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Continuing Professional Development (CPD)

A summary of the state of knowledge about physician training

Members of the Swedish Society of Medicine and the Swedish Medical Association joint working group



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Preface

Continuing education for physicians is a term that summarises the further training and learning necessary for physicians to refresh and develop their professional skills. This is not only a matter of medical knowledge but also encompasses subject areas such as management, communication and ethics. Internationally the term Continuing Professional Development, CPD, is used. The continuing education and development of physicians is fundamental to improving medical care and healthcare, as well as patient safety.

The Swedish Society of Medicine and the Swedish Medical Association are pleased to have jointly compiled a review of the current status of the continuing development of physicians.

Through this review we want to draw attention to the CPD systems that are currently in place. Our intention is to raise awareness about the continuing development of physicians and to stimulate interest in further development, research and discussion.

We would like to thank the working groups and encourage everyone interested in continuing development to read this interesting and inspiring document.

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Swedish Society of Medicine and Swedish Medical Association joint opinion on ensuring the competence of specialist physicians to improve quality and patient safety in medical care and healthcare

Competent doctors are a prerequisite for high quality in medical care and healthcare and to maintain a high level of patient safety. The continuing development of physicians over their entire working lifetime, after having acquired specialist competence, is therefore essential to maintain and improve medical care and healthcare in Sweden.

The continuing development of specialist physicians is therefore an important facet of quality assurance management within healthcare and must not be viewed as being the sole responsibility of the individual doctor.

By continuing development we mean continuing professional development, CPD. Continuing development must be regarded as an ethical obligation for every physician and comprises all of the activities that doctors participate in to improve their medical competency and to develop themselves in their role as a doctor. In addition to medical knowledge, continuing development also includes competency within subject areas such as leadership/management, communication, scientific ethics, IT etc.

According to SOSFS 2005:12 (the Swedish National Board of Health and Welfare's provisions governing patient safety and quality management systems within medical care and healthcare) Chapter 4, Section 3 § the management system for each care providing organisation must ensure that there are procedures to make certain that the personnel have the competence necessary to perform work duties, procedures that make clear what responsibilities and authority members of staff have, and plans for improving staff competencies based on the needs of the organisation.

Continuing development must therefore be systematic and must be based on needs assessment with regard to current and future work duties.

All specialist physicians must therefore have an individual continuing development plan that should be documented

and followed up in annual appraisal discussions. Examples of continuing development are learning in daily practice, internal education, e-learning activities and case studies, personal study and participation in courses and conferences.

There are currently established management systems for following up operational activities within laboratory medicine by accreditation via Swedac, where the competence development of employees is included as part of the auditing procedure. For patient-focussed care there are also applicable systems for follow up monitoring in the form of ISO certification.

These systems have to date not spread widely throughout the healthcare sector. We recommend that there be a more systematic follow-up monitoring of continuing professional development. The active participation of physicians in the certification of medical care and healthcare is essential to ensuring the continuing development and competence of specialists.

In public procurement agreements for healthcare provision there should be stipulations of how continuing development will be performed, monitored and recorded.

To ensure the quality of continuing development it is proposed that some form of external review be introduced, which is owned and carried out by the profession and where the SPUR inspection model serves as a good example. It is also imperative that courses and similar events are independent and are quality assessed.

Assessing the requirements for theoretical education/courses for ensuring adequate competency within specialist areas should be performed within every department/specialist association. Continuing development coordinators, or equivalent functions, are recommended within each specialist area.

We reject mandatory demands for compulsory reporting of CME credits, or equivalent, as this has not been demonstrated to be associated with professional development and quality.

**For the members of the Swedish Society of Medicine and
the Swedish Medical Association joint working group in Stockholm on September 2009**

*Kerstin Nilsson, chair
the Swedish Society of Medicine's Education Delegation*

*Hans Hjelmqvist, chair
the Education and Research Delegation of
the Swedish Medical Association*



Kerstin Nilsson

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Introduction

Skilled physicians are a prerequisite for high quality healthcare and to maintain high standards of patient safety. These are the introductory words in a statement on continuing development where the Swedish Society of Medicine and the Swedish Medical Association take a joint stance on the need to establish a systematic structure for the further training of physicians such as the continuing professional development of physicians that takes place throughout their entire working life.

In contrast to first cycle medical training (AT) and specialist medical training (ST), which are both regulated, there are no current provisions governing the continuing development of physicians. Continuing development must be regarded nevertheless, despite the absence of formal directives, as both a duty and a right of the individual physician. It is an ethical obligation for every physician to continuously improve his or her competency and to develop competency based on the demands set by his or her working duties. It is also a right to be given opportunities to gain access to the competence development measures required for current and future activities. There is also a legitimate demand that physicians, similarly to other professional groups working in societal areas, must be able to demonstrate that they are highly competent to perform the tasks entrusted to them.

In the light of this it is obvious that some form of systematic process is needed for the continuing development of physicians that is credible and transparent to the surrounding community. This may be seen increasingly in the form of demands for compulsory documentation of hours of training (CME credits) and even in some cases in the form of proposals for follow-up evaluations and certification.

It is our absolute conviction that this would be best accomplished in line with the deliberations concerning further training that are embodied within the framework of the pedagogic term of continuous professional development (CPD).

In this document we present a number of texts that all contribute to the discussion and

provide more in-depth information on the concept of the continuing development of physicians. The texts also provide a coherent conceptualisation of the CPD process encompassing the three subcomponent aspects of quality improvement, quality assurance and quality control as a continuous process for continuous professional development in a wider sense.

The introductory section provides a background and analysis of further training and continuing professional development from various perspectives.

The first part of the review concerns quality improvement. In the section entitled "Managed continuing professional development; the evidence and the context" Janet Grant describes the evidence for expedient continuing development; what this is and how it can be accomplished in a systematic and transparent way that is also possible to audit. In addition to being inspiring text, this section also contains several very useful references.

Stefan Lindgren discusses the demands imposed on physicians to be able to cope with continuously changing professional role and the importance of being equipped with the correct tools for lifelong learning already as a student. The WFME standards for medical training at all levels, in part the minimum level and in part the level representing continuing development, are presented in the chapter, something that those interested in medical training at all levels will surely find thought provoking.

The second part of the text concerns quality assurance and monitoring continuing development from a regulatory authority perspective. Thomas Zilling, discusses how the require-

ments for learning may be catalogued and the circumstances that have led to demands for mandatory follow-up evaluations from certain circles, as well as how a Swedish model could be established based on this, without the need to introduce bureaucratic models that are too unwieldy.

Hans Hjelmqvist and Thomas Zilling then document the international views on continuing development and systems of evaluation in one section, and Christian Löwbeer describes the regulations that apply today within licensed organisations, as well as the standards that are suitable for clinical care application. With regard to the third aspect of CPD, quality control, there is consensus agreement that if one works actively with the first two quality aspects, as described in this review then there is no need for quality control in the form of direct knowledge testing.

We are also happy to be able to present three good examples of continuing development activities from three different specialist areas with different perspectives.

Continuing development within general medicine is presented from a professional perspective, management responsibilities are presented in the area of CPD in clinical chemistry, and an example of continuing development in internal medicine is presented from a regional perspective. The review also includes a glossary of terms and the joint statement on continuing development from the Swedish Society of Medicine and Swedish Medical Association, as well as a translation of the document about CPD that has been adopted at the European level with the support of the EU Commission.

We hope and believe that this review, which is the product of a joint collaboration between the education delegation of the Swedish Society of Medicine and the training and research delegation of the Swedish Medical Association, will be inspiring reading will be able to contribute to creating a sustainable Swedish model for how the continuing development of physicians can be performed and documented based on our professional obligations.

Stockholm, September 2011

Kerstin Nilsson



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Janet Grant was lecturer in medical education at King's College Hospital Medical School. She then became assistant director of a World Health Organization (WHO) Collaborating Centre for Medical Education. She is a special adviser to the World Federation for Medical Education and to WHO on implementing global standards for medical education. In addition to serving as a faculty member for the FAIMER Institute, Janet has served as a faculty member for the Brasil-, CMCL-, GSMC-, PSG-, and Southern Africa-FAIMER Regional Institutes.

Managed continuing professional development: the evidence and the context

Continuing professional development (CPD) has some key purposes:

- to ensure the standards of professional practice,
- to demonstrate to the public and employers that each doctor is up-to-date with modern practice and knowledge, thus ensuring patient safety,
- to be accountable to regulatory authorities and to the profession.

CPD also has the effect of increasing job satisfaction¹ and is an important aspect of professionalism in medicine².

The context of CPD is therefore one of integration with professional practice development, in a demonstrable and accountable manner.

The most common model of CPD worldwide, however, is one which simply sets out the types of activity that would be accepted by regulators (or record keepers) as CPD, in tandem with a system of counting the hours spent per year in undertaking such activities.

But is there an evidence-base that would support this simple, common approach?

The answer seems to be that there is not. The evidence-base suggests that there is a better way.

So CPD systems should be designed to take into account:

- The evidence
- Integration with professional practice
- Accountability

I. WHAT MAKES CPD EFFECTIVE? THE EVIDENCE

In 2000, a review of the literature concerning the effectiveness of CPD for the United Kingdom's Chief Medical Officer³, found that:

The key to effectiveness of CPD is not to be found in the learning methods adopted.

There is not a best learning method and no best approach to learning. Instead, the key to effectiveness is to make sure that the process of CPD is effectively managed to have the following components:

1. A stated reason for the CPD to be undertaken. This might be specific (for example, a need to develop a new skill). Or it might be a general professional reason (for example, a wish to undertake general professional updating with colleagues at a conference). It might also arise from the needs of the service (for example, to develop the skill to offer new areas of care to patients).
2. An identified method of learning which might be formal or informal.
3. Some follow-up after the CPD for reinforcement and dissemination of the learning that can also demonstrate its benefits. This might be actions such as reporting back to colleagues, developing new services, demonstrating new skills, or simply feeling more confident.

These conclusions match those of Davis et al⁴ in their review of randomised controlled trials⁵ of CPD.

The more recent review conducted for the UK Academy of Medical Royal Colleges and the General Medical Council, reaches the same conclusion⁸. Such a conclusion would also support the Swedish Medical Association's four-step guidance⁶ which advises to:

1. Analyse the need and start the process
2. Develop supporting functions
3. Collaborate
4. Follow up and evaluate

In the wake of increasing interest in CPD, other reviews have been conducted since 2000. They reach the same conclusions about effectiveness.

There are many competing and complementary definitions of CPD, depending on the main perspective; thus, for example, CPD can be:

*A continuing process, outside formal undergraduate and postgraduate training, that allows individual doctors to maintain and improve standards of medical practice through the development of knowledge, skills, attitudes and behaviour. CPD should also support specific changes in practice.*⁷

Or it is:

*...a continuing learning process that complements formal undergraduate and postgraduate education and training. CPD requires doctors to maintain and improve their standards across all areas of their practice ... CPD should also encourage and support specific changes in practice and career development".*⁸

Or it can have a number of purposes, as outlined by the Basel Declaration of the UEMS⁹:

- i) improve the safety and quality of medical practice
- ii) to encourage lifelong learning
- iii) to make transparent the outcomes, processes and systems required.

These definitions are not objective, but simply depend, partially, on the agency, whether that is a professional body, a regulator or an educationalist.

Whatever the definition, however, they have in common the safety and improvement of a doctor's practice. That being the case, we should consider how CPD can be a part of this inevitable developmental process.

2. INTEGRATION WITH PROFESSION PRACTICE

For CPD to be an integral part of the development of professional practice, it must tap into those processes whereby doctors already reflect on their experiences and determine to improve. This involves us in making the correct assumption that doctors, as any profession, are indeed lifelong learners already and do reflect on their practice without having to be trained to do so. Indeed, Schön's work explained that professionals do reflect – not that they need to be taught to do so!¹⁰

So what professional processes should be the basis of an effective CPD system?

*The Good CPD Guide*⁵ identified three sets of existing professional behaviours that are reflected in the three steps of an effective CPD system identified above. These are summarised in Table 1 below. The AoMRC-GMC report¹⁰ identifies some of the same behaviours. From that table we can see evidence of the rich continuing professional education strand that runs through professional life as a whole.

The question we must now ask is:

How can we build on this to create a managed and effective CPD system that will satisfy the doctor, the profession, the public and regulators?

Table 1: Existing professional behaviours that reflect the three steps of an effective CPD cycle

STEP 1: A stated reason for the CPD to be undertaken	STEP 2: An identified method of learning	STEP 3: Follow-up after the CPD for reinforcement, dissemination, measuring outcomes
<p>The clinician's own experiences of direct patient care:</p> <ul style="list-style-type: none"> • Blind spots: technical and knowledge deficiencies • Clinically generated unknowns: an unrecognisable clinical picture • Competence standards • Dairies • Difficulties arising in practice • Innovations in practice • Knowledgeable patients • Mistakes • Other disciplines' knowledge • Patient complaints and feedback • Post-mortems and clinico-pathological conferences • PUNs and DENs (patients unmet needs and doctor's educational needs) • Reflection on practical experience. <p>Interactions with the clinical team and department:</p> <ul style="list-style-type: none"> • Clinical meetings • Department business plan • Departmental educational meetings • External recruitment: new people • Junior staff • Management roles • Mentoring others <p>Non-clinical activities:</p> <ul style="list-style-type: none"> • Academic activities • Conferences • International visits • Journal articles • Medico-legal cases • Press and media • Professional conversations • Research • Teaching <p>Quality management and risk assessment:</p> <ul style="list-style-type: none"> • Audit • Morbidity patterns • Patient adverse events • Patient satisfaction surveys • Risk assessment <p>Specific needs assessments:</p> <ul style="list-style-type: none"> • Critical incident surveys • Gap analysis (Where do I want to be? Where am I now?) • Knowledge and skills assessments • Observation • Revalidation • Self- assessment • Video assessment of performance <p>Peer review:</p> <ul style="list-style-type: none"> • External peer review • Informal per review of the doctor • Internal peer review • Multidisciplinary per review • Physician assessment 	<p>Academic learning:</p> <ul style="list-style-type: none"> • Medico-legal work • Reading • Writing service and research protocols <p>Meetings:</p> <ul style="list-style-type: none"> • Clinical meetings • Conferences • Case reviews • Post-mortems and clinico-pathological conferences • Telephone conferences <p>Learning from colleagues:</p> <ul style="list-style-type: none"> • Collaborative learning • Consulting other professionals • Joints ward-rounds and clinics • Library professionals • Peer review • Multi-professional peer review • Peer tutoring • Professional conversations • Visits and travelling clubs <p>Learning from practice:</p> <ul style="list-style-type: none"> • Dairies • Evidence-based medicine • Experiential learning • Mistakes • Professional conversations • Visits and travelling clubs <p>Technology-based learning and media:</p> <ul style="list-style-type: none"> • Audio-visual presentations • Communication and information technologies (e-learning) • Computer support systems • Distance learning • Mass media • Simulations • Telemedicine and telemonitoring • Videoconferencing • Video review of performance <p>Management and quality processes:</p> <ul style="list-style-type: none"> • Accreditations • Audit • Inspection visits • Quality assurance schemes <p>Specialty-arranged events:</p> <ul style="list-style-type: none"> • Attachments and secondments • Sabbaticals 	<ul style="list-style-type: none"> • Accreditation/certification of the individual • Accreditation of services • Appraisal • Assessment of learning • Assessment results of trainees • Audit • Changes in person specification • Changing practice • Clinical effectiveness • CPD credit points • Collaborative assessment • Confidence levels • Corporate image • Decreasing professional isolation • Educational culture • Educational records and log-books • Effects on the team • Enhancing practice • Learning diaries • Learning portfolios • Networking • New services • Obsolete and inappropriate practice • Peer review of the doctor's CPD • Peer review of the medical team • Personal invigoration • Protection from successful litigation • Recruitment of medical staff • Reduction in burnout and early retirement • Referrals to the doctor • Remunerative benefit • Reporting back to colleagues • Reputation as a trainer • Research • Risk management • Self-assessment • Time-efficient working • Video assessment • Video-stimulated recall • Written reports

3. AN EFFECTIVE CPD SYSTEM

It is clear that an effective CPD system for today’s context must not only ensure personal learning, but must also have some effect on practice and be amenable to regulation, or be accountable and transparent. Fortunately, the evidence on effective continuing learning aligns well with the ways in which doctors do actually continue to learn, and these can, in turn, be aligned with the requirement of regulators or the profession to show that CPD is being undertaken. It is a fortuitous combination.

*The Good CPD Guide*⁵, more than ten years ago and now in its 2nd edition, sets out an approach to CPD that is managed and meets all these requirements.

3.1 The steps in a managed CPD cycle

The evidence, as presented in *The Good CPD Guide* literature review, shows that there must be at least four steps in the process of a well-managed CPD cycle. These are:

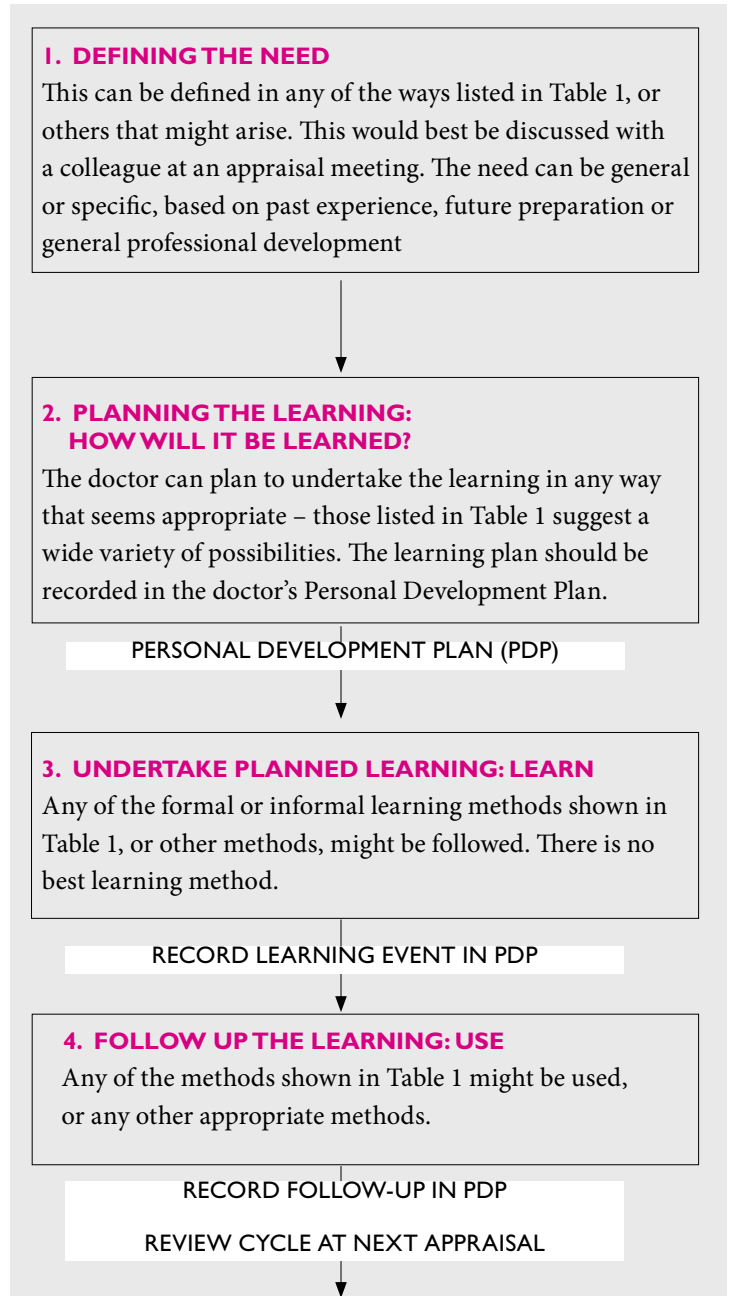
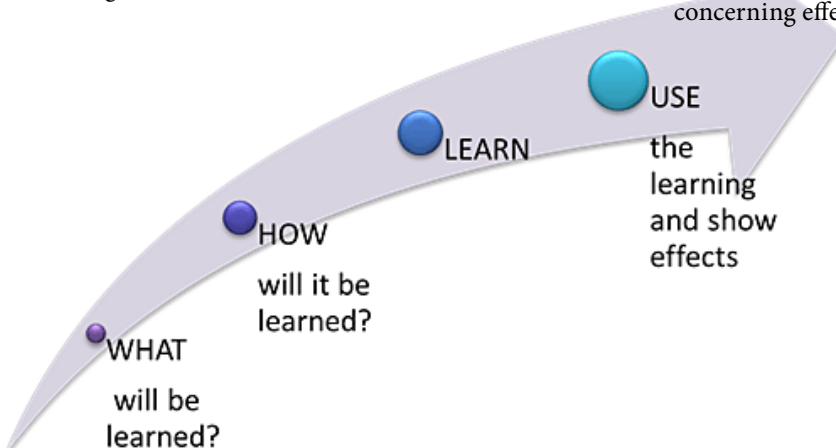
- A stated reason for undertaking the CPD
- A planned method of learning
- The learning itself
- Active follow-up of the learning

Each of these steps fits in well with existing professional behaviours and the need for clarity, transparency and accountability.

4. ACCOUNTABILITY

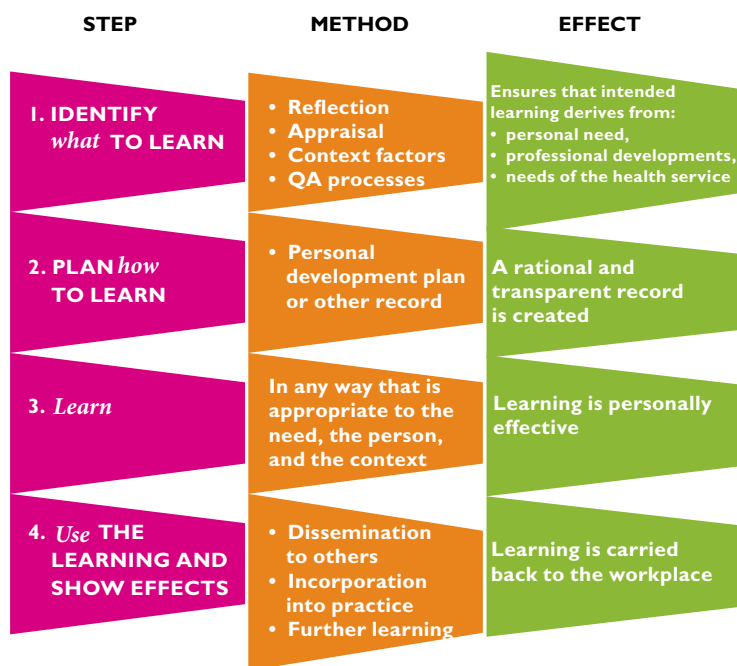
The purpose of systematising this rich collection of activities into a managed CDP system is partly to improve CPD by ensuring that all the necessary steps are present, but it is also to make the profession and the individual doctor accountable for their CPD. How does this happen?

We can present the four steps of managed CPD in the following illustration:



This cycle requires only streamlined documentation, (available in *The Good CPD Guide*, 2nd edition, in press), is integrated with doctors’ normal ways of learning and with a process of peer review. It reflects the evidence concerning effective approaches to CPD.

Table 1. The system of managed CPD



Managed CPD is a systematic approach to continuing learning and development for medical practitioners which will:

- Relate CPD to needs of the changing and developing health care service
- Ensure the personal and professional development of the individual doctor
- Provide an accountable and transparent system which can be used for regulatory, quality assurance, and re-licensure purposes.

The approach to managed CPD presented is based on the published literature, on the established practice of doctors who have integrated their own continuing learning and development with the provision of patient care, and on the professional and regulatory environments which operate in different countries. These all share the requirement for doctors to be transparent about their CPD activities and to keep records.

We can see that managed CPD, especially when integrated with the appraisal process, does include record keeping and a clear indication of the decision-making and activity process.

It is fortunate that the demands of the regulatory environment will improve the effectiveness of learning. Managed CPD fits into the demands of regulators by having the following features:

- Records are streamlined and easily submitted, if required
- It is based on evidence of effective CPD, with peer appraisal to confirm the process
- The CPD cycle is clearly set out, comprehensible because it relates to existing practice, and can be supported by accessible documentation
- Records of the CPD cycle are straightforward
- It fits in with existing practice
- Regulators are not required to introduce new systems or alien processes specifically for regulation.

In those countries, such as the UK, where regulators are thinking about revalidation of doctors every few years to continue their licence to practise, CPD will be a crucial element of this revalidation process. So, for example, the 2004 GMC guidance indicated their thinking about the relationship between CPD and regulation:

You must keep your knowledge and skills up to date throughout your working life. In particular, you should take part regularly in educational activities which maintain and further develop your competence and performance .

More recently, it is clear that CPD will play a significant part in revalidation of the doctor’s registration which is a primary regulatory function.

We must conclude, therefore, that an evidence-based, managed approach to CPD, complies with all good principles of regulation, education, and professional development and practice.

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How can we achieve and guarantee the quality of efficient continuing development?

LIFELONG LEARNING

For the majority of physicians the competency acquired during their basic training are revisited and developed. Their work environment also develops continuously, with concomitant demands for management skills, participation in professional teams and interdisciplinary collaborations. It is therefore no longer possible for the basic training

period to provide the knowledge and skills and approaches that can subsequently be applied throughout a physician's entire working life. Instead the basic training period must prepare the physician in training for a variable working role and at the same time provide the competency necessary to be able to perform work tasks during the initial period after qualifying as a specialist, as well as for future training stages.



Figur 1. De olika utbildningsfaserna inom den kontinuerliga professionella utvecklingen.

The key to succeeding with this difficult mandate is to focus on core competence. This competence must encompass insight into the necessity for lifelong learning and a scientifically critical approach, even to personal development needs. If this is not accomplished there is a great risk that the knowledge and skills acquired during basic training will progressively deteriorate and will be replaced by a less critically analytical professional role where decisions about development and change are deferred to others. Much of the work to change the processes of basic medical training is in fact aimed towards augmenting this long-term perspective of the perception of the role of the physician.

The new specialist training programme, with aspects of management, communication and science, is a distinct step towards establishing this general and long-term competence. Effects could however have been even greater if, during the planning of specialist internships, consideration had been given to the strong

development that has occurred within basic training and built on this to a greater extent.

FROM GOAL-ORIENTED LEARNING TO INDIVIDUAL RESPONSIBILITY

While both basic and specialist medical training is governed by regulations and is supervised, the primary responsibility for continuing professional development as a qualified specialist lies in the first instance with the specialist himself or herself. There is nothing controversial in this per se; the responsibility for the development of a profession always lies with the members of that profession. It is the individual physicians who have the ultimate responsibility to ensure that they have the development and tangible competency required to be able, in the light of current knowledge, to offer their patients optimal help and support, as well as being able to contribute to further knowledge development.

Physicians find the motivation to develop in their own efforts to offer patients optimal care,

as well as in their desire to meet the expectations of their employer and to achieve job satisfaction. Continuing development can therefore be viewed as a continuous process of reflection.

There are no scientifically structured studies that have attempted to illuminate general effects, in terms of measurable changes in routines or standard practices, of continuing development within the entire CPD area. There is however evidence that initiatives targeting special problems or needs do have the expected effects, at least over limited follow-up durations. At the same time it is apparent that continuing development has such effects, as in principle all of the extensive advances in medical care and healthcare have their origins in the research and development efforts performed within the profession itself.

PRACTICAL LEARNING FOR PHYSICIANS

Continuing development for specialist physicians must always be based on perceived needs in daily medical practice. Development should therefore have daily clinical practice as the starting point and it should contribute to improving and facilitating clinical tasks and should also illuminate and critically evaluate the supporting theoretical and scientific data available. Without sufficient links to clinical issues there is a risk that continuing development will be arrested at the knowledge level. Without concomitant association with underlying theory, mechanisms and rationale there is a risk that continuing development will become a programme of action guidelines at the practice level, without answering the question 'why'.

There is overconfidence in the belief that guidelines can encompass all conceivable paths of development in complex and novel situations and that revision of procedures can prevent erroneous decisions and interventions. Instead the safest course of action should be to expand the knowledge about and understanding of how the patients' problems and disease presentation have arisen, which underlying mechanisms and requirements are affected and what scientific support exists for our interventions.

THE LEARNING ENVIRONMENT

Adult professionals learn independently of their teachers and in close association with job-related experiences. This presupposes a good and stable collegial environment that can provide feedback and reflection in a structured way, based on scientific and proven experience. In this respect it is likely that senior physicians are not currently fully utilised. Development of method support for such feedback and reflection should be an important duty for,

for example the Institute for the Professional Development of Physicians in Sweden (IPULS). External courses and training programmes selected according to the needs of the organisation and the individual are an important complement to learning on the job. But these can never be more than supplementary. It is therefore not particularly interesting or constructive to define continuing development only as a number of hours of external lectures.

To be effective continuing development must be targeted to all aspects of professional skills and not just theoretical knowledge. This is the concept behind the use of the term continuing professional development (CPD) instead of continuing medical education (CME). CPD encompasses all formal and informal activities that physicians practice and that contribute to developing knowledge, skills and attitudes based on patient needs. Commitment to CPD is both a professional obligation and a prerequisite for the development of medical care and healthcare. Even the most experienced specialists need constant professional development to maintain professional competence.

For the majority of physicians undergoing specialist training, or for already qualified specialists, case-method studies work well, with validation of suggestions for solving problems and treatment options from current scientific literature as a good pedagogic model. In contrast, seminars where themes are selected by those providing the education programme have limited effects in clinical practice, regardless of the quality of the presentation. Direct knowledge transfer can fulfil a need for state-of-the-art competence within an area, but group learning with discussions supported by literature, preferably in conjunction with personal research, is even better. Non-structured participation in international symposia is a less efficient method for non-scientific practising physicians to develop personal clinical competency, with regard to time and costs. See Davis et al JAMA 1999.

An efficient and essential complement to these types of organised educational activities is regular reading of clinical scientific journals within personal areas of interest, to familiarise the physician with developments in that area. Discussions with colleagues at journal clubs are naturally even better, but not an essential prerequisite.

The planning and performance of continuing development must have its origin in both the needs of the physician and the medical practice. If this is not the case there is a distinct risk that continuing development will be limited to areas where the physician is already highly skilled and that activities acquire more of a character of networking than continuing professional development. Attempts to

establish structured continuing development plans have been made in several different contexts but have found it difficult to achieve lasting success. Such attempts are significantly more constructive, however, than just counting CME credits for attending training activities and symposia, even if it can be cohesively argued that CME credits are better than nothing at all.

FOLLOWING UP CONTINUING DEVELOPMENT

There is no self-evident method for following up the quality of continuing development. Formal competence testing is both reasonable and necessary for quality accreditation of a newly qualified specialist, but recertification of practising specialists is significantly more complicated. Qualified specialists are seldom active within the entire spectrum of their specialist area and can therefore function with high competence even if knowledge gaps can be demonstrated in some aspects of the specialist area. Instead a system for on the job assessment is needed. Such models exist internationally, but are very resource-demanding.

One example is the American Board of Medical Specialties, which evaluates practising specialists every seven years with respect to:

- Bedside manner
- Medical knowledge
- Interpersonal and communication skills
- Professionalism, including compliance with ethical regulations
- System-based practical clinical work
- Learning and development efforts based on personal practice needs.

In Sweden augmenting the profession's own primary responsibility for continuing development and the development of good methods for both on the job learning and external learning activities, together with individual development plans, follow-up and obvious support from the employer for continuing professional development should be a more achievable and expedient path.

Assessment and follow-up with the help of international standards can also contribute to quality assurance. The World Federation for Medical Education (WFME), a global organisation working with medical training issues

at all levels, has developed standards for quality assurance and quality development in basic training, specialist training, continuing development and recently also in research education. The standards define the minimum requirements and can be used among other things for accreditation purposes, but standards are also provided for continuing quality development.

The continuing development document has nine areas with standards for the structure of training, processes, content, learning environments and results. These are widely internationally accepted and have been documented to function well, after having been adapted to local situations in many places around the world.

Continuing professional development (CPD) is a necessary and self-evident part of the professional life of a physician. CPD is in the first instance a professional obligation for the individual physician and must be adapted to the special needs of the medical practice and the physician, and should utilise many different learning methods, with a focus on independent and active learning. At the same time preconditions must be created for continuing professional development to become a natural and integrated part of daily working routine. For this reason financing of CPD must be included in the medical care and healthcare budget.

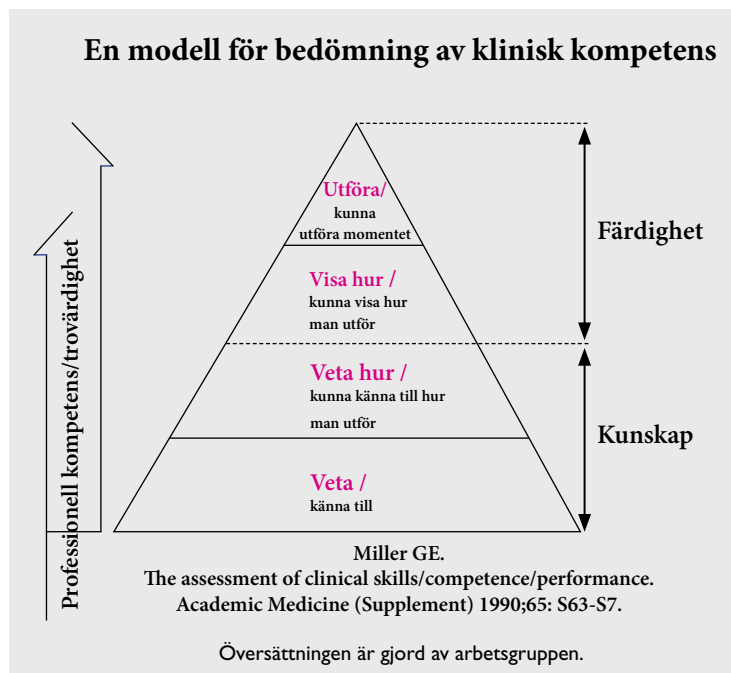


Figure 2. Millers pyramid

Table 1

Specifika krav för ackreditering av utövare inom medicinsk undervisning

- **Officiellt mandat**
- **Självständig från myndighet eller tjänsteleverantör**
- **Trovärdig och erkänd av berörda parter**
- **Krav på öppenhet**
- **Fördefinierade ämnesområden med specifika krav**
- **Använder externa experter**
- **Utvärdering genom en kombination av självutvärdering och extern granskning**
- **Utfärdar officiella beslut**
- **Publicerar årsberättelse och officiella beslut**

Table 2

WFME Trilogy of global standards in medical education: Areas

Basic Medical Education	Postgraduate Medical Education	Continuing Professional Development (CPD)
1. Mission and objectives	1. Mission and outcomes	1. Mission and outcomes
2. Educational programme	2. Training process	2. Learning methods
3. Assessment of students	3. Assessment of trainees	3. Planning and documentation
4. Students	4. Trainees	4. The individual doctor
5. Academic staff/faculty	5. Staffing	5. CPD-providers
6. Educational resources	6. Training settings and educational resources	6. Educational context and resources
7. Programme evaluation	7. Evaluation of training process	7. Evaluation of methods and competencies
8. Governance and administration	8. Governance and administration	8. Organisation
9. Continuous renewal	9. Continuous renewal	9. Continuous Renewal

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Regulating the continuing development of physicians from an EU perspective

During the 1990s an intensive debate began within the Swedish medical profession about the advantages and disadvantages of introducing compulsory recertification of physicians based on CME (Continuing Medical Education) credit points, in accordance with the North American model. This discussion was already well developed in Europe and the issue was actively driven by individual specialist associations within UEMS (the European Union of Medical Specialists), an umbrella organisation for specialist associations throughout Europe. The official policy of the organisation is against compulsory recertification based on CME credits due to the lack of evidence that a system of mandatory continuing education that is solely based on participation at symposia provides any guarantee that competency is maintained and developed^{1,2,3}.

EACCME, THE EUROPEAN ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION – CME CREDITS

Despite this the authorities in a number of European countries have introduced legislation concerning the recertification of physicians based on the CME credit system. This was the reason for the UEMS founding the EACCME (European Accreditation Council for CME) for the purpose of accrediting international courses and conferences and awarding CME credit points. The UEMS now considered it a duty to use the EACCME to make it easier for physicians in countries demanding the accumulation of CME credits to participate in international courses and conferences. The Council has national collaboration partners and it is the Institute for the Professional Development of Physicians in Sweden (IPULS) that has the mandate to award CME credits when international courses and conferences are arranged in Sweden. The EACCME also collaborates with The American Board of Medical Specialities,

which approves credit points for 145 different specialist training qualifications in the USA. In the USA we can now see there is a distinct trend in moving away from the CME credits system and towards CPD (Continuing Professional Development). A good example of this is provided by the general qualification requirements of the Accreditation Council for Graduate Medical Education (www.acgme.org), which include:

1. Patient care
2. Medical knowledge
3. Practice Based Learning and improvement
4. Interpersonal and Communication Skills
5. Professionalism
6. System Based Practice

To be able to understand why certain countries have elected to introduce mandatory continuing education requirements when others have not it is important to understand who it is who has the right to issue specialist qualifications. In Sweden this is the National Board of Health and Welfare, but in many countries the task of regulatory authority responsibility is delegated to the profession, through its own organisations. Examples of this are the Academy of Medical Royal Colleges in England and the German Medical Association (Bundesärztekammer) in Germany. For these associations/colleges there are financial incentives to take responsibility for monitoring the continuing development of their members. As can be seen in table 1, the picture throughout Europe varies. Continuing development from a regulatory authority perspective is a matter of everything from a voluntary system, such as in Sweden, to a legislated mandatory system. This is based on accumulation of CME credits in some countries and in others there is a comprehensive process for renewal of qualifications or recertification. There are also financial

sanctions in place. In Germany, for example, there are financial sanctions directed towards private practitioners who do not meet demands for a sufficient number of accumulated CME credits over five years.

It is important to emphasise that a fully developed system with mandatory continuing development and compulsory recertification is very costly and there is currently no research that demonstrates that this leads to increased patient benefit or patient safety^{2,4}.

NO OVERALL REGULATION OF CONTINUING PROFESSIONAL DEVELOPMENT FOR PHYSICIANS WITHIN THE EU

Concomitant with some countries in Europe introducing compulsory continuing professional development while other countries having no such requirements the question has naturally arisen if the EU Commission has any directive for regulation or a position on the issue. When Bernhard Grewin left his post as President of the Swedish Medical Association he became President of CPME (Standing Committee of European Doctors).

During 2004–2005, while serving as President of CPME, he showed great interest in the continuing professional development issue, and especially in the aspect of regulation. During the period Grewin was President of CPME this was regarded as an umbrella organisation for medical professional organisations throughout Europe. This is currently not the case for CPME, after France, Italy, Spain and Portugal elected to leave the organisation. Under the leadership of Grewin the Swedish Medical Association published a new policy paper on a programme for the continuing development of physicians, known as the Four Steps⁵. The programme prescribed continuing development according to the CPD definition and was translated into English and published in 2001. This programme formed for the most part the underlying principles of the CPME policy programme on the issue of continued development, in the development of which all of the medical organisations in Europe were invited to participate (table 2). When Finland took over the presidency of the EU in 2006, CPME and its new president, Daniel Mart, arranged a consensus meeting to discuss the continuing development of physicians. The meeting was held in Luxembourg on 14 December 2006. At that meeting a consensus document was finally agreed upon, which the EU Commission and all of the professional medical organisations supported. This document can be viewed in its entirety on page 33 and has been translated into Swedish.

The most important messages are that the continuing development of physicians shall not be documented through general European demands for CME credits and that the

efforts of regulatory authorities with regard to the continuing development of physicians is a matter of national concern. The EU Commission has raised the question of whether the CPD requirements should be introduced into the Professional Qualifications Directive, which is currently under review.

The profession has replied to the Commission that the national requirements of each country shall apply and that national authorities upon request, shall provide documented proof that a physician is licensed to practice.



Participants in the European.....Läkärorganisationernas arbetsgrupp kring CPD.

Back row from left: Dr J-P Joset (CPME), Dr L-J Calloc'h (CIO), Dr A Bertrand (FEMS), Dr J W Jensen (PWG), Dr H A Holm (CPME), Dr P Mortensen (UEMO), Mr G Lonquist (Swedish Medical Association), Dr T Zilling (AEMH), Dr T Kennedy (Danish Medical Association).

Front row from left: Dr C. Leibbrandt (UEMS), Dr M Worsoe (CPME) and Dr B Grewin (CPME).

Missing in the picture: Dr N Schneider (EFMSA/IFMSA), Mr J Veldhuyzen

Table I

SAMMANSTÄLLNING AV UPPFÖLJNINGSSYSTEM FÖR ENSKILDA LÄKARES FORTBILDNING I EUROPA (Uppgifter finns från 30 av Europas 42 stater)

Länder med frivilligt deltagande i CME/CPD	Länder med lag om skyldighet att delta i CME/CPD	Länder med certifiering
Belgien	Cypern	Nederländerna
Bulgarien	Frankrike	Storbritannien
Danmark	Italien	Irland
Estland	Norge (för allmänläkare)	Kroatien
Finland	Polen	Rumänien
Grekland (privatläkare)	Grekland (offentliganställda)	
Luxemburg	Slovakien	
Island	Slovenien	
Spanien	Schweiz	
Malta	Tjeckien	
Portugal	Tyskland (för sjukhusläkare)	
Norge (för specialitläkare)	Österrike	
Sverige	Ungern	
	Polen	

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Table 2

EUROPEAN MEDICAL ORGANISATIONS

- AEMH** European Association of Senior Hospital Physicians
CPME Standing Committee of European Doctors
CEOM European Conference of Medical Orders
EMSA European Medical Students' Association
FEMS European Federation of Salaried Doctors
PWG Permanent Working Group of European Junior Doctors
UEMO European Union of General Practitioners

INTERNATIONAL MEDICAL ORGANISATIONS

- ABMS** American Board of Medical Specialities
AMA American Medical Association
GAME Global Alliance for Medical Education
IFMSA International Federation of Medical Students' Associations
MEDINE Medical Education in Europe
WFME World Federation of Medical Education
WHO World Health Organisation
WMA World Medical Association



<http://www.uems.net>

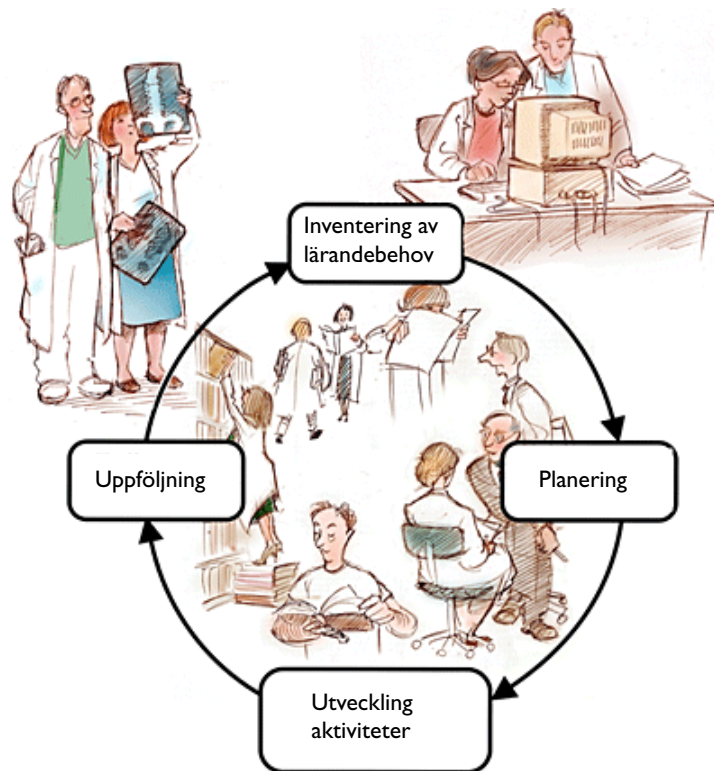
The European Union of Medical Specialists (UEMS) represents national associations of medical specialists in the European Union and its associated countries. With a current membership of 35 countries and operating through its 37 specialist sections and European Boards, the UEMS has been active at the European level since 1958 in order to promote the free movement of European medical specialists while ensuring the highest quality of medical care for European citizens. Swedish member is the Swedish Medical Association and the Swedish Society of Medicine.



Thomas Zilling

Associate professor and specialist in general surgery. Chair of the Swedish Association of Senior Hospital Physicians and vice president of the AEMH (European Association of Senior Hospital Physicians). Thomas Zilling has been a member of a number of working groups at both national and international level to address the question of continued development and is one of our leading experts on the subject of continuing development according to the CPD definition.

Cataloguing training requirements



At the end of the 1990s what became known as the Bristol case attracted attention far beyond the boundaries of medical circles. The background to the case was the high mortality observed for children treated by certain paediatric heart surgeons at the thoracic department of the Bristol Royal Infirmary and the inferior survival statistics compared to other hospitals. This situation was revealed when an anaesthetist at the hospital raised the alarm about the remarkably high numbers of deaths. In the investigation carried out by the General Medical Council (GMC, the British equivalent of the Swedish National Board of Health and Welfare) one of the surgeons claimed that he was 'in the learning phase of the curve' for a new operation¹. When he was to perform the operation for the first time it had been five years since he had last assisted at the same type of operation.

The investigation revealed an insular organisation with a lack of transparent auditing. Mistakes and deviations were concealed instead of being used to learn from and improve quality. The subsequent debate led, among other things, to the GMC proposing a requirement for the re-examination of physicians; a system that has now been introduced in the United Kingdom. Re-examination from the perspective of the regulatory authorities in the United Kingdom and several other Anglo-Saxon countries is encompassed by the concept of "learning needs assessment" which has great significance in its political value within medical care and health-care.

The English term is important to be aware of as it forms the basis of re-examination or re-certification in countries with legislation governing continuing development that is not

solely coupled to a passive system of accumulating credit points. The British authorities introduced the term in 1998 as a compulsory aspect of continuous learning, Continuing Professional Development (CPD), for all healthcare personnel. The objective is to identify organisations in need of improvement and to ensure that education and training needs are met².

An equivalent term to "learning needs assessment" exists in Swedish teaching circles with "behovsinventering" (cataloguing needs). A Google search using this Swedish term coupled with the Swedish word for medicine results in 2340 hits. The equivalent search for learning needs assessment and medicine results in 7,610,000 hits. This illustrates that we currently do not have any established Swedish term in medicine that equates to the English phrase.

A formal translation of the noun *assessment* into Swedish is "utvärdering" or "bedömning". *Learning* is often translated as "lärande", i.e. to acquire knowledge and skills. In combination with the word *need* signifying in Swedish "behov", a literal translation of the term into Swedish would be "utvärdering av kunskapsbehov"³.

It is important to differentiate between *assessment* and the term *needs assessment*. The term *assessment*, used on its own, is used in pedagogic literature in English, particularly in relation to examinations in education courses that have defined learning targets and that commonly lead to a qualification or academic title.⁴ Jane Tipping and Joan Sargeant define the term "*needs assessment*" as "a process of establishing learning requirements and need for change within an organisation for a target population with the purpose of setting educational targets and implementing development activities".

Learning need defines the gap between current knowledge and the desired state, which can be described in terms of knowledge, skills, attitudes, performance or achieving healthcare target numbers.

Needs assessment is in addition the instrument we employ to identify and measure the distance between the current status and the desired status.

Tipping and Sargeant describe three different types of *learning needs* of significance to the views of Anglo-Saxon countries when it comes to the process for the re-examination of physicians:

1. *Perceived needs* – awareness of requirements.
I am aware of how much I do not know.
2. *Unperceived needs* – no awareness of requirements.
I am not aware of how much I do not know.
3. *Misperceived needs* – erroneous view of requirements.
I believe I am aware of how much I do not know.

Perceived needs are easy to catalogue during development appraisal discussions, by focus groups or during meetings at the workplace. Unperceived needs are harder to audit. According to Tipping and Sargeant this may require direct knowledge testing⁵.

This opinion is not shared by Grant, who has identified more than forty different methods of identifying the continuing development needs of physicians (table 1)⁶.

In countries with a compulsory re-certification system the cataloguing of development needs becomes condensed into single instruments, such as peer review or written examinations that form the basis of re-certification. According to Norman and colleagues this is both expensive and is often difficult to individualise. Norman would like to see a system of more anarchistic self-assessment⁷.

A SUSTAINABLE SWEDISH MODEL

Traditionally in Sweden, following obtaining specialist qualifications, physicians have been accorded professional freedom with regard to continuing development and continuous maintenance of sufficient competency to perform their medical duties. Patients expect their doctors to be competent and up-to-date. Internationally this has become increasingly called into question, which has led to demands for compulsory assessment of development requirements.

As Grant has demonstrated, the methods for cataloguing training requirements and learning are manifold and efforts to try to introduce a compulsory system would surely incur significant social costs with little patient benefit. As described by Christian Löwbeer in the following chapter there is currently a system of governance in existence to manage competency development within an organisation. If this is followed the development of employee competence is guaranteed, without the need to impose, on the individual or society, unwieldy bureaucratic systems at the individual level. What is lacking, however, is an inspection agency to ensure that the employer lives up to the demands imposed by society for competency development within the medical profession.

An inspection agency, similar to the example of the further education board SPUR (Specialist Training Council within the Swedish Medical Association), should provide good support for the employer and place a focus on competency development within individual organisations. If Sweden could develop a well functioning inspection agency for continuing development, preferably initially within the framework of a research project, this would be of great interest to many countries in Europe, and this should be a priority issue for both the Swedish Medical Association and the Swedish Society of Medicine.

Table 1

Methods for cataloguing requirements for the lifelong learning of physicians according to the Good CPD Guide⁶

Clinician's own experiences in direct patient care

- Knowledge gaps ("Blind spots")
- Clinically generated unknowns
- Competence standards within the organisation
- Clinical diaries
- Difficulties arising in practice
- Innovations in practice
- Knowledgeable patients
- Mistakes in clinical practice
- Other disciplines
- Patients' complaints and feedback
- Necropsies and the clinico-pathological conference
- PUNs (patients unmet needs) and DENs (doctors educational needs). A system for the identification of knowledge "blind spots" by questioning a number of patients
- Reflection on practical experience

Interactions within the clinical team and department

- Clinical meetings – departmental meetings and rounds
- Department educational meetings
- Competence development through external recruitment
- Learning environment using teaching physicians
- Management roles
- Mentoring

Formal approaches to quality management and risk assessment

- Audits
- Morbidity patterns
- Patient adverse events
- Patient satisfaction surveys
- Patient risk assessment

Specific activities directed at needs assessment

- Clinical incident surveys
- Cataloguing training requirements (Gap analysis)
- Objective tests of knowledge and skills
- Observation
- Revalidation (re-examination) systems
- Self-assessment of training needs
- Video assessment of performance

Peer review

- External
- Informal contacts between colleagues
- Internal (development appraisal discussions)
- Multidisciplinary
- 360° assessment of physicians – a system from the USA where doctors grade each other

Non-clinical activities

- Academic activities
- Conferences
- Study visits
- Scientific publications
- Medico-legal cases
- Press and media
- Discussions in environments conducive to learning
- Research
- Teaching

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Rules, standards and policy documents

There are no laws, regulations or provisions that in detail govern how the continuing development of a physician shall be organised, but in the provisions of the National Board of Health and Welfare there is a requirement for the competence of personnel to be managed within the framework of the management system for quality and patient safety of the care provider. Different ISO standards that are used within healthcare describe the competence requirements and the structure of staff training. There are also international and national policy documents outlining guidelines for the continuing development of physicians.

PROVISIONS OF THE NATIONAL BOARD OF HEALTH AND WELFARE

In the provisions of the Swedish National Board of Health and Welfare concerning the management system for quality and patient safety in medical care and healthcare (SOSFS 2005:12) the following is stated in chapter four:

”Competence

3 § The management system shall ensure that there are

1. procedures to ensure that personnel have the competence required to perform work duties,
2. procedures that state the responsibilities and authority of personnel, and
3. plans for the competence development of personnel based on the needs of the healthcare provider.”

As an example of standards that can fulfil the requirements for this type of management system ISO 9001:2000 (currently ISO 9001:2008) is cited.

ISO-STANDARDS

In the standard SS-EN ISO 9001:2008, which is used for the certification of patient-oriented care, requirements for competence, practical training and knowledge are described in four points:

- Established competence requirements.
- Measures to meet competence requirements.
- Assessment of the efficacy of these measures.
- Documentation of theoretical and practical training, skills and experience.

A guide to how ISO 9001 can be used within medical care and healthcare can be found in the document: Quality management systems in medical care and healthcare – A guide to using EN ISO 9001:2000.

The standards ISO 17025:2005 and ISO 15189:2007 are used in laboratory medicine and contain significantly more detailed guidelines for how the training of personnel should be structured in order to be acceptable. In ISO 15189:2007 in particular there are detailed requirements concerning how the competence development of employees should be organised. It is the management of the care giver organisation that has the responsibility to ensuring that employees are competent. The management should have policies and procedures for identifying the development needs of employees. Training programmes must be relevant to the activities at the medical practice and the current and anticipated future duties of the individual. Educational activities must be efficiently evaluated. Continuous assessment is performed using documented records (verified) in the form of reports from relevant training, practical work, experience and demonstrated skills. Advertised jobs and job descriptions must state the responsibility areas and concomitant demands for expert knowledge, experience, qualifications and proven skills and the training courses that have been completed must be defined.

FACTS IN BRIEF

From 1 January 2012 SOSFS 2005:12 was replaced by the provisions of the Swedish National Board of Health and Welfare and the general recommendations for systematic quality management systems (SOSFS 2011:9).

In SOSFS 2011:9 there are no specific provisions concerning how continuing development should be structured other than that terms such as continuing development, training and competence are considered to be self-evident aspects of the development and quality assurance of the organisation. Chapter 4 section 1 § provides the general advice that standards, technical specifications and models for quality development and the development of the organisation can provide support when a management system is to be established. The Swedish Society of Medicine and the Swedish Medical Association joint opinion on the continuing development of physicians should also be used as a guide here.

It is very difficult to define just a few variables that can be used to assess the effects of continuing development within medical care and healthcare. In contrast, in an accredited organisation where continuing development is governed by documentation and is part of the quality and patient safety management system there are several different all-encompassing general tools for assessing the efficacy of continuing development, of which the most important are:

- Personal appraisal/development discussions
- Management review of the management system
- Incident reports
- Quality indicators
- External inspections (SWEDAC, SPUR/IPULS or certification agencies)
- Follow-up meeting with the party commissioning an activity in accordance with planned reviews (public procurement activities)
- Customer satisfaction/patient surveys



WFME GLOBAL STANDARDS

The World Federation for Medical Education (WFME) is the global organisation working with issues concerning the training of physicians at all levels. The document "Continuing

Professional Development (CPD) of Medical Doctors WFME Global Standards for Quality Improvement" contains detailed guidelines for the continuing development of physicians. The document addresses two levels, basic standard and standard for quality development. These levels, in an analogous manner to the terminology in the ISO standards, should be able to be translated into requirements and quality targets, respectively, for continuing development. Both basic standards and standards for quality development are targeted alternately towards the individual physician and to the medical profession as a whole.

In 2006 the European Commission, CPME, UEMS, UEMO, AEMH and others adopted the mutual consensus document "Continuing Professional Development Improving Healthcare Quality, Ensuring Patient Safety" where the EU policy for the continuing development of physicians was set out.

SWEDISH SOCIETY OF MEDICINE AND SWEDISH MEDICAL ASSOCIATION JOINT OPINION ON CONTINUING DEVELOPMENT

In the policy document "The Swedish Society of Medicine and Swedish Medical Association joint opinion on ensuring the competence of specialist physicians to improve quality and patient safety in medical care and healthcare" tangible guidelines are presented concerning how the competence of specialist physicians shall be ensured. Among other things it is proposed that the continuing development of physicians is an important part of quality assurance efforts within healthcare and must not be viewed as being solely the responsibility of the individual physician. All specialist physicians must have an individual continuing development plan that should be documented and followed up in annual appraisal discussions. In addition it is proposed that there should be some form of external review and it would be most suitable for courses and similar events to be independent and quality reviewed. Assessing the requirements for theoretical education within specialist areas should be performed within every department/specialist association. Continuing development coordinators within each specialist area are recommended.

DOCUMENTS

Swedish National Board of Health and Welfare

Provisions of the Swedish National Board of Health and Welfare for quality and patient safety management systems in medical care and healthcare (SOSFS 2005:12).

ISO-standards

EN ISO 9001:2008, ISO/IEC 17025:2005, ISO 15189:2007, Quality management systems in medical care and healthcare – Guidelines for the use of EN ISO 9001:2000.

WFME

Professional Development (CPD) of Medical Doctors WFME Global Standards for Quality Improvement 2003.

EU

Continuing Professional Development Improving Healthcare Quality, Ensuring Patient Safety 2006.

Svenska Läkaresällskapet och Sveriges läkarförbund

Swedish Society of Medicine and Swedish Medical Association joint opinion on ensuring the competence of specialist physicians to improve quality and patient safety in medical care and healthcare. Stockholm 2009.



Sara Holmberg

Doctor of medicine, general practitioner in Växjö and chair of SFAM-Kronoberg.

Continuing development – good examples

Here we present three "Good examples" of continuing development in daily clinical practice in Sweden. These are not intended as a representative cross-section and nor are they based on any form of assessment with regard to more or less successful projects. We have instead selected these examples to illustrate the diversity that exists within

continuing development, where the shouldering of responsibility can come from different angles and yet still work well. What these examples have in common is a robust structure that has functioned for many years, without being costly and without the need for lone individuals to function as the driving force.

The interviews were performed and transposed by Turid Stenhaugen, Swedish Medical Association.

General practice

Sara describes the activities for continuing development for general practitioners in the Kronoberg County Council health authority that have been in operation since the end of the 1970s. On five to eight weekends each year the general practitioners in the county have gathered for regular educational days. This is something that has occurred continuously for more than 30 years. During this period there have been 25 health centres in the county, employing approximately 90 general practitioners.

The local DLF association was initially responsible for the programme but SFAM-Kronoberg took over responsibility for the structure and content of the educational meetings during the middle of the 1990s. The ambition has been to offer wide scope and relevance in the range of topics, rather than focussing on specific organs and diseases. The structure has been traditional, with lectures and ample time for discussions about clinical applicability. The days have been organised as two identical half-days of lectures so as to minimise disruption to daily clinical practice.

SUPPORT FROM THE EMPLOYER

The programme has been run exclusively by the profession and has itself decided the content and structure. The employer has however understood the importance and has provided good preconditions in the form of time off from work for the participants, remuneration for external lecturers and for the hire of venues and help with the practical arrangements.

COLLABORATION WITH THE R&D SECTION

Within the County Council health authority there is also R&D-Kronoberg. This began in 1984 as a small development section within primary care, which has contributed to creating a scientific climate and via which many general practitioners have obtained doctoral degrees over the years. In 1997 this section grew to encompass the entire County Council health authority, with the objective of creating a creative scientific environment with permanent study supervision resources and teaching activities. The R&D section is currently involved in several projects focussing on patient-oriented research and development. The group of dedicated physicians with doctoral degrees who have been part of the R&D section have become the nucleus of the local efforts of SFAM, where continuing development has been an important element.

SUCCESS FACTOR

When asked about why the educational activities have functioned so well Sara answers that she believes that it has been because it has been the profession itself that has established the guidelines for the activities. It has also been inherent that close links have been established between research, continuing professional development and local commitment within SFAM and DLF.



Hans Wallinder

Laboratory Director, head of technology and QA manager at the Department of Clinical Chemistry, Aleris Medilab. President of the Swedish association for hospital chemists and EFCC, European Federation of Clinical Chemistry Swedish representative.

Clinical chemistry

Aleris Medilab is a company that performs laboratory testing for primary care, outpatient specialist care, hospital departments and the international pharmaceutical industry. Hans Wallinder is the head of the clinical chemistry department. The department has approximately 130 employees, two of which are physicians. The majority of employees are biomedical analysts but members of staff also include microbiology research scientists. Activities are commissioned by the Stockholm County Council health authority through public procurement and are performed at a central laboratory in Täby and at some 30 regional laboratories throughout the Stockholm area.

One of the quality stipulations of the Stockholm County Council health authority is that all laboratory activities must be accredited by Swedac, which is a government agency that has a mandate that includes the accreditation of laboratories.

It is a fundamental requirement for Swedac accreditation that activities are systematically followed up in line with the European standard ISO/IEC 17025:2005. The county health authority commissioning the work also has specific demands with regard to the competence development of employees and Aleris Medilab is obliged to meet these requirements in order to retain its commission. A fundamental requirement of the ISO standard is that all personnel must have the competence required to guarantee the accuracy of laboratory test results. The competence requirements include the fundamental requirement for competency to use equipment and demands for continuing development to maintain and improve work-related knowledge and skills.

In brief this means that those working directly with the equipment at the laboratory must pass tests to be issued a licence or certificate to perform specific laboratory investigations. It is also a mandatory requirement that this licensing is reassessed and revalidated at least once every two years. An important part of the continuing competence development

of the members of staff is that those working with analyses continuously change work duties, which Hans Wallinder considers to be both good for the work environment and for improving competence.

Accreditation from Swedac imposes defined requirements for a structure for continuing development. This means that the management of the laboratories must have a policy and procedures for identifying the learning needs of the staff members and for providing suitable education and training.

Departments must have both an overall continuing development plan and individual development plans for every member of staff. The individual development plans are agreed upon during the annual appraisal discussions. The continuing development plan must include both internal training and external courses, as well as learning on the job. It is the joint responsibility of the employee and the management to ensure that each and every employee has good continuing education. Aleris Medilab has a programme of internal training with its own specialists and invited speakers. This programme usually comprises eight to ten occasions each year. The members of staff who participate in external continuing education activities give presentations about these at departmental meetings as a part of the internal training programme.

Documentation files are then audited during the inspections carried out by Swedac. Swedac also demands that the effects of educational activities are evaluated. Something that in practice, however, is often hard to achieve.

There is a dedicated budget for the continuing education of personnel, but a number of courses are also funded by the medical technology industry.

Much of the competence development is fully integrated in daily practice.

Evaluation of new analysis methods takes place continuously as part of the quality management, but also has scientific aims. For this reason the laboratory has published its results on several occasions as articles in

scientific journals. All members of staff are also trained in the structure of the quality, environmental and work environment management systems with the objective of establishing an understanding of the continuous quality endeavours.

Hans Wallinder is happy with this system and believes that this tangibly contributes to high quality, a good work environment and a low staff turnover. It is also a natural part of the continuous quality management process. He states that it is nevertheless essential that continuing development is followed up by external inspection. If there were no inspections he is not at all sure that the system would work as well as is currently the case.

EDUCATION FOLDER

All continuing education must be documented in specially designated education folders. Each member of staff has an education file in the education folder where all of the educational activities, both internal and external, are recorded. It is the responsibility of each individual member of staff to keep records updated, but the entries must also be signed by the employee's superior. The folders are stored publicly in the coffee room at the department. External education activities for physicians often take the form of one or two scientific symposia each year, national or international. External education may also comprise training in the use of instrumentation, which is performed by the supplier either in Europe or in the USA in the case of biomedical analysts. Hans Wallinder does not think that there is any jealousy between the groups and he believes that the participants in the training programmes expect high standards as they will then present what they learn to other colleagues as part of the internal education programme.



Leif Lapidus

Study Director in internal medicine, Västra Götaland region.

Leif works as the regional director of studies responsible for the specialist area of internal medicine in the Västra Götaland region as 25% of his full-time employment. The rest of the time he works as a consultant physician in internal medicine at the Sahlgrenska University Hospital.

Internal medicine

Within the Västra Götaland region a regional competence development board for the continuing development of specialists was established in 2006. This development board was founded following an agreement about regulations for collaboration between what is now SKL and the trade association for the research-based pharmaceutical industry in Sweden, LIF, in 2005. There was concern that the agreement would lead to a worsening of conditions for the continuing development of specialists and the development board was formed as a way of preventing this from happening.

A director of studies responsible for specialists was established as a 25% position for each of the 13 major specialist areas, with a mandate including the performance of educational programmes for the specialists in the region. The study director responsible for the specialist area was expected to discuss the structure and content of joint education programmes within each respective specialist sector with the specialist development board and the management of the healthcare providers in the region.

Within internal medicine a model for continuing education was created which worked well. All 400 or so specialists within internal medicine were offered continuing development in the form of nine one day courses per year. All of the courses are held annually. Each specialist is expected to attend at least three one day courses each year, which means that a course programme of nine days is completed in around three years. After that the course content is updated so that the participants can benefit from attending subsequent course periods.

The programme focuses on the medical knowledge that all specialist physicians within internal medicine should be familiar with, particularly if serving as an on call doctor or doctor on stand by. The aim is for all clinically active physicians within the specialist area to be able to keep continually updated and in this way be able to offer safe

patient care. The programme must include all specialist branches of internal medicine, as well as closely related areas such as infectious diseases, rheumatology and neurology. Similar systems with recurrent theme days have also been established for the other specialist areas within the region.

The education programme has been structured in part on pedagogic lectures and in part on reviews of patient cases, which have formed an important basis for discussions. An electronic voting system has also been used to help facilitate an active discussion climate. The education courses are continuously evaluated and the participants have been very pleased with both the structure and content. It has been of great benefit that the participants have been able to get to know colleagues and establish networks for the exchange of ideas and experience. The courses have often been held using specialist expert lecturers from the region and have not been at all subject to influence from the pharmaceutical industry.

Of the approximately 400 internal medicine employees within the VG region around 250 are participating in the education programme. The reasons for non-participation by the remainder will now be catalogued with the assistance of the management of the care provider organisations. The reason that is often cited is that it is difficult to find the time to attend the courses. There is also a group of specialists who do not have work duties that justify participation.

The programme has now been ongoing for four years and has now reached a stage of identifying a need to develop and expand the programme. How can this become more systematic? How can non-medical issues such as leadership and ethics be included etc.? How can the many new technological possibilities for improving teaching and learning using interactive education via the internet and by simulator training be exploited? Also of importance to consider is if it is possible to make specialists feel obliged to participate?

Glossary of terms

Translation of the terms developed by the Rome CME/CPD Group *

* The Rome-group is a group of independent experts within CME/CPD from Europe and North America.

The terms have been translated by Michael Rolfs and Turid Stenhaugen, Swedish Medical Association.

Accreditation • Ackreditering av utbildning

Beslut om godkännande av att en leverantör uppfyllt de kvalitetskrav vad gäller utbildning med mera, som ställts av en ackrediteringsorganisation.

The decision that a provider has met quality, educational and other criteria set out by the accrediting body.

Activity • Utbildningsaktivitet

En utbildningsaktivitet för läkare som baseras på identifierade behov, har specificerade pedagogiska mål och som utvärderas för att visa att behoven har uppfyllts.

An educational event for doctors which is based upon identified needs (a needs assessment), has specified educational objectives and is evaluated to demonstrate that the needs have been met.

Andragogy • Andragogik

Pedagogik för vuxna. (Alexander Kapp, 1833).

Educational training for adults (Alexander Kapp, 1833).

Pedagogiska metoder för barn överfört till utbildning för vuxna. (Knowles, M 1975).

The methods of training in childhood (pedagogy) transferred to the training of adults. (Knowles, M. 1975).

Självstyrt lärande (Chicago: Follet). Det beskriver processen att engagera vuxna i ett strukturerat lärande.

Self-Directed Learning. (Chicago: Follet). It describes the process of engaging adult learners in the structure of the learning experience.

Audit (clinical) • Intern klinisk kvalitetssäkring

En process som syftar till att kontinuerligt höja behandlingskvaliteten genom systematiska utvärderingar med tydliga kriterier och påföljande förändringsåtgärder.

A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria leading to the implementation of change.

Audit (general) • Extern kvalitetssäkring

En utvärdering av en person, organisation, system, process, projekt eller produkt som utförs mot fastställda standarder. Detta för att säkerställa giltigheten och tillförlitligheten av given information samt också bidra med en bedömning av den egenkontroll som finns i ett system.

An evaluation of a person, organization, system, process, project or product, performed against defined standards or criteria, to ascertain the validity and reliability of information, and also to provide an assessment of a system's internal control.

Assessment • Bedömning/utvärdering av en individs kompetens

Bedömningen är ett sätt att mäta framsteg för en individ vid en viss tidpunkt, vanligen mot förutbestämda standarder.

Utvärderingen mäter framsteg i förhållande till fastställda kursplaner och resultatet av utvärderingen kan leda till betygssättning om detta är lämpligt.

(BMJ, Appraisal: a guide for medical practitioners).

Assessment is the measurement of the performance of an individual at a particular point in time, usually against predetermined standards. Assessments measure progress based on relevant curricula, and the results of assessment may lead to appraisal scoring if appropriate.

(BMJ, Appraisal: a guide for medical practitioners).

Competency/Competencies • Kompetens

Denna term används som ett sammanfattande begrepp för kunskaper, färdigheter, attityder, beteenden och prestanda. Effektiviteten av en utbildningsaktivitet kan utvärderas genom att dokumentera en förändring i en eller flera kompetenser. Detta är dock inte det enda sättet att utvärdera utbildningsaktivitetens effektivitet.

This term is used to encompass knowledge, skills, attitudes, behaviours and performance. The effectiveness of a CME/CPD activity may be evaluated by documenting a change in one or more competencies. However, this is not the only way of evaluating effectiveness.

Continuing Medical Education (CME) • Medicinsk fortbildning

CME är ett begrepp som beskriver pedagogisk verksamhet som syftar till att bevara, utveckla, eller öka de medicinska kunskaper, kompetenser och professionella förhållnings-sätt som läkare använder för att tillhandahålla tjänster till patienterna, allmänheten och till den egna professionen. Innehållet i CME är den kunskap och skicklighet som är erkänd och accepterad av läkarprofessionen, den medicinska vetenskapen och av sjukvården.

Continuing medical education consists of educational activities that serve to maintain, develop or increase the knowledge, skills and professional behaviours that a doctor uses to provide services for patients, the public and the profession. The content of CME is the body of knowledge and skills generally recognised and accepted by the profession, by the basic Medical sciences, the discipline of clinical medicine, and the provision of health care to the public.

Continuing Professional Development (CPD) •**Fortbildning CPD**

CPD är det utbildande syftet med att uppdatera, utveckla och öka de kunskaper, färdigheter och förhållningssätt som krävs i arbetet som läkare. CPD-begreppet innefattar CME men även andra kompetenser som läkare behöver för att kunna fullgöra sina arbetsuppgifter, som kunskaper i ledarskap, kommunikation, IT, handledning, etik, forskningsmetodik m.m. Dessa kompetenser beskrivs i dokumentet "Good Medical Practice" (UK; General Medical Council:2006)

CPD is the educative purpose of updating, developing and enhancing how doctors apply the knowledge, skills and attitudes required in their working lives. This includes CME, professional and managerial (non-clinical) competencies, and all elements of "Good Medical Practice" (UK; General Medical Council: 2006).

CME/CPD activity • Fortbildningsaktivitet

En utbildningsaktivitet för läkare som utförs för att uppfylla identifierade utbildningsbehov eller behov av professionell utveckling. Aktiviteten ska ha specificerade pedagogiska mål som utvärderas för att visa att de definierade utbildnings/utvecklingsbehoven har uppfyllts.

An educational event or product (activity) for doctors, based upon identified needs, has an educational purpose or objectives, and is evaluated to ensure that defined educational or professional development needs are met.

CME/CPD Approval •**Kvalitetsgranskad fortbildningsaktivitet**

Beslut om att en utbildnings/utvecklingsaktivitet har uppfyllt kraven för CPD.

The decision that an event or product (activity) has met the requirements for CPD.

Curriculum • Curriculum

En redogörelse för syfte och mål, innehåll, förväntade erfarenheter, resultat och processer i ett program inkluderande en beskrivning av struktur och förväntade lärandemetoder, undervisning, återkoppling och handledning. Kursplanen ska redovisa vilken/vilka kunskaper, färdigheter, attityder och förhållningssätt som deltagarna förväntas uppnå.

A statement of the intended aims and objectives, content, experiences, outcomes and processes of a programme, including a description of the structure and expected methods of learning, teaching, feedback and supervision. The curriculum should set out what knowledge, skills, attitudes and behaviors the participants (alt students) will achieve.

European CME Credit (ECMEC) • CME-poäng

En CME poäng är lika med en timmes fortbildningsaktivitet. Staterna i Europa kan ha olika relation mellan tid och poäng. ECMEC kan omvandlas till de olika ländernas sätt att beräkna CME.

A CME credit that equals one hour of educational activity. Different countries may have a different relationship between time and educational credit, and the ECMEC may be converted to the credit currency of each country.

Facilitator • Facilitator

En utbildare vars uppgift är att underlätta lärande för enskilda eller grupper av studerande. Pedagogens uppgift är att underlätta för dessa att förvärva nya kompetenser genom en process med självstyrt lärande.

An educator whose role is to give direction and encouragement to individuals or groups of participants (alt students), to enable them to acquire new competencies through a process of self-directed learning, either individually or in groups.

Knowledge • Kunskap

Den del av kompetensen som inkluderar en förståelse av kända fakta, såväl teoretiska som praktiska aspekter inom ett ämne eller ämnesområde.

The part of competency that includes an awareness of facts; both theoretical and/or practical understanding of a subject or a specific topic.

Learning Objective • Lärandemål

Ett avsett mål för en utbildningsaktivitet som anordnats av en utbildningsgivare avseende färdigheter, kunskaper eller förhållningssätt erhållna av deltagarna i utbildningsaktiviteten. Målen ska tydligt ange vad deltagaren ska kunna eller kunna prestera efter att ha deltagit i utbildningsaktiviteten.

An intended educational outcome for an activity held by an educational provider, relating to skills, knowledge and/or attitude/behavior gained by participants from the course/training. The outcomes should clearly describe what the participant should have learnt or be able to do after participating in the CPD activity.

Learning Methodology • Lärandemetod

Lärandemetod som använts för hel eller del av CME/CPD-aktivitet.

The type of educational method used to deliver all or part of a CME/CPD activity.

Needs Assessment • Bedömning av fortbildningsbehov

En process med insamling och analys av data som ger insikt om behovet av en specifik utbildningsaktivitet. En utvärdering av skillnaden mellan nuvarande och önskvärda kunskaper, färdigheter och förhållningssätt och beteenden använd för att fastställa prioriteringar i utvecklandet av utbildningsaktiviteter och deras definierade lärandemål.

A process of acquiring and analyzing data that reflect the need for a particular educational activity. An evaluation of the difference between current and required knowledge, skills, attitudes or behaviours – used to determine priorities in developing educational activities and to define learning objectives.

Outcome • Utfall, effekt, effektivitet

En förändring av kunskap, färdigheter eller förhållningssätt som ett resultat av deltagande i en CME/CPD-aktivitet.

A change in knowledge, skills attitude or behaviour as a result of participation in a CME/CPD activity.

Peer review • Referentgranskning

En granskning av utbildnings- eller vetenskapligt material eller av en individs professionella arbete, där detta arbete är utfört av en expert inom samma professionella område.

A review of educational or other scientific material or of an individual's professional activity by others who are experts in the same professional field.

Portfolio • Portfölj

En organiserad samling av en individs utbildning, arbete eller färdigheter. En sammanställning av professionella aktiviteter utförda antingen i nutid eller tidigare av en individ och som inkluderar lärande och professionell utveckling.

An organized documentation of an individual's educations, employments and/or skills. A compilation of professional activities carried out in the past and present that include learning and professional development.

Profession • Profession

Ett yrke eller anställning där specialiserad kunskap av ett ämne, ämnesområde eller vetenskap behövs. (P.J. Corfield, *Power and the Professions in Britain, 1700–1850*, Routledge, London, 1995).

An occupation, vocation or career where specialized knowledge in a subject, topic, or science is applied. (P.J. Corfield, *Power and the Professions in Britain, 1700–1850*, Routledge, London, 1995).

Professionalism • Professionalism

Ett antal värderingar, beteenden och förhållningssätt som förtydligar det förtroende som allmänheten har för doktörer. (Doctors in Society. *Medical Professionalism in a changing world*. *Clinical Medicine*, 2005; 5).

A set of values, behaviours and approaches that clarifies the trust the public has in doctors. (Doctors in Society. *Medical Professionalism in a changing world*. *Clinical Medicine*, 2005; 5.)

Revalidation • Revalidering

Formell granskning, oftast utförd av en certifierad granskningsorganisation, av en persons yrkesutövning i syfte att ge godkännande till att en läkare, under en definierad tidsperiod, får fortsätta sitt kliniska arbete som läkare (relicensiering) eller som specialist (recertifiering).

The process, normally carried out by a Regulatory Body that allows a doctor to continue to practice for a defined period (Relicensing) or maintain his/her specialist certification (Recertification).

Self education • Egenlärande

Den lärande tar ansvar för sin egen utbildning och kontinuerliga professionella utveckling.

The learner takes overall responsibility for his or her own educational needs and continued professional development.

Skills • Färdigheter

Den delen av kompetensen som inkluderar den praktiska och tekniska färdighet som en läkare behöver för att utföra sitt professionella arbete. En färdighet är en inlärd kapacitet eller inlärd förmåga att utföra en specifik procedur vanligen med ett minimum av tid och energi.

The part of competency that includes the practical and technical skills needed by a doctor in order to carry out his or her professional work. A skill is a learnt capacity or ability to carry out a specific process, usually with minimum outlay of time and/or energy.



Konsensusdokumentet

År 2006, den 14 december, arrangerade CPME ett möte tillsammans med den Europeiska Kommissionen och läkarprofessionens organisationer på EU-nivå.

Många andra organisationer var också företrädare såsom nationella hälsovårdsmyndigheter och EU- övergripande patientorganisationer. Syftet var att anta en gemensam policy för läkarnas kontinuerliga utbildning, CPD.

Resultatet blev nedanstående 12 punktsprogram som Läkarförbundet översatt och antagit som del av sitt utbildningspolitiska program.

1. Med CPD, Continuing Professionell Development, avses alla de möjligheter till lärande med vars hjälp läkare upprätthåller och utvecklar sin medicinska kunskap och kliniska kompetens. CPD innefattar och utvidgar det tidigare använda begreppet CME, Continuing Medical Education.

2. Det är ett etiskt och professionellt ansvar för praktiserande läkare att försäkra sig om att den vård de bedriver är säker och byggd på vetenskaplig grund.

Därför måste varje läkare ta aktiv del i CPD som är anpassad till just den vård de bedriver.

3. Det är till sist patienten som får nytta av läkarnas engagemang i utbildning genom en bättre och säkrare sjukvård. Patienterna kan också tillgodogöra sig den förbättrade tillgången till medicinsk information så att de får mer kunskap om sin hälsa och olika behandlingsmöjligheter vid sjukdom. Denna kunskap skulle kunna förbättras genom att ytterligare förstärka läkarnas roll i att informera och kommunicera med sina patienter.

4. Oavsett hur sjukvården finansieras måste resurser avsättas för att läkare ska kunna ta del av och engagera sig i CPD. Särskilda resurser måste avsättas för att läkare ska kunna delta i utbildningar och vetenskapliga möten och ha tid för och tillgång till informationssökning via litteraturstudier och internet.

Likaså måste tillräckliga resurser finnas för ett arbetssätt där kollegial dialog och kunskapsöverföring underlättas i det dagliga arbetet och där det är en självklarhet att läkare ska kunna engagera sig i utbildning för kollegor och teammedlemmar.

5. Läkare har stor studievana men inhämtar kunskap på olika sätt beroende på individuella skillnader och olika förutsättningar. Läkare måste därför få stöd för att använda de inlärningsmetoder som är mest lämpade för utbildningsbehoven.

Det bör finnas olika former av utbildningsaktiviteter och läkare bör uppmuntras att hitta nya sätt att inhämta kunskaper och färdigheter och använda IT-teknologins möjligheter.

6. Varje praktiserande/kliniskt verksam läkare har en skyldighet att upprätthålla och utveckla den kompetens som är allmängiltig för alla läkare som exempelvis kommunikation, teamarbete och vetenskapligt förhållningssätt.

På samma sätt har varje läkare en skyldighet att fördjupa de kunskaper inom specialiteten som är relevanta för det område där läkaren verkar.

7. Särskild uppmärksamhet måste ges till varje läkares arbetsmiljö så att det finns goda möjligheter att lära av kollegor och av alla de situationer som uppstår i det dagliga arbetet. Detta kommer att uppmuntra läkare att reflektera och lära av situationer som är relevanta för deras kliniska verksamhet. Utifrån sin roll som betydelsefulla medlemmar i sjukvårdens teamarbete bör läkare också uppmuntras att delta i utbildning för multiprofessionella team.

8. Läkare bör också ha möjlighet att ta del av extern utbildning utanför arbetsplatsen såsom utbildningar, vetenskapliga möten, litteraturstudier, auskultation och erfarenhetsutbyte i smågrupper. Detta främjar nytänkande och bör vara baserat på standards som sätts utanför den egna kliniska vardagen.

9. Det är viktigt att utbildning ska ses som en positiv och självklar konsekvens i situationer där det uppstått problem att upprätthålla fullgod kvalitet eller där allvarliga incidenter skett.

10. Läkare ska, som en naturlig del av sitt arbete, reflektera över vad de lär sig och hur lärdomarna ska kunna komma till nytta i deras kliniska vardag.

Varje läkare bör tillsammans med sin chef och sina kollegor följa upp sin fortbildning och reflektera över vad tidigare utbildningsinsatser gett för resultat och sätta upp nya mål kontinuerligt. För att underlätta det arbetet är det nödvändigt att varje läkare dokumenterar sin fortbildning kontinuerligt och på så sätt säkrar sin kompetensutveckling.

11. För att garantera att de utbildningar som läkarna deltar i håller en hög kvalitet bör kvalitetsgranskning ske av läkares utbildningar på nationell nivå. På internationellnivå finns en organisation uppbyggd, European Accreditation Council for CME, EACCME, där professionens organisationer gemensamt tagit ansvar för kvalitetsgranskning av internationella utbildningar och kongresser.

12. Det måste finnas en adekvat granskning av att utbildningar och konferenser som riktas till läkare är fria från all form av påverkan från kommersiella intressen. Det måste finnas en tydlig deklaration från utbildningsgivare och föreläsare om eventuella intressekonflikter och all finansiering av läkares utbildningar måste ske med full insyn.

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