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The Core of Continuing Professional Development (CPD) for Physicians and its Relation to the Pharmaceutical Industry and Legal Authorities.



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There is a natural endeavour for development in the medical profession. Through medical school, internship and specialist training, the development of skill is standardised and performance is controlled by the medical faculties and the legal authorities. Once the specialist certification has been achieved, the conditions for continuing professional development (CPD) are no longer specified.

CPD is a process that includes continuing medical education (CME) in the meaning of medical knowledge and skills in addition to subjects such as leadership, communication skills, economics, law and what ever is needed to perform as a physician¹. The continuing professional development of hospital physician in particular, is a question of what the possibilities are like for the individual physician, within the framework of their everyday practise, to actively search for new knowledge in order to develop in their role as doctors.

The Dublin Declaration Emphasizes the Responsibility of the Individual Physician to Obtain CPD

According to the three first statements in the Dublin Declaration continuing medical education is an ethical duty and the individual responsibility of every practicing doctor throughout his or her professional life. Its final purpose is to promote the highest possible and continually rising standards of the medical care provided to the population. It consists of the continuous renewal, extension and updating of scientific knowledge and technical skills necessary to maintain the highest possible professional standards.

In order to live up to these statements, both time and money are required. Throughout Europe the cutbacks in funding and staffing levels in recent years have brought into focus medical productivity, given staff training a lower priority. As a consequence the obligation of maintaining CPD may be jeopardized. It is the duty of the employer to ensure that physicians and staff uphold the necessary professional skills, so that the appropriate medical care can be provided, thus maintaining patient safety.

In order to involve hospital physicians in the CPD-process it is therefore important to start a dialogue between the clinical director and the doctor. They must focus on the needs of both the doctor and the organisation and specify these in a written personal development plan.

The employer's financial responsibility must be made clear by setting aside funds in the budget for this. Although it is a well known fact that this process is a successful tool, it is rarely used (Figure 1).

Is there an Unethical Relationship between Physicians and the Pharmaceutical Industry?

In many European countries the initiative for CME-activities are taken by the medical industry i.e. pharmaceutical companies and providers of medical equipment.

The close relation between the medical profession and the industry has been questioned by the society, especially if social activities have been included. If the CME activities only purpose is to market a product, this criticism can be relevant. However since medicine and the techniques used are becoming more complex the doctor can be considered a consumer representative. In this situation the medical industry has a responsibility to keep the doctor updated.

It makes no sense to create an iron curtain between the medical industry and physicians. Nevertheless, physicians must have the sensitivity, integrity and courage not to accept gifts or invitations to social activities that might influence their impartiality. The reputation of the medical industry will improve if there are ethical rules within the company on how to inform and how to market its products. Throughout Europe there are significant differences in the cultures and in the law regarding bribes. It is very important to remember the fact that there must not be a businesslike relationship between a pharmaceutical company and a doctor. The doctor is solely responsible for giving the patient the right treatment. As the patient representative he or she needs the latest tools and the cost for these should be carried by the employer. The industry can contribute. The integrity of the doctor towards the industry must never be questioned and the responsibility is mutual. Oversight can easily be done by a bureau which is critically reviewing and certifying CME/CPD activities, independent from the medical industry. EACCME (European Accreditation Council for Continuing Medical Education) in Brussels can act as an umbrella to perform this. In several European countries national accreditation bureaus are also being formed.

You Don't Learn to Play the Piano by Simply Listening to the Concert!

In some countries in Europe there is a demand for recertification of physicians at an authority level based on earned CME-credit points. The CPME (the Standing Committee of European Doctors), The European specialist associations within the UEMS (European Union of Medical Specialists) and the AEMH (the European Association of Senior Hospital Physicians) oppose all sanctioning forms of control at authority level. It must be emphasized that whereas the costs for mandatory recertification programs are enormous, there is no evidence that it will affect quality or improve patient outcome. Outcome of clinical practice is fare more complex.

The shortage of resources for CME/CPD can not be solved by directing requirements of CME-credits on individual doctors. The risk is that there might be a chaotic scramble for creditpoints in a system with a heavy bureaucracy far away from the scope or intentions of the CPD process.

The registration of credit points does not measure quality. The score usually indicates the extent of education in hours, and is therefore in most cases only a rough measure of time

spent. Modern healthcare is too complex to put such quality measures solely on the *individual* hospital doctor. Quality control must be managed by the healthcare provider and focus on *the entire healthcare process* in which CPD is a part.

The strongest factor for determining Quality Control in surgical care is hospital mortality. Bennett-Guerrero and co-workers have shown that risk-adjusted mortality rates following major surgery were four times higher in the United Kingdom (UK) compared to the United States (USA). This is not explained by the doctors training. The most likely explanations are factors such as hospital resources and organisation of national healthcare. Thus to provide enough patients of a certain disease within the organisation to give a critical mass to achieve a learning environment to improve and develop quality. For instance, the number of critical care bed per capita in the UK is 8.6 per 100 000 compared to 30.5 in the USA². It is a well known fact that there is an inverse relationship between hospital volume and hospital mortality for major surgery. There are now even reports that high-volume hospitals have significantly longer five-year survival for patients compared to low volume hospital for major cancer surgery³.

CME is Not a Tool to Detect Poorly Performing Doctors

A major problem for national licensing bodies is to detect poorly performing doctors. There is today no evidence that recertification or revalidation nor mandatory CPD are helpful in the early detection of incompetent or underperforming doctors. There is only a small minority not fit to praxis medicine. To identify them and give them a fair chance requires an organisation with a validated assessment program.

A leading country in this field is the United Kingdom where the General Medical Council has developed both an organisation and an assessment program for handling these difficult problems⁴. The criteria is broad and considers lack of medical knowledge, bad relations to patients, arrogance and strange behaviour towards patients. Such a system needs to be adopted within the European Union.

References:

1. Chambers E, Grant J and Jackson G, editors. *The Good CPD Guide-a practical guide to managed CPD*. Sutton, Surrey: Reed Business information; 1999.
2. Bennett-Guerrero E, Hyam JA, Shaefi S, Prytherch DR, Sutton GL, Weaver PC, Mythen MG, Grocott MP, Parides MK. Comparision of P-POSSUM risk-adjusted mortality rates after surgery between patients in the USA and the UK. *Br J Surg* 2003; 90:1593-1598.
3. Wenner J, Zilling T, Bladström A, Alvegård TA. The influence of surgical volume on hospital mortality and 5-year survival of carcinoma of the oesophagus and gastric cardia. *Anticancer Res* 2004; 24: in press.
4. Southgate L, Cox J, David T, Hatch D, Howes A, Johnsson N, Jolly B, Macdonald E, McAvoy P, McCrorie P, Turner J. The assessment of poorly performing doctors: the development of the assessment programmes for the General Medical Council's Performance Procedure. *Medical Education* 2001;35(Suppl.1):2-8

Definitions

Continuing Professional Development (CPD): designates the continued professional development that follow after formal qualifications have been obtained. The methodology for acquiring knowledge is based on the educational principles characteristic of adult learning, including self-controlled learning, problem-oriented learning, teamwork and on the job learning. This educational methodology is now used successfully during all stages of training.

Continuing Medical Education CME: Expression previously in general use which mainly referred to education in the form of courses, conferences and equivalent, with the purpose of giving specialist doctors new medical knowledge in their particular speciality.
