EUROPEAN UNION OF GENERAL PRACTITIONERS

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Euroopan Yleislääkärijärjestö – UEMO
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BASEL DECLARATION (UEMS D 0120)
UEMS POLICY ON CONTINUING PROFESSIONAL DEVELOPMENT

INTRODUCTION

This paper sets out the policy of the Union Européenne des Médecins Spécialistes/ European Union of Medical Specialists (UEMS) for the implementation of continuing professional development (CPD) for specialist doctors in Europe. CPD is defined as the educative means of updating, developing and enhancing how doctors apply the knowledge, skills and attitudes required in their working lives. The UEMS therefore believes that CPD is essential for ensuring high standards of medical practice.
This paper represents the policy of UEMS on CPD as a form of Quality Improvement within healthcare; its policy on Quality Assurance is available separately and is being further developed.
The paper is addressed to all who have an interest in this area: patients, doctors, medical associations, health service employers and fund-holders, CPD decision-makers, national and European legislators. While these groups may start from different positions when considering the subject of CPD, the UEMS believes that all can be united by a common agenda. This consensus requires the implementation of a system based on:

I. defining the desired outcomes of CPD - both the maintenance of safe standards of practice, and encouraging the achievement of the highest quality standards;

II. determining the processes required to achieve these outcomes, making CPD more readily available and making involvement in CPD more effective and verifiable;

III. agreeing structures and funding sources - specific to each country's healthcare structure - that will support the implementation of CPD for all specialist doctors.

The following summary provides a list of recommendations drawn from the text and is designed to act as a means of identifying those who can assist in implementation. It also acts as an index to specific paragraphs of the paper.

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RECOMMENDATIONS

CPD incorporates and goes beyond CME; it should therefore be the preferred concept (3 and 4)
Action: All interest groups.
CPD builds on the well-developed tradition of life-long learning in the medical profession (5,6,9) and is part of the ethical responsibility of every doctor (7, 25)
Action: Doctors, medical associations.
There must be a greater recognition of the legitimate interests in CPD of all who hold a stake in the quality of medical practice: patients, profession, employers and health service fund-holders (10).
Action: All interest groups.

Ultimately it is the patient, as the consumer of medical services, who pays for CPD and benefits from the improved quality of healthcare that results from this (11, 41).
Action: All interest groups.
To develop an optimal system for CPD it is necessary to determine the desired outcomes, consider the processes involved and agree the structures required to deliver these (15, 16)
Action: All interest groups.
CPD should be supported for all doctors, who should acknowledge their responsibility for its implementation and in ensuring its effectiveness (17, 25, 42)
Action: Employers, fund-holders, doctors, medical associations.
CPD is an essential means of improving the quality and safety of medical practice (18)
Action: All interest groups.
The educational impact of CPD should be audited and more accurate indicators should be developed to support this (20, 21)
Action: Medical associations, CPD decision-makers.
CPD is a developmental process. It serves a different purpose and is distinct from processes that confirm continuing fitness to practise, or that deal with practitioners with problems (22 - 24, 46)
Action: Employers and fund-holders, CPD decision-makers, national and European legislators.
Each doctor should confirm their involvement in CPD and review its educational outcomes (28 - 30)
Action: Doctors, medical associations.
Account must be taken of different learning methods and new information technologies when developing educational activities (33, 34)
Action: Doctors, medical associations, CPD decision-makers.
When determining educational needs consideration must be given both to core CPD and to specialised CPD components (35)
Action: Doctors, medical associations, CPD decision-makers.
When assessing the implementation of CPD, it is essential to consider both the individual doctor and their work and learning environment (36 - 38)
Action: Doctors, medical associations, employers and fund-holders, CPD decision-makers.
Greater consideration must be given to the nature of CPD activity: active learning having a greater impact on the quality of practice (34, 37)
Action: Doctors, medical associations, CPD decision-makers.
Readily accessible registers of available educational activities must be maintained (39, 40)
Action: Medical associations, CPD decision-makers
While the outcomes of CPD may be common for all doctors, the principle of subsidiarity - specificity according to national circumstances - should be accepted for educational

structures, funding and accountability mechanisms (19, 44 - 47)
Action: Medical associations, employers and fund-holders, national and European legislators.
Appropriate resources must be made available for CPD. These include time, money, peer-support, and educational opportunities (41, 42, 48)
Action: Health service employers and fund-holders, national and European legislators.
Irrespective of the funding stream, a specific budget to support CPD must be maintained (41, 48)
Action: Medical associations, employers and fund-holders, national and European legislators.

SECTION 1: INTRODUCTION

The role of the UEMS

1. The Union Européenne des Médecins Spécialistes/ European Union of Medical Specialists (UEMS) is the representative organisation for specialist doctors from the national associations of all EU/EEA states and a number of non-EU/EEA countries. Its activities cover the full range associated with specialised medical practice and are jointly carried out by its Management Council and more than thirty Specialist Sections.

2. The UEMS believes that it has a responsibility to assist in achieving a consensus on the future of the continuing professional development (CPD) of doctors in Europe. It is the aim of this paper to develop this agenda rather than merely to describe the current situation.

What is CPD?

3. The UEMS defines CPD as the educative means of updating, developing and enhancing how doctors apply the knowledge, skills and attitudes required in their working lives. The goal of CPD is to improve all aspects of a medical practitioner's performance in his/her work.

4. CPD therefore incorporates the concept of CME, which generally is taken to refer only to expanding the knowledge and skill base required by doctors. While the initial model of continuing education for practitioners focused on CME, an increasing recognition of the many components that contribute to good medical practice has led to CPD being accepted as the more appropriate concept.

5. There is a continuum from undergraduate medical education (UGE) through postgraduate training (PGT) to continuing professional development (CPD). CPD forms part of a personal programme of life-long learning that every doctor is engaged in from his/her first day at medical school until their retirement from practice.

The traditional bases for CME and CPD

6. There is a strong tradition of continuing education in the medical profession and the most powerful motivating factors are positive ones. These include each doctor's awareness of their responsibility for safe medical performance, the recognition of peers, and a collective emphasis on the quality of medical practice. While they certainly may play a part, potentially punitive factors - such as loss of status, a formal need to engage in CME/CPD activities and requirement for employment purposes - are less frequently relevant.

7. The UEMS believes strongly that CPD is part of the ethical responsibility of every doctor and recommends that all doctors should be able to verify their involvement in CPD activities. While there is considerable debate over whether CPD should be mandatory or voluntary, there is no European-level consensus on this.

Doctors as life-long learners

8. CPD also incorporates the principles of adult learning, in which doctors are expected to assess their educational needs and to identify the means of achieving these. There is also a shift from relying on passive learning (the traditional method of education through lectures) to a greater emphasis on active learning - in which the individual is expected actively to seek appropriate educational opportunities, synthesise these, and apply them to their own practice.

9. Doctors typically want to improve their practice, have many ways of learning, can identify their learning needs, and want to be supported as adult learners. They work in a learning-rich environment and, by the nature of their work, are capable of demonstrating positive outcomes from their engagement in CPD. These characteristics are particularly important as they provide the opportunity for determining a more reasoned approach to CPD.

CPD in a modern context

10. The provision of healthcare involves four broad groups of stakeholders, each of which has a legitimate interest in ensuring that the highest standards of medical performance are achieved. These groups can be summarised as: society as a whole and individual patients; the professionals who care for them; health service employers; and those that provide the funding for healthcare.

11. Due to the differences in the health service systems in Europe, considerable variations exist in the relationships between these groups. It is a common principle however that ultimately it is the patient, as the consumer of medical services, who pays for CPD and benefits from the improved quality of healthcare that results from this. This occurs either directly, in the case of private healthcare, or indirectly, in insurance-based systems or taxation-funded national healthcare systems.

12. CPD has become a contentious issue. This is due to changing societal expectations, the changing role of doctors, the development of new medical technologies, and increasing difficulties in funding healthcare systems. CPD is also seen as a tool to improve clinical efficiency and increase practitioner accountability.

The power of consumers

13. Doctors, in common with other professional groups, are being challenged by what can be described as a “consumerist agenda”. Society has for a long time had an absolute requirement for an increasing quantity of medical care; more recently there has also been a greater focus on the quality with which those services are provided. Similarly, through deregulation, there have been attempts to review the responsibilities of the professionals who provide healthcare. These changes have also been accompanied by a greater emphasis on accountability, openness and transparency.

14. While this may be considered threatening by some doctors, the UEMS believes that the consumerist agenda provides the medical profession with the opportunity to demonstrate the large amount of good work that already has been achieved in delivering efficient, high quality medical services.

The approach of this paper

15. The UEMS believes that an analysis based on outcome, process and structure is required to address the future of CPD. On the following pages this paper focuses on each of these individually.

SECTION 2: WHAT DO WE WANT FROM CPD?

Desired outcomes

16. The UEMS believes that consensus exists among the four major stakeholders - patients, profession, employers and fund-holders – that the primary outcome is that all can be assured that each doctor is maintaining and developing his/her performance in their field of practice. This involves both the maintenance of safe standards of practice, and encouraging the achievement of the highest quality standards.

Maintenance

17. CPD – through focusing on its defined aims of updating and enhancing how doctors apply their knowledge, skills and attitudes – is essential to ensuring that doctors maintain and improve performance in their working lives. If appropriately implemented, CPD will also enable doctors to demonstrate that they are actively working to achieve these aims.

Development

18. With rapid advances in scientific progress and the introduction of new technologies, it is essential that these are introduced with safety being a priority. It is generally accepted that practitioners who are well educated and trained to fulfil specific tasks are less likely to make errors when using these new therapeutic modalities. Education is therefore recognised as a safety mechanism, with the concept extending from CPD to improved quality to increased safety of practice.

Specialty-specific outcomes

19. The UEMS believes that, given the consensus that likely exists regarding the general outcomes of CPD, it will also be possible to develop specialty-specific outcomes that could be applied in each country's CPD system. While most work in this area will be done at a national level, the Specialty Sections of UEMS would be well-placed to assist in harmonising such outcomes between European countries.

Assessing effectiveness

20. With increasing constraints on healthcare budgets, the funding of CPD will become more dependent on its proponents being able to demonstrate its worth. Thus far relatively little research has been carried out in this area but this would be essential to the development of a planned audit loop for the provision of CPD. By assessing the impact of CPD as an educational intervention, it will be possible to ensure that better quality CPD is provided and also to allow doctors to show that they are engaged in an activity that produces a quantifiable improvement in their practice. The UEMS therefore strongly supports the continued development of work in this area.

21. Suggested measures that would be able to provide such information include performance indicators that demonstrate improved patient care. These may either be global and related to the totality of a doctor's practice, or surrogate indicators specifically focused on discrete educational outcomes. The latter category includes measures that demonstrate learner satisfaction, beneficial changes in practice and

positive changes in attitude. More difficult to measure, but readily assessed by peer review, is the development of reflective practice, in which doctors consider their clinical work in the light of educational information and use this as a learning opportunity, developing a "learn, work, learn" cycle.

The quality agenda

22. Much has been written on the subject of quality within healthcare; unfortunately this has not always increased clarity in this area. The UEMS believes strongly that components of quality management as applied to medical care have specific applicability and must be kept separate. In the context of this paper the UEMS defines Quality Improvement (QI) as a continuous striving to provide better practice. CPD can therefore be described as a QI process that ensures that good doctors remain good and get better.

23. The concept of Quality Assurance (QA) should be kept separate from QI. Examples of QA processes include audit and performance review, both best applied to the confirmation of continuing fitness to practise. In a similar manner Quality Control (QC) is a wholly distinct area, related to medical regulation, in which doctors who have been identified as having difficulties with their practice are assessed and appropriate action is instituted.

Accountability

24. It is essential that this separation of QI, QA and QC components is maintained when ensuring that appropriate methods of accountability are implemented. These should correctly be dealt with by separate bodies, each with a specific responsibility. It is for this reason that the UEMS does not support the use of CPD as a means of revalidating a doctor's registration or recertifying a doctor's practice privileges; this would be an inappropriate confusion of QI and QA, and could lead to the discrediting of both types of initiatives.

25. Doctors must recognise that they are accountable for their involvement in CPD, and that this is to each of the four major stakeholders. To their medical peers, and indeed to themselves, they are accountable on ethical grounds for ensuring that CPD maintains and develops their safe practice. In addition to their patients, their employer(s) and healthcare fund-holders they are accountable by virtue of their performance and the funding of CPD.

SECTION 3: HOW BEST CAN WE ACHIEVE THESE DESIRED OUTCOMES?

Introduction

26. A few basic principles related to educational theory as applied to healthcare organisations will help in determining the best means of achieving these proposed outcomes of CPD. Healthcare systems are complex and tend to respond slowly and cautiously to innovation; they also tend to have complex problems. To implement change requires careful preparation and a high degree of consensus. People, however willing, are more able to deliver change if they have the time to do so and the financial resources that are required.

27. Every action has an equal and opposite reaction: assessment determines learning and outcome. All learners tend to bias their educational work towards what they know will be required of them. CPD must therefore be sufficiently all-encompassing and developmental for specialists to feel able to take part without feeling threatened.

Supporting adult learning

28. Each doctor should be able to verify their involvement in CPD. This can readily be achieved via a personal portfolio in which all relevant information is gathered. Ideally this would include a documented overview of the doctor's clinical activities followed by an assessment of CPD needs and a proposed CPD programme. Electronic registration and certification would further help the doctor to confirm that these CPD activities had been completed.

29. Various methods have been described to support doctors in their continuing development. One example is that of peer-review and formative assessment, in which the doctor meets with a colleague to discuss and evaluate their CPD programme. Doctors who take on the responsibilities of this peer-review role should themselves be specifically trained for this, and should command the respect of their colleagues and those funding CPD.

30. After having taken part in educational activities, doctors should assess the outcome and appropriateness of these. This may be through a personal review of the resultant changes in their practice or, through a process similar to that described above, through discussion with a peer. Again, a cycle of "learn, work, learn" is to be encouraged.

31. The resources required for CPD involve time, money and continuing peer support. While the source of these resources and the means by which they are allocated will differ according to the structure of the healthcare system in which the doctor works, without these resources plans to implement CPD will fail. The major interest groups must agree that it is to all of their advantage that doctors are supported in well-resourced CPD programmes.

32. Irrespective of the nature of the healthcare system the learning culture in medicine must be developed further. Doctors must be able to recognise that their educational activities are valued and are given full support. At the same time all interested groups should be able to feel that doctors are engaged in a meaningful CPD programme that produces valid outcomes.

Learning methods

33. Educational research informs us that doctors have individual learning methods and that no single method is applicable to all. Individuals develop their own ways of learning and, while they continue to acquire new methods of learning, tend to rely on those with which they feel familiar. However, it is inappropriate to rely wholly on stereotyped forms of instruction. New technologies, such as interactive CD-ROMs or internet-based education, may prove increasingly attractive.

34. As adult learners, doctors must therefore be able to engage in a range of educational activities. At the same time it must be recognised that some degree of direction is required. For example, while didactic teaching is a popular and efficient learning method, it is less likely than other methods to influence practice as it requires a relatively passive response from the audience. In contrast to this, self-directed learning is an active process and, while relatively time-intensive, is more likely to be effective. In reality both methods are necessary for optimal learning.

35. This is particularly relevant when the concept of core CPD is introduced through which doctors engage in educational activities that update their basic medical practice. Many generic skills and behavioural attitudes fall into this category, which

are important in the overall context of CPD. An appropriate balance therefore must be achieved with the areas of knowledge and skills development that are the focus of the doctor's specialist practice and belong to their optional (or specialised) CPD – the area of knowledge and skills development that are the focus of their specialist practice.

Accountability methods/ Monitoring Quality

36. For a full assessment to be made it is essential that both individual doctors and the healthcare organisations within which they work and learn are subject to regular review. In this manner the relative influences of each factor can be considered: the learner and their learning environment.

37. For individual doctors, methods such as a CPD portfolio, a points-based logbook of CME/CPD activities, or an education-based assessment of their clinical practice may be relevant. In keeping with a QI process this review should primarily be a formative one. Where a points-based system is used to confirm CPD activity, greater consideration should be given to differential scoring depending on the nature of the educational activity. An active process, while less readily quantified in terms of time, is more likely to yield educational results than a lecture attended. Simply being present at an educational event cannot of itself be considered a meaningful learning outcome, and consequently is a poor basis for any accountability method. This process of review must incorporate these concepts in order to be methodologically valid, retain the confidence of doctors and be supported by them.

38. It is also important that external review of the learning environment is performed. This is a collective review process and may include departmental visits - such as those performed by the Specialist Sections of the UEMS in accordance with its 1997 "Charter on Visitation of Training Centres". Other methods include the departmental analysis of critical incidents, or national reviews of patient deaths. Problems that initially may be reflected in the inadequate CPD of one individual may thus be considered in a wider context; beneficial changes are likely to require a similarly broad approach.

Register of available CPD activities

39. It is essential that a range of educational activities is made available to doctors, both in terms of their nature and where they are offered. The range should, for example, include CPD activities offered by individual departments, employing bodies and educational authorities, and listings should draw attention to local, national and international meetings. The use of modern information technology systems, such as updated websites, should be considered as a means of ensuring that this is achieved.

40. In its "Charter on Continuing Medical Education", published in 1994, the UEMS recommended that "the professional co-ordinating authority or its delegate should keep a register of continuing medical education activities both in the country and abroad". This remains valid but regrettably has not always been achieved.

Funding

41. The remuneration of doctors in Europe varies according to the nature of the healthcare structures within which they work. Practitioners work in private practice, insurance-based systems, are employed by hospitals or by their government. As a general principle, it must be recognised that CPD benefits all four major interest groups; it is therefore appropriate for CPD to be a defined part of the remuneration package for doctors. It is also a general principle that ultimately it is the patient, as

consumer, who pays for CPD, either directly as part of their payment for medical services, or indirectly through insurance premiums or through general taxation. Irrespective of the funding stream, a specific budget to support CPD must be maintained.

42. CPD can therefore be considered part of a wider "social contract" between doctors, their patients, their employers and healthcare fund-holders. Resources, including funding, are provided for doctors to undertake appropriate educational activities; in return they are required to demonstrate positive outcomes from their educational activities. It is the strongly held view of the UEMS that without the necessary resources doctors cannot be expected to deliver the comprehensive CPD agenda recommended here.

43. The UEMS believes that because of the different healthcare structures in Europe - in addition to its own efforts - it is the responsibility of national bodies to promote the development of CPD, motivate for the provision of necessary resources, and encourage the involvement of all doctors in CPD activities and programmes. This reflects the view recently taken by the European Parliament but should not exclude the potential for a more harmonised approach to CPD provision and funding.

SECTION 4: WHAT STRUCTURES ARE NEEDED TO ACHIEVE THIS?

Educational opportunities

44. It should be clear from the functional approach adopted above that an appropriate balance between local, national and international CPD activities must be made available. Doctors need access to all of these. Each country will have its own means of delivering CPD; it is only necessary here to recommend that these structures are developed, are well funded and managed, and are accountable to doctors - who in this context are themselves the consumers - for the quality of CPD provided. The UEMS "Charter on Continuing Medical Education" provides additional detail about these recommended structures.

Means of delivery

45. Again the principle of subsidiarity must be acknowledged. It is essential that the full range of CPD activities is made available at each structural level and that doctors are able to engage in CPD in a manner that is suitable to their personal portfolio needs and to their preferred learning method. Currently in Europe there is a bias towards more didactic means of CPD delivery. The UEMS challenges all providers of CPD to widen the range of their activities and invites innovative thinking in this area.

Relevant organisations

46. There are significant variations between European countries as regards the structure of organisations providing and managing CPD. These may be any or all of a range of governmental, collegiate, hospital-based or private educational institutions. In accordance with its view that QI, QA and QC must be kept separate, the UEMS believes that a functional approach provides a necessary and simple means of determining which national or regional structures are best suited to each of these roles. It is the responsibility of national medical associations to ensure that the relevant bodies are identified or established.

How to link these

47. As yet the links between CPD providers have tended to be at a national level. The UEMS has established the EACCME - an international structure that has defined quality requirements for the recognition of CPD activity and provides the opportunity for CPD recognition to be extended beyond national boundaries (see appendix 1). Models of this nature increase the potential for the harmonisation of outcomes of CPD while acknowledging subsidiarity for the structures that provide it.

Funding

48. The structures responsible for the delivery of funding of CPD will vary depending on national arrangements and the balance between the private, insurance-based and employed sectors. The UEMS believes that the governing principle is that the methods for financial accountability - both for individual doctors and for CPD providers – must command widespread confidence and be based on openness and transparency. Funding from third parties, such as the pharmaceutical industry, must comply with these criteria and should only be permitted in accordance with national and international guidelines.

Adopted unanimously by Management Council, 20 October, 2001.

Appendix 1, the EACCME:
The UEMS established in 2000 the EACCME, the European Accreditation Council for Continuing Medical Education. Its purpose is:

- Harmonization and improvement of the quality of continuing education in Europe,
- Provision of non-biased education to European colleagues according to mutually agreed quality requirements.
- Guarding of the authority of national CME regulatory bodies in the European countries
- Linking the national CME regulatory bodies in a system of mutual recognition of accreditation of CME activities.
- Providing a system in which CME credits obtained abroad in EACCME accredited activities are recognized by the national CME regulatory bodies.
- Providing links with similar systems outside Europe.

The EACCME improves the accessibility to CME for the medical specialists in Europe and encourages international exchange of knowledge and skills.
The practical instrument to improve the quality of CME in Europe is the facilitation of transfer of CME credits obtained by individual specialists in CME activities that meet common quality requirements:

- Between European countries
- Between different specialties
- In case of migration of a specialist within Europe
- Between the European credit system and comparable systems outside Europe.

Although the transfer of CME credits is presently the main goal of the EACCME, in the next future the European transfer of CPD credits/outcomes will be fitted into the system. A reliable conversion system has to be designed for this purpose.
Appendix 2, References:
See UEMS website, corresponding pages and yearly lists of numbered documents:

1. Comité Permanent: Dublin Declaration, Funchal update 1994. UEMS website, page "CME"
2. UEMS Charter on Continuing Medical Education, 1994. UEMS website page "CME"
3. UEMS position on Continuing Medical Education, 1994. UEMS website, page "CME"
4. Comité Permanent Policy statement CP2001/082 (www.cpme.be), UEMS D 0130
5. CME, European Quality Requirements, see document D 9908.
6. EACCME, History and Political Background, document D 0134.

7. EACCME, Purpose and Procedures, document D 0140.

8. EACCME general information, see corresponding page "EACCME" on UEMS website

9. UEMS Specialist Sections and European Boards, CME policy, see corresponding pages "Sections" and "CME" on UEMS website.

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