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# Continuing professional development and clinical governance: the role of scientific societies

C. Carbon

Xavier Bichat Medical School, University of Paris, Paris, France

## ABSTRACT

To date, the rules and state of development of the processes of continuing education and the evaluation of skills and competence vary considerably from one European Member State to another. The recognition of the freedom of establishment of health professionals throughout Europe must be made conditional upon the possession of a given qualification, and also the demonstration of maintained levels of expertise, knowledge and skills. This appears to be of primary importance in order to maintain a good quality of care, and to improve the performances and responsibilities of the infection specialists, within the healthcare system. The role of scientific societies such as The European Society of Clinical Microbiology and Infectious Diseases (ESCMID) can be envisaged as follows: (1) to play a key role in the coordination of the processes; definition of the main topics and visions, accreditation of the teaching courses and modalities of evaluation (which supposes a high level of cooperation with the platform for professional qualification) (2) to manage training courses (e.g., ESCMID School, postgraduate courses, technical workshops, educational activities within congresses). In order to make the system clearer and easier to apply, a proposal for a single, comprehensive directive is highly necessary.

**Keywords** Clinical expertise, clinical governance, CME, ESCMID, evaluation of skills

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## INTRODUCTION

Medical education can be seen as a continuing process, beginning with undergraduate education and specialty training, and culminating in continuing medical education (CME) as a professional. The recognition of the freedom throughout Europe to establish the criteria for health professionals must be made conditional upon the possession of a given qualification, and also upon the demonstration of a maintained level of expertise, knowledge and skills.

This appears to be of primary importance in order to maintain a high standard of care, and to improve the performance and level of responsibility of the infection specialists, within the healthcare systems. Therefore, medical education should be considered as the progression from the acquisition of knowledge and skills, through the demonstration of competence, to an assessment of

performance and practice. Continuing professional development (CPD) is thus essential.

## DEFINITION OF CONTINUING PROFESSIONAL DEVELOPMENT

The European Union of Medical Specialists (UEMS) (<http://www.uems.net>) defines CPD as the educative means of updating, developing and enhancing the way doctors apply the knowledge, skills and attitudes required in their working lives. CPD is part of a personal programme of life-long learning, from medical school to retirement. The most powerful motivating factors for CPD include: each doctor's awareness of his or her responsibility for safe medical performance, the recognition of peers, and a collective emphasis on the quality of medical practice. CPD is part of the ethical responsibility of every doctor. Many studies have suggested that CME should be linked more closely to physician learning at the point of care. At the same time, healthcare outcome data indicating the need for and effectiveness of educational interventions should become integrated into standards of practice for CME providers [1].

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Corresponding author and reprint requests: C. Carbon, Xavier Bichat Medical School, University of Paris 7, 9 rue Léopold Robert, 75014 Paris, France  
E-mail: [claudes\\_carbon32@hotmail.com](mailto:claudes_carbon32@hotmail.com)

## CLINICAL GOVERNANCE ORGANISATIONAL LEARNING

This concept concerns the corporate responsibility of all healthcare workers to deliver high quality standards, in the hope that this will translate into better quality of life in a cost-effective manner. Clinical governance represents one of the most significant policy developments in recent years. It places on all healthcare delivery organisations a statutory duty to develop the systems, standards and processes necessary to improve healthcare quality and manage risk. Many healthcare organisations are seeking new ways in which learning can be retained and deployed more widely within the organisation, an initiative that is termed organisational learning. Both approaches emphasise cultural changes as essential underpinnings to quality improvement. However, the two approaches also differ fundamentally in their logic of action. Clinical governance is essentially 'top-down', and is built around formal standards, established procedures, and regular monitoring and reporting. In contrast, organisational learning emphasises 'bottom-up' changes in values, beliefs and motivations in such a way that learning and change are prioritised [2].

A good example is provided by governance and infection control in the UK. It is within this framework that workers in infection control were asked to develop their own methods of applying clinical governance. This example illustrates clinical governance as a tool to engage colleagues on a multidisciplinary front [3].

## THE MOCOMP EXPERIENCE

The maintenance of competence programme (MOCOMP) is a voluntary continuing education programme developed by the Royal College of Physicians and Surgeons of Canada to help specialists manage their personal continuing education themselves (<http://www.cpa-apc.org/publications/archives/bulletin/1996>). It has also been used by the Institute of Australasian Psychiatrists (IAP): (<http://www.iap.org.au/mocomp.html>). The PC Diary software in MOCOMP is used by physician subscribers to define their learning needs and keep a portfolio of learning generated from practice, reflection on clinical experiences, CME meetings, journal reading, and 'hallway consultations'. The PCDiary software

contains powerful searching, sorting and report-generating capabilities to encourage reflection on and appraisal of learning entries. A searchable database is generated from entries into PCDiary to produce a 'question library' available on the web that allows physicians to compare with peers their learning needs and practices. MOCOMP contains the tools to enable doctors to move from the traditional medical school model of learning to self-managed learning with reflection about experiences from their own practice.

## THE CURRENT SITUATION WITHIN THE EUROPEAN UNION

There is a great heterogeneity of CME concepts, processes and timing, but no consensus upon whether CPD should be mandatory or voluntary. There are very different methods of evaluation and no common process of recertification.

In most countries, programmes only evaluate documented participation in continuing education as evidence of continued competence as a specialist. Recertification programmes in the USA use examinations and performance assessments as 'snapshots' of competence taken every 7–10 years.

Recertification should assess both real performance in practice and competence to continue to learn. The purpose of revalidation is to reassure the public that their doctors are competent and maintain high ethical standards.

The UEMS has designed core training programmes in infectious diseases and medical microbiology.

In addition, the UEMS has proposed 17 recommendations for CME as part of CPD (see <http://www.uems.be>). The main features are a national basis for such programmes, internal (national) and external credits, and an accreditation system of education courses.

Recently, the European Union commission presented a document on the education and training programmes until 2006 (9/03/2004-COM(2004)156). Three main objectives are given: to increase the quality of education in the European Union, to improve the access to education and life-long learning, and to open the education systems to a broader spectrum of individuals and organisations. Putting the learner at the centre is the prime objective of the education process.

Different programmes are presented in the document: the integrated programme with four

components (Comenius, Erasmus, Leonardo da Vinci and Grundvig) and, in addition, the transversal and the Jean Monnet programmes. The external policy will include TEMPUS PLUS, an assistance programme for life-long learning, 80% of which is planned at the national level.

### THE CONTINUING MEDICAL EDUCATION SUMMIT

In 2000, a continuing medical education summit 'with implications for the future' was held in Chicago [4]. It was suggested that CME should be linked more closely to physician learning at the point of care. It was also suggested that technology might be used more successfully to address physician-learner needs by helping them to manage volumes of evidence for treating patients more effectively. At the same time, healthcare outcome data on the need for and the effectiveness of educational interventions should become integrated into standards of practice for CME providers. It also appeared that public demand for evidence of continuing competence in practice is driving the profession in most countries to explore new approaches to the continuing education and assessment of physicians. Most groups have called the value of traditional CME into question and are exploring the use of self-directed CME methods, self-assessment and quality improvement as the main instruments for maintenance of certification.

The conference participants agreed upon the importance of communication networks that would facilitate information-sharing and avoid duplication of research efforts.

### CURRENT NEEDS AND FUTURE DEVELOPMENTS

The main issues concerning quality in continuing medical education were outlined by Holm [5]:

- A doctor's desire to be more competent in the delivery of healthcare is the most important motivating factor for continuous learning and change.
- CME must be planned to meet the needs of doctors and be based on both self-assessment and peer review.
- The role of mandatory traditional programmes in maintaining competence is questionable.

- Medical colleges and societies need to improve their educational competence to be able to deliver high-quality CME.

- More programmes should be linked to the workplace; they should include group-based activities and use quality improvement tools.

Practising physicians generally find these programmes unattractive for the following reasons: lack of compensation for such work; the perception that efforts toward improvement in performance add no value and are a waste of time; the lack of knowledge and skill in the use of basic tools for outcomes measurement and performance improvement; and the failure of medical educators to teach these skills.

There is a clear need to develop new tools for education and evaluation. For individual doctors, methods such as a CPD portfolio, a points-based logbook of CME/CPD activities or an education-based assessment of their clinical practice may be relevant. Where a points-based system is used to confirm CPD activity, greater consideration should be given to differential scoring, depending on the nature of the educational activity. An active process, while less readily quantifiable in terms of time, is more likely to yield educational results than a lecture. Simply being present at an educational event cannot in itself be considered a meaningful learning experience or guarantee an outcome, and consequently is a poor basis for any accountability method. It is also important that external review of the learning environment is performed.

Self-directed learning can be defined as: 'A process in which learners take the initiative for increasing self and social awareness; critically analysing and reflecting on their work, defining their learning needs, formulating goals, identifying human and material resources for learning, choosing appropriate learning strategies, and reflecting on and evaluating their learning' [6].

This process may help define practice and professional development plans that appear to be feasible in family practice [7]. The traditional clinical examination has been shown to have serious limitations in terms of its validity and reliability. The objective structured clinical evaluation provides some answers to these limitations and has become very popular. Many variants on the original objective structured clinical evaluation format now exist [8]. Nothing, however, exists in the field of infection specialties.

Some continuous recertification programmes use computer technology to document self-directed learning from practice and to monitor performance. Poor performers can be recognised early.

## THE ROLE OF SCIENTIFIC SOCIETIES

The following suggestions regarding the involvement of scientific societies are made:

- lobbying towards a European Directive (or at least recommendation) on CME/CPD for health professions;
- clarifying what should be done at the national vs. the European level, keeping in mind that European validation of CPD should be envisaged as mandatory for those professionals wanting to move from one country to another;
- defining coordination with other groups and societies and working towards the creation of a single network involving, for example, the platform for professional qualification, the UEMS, and its accreditation service, the European Accreditation Council on CME (EACCME), but also the European Medical Association (EMANET) (<http://www.emanet.org>) and other networks such as the European Public Health Association (EUPHA) (<http://www.eupha.org>), TropEd (<http://www.troped.org>) and other societies with a common interest in infection;
- defining the fields to be covered in the CME/CPD processes at the European level;
- elaborating plans for training of trainers and researchers;
- defining research modalities on evaluation methods and pertinence of the policies, especially for e-learning;
- establishing contacts with other European scientific societies that are already engaged in distance-learning.

Of course, societies such as the ESCMID are already engaged in training programmes for all three specialties. These programmes are presented on the web-site of the society: <http://www.escmid.org>.

## CONCLUSIONS

CME/CPD must become a more visible, integrated, and well-planned activity for which both

protected time and adequate funds must be provided. Academic institutions and medical organisations must improve their educational competence, show a stronger commitment to educational research, and demonstrate appreciation of faculty members who take on these duties.

Certification and recertification requirements must be tuned to support CPD and continuing quality improvement if they are not to be rejected.

If we were able to organise education and training along these lines, it would help decrease the dependence on time as a surrogate for competence and performance, and it would enable us to assess outcomes much more quickly. This approach has obvious benefits in the context of implementing the European Working Time Directive, and those of us with an interest in medical education should work to develop this approach as rapidly as possible. Societies such as the ESCMID may and should play a significant role in the development of adapted CME/CPD programmes at the European Union level.

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