European Requirements for GP/FM Continuous Medical Education (CME)

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Summary of Principles for Effective CME for GPs/FDs

CME should:

- Be based on learning needs relevant to current practice
- Use methods which involve practitioners actively and encourage reflection
- Include the perspectives of what patients want and need from their healthcare, balance the patients' needs and demands
- Ensure that physicians are encouraged to change practice appropriately
- Be evaluated and adapted to changing needs
- Be free of conflicts of interest
- Encourage social contact with peers through communities of practice.
- Acknowledge the need to support physicians' well-being.

Introduction

The European Academy of Teachers in General Practice and Family Medicine is the education network of WONCA Europe. The Continuing Medical Education (CME)/Continuous Professional Development (CPD) group has produced this document, following a review of the current literature, to support colleagues who are seeking to improve and develop CME programmes for General Practitioners/Family Doctors (GPs/FDs).

Although CPD and CME are frequently used interchangeably, most literature has now defined CME as being an ingredient of CPD; CPD is a broader concept and a of lifelong personal development and maturation, manifested not only in education and professionalism, but also in ethics, values, attitudes or communication skills of the doctor in relation to the patient. We will use only the term CME for the purposes of this document.

Definition of CME

CME is defined as 'Any activity which serves to maintain, develop or increase the knowledge skills and the professional performance and relationships that a physician uses to provide services to patients, the public or the profession' [1]. It is an essential part of all doctors' professional lives, as the old idea that medical school equipped one for a lifetime of practice is no longer acceptable given the rapid pace of change in medical practice.

Impact of CME

There is good evidence that CME can be effective and has an impact on physician performance and patient health outcomes [2]. There is agreement that this impact is apparently greater on physician performance than on patient health outcomes [2].

How Adults Learn

An understanding of the theories about how adults learn is important when considering how to plan CME activities. Adults want to learn, they are self-directed, and they need learning to be relevant and applicable in their setting; when these conditions are met, they are highly motivated [3]. In many countries, GPs/FDs work in small practices and are often geographically isolated. These particular factors are important when considering the CME provision for this group.

Effective Interventions

Given the recognition that CME is effective, the next question is how to deliver CME interventions that support doctors to change their practice and improve outcomes for patients. The first step is to recognise that learning is dynamic and occurs on a daily basis as the GP/FD encounters difficult problems. Needs assessment has a role and several approaches to this are required. Doctors use self-awareness to identify their learning needs. If this is done well there is some evidence that practice is more likely to change [4]. The best methods for self-assessment are those that support deliberate reflective practice such as logging daily issues where uncertainty occurs, feedback from prescription data, diagnostic test ´behaviour´ and referral data and discussion on these data with peers and medical specialists. CME providers should in addition use some objective assessments of learning needs such as peer review in quality groups, expert opinion, literature review, physician performance data and standardized assessments [1]. There are examples of this 'top down, bottom-up approach' for the development of GP/FD CME programmes [3,5].

Embedding quality improvement approaches within CME activities is an interesting development [6]. A method which incorporates these principles is the Quality Circle where small groups of health professionals meet regularly to reflect on and improve practice [7]. In rural areas this kind of work can be arranged through online communities of learners. These have been shown to have effects on changing behaviour, affirming self-esteem and increasing professional confidence [8].

Needs Assessment

The identification of needs, together with an assessment of what is to be learnt and why, will lead to some clarity about the objectives and will enable the development of a learning plan. These should be clear, concise and ideally measurable. However there also needs to be the acceptance that training - to resolve the most difficult clinical problems - cannot always be easily summarised within an educational objective.

The identification of objectives can enable educators to provide more effective learning opportunities. It is clear that no single modality of learning works under all circumstances. Effectiveness increases when a variety of methods are used allowing for interaction, multiple exposures, and longer programmes rather than shorter and that focus on outcomes considered important by physicians [2]. The opportunity for interaction is essential. This can be done both face to face and electronically. The traditional lecture (often favoured by doctors) and the dissemination of printed material are the least effective methods of CME. These are however commonly used. Lectures if short can have an important role in setting the scene and providing knowledge updates, prior to discussion in small groups of e.g. case studies. This discussion allows for an important stage in adult learning – reflection on the relevance of what has been learnt and how it might be applied to practice. Multiple exposures in different formats facilitate behaviour change [2].

The Role of Information Technology

Widespread access to Information Technology enables the development of new mechanisms of learning through on-line courses that can be of particular relevance to GP/FD. Online courses need to follow the same principles as face-to-face CME. They need to be easy to use, involve practical exercises, repetition and feedback. Online communities of learners can be formed that further facilitate interaction and these networks are of particular relevance to doctors who work in isolation. In addition, learning can be reinforced within clinical IT systems. This can be done by the integration of guidelines and the ability to search for diagnostic and therapeutic interventions relevant to specific patient presentations. There must be a process for updating these guidelines. There is much still to learn about this area and how best to use in education.

Self-audit and self-assessment

It is necessary to develop IT tools that allow GPs to audit their work and compare that with the performance of others using quality indicators. This should include information on the monitoring of chronic non-communicable diseases, major surgeries, history of illnesses, vaccinations, allergies, etc. All this data must be easily accessible to the GPs who can gain insight into their own work. This can help to build profession confidence and improve self-esteem.

General Data Protection Regulation (GDPR)

GDPR must be respected. There should be clarity about who has access to the data in Electronic Medical Record (EMR) that is created by GPs and in Electronic Personal Records (EPR) created by patients. All CME for GPs/FDs based on review of patient data has to be ensure that this data is not identifiable and complies the regulations.

Evaluation of CME activities or programmes

CME can be provided by different institutions or organisations. Often it is organised in cooperation with the medical association. To improve and guarantee quality of CME programmes the WONCA World Education Working Party has established a set of standards that can be consulted [9].

It is important that providers of CME evaluate the learning activities that they develop. The Kirkpatrick model for training evaluation has been widely used. It describes four levels at which evaluation can occur: participant satisfaction, knowledge and attitude change, improvement in physician clinical outcomes and improvement in patient outcomes [10]. A more recent model has been proposed by Stevenson and Moore (2018) with seven levels which includes at its peak the impact on community health [11]. Evaluation beyond the lower levels on both models is not common; however, these levels must not be neglected as well as it is important that GPs/FDs find CME interesting and stimulating. The criteria for determining which levels to measure and how robust an evaluation is required depend on the type of educational programme delivered.

Learning in the workplace

Workplace based learning fits well with what is known about how adults learn. It is efficient and effective, enabling clinicians to gain knowledge in the setting where this knowledge can be applied. It is of particular relevance in primary care as GPs/FDs work in units which are

dispersed within the community. These communities of practice can be very rich learning environments, provided that everybody has an eye on continuous development.

The Role of Health Care Organisations and Employers

Employers and Health Care organisations need to understand the important role that CME plays in developing the quality of care and maintaining motivated and engaged professionals. They need to enable GPs/FDs to participate in CME during their working week. Professional bodies and regulators need to recognise that the accreditation of hours of learning is not a surrogate for improved competence. Doctors need to be allowed flexibility in the type of learning that is recognised, and this should include learning that can be demonstrated to change practice.

There also needs to be an awareness of the effect that industry-sponsored activities may have on influencing doctors' behaviour particularly in relation to prescribing [12,13]. CME providers need to be able to react promptly to sudden changes in society and in disease prevalence such as rapid mass migration or a pandemic. There needs to be a readiness to review needs and deliver effective learning modules rapidly. This has been recently required during the COVID-19 pandemic which produced and rapid change in the delivery of CME as face-to-face activities were no longer possible.

It is in the interest of every society to have doctors providing quality and safe care, and therefore requires them to keep their knowledge and skills up to date. This process of formal claim and evaluation is called recertification. In some European countries this process is mandatory, in some places it is recommended, in some cases it is not formally established at all as such. The first European country to introduce mandatory CME re-certification was Norway (1985), followed by Slovenia (1992). Most other European countries joined after 2000. It can be a necessary precondition for the renewal of a doctor's license or registration, it is usually tied to professional evaluation and bonuses. In some countries it is related to professional or financial sanctions or even to the loss of license

The Future

There is still a need to develop CME approaches that support doctors in changing their practice, improving patient outcomes and community health. More work is needed to include the perspective of the patient in a meaningful way to CME. In addition, their needs to be

increasing focus on learning with other professionals who are providing primary care in order to ensure patients receive effective coordinated care. [14]

This emerging evidence about the most effective ways to deliver CME in Primary Care can be used to establish common standards throughout Europe, which will enable individual countries to develop and improve the health of the community.

Conclusion

In conclusion all CME providers need to recognise that GPs/FDs will respond best to programmes which are relevant to their practice and clearly address their needs in an accessible way. Delivery should involve a combination of knowledge updates and interactive learning. CME should lead to quality improvement and better patient outcomes.

This document outlines the principles for the provision of effective CME for GPs/FDs that are based on the current state of the evidence base. As the evidence base develops there will be a need to review and refine them. The CME committee of EURACT has produced a series of background documents which outline the above principles in more detail.

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