

**THE UEMS OCCUPATIONAL
MEDICINE MONOSPECIALIST SECTION:
PROPOSAL FOR
CONTINUING MEDICAL EDUCATION (CME)**

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1. Introduction

There has been increasing focus on continuing medical education after specialty recognition in the past five years. The European Union of Medical Specialists has already in 1994 written a charter on continuing medical education, CME (see appendix 1). Several other monospecialist sections have already formulated their CME proposals. Some countries have established CME programmes with varying degrees of voluntary participation. On this background it was decided at the meeting of the occupational medicine monospecialist section in October 1998 in Brussels to establish a working group with the purpose of developing a proposal for a CME programme. The working group met in Copenhagen September 2 and 3, 1999. Members of the working group are:

Sven Viskum, chairman, Denmark,

Ewan Macdonald, UK

Vlasta Deckovic- Vukres, Croatia

Jadranka Mustajbegovic, Croatia

David Sherson, Denmark.

2. Definition, scope and goal

CME is all formal educational activities after receiving specialist recognition in occupational medicine, that serve to maintain, develop and enhance knowledge, capabilities and professional behaviour which are necessary when functioning as a physician for patients, colleagues, businesses and the public. The aim of this process is to support the individual physician and in a helpful and constructive manner assist them to maintain and where necessary improve competence .

The minimum goal is to maintain the list of core competencies agreed upon by the monospecialist section of occupational medicine (see appendix 2). The concept of CME is very broad and can include the following areas:

- quantitative point system
- peer review of CME activities
- clinical audit
- reading of literature and journals

CME should be seen as part of a quality assurance system to maintain the doctor's continuing competence. On its own a self-directed CME programme may not always be effective. The CME

record of the doctor is usually subject to periodic audit by the professional body which has responsibility for occupational medicine in each country .However the doctor should have annual peer review and appraisal by another occupational medical specialist to assist the doctor in identifying his or her training and development needs. The purpose and outcome of such review should be to help the doctor plan his or her future CME programme.

The current proposal primarily focuses on a quantitative point system as already exists in a V number of countries. In the future it will be an important task for the monospecialist section to further develop CME to include the additional above mentioned areas.

CME structure and development should be controlled by the profession itself.

3. Responsibility for CME

Both the physician and employer share an ethical and moral responsibility to maintain continuing medical education as described in appendix 1.

- 3.1 The individual physician has the responsibility to actively seek and participate in CME activities.
- 3.2 The employer has the responsibility to provide economic and structural support including paid educational leave, transportation costs, congress/course fees, etc.
- 3.3 The suggested minimum level of activity should be: 50 hours per year averaged over a 3 year period.

4. Any CME-programme should have the following characteristics

- 4.1 Visible and documentable
- 4.2 Relevant and need related
- 4.3 Life long
- 4.4 Structured
- 4.5 Evaluate able
- 4.6 Ensured quality
- 4.7 Develop quality

5. Any CME-programme should have the following organization and tools

- 5.1 CME log book/diary
- 5.2 Central registration of CME activities, e.g. using internet

- 5.3 Accreditation of CME providers and activities
- 5.4 Approval of CME activities
- 5.5 Annual reporting of overall activities
- 5.6 Annual individual reporting (only the individual should have access to his or her data)
For general organizational considerations see appendix 1.

6. Structure

6.1 Quantity

CME should consist of a minimum of 50 hours per year averaged over a three year period. At least 30 of these hours should be EXTERNAL (see below).

6.2 Content

The content of CME should have multiple aspects, including the acquisition of scientific knowledge, attendance at courses and seminars, the development and maintenance of clinical skills. participation in scientific fora, and publication of scientific papers.

6.3 Active or passive

Activities may be active or passive, i.e. the extent to which the individual is involved in the learning process. Listening to a lecture would be regarded as passive, while presenting a lecture as active, particularly if it is a new presentation by the speaker. Active learning is more valuable than passive.

6.4 Internal

Internal CME is generally considered not to involve study leave or specific funding, but is of definite educational value. Particularly if the involvement is active. Internal CME could include:

6.4.1 -Audit and standard setting activities

6.4.2 -Journal Club

6.4.3 -Operational research

6.4.4 -Personal development courses e.g. management, IT skills.

6.4.5 -Other activities e.g. policy development. Lecturing

6.5 External

External CME usually requires specific funding and absence from normal work activity. It includes:

6.5.1 -Attendance at a wide variety of courses

6.5.2 -Conferences

6.5.3 -Workshops

6.5.4 -Scientific, symposia, and industry specific meetings with educational value

6.5.5 -Study visits to other institutions

6.6 Publishing, teaching, lecturing

These may be either viewed as internal or external activities. Peer reviewed publications will usually be of more worth than review articles or policy documents. Teaching is of more value if it is not a repetition of previous presented material. Lectures at a prestigious international conference are of more value than at a local professional meeting. All the following can be considered to be CME-activities:

6.6.1 -Presenting papers

6.6.2 -Structured clinical attachments

6.6.3 -Publishing peer reviewed papers

6.6.4 -Chapters

6.5 -Books

6.6.6 -Professional activities related to the development of the profession such as:

-examiner

-supervisions trainee

-working groups/boards.

6.7 Relative value of courses

Some courses may be of much more educational value than others and this must be considered in the planning of individual' CME activities. The highest value courses would be those for which there is prior CME accreditation, defined learning outcomes, good course material, high quality speakers, and testing and evaluation of attendees. Such courses would normally be available from academic institutions, such as universities, colleges and professional institutions and may include the acquisition

of degrees. The relative value of such courses can be apportioned by an appropriate points system which is used in some countries.

6.8 Audit And Quality Control

It is essential that effective mechanisms are in place to ensure that the CME process meets its objectives. Thus there should be evaluation and approval (prospectively or retrospectively) of courses and the individual 's CME activities.

The quality of what is done is as important as the quantity and a point system may be used to assess relative value.

7. Consequences/sanctions

A specialist who does not fulfil the requirements of the national CME programme cannot lose his or her status as a doctor or specialist, but must understand that he/she may be personally disadvantaged in other ways. Failure to maintain competence would require the doctor voluntarily to withdraw from the area of practice from which they are no longer competent.

8. Ethics and deontology

Ethical aspects are discussed and described in the UEMS charter on continuing medical education (see appendix 1).

9. Conclusion

CME is an important concept and is quite new and under development. The first task is to gain general acceptance among doctors, employers and authorities. The primary emphasis should be to ensure quality and development of the occupational medicine specialty in a positive manner rather than focusing on sanctions.