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The College

Report of the Working Group on Continuing Medical Education

Introduction

The Working Group on Continuing Medical Education (CME) met on four occasions between September 1990 and March 1991 with the membership of Drs J. Higgins (Chair), R. Williams, N. Prior, A. Fairbairn and Professors S. Brandon and J. Cox. Information was collected from various sources, particularly the other Royal Colleges and the American Psychiatric Association. Members attended an Open Forum of the Education Committee on the topic of CME addressed by Professor T. M. Hayes, Professor of Medical Education and Postgraduate Dean, University of Wales.

Remit

The remit of the Working Group was to review all aspects of CME as it relates to psychiatry and to make recommendations, the final draft of the document then to be circulated widely within the College for further discussion.

Definition

CME may be defined as all educational activities which relate to improving medical care, which occur after qualification and are not specifically directed towards passing examinations or fulfilling vocational or specialist training requirements (Hayes, 1990).

Importance of CME

The pursuit of continuing education is the mark of a professional person. A medical career is a long one. CME is therefore required to ensure the best quality of patient care within the facilities available, by keeping up one's knowledge base, learning new materials, practising old skills and learning new ones.

Consumers are increasingly concerned about standards of care in medicine as a whole, in psychiatry as a specialty and in the practice of individual psychiatrists. There is also increasing political interest, in part as a result of public pressure but also in an attempt to make members of the medical profession more accountable in managerial and financial terms for their style of practice. When resources are finite and demands virtually limitless priorities have to be determined and strenuous attempts made to get value for money. Audit of clinical practice is now mandatory in traditionally managed hospitals and associated services. Trusts will be no different. CME is a necessary consequence of deficiencies or weaknesses revealed by audit.

Current government views on CME

The attitude of the government to CME was expressed by the Secretary of State for Health in his address to the Joint Meeting on Postgraduate Medical Education on 6 July 1990. He accepted the recommendations for the future structure of postgraduate medical education and continuing medical education made by the Expert Advisory Group established by the Chief Medical Officer.

A number of important themes emerged.

(i) CME will not be entirely subservient to the demands of the service.
(ii) There must be comprehensive programmes for CME devised by regional health authorities
(iii) CME programmes must take account of the results of medical audit.
(iv) The system for delivery of CME should be part of the managerial structure, with clearly defined objectives, proper lines of accountability and budget holders, the funding disentangled from the current monetary headings and made explicit.
(v) Standards of CME should be monitored.
(vi) Standards of training for trainers should be recognised and met.
(vii) The Postgraduate Dean will act as Director of Postgraduate Medical Education in a region. The Postgraduate Dean will have certain "key tasks": to ensure that there are facilities of sufficient quality available for CME to be carried out; to ensure that the education is of sufficient quality; to secure positive links between the results of medical audit and educational programmes.

The Secretary of State's speech was followed by an executive letter from the NHS Management

[EL(90)79] which outlines the new arrangements for the delivery of PGME and CME in regions. This letter indicates that budgets for education will have "in year" protection, that the budget for CME will be held at unit level and that the costs will be recouped from income from service contracts in the usual way.

The new system will be introduced in stages. Regions will need to identify what is currently being spent on PGME and CME and these figures will be used to form the basis of budgets at regional (PGME) and unit (CME) level. Key figures for the delivery of postgraduate and continuing medical and dental education in the hospital sector are the Postgraduate Dean and unit clinical tutors who will be required on behalf of their regional health authority to provide comprehensive educational programmes "as informed by the Royal Colleges and the universities".

Current extent of CME in psychiatry

Many psychiatrists already perceive the importance of CME and approach this in various ways: regular reading of journals and textbooks; attendance and participation in postgraduate training activities for junior staff; attendance at specific CME activities organised locally or nationally by the College through Divisions and Sections, or at College Quarterly or Annual Meetings; attendance at educational activities organised by other bodies such as learned associations, universities, pharmaceutical companies, in this country or abroad. However, much of the value of such personally planned CME may be criticised on educational grounds as opportunistic and *ad hoc*, not thematic or systematic, not conforming with the well established principles and practices of adult learning.

Notwithstanding that many consultants undertake some forms of CME and this may be easier for some, for whom time and expenses are more readily available and who work in settings where an educational ethos is espoused and educational activities are readily to hand, there no doubt exists in psychiatry the equivalent of the mythical "underground orthopaedic association" described by the Orthopaedic Surgery Board of the USA and quoted by Mulligan (1989) as a group with "no meetings, no officers, no exams, no change". The membership of the British psychiatric equivalent is much more likely to be due to attitudes towards CME than the practical difficulties often quoted as reasons for non-participation.

Unlike medical audit, no specific sessional time is proposed for CME. It must be undertaken within the study leave allocation. All NHS consultants are entitled by their terms and conditions of service to 30 days study leave with expenses within a three-year period. The extent of the uptake of this entitlement is not known by the Department of Health (Reed, 1990). It is certainly less than complete, even allowing for the difficulties some experience in obtaining their entitlement.

The previous administrative arrangements for study leave – a regional study leave committee – ceased in April 1991. Study leave funding will, as has been described, be devolved to unit level. Unit managers have been told to expect future claims to be in line with what has previously been taken up. This new arrangement will lack the flexibility of the larger regional budget, albeit never specified, and in view of no doubt variable uptake between one consultant and another, in different specialties, in different parts of the country, difficulties in obtaining study leave in some centres have to be expected with the current level of CME activity, let alone any expansion as a result of the efforts of the College or the Department of Health.

Monitoring of CME

The quantity and quality of CME in all specialties will be monitored by Postgraduate Deans at a local level, but what stand should the College take in encouraging CME and setting standards for it?

Re-certification of established practitioners has been a topic of discussion in the United States for more than 50 years. Other countries, such as Mexico and Japan, have some re-certification procedures. So far, none are undertaken in Europe. In 1936, the American Advisory Board of Medical Specialties suggested re-registration (re-certification) of a stipulated interest and by 1940 the National Commission for Graduate Medicine advised a time-limit of certification and advised that a Board Certificate should be issued for a stated period only. No progress was made until 1967, when the National Advisory Committee of Health Manpower said that physicians' actions should be subject to review and evaluation by peers and that physicians should be accountable for proficiency and appropriateness of medical practice. The American Board of Medical Specialties has since been the driving force in specialty re-certification, with the objective of protection of the public and setting standards of care. In 1973 all Boards accepted the principle. In 1969 general practice led the way by introducing a 7-year certificate, but internal medicine the same year introduced only voluntary re-certification, which quickly failed for lack of interest and was withdrawn. By 1989, 23 Boards were committed to re-certification, only 17 of them issuing time-limited certificates, mostly for a duration of 10 years.

More recently there has been considerable pressure from state and federal legislation to introduce re-certification as part of re-licensing to practise, the

need for this being argued on educational grounds. Some feel this is essential and inevitable, particularly as licensing authorities are planning for it and it may be demanded by Medicare.

Various methods are in use to measure fitness for continuing to practice: (a) a written examination of "update knowledge"; (b) a "practice based oral"; (c) a review of "practice profile"; (d) peer review; (e) a requirement to undertake continuous medical education with 150 credit hours in three years.

There is no perfect method of assessment for re-certification. Assessment of proficiency (knowledge, skills and attitudes) is not proof of competence. Professional concern and even "paranoia" is felt by Boards to be understandable but unjustified, as a competent, skilled practitioner should have little difficulty in meeting the required standard; for example, by 1989, 507 orthopaedic surgeons had been re-certified with a pass rate of 95.2%. Once such a system is established, there may be a need to raise the standards gradually.

The American Psychiatric Association requires each active member to complete 150 hours of CME every three years as a condition of membership. The American Medical Association recognises two categories of educational activity: (a) category one activities – those which meet the criteria of the Accreditation Council for Continuing Medical Education or one of its approved sponsors, for example the American Psychiatric Association (at least 60 hours of CME must be in category one); and (b) category two activities – 13 varieties, including organised teaching programmes without accredited sponsorship, teaching activities, reading of literature, professional writing, preparation and presentation of papers, etc.

The certificate of accreditation is issued on the basis of a self-report stating that the requisite numbers of hours in each category have been undertaken. Those psychiatrists practising in states whose Boards require re-registration are presumed to have met the CME requirements by virtue of having met their state licensure requirements.

Should the College embark upon a certification procedure like that of the APA, it would need to set necessary requirements in terms of hours of CME undertaken and quality of educational experience obtained. It may wish to embark upon the more stringent methods of review as employed by some of the other specialties in the USA, described above. An alternative would be to restrict itself to the central monitoring of more locally-based assessment procedures and courses, only organising national activities when the topics are sufficiently specialised to demand this.

Whether or not the College embarks on some process of re-certification, it clearly will have an important role to play in advising Postgraduate Deans on setting up facilities for CME at a local level. Broad national standards will need to be produced and implemented on behalf of the College by local representatives, the most suitable being the Regional Adviser. In turn, the Regional Adviser might wish to delegate this specific activity to his deputy or even another deputy specifically appointed for this purpose.

The development of College expertise in such an important and expanding activity will be onerous and time-consuming and could perhaps best be undertaken by a designated College representative, e.g. a Sub-Dean with appropriate administrative and secretarial support.

The development of such an advisory structure for CME will prove costly. This might suggest that any certification procedure, mandatory or voluntary, should be self-financing.

Principles of CME

CME must be based on the well-established educational principles of adult learning. These indicate that it will only be effective when the topic is relevant to clinical practice, is dealt with in small groups in an interactive way and uses experience as a basis for learning. The topics chosen must meet the needs of the participant, these needs being assessed as objectively as possible. Topics high in interest but low in relevance, presented in a didactic form, in large lecture theatres, at central venues chosen by meetings organisers for reasons other than relevance, on the basis of perceived rather than the demonstrated needs of the participants, are unlikely to produce the incremental improvement in knowledge and skills of practical value in direct patient care in the settings in which the participants actually work.

It has been suggested by Hayes (1990) that the proper strategy necessary to plan an effective CME programme consists of five steps:

The setting of aims

An aim should be a statement of general intent, for example "all participants in this CME activity will, at the end of it, be able to manage effectively a resistant depressive illness".

A needs assessment

An individual psychiatrist's needs, or the needs of a group of psychiatrists, are measured by the discrepancy between the current state of knowledge, skills, attitude and performance within the facilities available and the desirable ones. There are then complex issues of how and by whom such needs assessment should be made. Obviously, the results of audit are important.

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The setting of objectives

Objectives should be reasonably specific and consist of much narrower statements of what a particular participant will be able to do on completion of the programme. Clear objectives will allow programme organisers to choose appropriate learning methods, will provide teachers with unequivocal information about what is expected from them and will allow easier evaluation of the success of the programme.

Choice of methods

Whereas immediate, highly-informed teaching on the presentation of a clinical problem is the ideal, it is unlikely to occur and therefore impossible to plan. The next best is to postpone teaching on such clinical issues to a future, but not distant, programmed meeting, after all parties have had an opportunity to prepare their contributions. But there has to be an abiding awareness of the limitations of *ad hoc*, unplanned teaching, not based on needs assessment.

The most convenient and economical teaching venue for participants and employers is as local as possible. Indeed, if CME is to become a mandatory and much more frequent activity, funding will not permit much travelling to distant venues. Local activities such as small seminars, workshops and discussion groups close to the work-place are much more likely to meet the needs of busy clinicians and ensure attendance. The use of multiple media teaching has been shown by the advertising industry to be a very effective method of information delivery and uptake and it proves a complement to more traditional methods.

Evaluation

The results of traditional educational practice in medicine are usually assessed by the degree of contentment of the participants – "happiness indices" – than by specific assessment of measured changes in knowledge, skills and attitudes which are fed back to the participants to allow comparison with colleagues and then later evaluation of practice to determine whether there has been a change in performance and an improvement in patient care.

If it is agreed that this model of good educational practice is sound, then it may be argued that most educational activities undertaken locally or centrally by the College and other bodies fall very far short of the ideal. If an attempt is to be made to meet such educational criteria, then the College will have to develop an expertise in principles of adult medical education to enable it to set national standards and to assess the value of CME provided locally and, perhaps most importantly, to organise "teaching of teachers".

Conclusions

Continuing medical education has always been an important feature of a medical career and rightly so. The major change is that new procedures are now to be introduced to organise, monitor and fund CME, but as yet it is not intended that CME become a mandatory requirement of employing authorities. The level of funding to units for CME will, in the first instance, be based on current expenditure. This is unlikely to meet present needs. In future, money will have to be raised from the clinical contracts. When money is short or competition fierce, training is always the easiest to cut.

The College must become an outspoken champion of CME, to ensure that it is undertaken by its members to a proper extent, to ensure that it is properly funded without detriment to clinical services and to ensure that the College develops sufficient expertise in the principles and practice of CME to set appropriately informed standards.

This will be a major undertaking, perhaps as large as the College's input into PGME and may require analogous structures. One member of the Working Group reported that "there is a general relief that the College is at last going to take this (CME) on". Another member expressed the view that "if we don't do it for ourselves, then others will do it to us". It is to be hoped that the optimism of the former is better founded than the pessimism of the latter.

Recommendations

Because of the importance and complexity of CME and its implications for so many aspects of College activities, the College should set up a standing committee such as a Special Committee of Council, to produce detailed recommendations on the role of the College in the implementation and monitoring of CME.

The Special Committee should consider a certification procedure, and if such a system is to be recommended, should:

(i) set standards of CME to qualify
(ii) determine the rate and style of introduction
(iii) decide upon what sanctions, if any, there should be for non-compliance
(iv) consider how this new College activity should be funded.

The Special Committee should enquire about the extent and quality of CME which is currently being undertaken by its non-training grade Members and Fellows. A proper understanding of the amount of study leave undertaken would enable the College to argue for a proper level of funding and how this could be protected. A survey of the types of CME currently being provided would give a good

indication of what is feasible and might provide examples of good practice.

The Special Committee should consider whether the Dean's office should establish a central mechanism responsible for all aspects of CME, to set national standards, to monitor regional activities, to provide a resource of material and expertise. It should also consider whether the Regional Adviser structure could be adapted to fulfil similar functions at a local level, in particular to advise Postgraduate Deans and clinical tutors and to support psychiatric tutors.

The Special Committee should review current College educational activities which could be considered relevant to CME and audit them against proven principles of adult learning.

References

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HAYES, T. M. Continuing Medical Education. October 1990.

MULLIGAN, P. J. (1989) Re-certification – Advantages and Disadvantages – Debate, Royal College of Surgeons of England.

REED, J. (1990) Department of Health. Letter to PRCPsych, 15 August 1990.

ROYAL COLLEGE OF GENERAL PRACTITIONERS. An Educational Strategy for General Practice for the 1990s. January 1990.

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June 1991

The College Library

CD-ROM

We are delighted to announce that the MEDLINE and EXCEPTA MEDICA (Psychiatry) databases are now available on compact disk in the Library. CD-ROM is extremely easy to use – no computer experience being required. Members are welcome to carry out their own literature searches although Library staff will be on hand to give assistance. References can be printed or downloaded onto disk.

Audio-cassette tapes

The Library holds tapes of sessions recorded at the College Annual Meetings of 1990 and 1991. A cassette player is available in the Library for members' use.

Redundant books

During the summer we culled and reorganised the Library bookstock in an attempt to alleviate the overcrowded shelves. Members interested in any of the withdrawn books should contact the Library staff.

Psychiatric Associations of the World

We are in the process of updating this register which the Library produced in 1987. We would be very pleased to hear from any College member who can provide details of associations representing psychiatrists in:

Afghanistan, Albania, Algeria, Bolivia, China, El Salvador, Ethiopia, Ghana, Indonesia, Laos, Libya, Malta, Mexico, Morocco, Nepal, Philippines, Sri Lanka, Sudan, Syria, Tunisia, Zambia, Zimbabwe.

The Class of (18)81

Many visitors to the Library exhibition at the recent 150th Anniversary Conference commented on the group photograph of members of the Medico-Psychological Association taken in 1881 during the Annual Meeting. The group of 64 men who posed on the steps of University College, London, includes many of the great names of British psychiatry – Hack Tuke, Clouston, Yellowlees, Hayes Newington, Savage and ClayShaw. Copies of the photograph and accompanying identification key are available from the Library:

size 12 × 15 £10.00
size 9.5 × 12 £6.50

Donations to the Library

Members have continued to be most generous in giving copies of their published works to the Library.

During the last six months books have been gratefully received from the following members:

Prof B. Barker, *Basic Behaviour Therapy*
Dr M. G. Barker, *Barrow Hospital: 50 Years of Caring*
Dr S. Bloch, *Psychiatric Ethics, 2nd edition*
Dr D. Bennett & Prof H. L. Freeman, *Community Psychiatry: The Principles*
Dr J. Collinson, *Across the West Wood*
Dr M. D. Enoch, *Uncommon Psychiatric Syndromes*
Prof A. H. Ghodse, *Substance Abuse and Dependence*
Dr I. B. Glass, *The International Handbook of Addiction Behaviour*
Prof D. Goldberg, *The Public Health Impact of Mental Disorder*
Dr L. Goldie, *Pain – Research and Treatment*
Dr J. R. Gomez, *Psychological and Psychiatric Problems in Man*
Prof I. Gottesman, *The Origins of Madness*
Dr M. T. Haslam, *Psychiatry Made Simple*