

MOVING FROM CONTINUING MEDICAL EDUCATION TO CONTINUING PROFESSIONAL DEVELOPMENT WITHIN EUROPE – MODELS FOR THE FUTURE

Proposals for consideration by CME/CPD group prior to Amsterdam

BACKGROUND:

In consideration of the way forward we need to incorporate the UEMS Policy Paper on Continuing Professional Development (CPD) as tabled by Edwin Borman , UEMS CPD Working Group (23rd May 2001). The recommendations of this paper include:

- a. CPD is an educative means of updating , developing and enhancing how doctors apply the knowledge , skills and attitudes required in their working lives and it both encompasses and goes beyond CME. CPD is part of the ethical responsibility of every doctor
- b. To develop an optimal system for CPD it is necessary to consider the process involved ,the desired outcomes and the structures required to deliver them
- c. CPD should be supported for all doctors , who should acknowledge their responsibility for its implementation and efficacy.
- d. We should recognise the importance of CPD in improving the quality and safety of medical practice
- e. The participation in CPD should be subject to audit with each doctor confirming his/her involvement in CPD
- f. Readily accessible registers of available educational activities must be maintained
- g. When determining educational opportunities, consider both new information technologies and different learning methods
- h. When assessing the implementation of CPD , both individual doctors and their work and learning environments must be considered
- i. Give greater consideration to the nature of the educational activity with active learning having a greater impact on the quality of practice
- j. In relation to national societies , the principle of subsidiarity should be accepted for educational structures , funding and accountability mechanisms
- k. Appropriate resources (time,money,peer support and educational opportunities) must be made available for CPD

INTRODUCTION:

CESP does have a responsibility in developing a consensus and working models to improve CPD amongst Paediatricians throughout Europe. In essence, this is the whole purpose of the CPD working group. CPD forms part of a personal programme of life-long learning that is a continuum from undergraduate to postgraduate education. CPD incorporates the principles of adult learning in which paediatricians are

expected to assess their educational needs and to then identify means of achieving these. In modern societies there is a greater emphasis on accountability, openness and transparency and we are all subject to the 'consumerist agenda'. The implications of this are that employer and patient requirements need to be taken account of when an individual paediatrician plans his/her own CPD programme.

WHAT DO WE WANT FROM CME/CPD ? :

The major stakeholders (the patients and their parents, the paediatricians and the employers) are all interested in ensuring that the highest standards of medical performance are achieved.

The aims of CPD should be to update and enhance how doctors apply their knowledge, skills and attitudes to improve their performance in their working lives. With rapid advances in scientific progress and the introduction of new technologies, it is essential that safety is the top priority on their introduction. To close the audit loop, it is imperative that we develop methods to show that better quality CPD will produce a quantifiable improvement in paediatric practice. CPD can rightly be described as a quality improvement exercise directed at ensuring that good doctors remain good and get better.

To their peers, and indeed to themselves, paediatricians are accountable on ethical grounds for ensuring that CPD maintains and develops their safe practice.

HOW BEST CAN WE ACHIEVE THESE DESIRED OUTCOMES?

This is best achieved by supporting adult learning with individual paediatricians setting their own learning agenda. This should include a documented overview of the doctor's clinical activities followed by an assessment of CPD needs and a proposed CPD programme. The resources required for CPD involve time, money and continuing peer support. Improved methods of confirmation of CPD have been developed and these include electronic registration and certification and these facilitate accountability in this area.

For paediatricians who have a lifelong involvement in CPD, new technologies such as internet-based education are increasingly attractive. Self-directed learning is an active process and is more likely to be effective than traditional didactic teaching but it is, however, more time consuming.

In monitoring the quality of CPD, points-based logbooks of CPD activities are popular but one should give consideration to differential scoring depending on the nature of the educational activity. The result of CME activity and certificates of attendance at educational meetings should be entered in each paediatrician's personal portfolio.

For individual paediatric departments, it is important that an external review of the learning environment take place and this may include a formal departmental visit by the relevant national society.

CESP believes strongly that each national society should promote the development of appropriate structures for CPD, motivate the provision of necessary resources and encourage the involvement of all paediatricians in CPD activities and programmes. In the CME Charter, CESP recommended that 'The professional coordinating authority should keep a register of continuing medical education activities both in the country and abroad'. Irrespective of the method of funding, adequate provision must be made to ensure that a specific budget to support CPD in each country is maintained.

WHAT STRUCTURES ARE NEEDED TO ACHIEVE THIS ?

Each country will have its own means of delivering CPD and the role of CESP and UEMS is to ensure that structures, once established, are well funded and managed.

For quality improvement, responsibility for the maintenance of standards usually rests with national educational bodies.

The European Accreditation Council for CME (EACCME) is an UEMS structure that is responsible for the recognition of CME/CPD across national boundaries.

The structures responsible for the delivery of funding of CPD will vary depending on national arrangements and the balance between the private, insurance and employed sectors. Funding from third parties, such as the pharmaceutical industry, must be transparent and should only be permitted in accordance with national and international guidelines.

PROPOSED BASIC AND ADVANCED MODEL STRUCTURE:

We wish to highlight in full both models and propose that, if acceptable, individual countries and paediatric associations adopt and amend either model depending on their particular stage of development. It is also proposed that one would, in time, naturally progress from the basic model to the advanced one. It is important to stress that these are only templates and it is felt that national associations will amend and adjust these models to suit their own needs and circumstances.

The essential difference between the basic and advanced models is that the basic model does not require either a Professional Development Plan (PDP) or a portfolio.

A. BASIC MODEL FOR CME/CPD :

1. Mission statements:

a. Medical education is to be a lifelong and never-ending process

b. Paediatrics is global and paediatric education should also be

2. Basic constituents and their individual functions:

(a) Relevant medical/paediatric association:

This system may operate on a regional/state or national basis and is the responsible authority for setting appropriate CPD targets for individual paediatricians. The recommended standard is at least 50 hours per year. Paediatricians are required to identify educational activities as clinical, academic and professional. At least 80% of activities should be in the clinical category. There should be an equal split between internal (those carried out with colleagues within one's own institution / practice) and external (those carried out outside one's own institution/practice).

Recording of CPD activity is voluntary and the relevant medical/paediatric association should set out a CPD record book that is simple to follow and the individual paediatrician should send back their CME credit details to the relevant association on a yearly basis. An audit of returns must be kept and targets for completed returns must be revised upwards on an annual basis. Each association must have a chairperson who is responsible for CPD and who oversees these returns. Targets for completed returns should be modest on year 1 (20%) but should rise to > 80% by year 5 of the successful implementation of the programme. Random audits of individual paediatrician CPD credits (whether returned or not) should be conducted and these should be presented, on an anonymous basis, to the board of the national/state/regional association for discussion.

(b) National/international meetings:

All meetings should have a pre-meeting validation system whereby a set number of CPD credits is assigned to the meeting and the content of the meeting and meeting programme is sent out in advance to the CPD chairperson of the relevant association who then issues the number of credits that the meeting is recognised for. All meetings require an attendance list to be kept and all are required to clearly display to participants the number of CPD credits per session of the meeting. All meetings should include a meeting/ session evaluation record and a resume of this evaluation should be sent by the meeting organizer to the CPD chairperson. The issue of sponsorship by pharmaceutical companies is a difficult one and the CPD

credits issued are always at the discretion of the CPD chairperson . National scientific meetings should try to incorporate specific CPD sessions with small group discussion and active audience participation

(c) *European Accreditation Council for CME/CPD (EACCME):*

The EACCME was established in 1999 to coordinate reciprocal accreditation of CPD activities in Europe. The growing integration of Europe and the right to free movement between countries necessitates European coordination and EACCME fulfils that purpose. The EACCME will not provide accreditation of CPD activities directly but will connect existing and emerging accreditation systems in Europe and will act as a clearing house for accreditation of CPD in Europe. It does not supercede the national authority for accreditation of CPD.

UEMS/EACCME criteria for quality of CPD should be developed to emphasise the following :

1. members of the target audience should be on the planning committee for meetings
2. learning objectives should be derived by needs assessment
3. evidence-based methods for paediatric practice should be emphasised
4. the opportunity for participants to receive feedback on their learning should be built in

(d) *PREP programme:*

Following excellent work by Helmut Helwig and others , the American Academy of Paediatrics PREP programme has been made available at lower cost to CESP members and paediatricians throughout Europe. Uptake to date has been variable but there is a role for this programme in aiding CPD within Europe

SUMMARY:

Under the guidance and supervision of the national /regional paediatric society , the above 4 components are the cornerstone of a successful CPD process which can be built upon if one wishes to progress to the advanced CPD model

B. *ADVANCED MODEL FOR CME/CPD:*

Continuous lifelong learning has always been a feature of effective medical practice. In this advanced model the term CONTINUING PROFESSIONAL DEVELOPMENT (CPD) is used and the intention is to help paediatricians to maintain standards , interest and enthusiasm in their practice , to protect their skills and professional competence and to develop new skills in accordance with changing medical practice

This advanced model for CPD is intended to be practical , flexible and realistic. It should support the paediatrician's professional development and should be easy to follow and not intrusive.

For advanced CME the essential elements include :

(a) *Relevant medical/paediatric association:*

Validation and monitoring of the CPD process is the responsibility of the relevant medical/paediatric association

External CPD usually requires study leave in protected time and includes organized meetings and courses and personal visits to outside institutions to acquire new skills. Internal CPD includes unit clinical meetings , multidisciplinary meetings , grand rounds , community education sessions and clinical audit meetings.

The relevant medical/paediatric association should specify that:

- (1) the basic unit of CPD will be one hour
- (2) The target will be 50 hours per year
- (3) One whole study day will normally be allocated 6 credits in educational time with a maximum of 7 credits if evening sessions are included
- (4) Half day sessions will be allocated 3 credits
- (5) At least 50% of credits will come from external CPD with the remainder from internal CPD
- (6) The CPD certification period will be five years from entry into the cycle
- (7) Attendance at international events will be considered individually by the CPD subcommittee and prior authorization from the CPD office is required
- (8) Doctors in part-time employment/job-sharing arrangements need to fulfill the same CPD requirements as those in fulltime employment
- (9) A CPD record will be sent to each paediatrician and details relating to all internal and external CPD activities attended should be entered in this CPD record and this should be retained by the individual paediatrician with 3 monthly postcards sent to the relevant medical/paediatric association indicating CPD credits obtained
- (10) Monitoring of CPD will be via a random review of the CPD records on an annual basis. This will require that the individual paediatrician selected will be required to send in additional documents to verify activities attended
- (11) Participating paediatricians may request an annual summary statement of their CPD credits
- (12) A list of those who have fulfilled the CPD requirements will be maintained by the relevant medical/paediatric association
- (13) Satisfactory completion of a 5 year cycle will earn a CPD certificate
- (14) Participation in the CPD scheme is necessary if a paediatrician is to be deemed to be 'in good standing' and non-participation should exclude a paediatrician from being an office holder in the association or from being an examiner
- (15) Issues such as paediatricians working in geographically isolated areas, those with an inadequate study budget and those with increased domestic commitments need to be explored by the relevant medical/paediatric association

(b) Personal portfolio-based learning:

This is a process whereby one keeps a record of less formalized learning and this may be tabulated in a REFLECTIVE NOTES format which would describe a clinical experience and detail how this experience highlights any further learning needs. The maximum number of credits claimed for this should be capped and may vary between national organizations. Small group discussions and shared experiences with a clinical practice review format are extremely useful and may be aided by a telemedicine link in areas of geographical isolation

(c) Online CPD 'Home':

This is adapted from the American Academy of Paediatrics and is based on the PREP programme and it allows paediatricians design their own CPD programme and gain individual feedback from the system. It starts with a subjective needs assessment and there is then a response with some recommendations. The site is customized to each user and is endlessly revisable. Updates on CPD requirements occur automatically and are available to each user. This system is in operation in the USA and has been very successful.

SUMMARY:

The advanced CPD model brings in an element of validation of CPD returns by the relevant medical/paediatric association and also entails the personal learning experience (either portfolio-based or created via CME on line 'home') and the Professional Development Plan (PDP). Both systems require funding and commitment by the relevant paediatric association to succeed. Thus CPD 'belongs' to the individual paediatrician and is not 'run' by an agency but there is a need for the organised collection of evidence of appropriate activity together with some audit of the adequacy of any individual paediatrician's programme for CPD. Effective CPD schemes are flexible and are largely based on self-assessment so that paediatricians can develop what they do in the context of their individual professional practice while also being able to prove they are doing so when subjected to external scrutiny.

We, in CESP, can achieve a CPD programme that complies with the Basel Declaration of UEMS, these being (a) to improve the safety and quality of medical practice, (b) to encourage the principles of life-long learning, (c) to make transparent the outcomes, processes and systems for successful implementation and (d) to audit progress.

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