The influence of Continuing Medical Education (CME) and Continuing Professional Development (CPD) on the quality of medical practice

When educationalists “invented” lifelong learning and emphasised the need for it, many doctors gave another in a series of long-suffering collective sighs. Was it really being suggested that members of the profession that cares for patients from cradle to grave and who, in order to do so, study almost as long, did not learn for the whole of their professional lives?

Doctors know that it is only through continuing study that we are able to qualify, practise Medicine, keep up-to-date, develop new techniques, use new drugs; in effect, do all that is needed to provide the best possible care for our patients. If we didn’t learn, all our lives long, the many advances that Medicine has made would not have been introduced into everyday practise.

It seems obvious that CME/CPD has contributed enormously to improvements in medical care, but there are surprisingly few research studies that demonstrate a measurable positive impact of CME/CPD on clinical outcomes and practitioner performance. We know intuitively that continued learning is essential to these, but it’s not easy to show it explicitly. Of course, there is the cynical view that if education of doctors didn’t change their practise, why would drug companies put so much money into it?

This “failure” of definitive research could not have come at a more inconvenient time; politicians, funders of healthcare, the media and the public want greater accountability from doctors as regards their clinical outcomes, their use of limited healthcare resources, indeed, all aspects of their professional performance.

So why is it that we can’t we prove that CME/CPD improves performance? The usual academic responses in situations such as this are to reconsider the primary hypothesis or the research methodology, to commission further research, perhaps do a meta-analysis. While all of these may be valid justifications for further research, politically the medical profession just doesn’t have the time to wait for definitive results while confidence in our professionalism so clearly is under threat. The media are happy to give widespread coverage to stories that highlight problems with medical practice, and to leave the profession to deal with the consequences.

This is particularly frustrating because for centuries good doctors have measured the quality of their work with the aim of learning what interventions allow them to improve the care of patients; they just hadn’t done so using modern research methods or talking about it with current terminology. It is also frustrating to note that, partly because of the paternalistic model that previously was accepted for patient-doctor and profession-society interactions, Medicine has not been good at advertising this longstanding emphasis on quality. It is against this background that representatives of the medical profession, across Europe, and in each of its countries, are promoting a more open awareness of, and greater emphasis on the...
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quality of healthcare. The UEMS, through its policy statements “The Basel Declaration on CPD” (adopted in 2001) and “Promoting Good Medical Care” (2004), has shown that it recognises the essential role CME/CPD has to play in maintaining and improving the quality of healthcare. Both these documents, which are available on the UEMS website, explore the rationale for promoting CME/CPD as an essential part of quality initiatives, and provide clear recommendations on how to achieve this.

The UEMS believes that every doctor must be encouraged, and funded, to maintain and develop the quality of their practice and, as their contribution to an implicit quality-based “contract”, should be willing to be accountable for doing so. The UEMS has taken the pragmatic decisions that CME/CPD provides an essential mechanism for ensuring quality improvement, and that systems based on peer review – such as audit, appraisal, and hospital/clinic visitation programmes – are the most appropriate means of assuring the quality of care provided to patients.

Patient satisfaction surveys show that most consultations with doctors and treatments provided by them are considered to be of a high standard but, in a profession that is granted the responsibility for making decisions that affect people’s lives, there is always the potential to do even better.

Sometimes it is necessary to lead, in the knowledge that research will follow, reviewing what already has been achieved and recommending further changes. The UEMS policy statements provide readily implementable systems for improving and assuring the quality of medical care, based on existing best practice; these are applicable to every specialist doctor in Europe. Whether by these or other systems, all doctors, as part of their everyday practice, should be ensuring that they are providing high quality care for their patients, that they are able to show this, and that they have the resources necessary to achieve these goals.

“Promoting good medical care”

Summary

This paper sets out the policy of the Union Européenne des Médecins Spécialistes/European Union of Medical Specialists (UEMS) on quality assurance (QA), which is defined here as the regular monitoring of medical care and the means of achieving these goals.

This UEMS policy paper builds upon considerable evidence of successful, well-established QA systems that are found in many parts of Europe. Fundamental features of these are that they are led by specialist doctors, who control resources allocated solely for the purpose of quality assurance. Accordingly, the UEMS recognises its responsibility to develop policy based on this experience, and invites all interested parties to support this.

The UEMS considers that QA is an essential component of an agenda focused on high standards of medical practice. The other parts of that agenda include continuing professional development as a form of quality improvement – covered separately in the 2001 UEMS policy document “The Basel Declaration” – and its policy, being developed, on regulating the medical profession.

This paper is addressed to all who have an interest in the quality of healthcare provision: patients, doctors, medical associations, Health Service employers and hospitals, fund-holders, regulatory authorities, national and European legislators. The UEMS considers that, in the context of the QA of medical care, all share the following agenda:

- of ensuring that systems for assuring the good quality of medical care are appropriately monitored, supported and funded;
- of working together, within a medically-led structure, to achieve continuing improvement in the quality of care;
- that the means of achieving the above is through the implementation of a QA system that considers all relevant components: the individual doctor, the team(s) within which they practise, and their work environment;
- that this system should be based on the QA cycle: monitoring medical care against standards accepted as medically valid, introducing improvements that are appropriately resourced, reviewing these changes, and ensuring that the system itself is adequately quality assured.

The UEMS draws attention to the lack of evidence to demonstrate any additional effectiveness of mandatory systems over the model described here.

Reference number of the Declaration: UEMS 2003/49