EASOM Summer School 2004

European and National Influences on Continuing Education in Occupational Medicine

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Contents of my presentation

- Introduction
- CME: development of a concept
- Assessment of Demands and Needs
- What about occupational medicine?
- European and national influences
- The role of EASOM

Introduction

What is CME for OM?

- GB: continuing professional education for specialists in occupational medicine
- D: Weiterbildung für Arbeitsmediziner
- NL: bij- en nascholing voor bedrijfsartsen
- F: éducation permanente pour les médecins du travail?
- I: ?

Introduction

Three types of educational activities:

- external: courses, seminars, conferences
- internal: practice / problem based, consultation with peers, case discussions
- enduring materials (print, CD, internet), with testing or assessment

Introduction

Large variety of CME 'producers':

- Universities, professional associations
- employers: occupational health services
- companies, industries (Glaxo)
- commercial educational bureaus

CME: development of a concept

CONTINUING MEDICAL EDUCATION

- education after certification / licensure
- longest phase of medical education
- traditional type of education
- ‘clinical update’
- teacher driven
- attendance is rewarded

CME: development of a concept

CONTINUING PROFESSIONAL DEVELOPMENT

- professional learning AND personal growth
- adult learning / self directed learning / reflective practice / lifelong learning
- topics beyond medicine
- managerial, social & personal skills
- learner driven
- ‘have learning objectives been achieved?’

CME: development of a concept

MOST CME AND CPD:

- passive training forms, lecture halls
- cost recovery nature
- process (not outcome) based accreditation

CME: development of a concept

Evidence:

POOR EFFECTS OF PASSIVE EDUCATIONAL ACTIVITIES ON PHYSICIAN'S BEHAVIOUR

Introduction

- Large gap between *evidence* and *practice:*
- We do not apply what we learn from training programmes
- Implementation of guidelines is not an automatism
- Change of behaviour: most difficult

CME: development of a concept

A new approach:

Knowledge Translation

University of Toronto

CME: development of a concept

KNOWLEDGE TRANSLATION:

- primarily practical settings
- methods for overcoming barriers to change
- not only clinicians or health professionals
- focus on evidence-based information
- testing of interventions
- medical, social disciplines

CME: development of a concept

KNOWLEDGE TRANSLATION allows attention to all participants in healthcare:

- practitioner, team, patient
- population
- policy makers

CME: development of a concept

Pathman-PRECEED model for KNOWLEDGE TRANSLATION:

1 Awareness
2 Agreement
3 Adoption
4 Adherence

CME: development of a concept

1. **AWARENESS**

Predisposing:

Distribution of printed information; journals; media campaigns; lectures, round; academic detailing

CME: development of a concept

2. AGREEMENT

Enabling:

Opinion leaders
Small group sessions for clinicians

CME: development of a concept

3. ADOPTION

Enabling, reinforcing:

Small group sessions for clinicians
Patient education methods
Clinical flowcharts or algorithms
Academic detailing
Small group sessions for audit and feedback

CME: development of a concept

4. ADHERENCE

Reinforcing:

Reminders (professional and patient), multiple interventions

Assessment of Demands & Needs

The ***need to learn*** is the only valid basis for any educational system

(Adult) learners need to feel a necessity to learn

Assessment of Demands & Needs

Needs assessment should really help planning CME, CPD, ..

- for individuals
- for professional associations
- for employers (they pay)

Assessment of Demands & Needs

- Traditionally it is the responsibility of the individual practitioner to do whatever is necessary to remain competent.

Assessment of Demands & Needs

- self assessment skills
- self directed learning skills

are difficult to develop:

Assessment of Demands & Needs

- **DEMANDS ←→ NEEDS:**
- **personal preferences ← → personal deficits**

Assessment of Demands & Needs

- Practitioners tend to choose topics they are already good at

- They tend to avoid areas in which they are deficient

→ Self monitoring is not effective

(Norman et al; Sibley et al.)

Assessment of Demands & Needs

Possible solutions:

- Formal peer review
- Recertification examinations
- Focus on outcomes (adverse effects; client satisfaction)

Assessment of Demands & Needs

Disadvantages of formal methods:

-- expensive
-- difficult to implement:
"Big Brother approach"
-- validity is discussed

Assessment of Demands & Needs

Strategies to identify learning needs:

Grant J et al. *The good CPD Guide.* Sutton: Reed Healthcare, 1999

describes 46 formal and informal methods of self assessment

Assessment of Demands & Needs

Strategies to identify learning needs:

-- reflection on action & reflection in action

-- diaries, log books, weekly reviews

-- peer review

-- observation

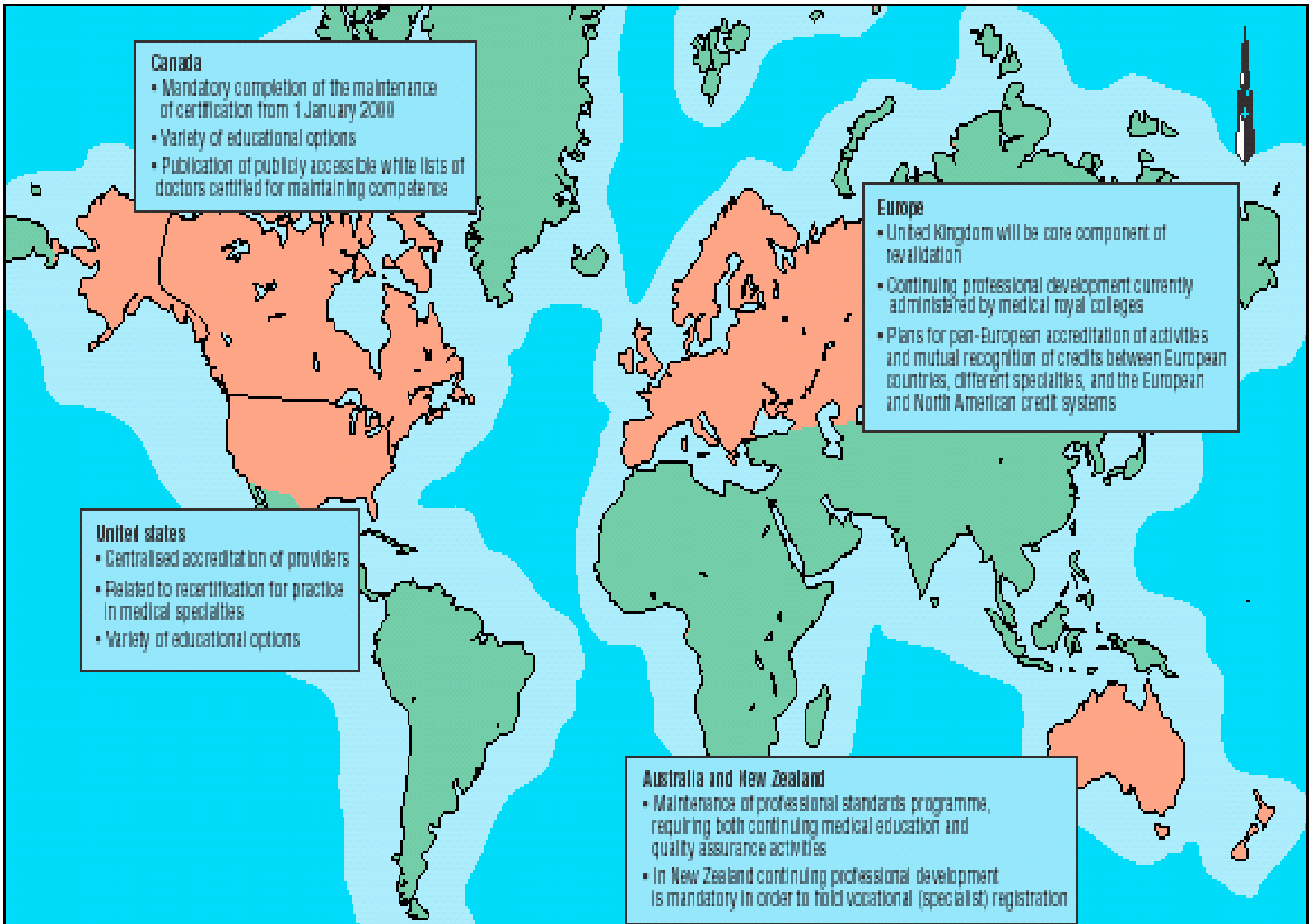
-- critical incident review

-- practice review

European and national influences

CME, CPD:

international comparisons


Canada
• Mandatory completion of the maintenance of certification from 1 January 2000
• Variety of educational options
• Publication of publicly accessible white lists of doctors certified for maintaining competence
Europe
• United Kingdom will be core component of revalidation
• Continuing professional development currently administered by medical royal colleges
• Plans for pan-European accreditation of activities and mutual recognition of credits between European countries, different specialties, and the European and North American credit systems
United states
• Centralised accreditation of providers
• Related to recertification for practice in medical specialties
• Variety of educational options
Australia and New Zealand
• Maintenance of professional standards programme, requiring both continuing medical education and quality assurance activities
• In New Zealand continuing professional development is mandatory in order to hold vocational (specialist) registration

European and national influences

Survey of Peck et al. (2000) in 18 European countries:

Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, United Kingdom, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland.

European and national influences

Survey of Peck et al. (2000) in 18 European countries: results

• Necessary:	yes: 17	no: 1
• Voluntary:	yes: 12	no: 6
• Mandatory:	yes: 6	no: 12
• Credit based:	yes: 9	no: 6
• External review:	yes: 4	no: 8
• Examinations:		no: 18
• Recertification:	yes: 1	no: 15

European and national influences

Survey of Peck et al. (2000) in 18 European countries (continued)

- Responsible organisation:
  - medical profession: 13
  - profession & govt: 4
  - self directed: 1

European and national influences

Survey of Peck et al. (2000) in 18 European countries (continued)

- Financing:
  - self: 2
  - employer: 4
  - pharmaceut companies: 4
  - mixed: 2

European and national influences

Survey of Peck et al. (2000) in 18 European countries (continued)

- Incentives:
  - certificate: 2
  - increase in fees: 1
  - influence on career: 2
  - none: 9

European and national influences

Survey of Peck et al. (2000) in 18 European countries (continued)

- Sanctions:
  - right to practise removed: 1
  - decrease in fees: 1
  - official reprimand: 1
  - list of doctors who fulfilled CPD: 1
  - none: 8

European and national influences

- **Survey of Peck et al. (2000) in 18 European countries (continued)**

Conclusions :

- diversity of systems
- no country followed US model
- most systems based on hours related credit system; validity is discussed

European and national influences

Summary of European situation:

- common features of content & process
- mutual recognition of diplomas in EU
- no mutual recognition of CME credits
- plans by UEMS for a
- ‘European Accreditation Committee’

What about occupational medicine?

- OM is part of medicine as a whole
- general medical CME is accreditated for OP
- general medical CME is not sufficient for OP
- CPD and KT appropriate for OM?

What about occupational medicine?

CONTINUING PROFESSIONAL DEVELOPMENT:

- professional learning AND personal growth
- adult learning / self directed learning / reflective practice / lifelong learning
- ***topics beyond medicine***
- ***managerial, social & personal skills***
- learner driven
- 'have learning objectives been achieved?'

What about occupational medicine?

KNOWLEDGE TRANSLATION:

- ***primarily practical settings***
- ***methods for overcoming barriers to change***
- ***not only clinicians or health professionals***
- focus on evidence-based information
- testing of interventions
- ***medical, social disciplines***

Dutch reality

- *introduced in 1999*
- *mandatory recertification valid for 5 yrs*
- *average of 20 hrs/yr accreditated CME*
- *average of 20 hrs 'other professionalizing activities'*
- *working in practice for at least 8 hrs/wk*

The role of EASOM

What we are: (or most of us):

- academics involved in CME 'production'
- working in a 'market' environment
- teachers' and learners' preferences driven

The role of EASOM

What we need:

- to work effectively
- quality assessment of CME, CPD, KT for OP
- personal needs based CME … practice
- CME database

The role of EASOM

What we should do:

- define ‘European’ quality criteria
- develop and test methods for QA, NA
- exchange experiences, teachers, students
- cooperate with UEMS, EU bodies, AMA
- getting funds for projects, database

References

- http://www.ktp.utoronto.ca
- http://www.uems.be/intent.htm

- Davis D et al.The case for knowledge translation: shortening the journey from evidence to effect. BMJ 2003;327:33-5.
- Grant J. Learning needs assessment: assessing the need. BMJ 2002;324:156-9.
- Norman GR et al. The need for needs assessment in continuing medical education. BMJ 2004;328:999-1001.
- Peck C et al. Continuing medical education and continuing professional development: international comparisons. BMJ 2000;320:432-5.