4.4 Declaration of Dublin on continuing medical education

Adopted at Dublin, 1982
Revised at Funchal, 1993

(CP 93/26 Final)

Introduction

The subject under consideration is the activity by which a doctor who is already fully trained and qualified to practice medicine renews, extends, and updates his professional skills. It is necessary to decide what name is given to this activity in each language and not to fix a title in one language and attempt to translate it into another. For example, the French use "formation continue" and the German "Fortbildung". In other contexts, "formation" is rendered into English as "training", but this word (from Latin "traho" – I pull or draw) though acceptable in the context of basic training and specialist training implies a master and pupil relationship inappropriate to the present subject. The title "Continuing Medical Education" (CME) is already firmly embedded in the Anglo-American literature and is acceptable. In English, "Education" implies the increase of every sort of capability – knowledge, skill, and attitude and covers self teaching as well as learning from instruction by others. This English text will, therefore, adopt the term Continuing Medical Education (CME).

The fully qualified doctor

The fully qualified doctor is legally entitled to offer medical services to the public independently of any supervision by other doctors. He must have successfully undergone the basic, and where appropriate, specialist training necessary for the form of practice in which he engages. He is not required by law or imagined by anyone to be in possession of all medical knowledge and skill though his basic training should have imparted that "theoretical and clinical knowledge à which should be common to all doctors whatever their future orientation" and it should cover the whole of medicine leaving "no important areas of total ignorance." It is likewise with specialist training. Although it should be of a high level, it can never cover all knowledge even in a specialist field.

Ethical responsibilities

It follows from this that the fully doctor has a double ethical duty to his patients. On the one hand, he must recognise his limitation and not undertake activities of which he is insufficiently capable; on the other hand, he must find ways of continually improving his capabilities in those fields in which he works. Only the individual doctor can know the true realities concerning his competence. Patients may easily be misled since even the most highly skilled treatment may fail while totally incompetent treatment may be followed through a lucky change, by brilliant results. At this level, examinations which mainly test factual knowledge are of a very limited use as indicators. They may reveal differences of opinion between one fully qualified doctor and another or they may lead to a stultifying orthodoxy of opinion: coupled with a system of relicensing, they would also bring to an end the concept of a free profession with its own ethical code. Furthermore, they could either render continued practice uncertain from one period to the next or else to avoid this, become a meaningless formality. Finally, they would determine and so fix the field of activity of each specialty.

The conclusion, therefore, remains that CME is an ethical obligation which every fully qualified doctor must himself discharge. It should, at the same time, equally be emphasised that every doctor has a right to participate in CME and adequate provision for this be available to the doctor.

Medical quality assessment

The medical profession has become increasingly aware in recent years of the importance of its taking the lead in medical quality assessment policies and procedures. The profession is engaged in this work on both the national and international level and this involvement by the profession to secure the availability of CME for the individual doctors is an essential part of this activity.

The declaration

1. Continuing Medical Education is an ethical (and professional) duty and individual responsibility of every practising doctor throughout his professional life.
2. Its final purpose is to promote the highest possible and continually rising standards of the medical care (for the public) provided to the population.
3. It consists of the continuous renewal, extension, and updating of (professional skills) scientific knowledge and technical skills necessary to maintain the highest possible professional standards.
4. Because it is in the interest of the patient, every doctor has the right to Continuing Medical Education and should be encouraged and assisted to exercise that right.
5. It is not a novel concept of the last decade, but a long-standing tradition already flourishing in the time of Hipocrates.
6. Many of its means are well established in the form of books, periodical literature, meetings of medical societies of all kinds, bedside discussions and so forth. New developments include quality assessment evaluation meetings, private study with audio-visual aids, self-assessment programmes and new organisational forms.

7. The stimulus to undertake Continuing Medical Education arises from day-to-day encounters with actual reality and it is this experience which must determine its content.
8. Both the general and detailed content of Continuing Medical Education must be responsive to real needs and must, therefore, be determined by the practising profession.
9. At the fully qualified level, further education generally comes from the interaction of informed and trained minds with one another and with external reality. Formal lectures and classes have only a part to play. Discussions among small group of colleagues with and without invited experts together with the classical activities enumerated above are the principal methods.
10. Acceptance of the ethical necessity of Continuing Medical Education and the desire to undertake it must be inculcated from the earliest training of medical student. The choice as to its precise form and content must be left for each doctor to determine freely for himself.
11. The need to engage in teaching is a powerful spur to learning. The more widely spread the opportunity to teach medical students and specialist trainees, the wider will be the enthusiasm for Continuing Medical Education.
12. All doctors should enjoy tax remission for Continuing Medical Education expenses and the contracts of salaried doctors should provide for sufficient study leave with expenses.
13. In many countries, satisfactory provisions have already developed to a considerable degree of advancement. These should be further expended always preserving the leading role of the practising profession, the independence of the profession in determining the form and content of Continuing Medical Education, and the principal of free choice.
14. The medical profession must be responsible for the coordination of Continuing Medical Education activities in Europe and for the accreditation of Continuing Medical Education and professional standards.

4.5 Advisory Committee on Medical Training

(CP 93/96) (See also ITEM 12)

Advisory Committee on Medical Training (ACMT) of the European Commission (CP 93/96)

At its Plenary Assembly in November 1993, the CP unanimously endorsed the following resolution of the ACMT and agreed to forward its support to the appropriate sectors of the EU:

"The Advisory Committee on Medical Training conscious of the importance of the task given to it by the Council of Ministers (Art. 2 Council Decision 75/364/EEC), recalling that for some years the resources available to the committee to carry out its task have been reduced, considers that the further reductions in services and resources allocated to it by the Commission call into question its ability to ensure a comparably demanding high standard of medical training throughout the Community as requested by the Council in its Decision 75/364/EEC. The ACMT unanimously agreed at its meeting on 23 June 1993 that its Chairman should formally write to the Council expressing its concern. The Committee wishes to emphasise that its role in ensuring a comparably demanding standard of medical training throughout the Community should continue, particularly in view of the trends to enlarge the Community and the establishment of the European Economic Area. This task however can only be carried out by action at Community level. Comparable standards clearly are not a matter for Subsidiarity. It is at national level that actions resulting from deviations detected in comparative studies at Community level will be required. The Committee therefore seeks the support of the council in ensuring adequate resources to carry out its taks."

4.6 Motion concerning migration of postgraduate medical trainees within the EEC

Adopted at Copenhagen, November 1979 (CP 79/151 R)

The Plenary Assembly of the Standing Committee of Doctors of the EEC, meeting in Copenhagen on 23-24 November 1979, on the recommendation of its Subcommittee on Professional Training recommends that the competent authorities of the Member States be urged to utilize, or if necessary, to change existing rules and structures to favour the migration of postgraduate medical trainees within the EEC ad that such activities be given full publicity.

4.7 Numerus clausus (1982)

Motion sur le numerus clausus

Le Comité Permanent des Médecins de la CEE rappelle que l'article 57/3 du Traité de Rome et la Directive II/75/363 subordonnent la libre circulation des médecins à l'existence de normes minimales pour les conditions de formation.

Rappelle

- que, conformément au prem er considerant de la Directive II, la libre circulation des médecins se base nécessairement sur la similitude de la formation dans les états membres.
- que le Comité Consultatif pour la Formation Professionnelle dans son rapport et dans ses recom-