

Continuing Medical education: Principles, concepts, and standards.

Aamir Jalal Al Mosawi

Abstract

Medicine is witnessing a continuous and tremendous progress in all fields. The enormous strides in the understanding of the bases of diseases have permitted more rational bases for the diagnosis and management of various disorders. New diagnostic tools and new therapies are continuously emerging and contributing to improved patient care and management, and raising the hope for more specific and certain therapy for many disorders. The medical practice is rapidly changing and the aim of this paper is to briefly review the Principles, concepts, and the generally accepted standards of continuing medical education and its impact on patient care.

Principles and concepts

The need of each physician to be always well informed on the newest methods in the diagnosis, treatment, prescribing, and rehabilitation of patients suffering from a variety of injuries and diseases is universally accepted, but not universally implemented.

Aamir Jalal Al Mosawi

Head department of pediatrics
University Hospital in Al Kadhimiyia
Al Kadhimiyia Baghdad Iraq
PO Box: 70025
E-mail: new_iraqijm@yahoo.com

This need for Continuing Medical Education (CME) has been compounded by the rapid advancements in medical science and technology. The medical doctor, dentist, pharmacist, nurse, clinical officer or laboratory technologist may not be current in the special knowledge and skills that were acquired during their college education and may therefore become professionally and functionally senescent and obsolete. So there is need to habilitate those skills in order to serve efficiently in providing health care. Some of the personnel did not have sufficient background education and hence would not benefit from rehabilitation programmes, let alone training in newer technologies. Even in the university faculties and departments that educate and train the prospective health care personnel, many of the teaching staff would also require rehabilitation of their skills that may have become obsolete. There is also constant need for such rehabilitation in the health research institutes in order to provide the relevant answers for the solution of national health problems [1, 2]. During this millennium, there is dire need to rehabilitate our health personnel in the new knowledge and skills that have become obsolete. Once-trained they are be able to apply contemporary methods to provide health care. Modern treatment and technological methods are essential to providing health care. New

technologies and protocols are more effective in curing patients and therefore ultimately more cost-effective.

CME (as well as continuing education) in (other) all health professions should incorporate rehabilitation of outdated knowledge and skills. Retraining on newer and more appropriate methods allows practitioners to provide good quality health care delivery. Services effects patients' quality of life, indeed life itself thus mandating CME therefore should be a condition for continued registration and certification if we are to achieve meaningful quality health care delivery.

The CME Programmes

Continuing medical education (CME) is an essential element of state-of-the-art medical practice. CME Programmes must be able to guarantee the quality of CME and its independence. There should, therefore, be an independent professional body at national level responsible for assessing and guaranteeing both quality and independence. This body will also have the power to oversee the participation of medical specialists in CME. A system of credits should be developed to express the professional value of continuing medical education activities. Each activity is credited with a certain score, which can be awarded to the participating specialist. CME should remain an ethical obligation subject to

the disciplinary authority of the profession itself. CME should be both an individual and also a collective obligation of the profession; in order to promote and make it effective, each member state must provide the means of making continuing medical education available to all physicians. CME is a strategic way to improve the quality of the health system [3]. Directors of courses are responsible not only for determining whether individual trainees have met educational goals but also for ensuring the quality of the training program itself [4].

In 2000, the Union of European of Medical Specialists (UEMS) established a body called European Accreditation Council for Continuing Medical Education (EACCME). Its purpose is: harmonization and improvement of the quality of continuing education in Europe; provision of nonbiased education to European colleagues according to mutually agreed quality requirements; guarding of the authority of national Continuing Medical Education (CME) regulatory bodies in the European countries; linking the national CME regulatory bodies in a system of mutual recognition of accreditation of CME activities; providing a system in which CME credits obtained abroad in EACCME accredited activities are recognized by the national CME regulatory bodies; providing links[5]

In many countries of the world doctors are under the obligation to participate in continuing professional education according to national guidelines [6]. The need for international standards has been emphasized in Europe. In Europe, emerging national structures of continuing medical education (CME) have to be connected in an umbrella structure of national authorities featuring the international exchange of accreditation and credits. In this umbrella structure, following topics need to be addressed: harmonization of the system of accreditation of providers of formally planned CME, the formulation of basic requirements for providers of formally planned CME, the system of quality assessment of the provided CME, and the system of awarding of CME credits to individual specialists [7].

There are differences between the CME programmes in various countries. In some the system is mandatory and in others is voluntary. Even in the countries where the system is voluntary, for those physicians participating successfully to the system, this leads to a diploma which can be used as an additional qualification of high standard continuous education in comparison to those who do not participate to the system. [8] It would be ideal if we could reach a state where the measuring system of an individual's participation in CME/CPD activities would be the same for all countries. An abundance of educational theory, design, and delivery of continuing medical

education (CME) learning interventions, including their impact on learners, are described in the health and social sciences literature. However, establishing a direct correlation between the acquisition of new skills by learners and patient outcomes as a result of a planned CME learning intervention has been difficult to demonstrate. In Australia. Positive relationship between acquisition of a new skill by learners and improved patient outcomes as a result of this planned CME learning intervention has been shown [9].

General principles universally or widely accepted requirements and standards for CME/CPD activities

1-Medical education background including undergraduate medical education in medical school and colleges. The integrity of undergraduate medical education should be maintained by adhering to the generally accepted standards of medical school and by national final examination rather than allowing each medical school to conduct their own final examination.

2-Postgraduate residency training and education. The integrity of Postgraduate residency training and education should be maintained by appropriately designed programmes and supervised by a qualified residency training committee.

3-The presence of a qualified body of accreditation of the CME activities and programmes.

Acknowledgement: The author is very grateful for Dr Benard Ferguson, president of the International Association of Medical colleges for his help in the revision of this paper.

References

4-The presence of appropriately designed scoring system for CME achievement and appropriate rewarding systems.

1. CPME final report: Questionnaire CPME 2004/091 Rev 1, CME/CPD as part of quality management in Europe, by P. Routil, 03.08.2005. www.cpme.eu

2-CHRISTODOULOU N. Continuing medical education and continuing professional development in the Mediterranean countries. EURA MEDICOPHYS 2007; 43:195-202

3-Quintaliani G, Zoccali C. [Continuous medical education]. G Ital Nefrol. 2004 Jul-Aug; 21(4):355-61. [Article in Italian]

4-Durning SJ, Hemmer P, Pangaro LN. The structure of program evaluation: an approach for evaluating a course, clerkship, or components of a residency or fellowship training program. Teach Learn Med. 2007

Summer; 19(3):308-18. Bethesda, Maryland, USA.

5. UEMS D 0217 - EACCME: History-political background and structure, by L. Harvey, 11.05.2003. www.uems.net

5-Routil W. [The system of continuing professional education of medical doctors in Austria. Structure, guidelines and quality management] Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz. 2006 May; 49(5):433-8. [Article in German].

7-Prien T, van Aken H. [Concept for continuing medical education of the European Union of Medical Specialists--EUMS]. Z Arztl Fortbild Qualitatssich. 1999 Oct; 93(8):563-7. [Article in German]

8-.DeLisa JA. Maintenance of certification and pay for performance: implications for psychiatry. Am J Phys Med Rehabil 2006; 85:187-91.

9-Bellamy N, Goldstein LD, Tekanoff RA; Support, Non-U.S.Gov't. Continuing medical education-driven skills acquisition and impact on improved patient outcomes in family practice setting. J Contin Educ Health Prof. 2000 Winter; 20(1):52-61.