders each professional with a unique body of knowledge, skills and attitudes which enables her or him to integrate medical, personal, social, moral, ethical, situational and managerial aspects into their decision making. Professionals’ decisions often rest on intuitive judgements which are not readily made explicit, and which do not always fit into guidelines.
Just because professional decisions are not always readily accounted for, or easily understood, they are not necessarily of low quality. It simply reflects that the practitioner often uses internalised experiential knowledge that is not readily broken down into explainable pieces.

The Process of CPD

Among the strongest motivating factors for continuous life long learning and change in the lives of doctors is the will and desire to maintain professional quality. The most important factor in determining the “curriculum of CPD” is the daily patient encounters. Through these encounters, doctors identify their needs for learning and change across the various types of competencies outlined above. The learning is self-directed, a characteristic of adult learning.

The process of self-assessment is essential for continuous learning, and may be enhanced by self-assessment programmes (e.g. programmes providing feedback on incorrect answers). It is noteworthy that self-appraisal of practice performance apparently more often leads to a commitment to change practice rather than participation in self-assessment programmes. A professional is, in fact, very competent in assessing his or her performance and will take actions to close the gap between actual and desired level of performance. This is an essential aspect of CPD. Interestingly, both as peers and managers of health care, our trust in our colleagues' ability to be effective self-directed learners (as opposed to ourselves) is rather limited, as evidenced in the trend towards more mandatory systems of recertification.

The most useful resources needed to facilitate the process of CPD are often those which should already be available in the working environment, namely time for reflection on practice, adequate information systems and a supportive working environment. Most doctors now work in teams with other doctors and other health personnel. The quality of the practice depends on the functioning of the whole team. We are part of a learning organisation. Reflection on clinical practice and interaction (both formal and informal) with peers and other health personnel, constitute important facilitating factors of a doctor's CPD. Certainly, in addition, more formal CME programmes are of importance, especially when they are actively selected by the practitioner to meet identified needs.
Reserved time is an essential prerequisite for proper CPD – doctors must be able to have periods away from clinical problems and practice in order to reflect upon, and if necessary, device new approaches to clinical problems. This may be reflection on his own, or as part of a team audit. Proper CPD cannot be successfully instituted if it depends on out-of-hours activity when practitioners may already be tired after a full day's clinical activities.
The need for the doctor to attain competencies in leadership, teamwork, communication skills, and the process of learning itself (needs assessment, planning for organisational learning and evaluation of the outcome) becomes apparent when the complexity of modern health care delivery is fully understood. These are parts of CPD which rarely are included in traditional CME. However, in recent years the offers of management and leadership programmes for doctors have shown a steady increase, often initiated by the professional organisations themselves. These programmes regularly include training in communication and mentoring skills.

Clarifying the Issue of Incompetence

The issue of incompetence needs to be addressed when discussing CME/CPD. Not because of any close relationship, but because the issue tends to confuse any constructive discussion related to CPD, since it often boils down to a discussion whether CME should be mandatory or not. On the one hand, there is little evidence in support of the assumption that mandatory CME, as we know the systems today, plays a substantial role in maintaining quality in the practice of medicine. On the other hand, there is hardly any need for research to make the assumption that a doctor unwilling, or failing, to keep abreast of current developments will soon become incompetent to meet the needs of the population he or she serves.

It is important that we discriminate between causes of professional incompetence. Remedial actions must, as in medicine in general, be based on proper analysis and diagnosis. This is not always easy, but it may be useful to analyse any case of incompetence from at least two different perspectives:

- incompetence as a result of personal failure and
- incompetence as a result of system failure.

Developing a proper occupational health service for doctors is essential for preventing doctors from acting incompetently as a result of mental or physical incapacity.

In many cases, there are elements of both personal and system failure, since failure of proper system monitoring – or process control – may well be the result of personal failure. But certainly doctors are also blamed for mishaps, or bad outcomes, in spite of doing what was possible given the resources available. This points to the importance of doctors properly reporting system flaws and failures as part of their professional duty.

Evaluating cases of alleged professional misconduct may easily go astray, and lead to personal and professional tragedies, if the context and process of the practice in question and evaluation procedures are poorly understood. One of the classical errors are cases related to one practice area, e.g. general practice, being assessed by persons working in a totally different setting, e.g. specialists (consultants), or practising specialists being assessed by academics. Violation of the principles of peer assessment represents a threat to perceived “fairness”. It is essential that any professional shall know that practising according to generally accepted professional standards (the norm) shall not lead to a verdict of professional misconduct, and allegations of misconduct should be exceptional when professional practice meets accepted standards. This is the bottom line for creating a system of accountability, transparency and trust.

Personal responsibility

Each professional carries a personal responsibility for his or her acts, whether working as self-employed or being employed. It is essential that patients and the public have a clear understanding of their doctor being responsible and accountable, irrespective of organisational structure.

Today many doctors are working within complex organisations where reporting lines and personal responsibility are less clear, and where inter-professional functioning may be less than optimal. It is well documented that a working environment, which is sub-optimal, may affect the healing process, even when the treatment given per se is beyond criticism.

Professional development must address these issues as well, and doctors, who have a leading role in most organisations, have a special responsibility to facilitate a caring and curing environment.

The challenge in the more complex organisations, especially when things go wrong, is to distinguish system failures, which are the responsibility of clinical management (managers and line superiors), from those caused by erroneous acts of professionals as outlined above.

The personal responsibility of professionals working within a system also includes the obligation to identify and report insufficient systems that may harm the patient (this includes technical, procedural, human or organisational aspects). It is in the best interest of the patient, as well as the health professionals, that there is a professional and organisational culture “demanding” that the practitioners to incessantly and vigorously look for areas of change and improvement, i.e. actively engage in continuous improvement of quality.
Doctors working in teams with other doctors and other health personnel have an obligation to contribute to the learning and development of their peers and other health personnel. Working with others means opportunities for continuous feedback and learning, powerful elements of CPD, which seldom are fully utilised.

Continuous Quality Improvement (CQI)

The terms quality control (QC) and quality assurance (QA) have been around for a long time and are often perceived by doctors as bureaucratic top-down inventions, more hampering than facilitating medical practice. In many countries QC and QA are part of the legal provisions governing and regulating medical practice.
The rationale behind these regulations, termed clinical governance, may sound reasonable i.e. ensuring that systems are in place to monitor the quality of clinical practice. Nevertheless, doctors often perceive such mechanisms as non-supportive, judgmental, critical and even alien to their prime task of patient treatment. Such feelings are understandable, since the design of these systems often represent a top-down procedure grounded in the perceived need for control. Of course, there are both honourable and useful examples of QA, but one lesson learned from these activities is that unless doctors are involved in, and acknowledge the process, very little impact on practice is achieved, and hence provides little benefit from a CPD perspective.
Furthermore, legal provisions governing medical practice will not disappear, and it is not easy to dismiss the need for systems to provide a framework for quality. On the contrary, doctors should welcome them, and, whenever feasible, contribute to the implementation of systems which support good clinical practice. (E.g. continuous learning is in itself a central element in the QA of any organisation and must be apparent in documents describing quality measures.)
QC, and also QA and clinical audit, are apparently designed to identify “bad apples”, so that they can be removed. QC and QA may have their useful applications, especially when it comes to define the systems and structures under which care is delivered. Such systems are often the core of accreditation systems. But they have less to offer in the process of care, which is at the heart for the clinician. Here is where continuous quality improvement (CQI) comes into play.
The very philosophy of CQI implies that the practitioners themselves are in control of the process, a bottom-up process. The practitioner identifies areas of improvement, designs the process of improvement, takes the appropriate action, evaluates the outcome, and takes responsibility for redesigning the process studied if indicated. This is the classic Plan-Do-Study (Check)-Act (PDSA) cycle attributed to EW Deming. This is in fact similar to what is termed "experiential learning", carried out on a day-to-day basis, described by Kolb, and the reflection-in-action and reflection-on-action described by Donald Schön after studies on how professionals learn.

CQI combines the process of continuous learning, affects patient care and offers a system of documentation (based on relevant indicators). CQI is linked to practice, visualises the complexity of clinical processes and demonstrates the interdisciplinary character of modern health care.
This does not mean that the concepts of TQM/CQI are easily adopted by doctors. They are seldom part of medical curricula, and, if taught at all, often presented as concepts not linked to a context identified by practitioners.