

Continuing Professional Development for Medical Practitioners

**A Report on the Project Conducted by the Royal Australian and New
Zealand College of Obstetricians and Gynaecologists on Behalf of the
Committee of Presidents of Medical Colleges**

This project was conducted by the Royal Australian College of Obstetricians and Gynaecologists (RANZCOG) on behalf of the Committee of Presidents of Medical Colleges (CPMC).

The College expresses its gratitude for the contribution made to the project by the Project Reference Group chaired by Dr Jack Sparrow.

Table of Contents

Executive Summary	4
Purpose.....	4
Rationale	4
Development And Summary.....	5
Future Directions.....	8
Continuing Professional Development – A Definition.....	9
Rationale for Reform.....	11
Conceptual Platform.....	13
Medical Professionalism – A Background.....	17
Medical Professionalism as a Platform to Underpin a CPD Framework for Medical Practitioners	26
<i>Clinical Expertise</i>	27
<i>Risk Management</i>	30
<i>Professional Values And Responsibilities</i>	31
Adult Learning Principles	35
Doctors’ Learning and Change.....	38
Continuing Professional Development – The Evidence.....	47
The Question of Mandatory CPD.....	59
The Current Situation of Medical Practitioner CPD in Australia.....	62
Overview.....	63
Program Structure	63
College CPD Activities.....	65
Guiding Principles for the Framework for Continuing Professional Development for Medical Practitioners	66

The Framework and CPD Activities: A Classification.....	69
The Framework In Operation.....	71
The Certificate Of Continuing Medical Professionalism	72
Project Consultations.....	73
Summary of Views of Organisations Invited to Comment on Priorities for Continuing Professional Development of Medical Practitioners.....	73
Summary of Views of Practitioners and Trainees Invited to Comment on Priorities for Continuing Professional Development of Medical Practitioners.....	78
<i>Site Selection</i>	79
<i>Establishing Forums At The Sites</i>	79
<i>Divisions of General Practice</i>	80
<i>Attendance at Forums</i>	81
<i>Forum Outcomes</i>	82
Response to Interim Report from Specialist Medical Colleges	86
Assessment and Evaluation of CPD Activities and Programs	88
Administration of CPD Activities and Programs.....	96
Summary.....	97

Executive Summary

Purpose

This report describes work conducted on the construction of a framework for Continuing Professional Development (CPD) of medical practitioners in Australia. In the context of the framework, medical 'practitioners' are considered to be doctors who have completed a prescribed period of postgraduate vocational training and are certified as possessing recognised expertise in a specific area of medical practice. Thus, the document is considered to have relevance to General Practitioners as well as specialists from other disciplines.

A framework for CPD of medical practitioners that will be applicable to a wide range of specialties is proposed, acknowledging the diverse roles that such practitioners undertake. It is based on the concept of what being a medical professional is deemed to entail, identifying ten components of *medical professionalism* that can be used as the basis for description of practice and, thus, CPD. Activities that are seen to constitute CPD for medical practitioners are identified and classified into three levels according to their perceived capacity to bring about change in practice or behaviour and improve patient health outcomes. Thus, a matrix of ten components of medical professionalism across three levels of activities can form the crux of the framework as described.

In addition to describing a framework for medical practitioner CPD that can be applied across a range of specialties, the document identifies and discusses issues relating to the implementation and operation of CPD for medical practitioners in Australia. Specific recommendations relating to these issues were not seen as the purpose of the work described in the document, and it is recognised that further work by relevant groups will be required to address some of the issues identified and discussed.

Rationale

Recent international developments in continuing education for medical practitioners evidences a shift away from the relatively narrow focus of maintenance of skills programs or continuing medical education (CME) to the broader concept of CPD that acknowledges the wider range of skills, knowledge and attributes now considered to be part of professional practice. Practitioners are expected to engage in activities to maintain or develop abilities that enable them to function as

safe and effective medical professionals who can provide high quality health care in their area of expertise across a range of domains.

Developments in Australia in the areas of medical registration, accreditation of specialist medical college training and professional development programs, medical indemnity insurance, increasingly aware health care consumers and the motivation of the profession to undertake continuous improvement have also resulted in an increased awareness of the need for medical practitioners to be involved in effective, ongoing CPD programs in this country.

As a result, the area of CPD has become an increasingly important, complex and debated component of practice for medical practitioners. An ad hoc or spasmodic approach to CPD can no longer be considered acceptable, and a uniform approach to this issue across the different specialties would appear desirable and logical.

Development And Summary

The work described in this document was funded by The Commonwealth Department of Health and Ageing (DHA) and conducted by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) on behalf of the Committee of Presidents of Medical Colleges (CPMC). A Project Reference Group comprising representatives from a range of interest groups was convened to advise and support the project. Members of the Project Reference Group are listed in Appendix A.

The overall purpose of the work described in this document was the design and development of a framework that can be considered 'best practice' in the field of specialist medical CPD, based on the data and information collected throughout the duration of the project, and which could be applicable to a wide variety of medical specialities. To that end, the project was informed by available literature and consultations with a variety of stakeholders in the health care field, including medical boards, medical defence organisations, health complaints organisations, specialist medical colleges and practitioners. Overwhelmingly the primary purpose of practitioners participating in ongoing CPD was, according to the consultations, the maintenance, development and improvement of skills that enable consumers of health care to be confident of the level of care that they receive, while recognising the need for CPD in the wider context of professional practice.

The framework uses the concept of medical professionalism as its theoretical platform, acknowledging the increasing awareness of a patient-focused medical workforce. Three main areas (strands) of medical professionalism are identified: *Clinical Expertise*, *Risk Management*, and *Professional Values and Responsibilities*. These strands are further divided into ten areas (components) as outlined below.

Clinical Expertise	Medical Expertise Clinical Judgement Medical Informatics (Clinical)
Risk Management	Communication Practice Management Medical Informatics (Practice) Personal Management and Insight
Professional Values and Responsibilities	Relationships and Accountability Advocacy and Equity Education

The purpose of constructing this theoretical platform was to enable practitioners across disciplines and settings to identify areas of practice that encompass their CPD needs and activities within these ten components. It is not the intention of the framework to communicate the perception that all practitioners should recognise facets of their practice or undertake CPD activities in all ten areas. The theoretical platform is an acknowledgement of the wider range of skills, knowledge and attitudes now being accepted as constituting the role of a medical practitioner.

The framework advocates the recognition of a wide range of as valid for medical practitioner CPD and recognises the existence of three levels of CPD activities: those that focus on increasing knowledge and skills; those that can facilitate changes in practice and health outcomes; and those where changes in practice and health outcomes are evaluated. In addition the framework specifically acknowledges general adult education principles, as well as the literature relating to the ways in which medical practitioners learn and that relating to the effectiveness of CPD.

As such, the framework advocates the prospective identification of learning and, thus, CPD, needs by individual practitioners, as well as an evaluation of what has been achieved by the CPD

undertaken by a practitioner throughout a defined CPD cycle. As far as possible and practicable, this evaluation should address changes that have occurred at the levels of practice and behaviour, as well as health outcomes. It is recognised that these aspects of the framework need to be addressed and conducted in such a way that is manageable for the practitioners involved, as well as for individual medical colleges from the perspective of infrastructure and capacity. The construction of the framework described in this document has been done with an attempt to achieve rigour and effectiveness in medical practitioner CPD programs, with a view to what is practical and achievable at the practitioner and institutional level.

The framework has been designed to be broad ranging and flexible in its application and operation. It is possible to construct a CPD program around the framework that can operate on the basis of a participant portfolio, or on the basis of a requisite number of hours or credit points, or a combination of the two approaches. The framework is considered to be flexible enough to meet all current statutory requirements currently operating in Australasia, and to be capable of accommodating any changes in this respect that may be introduced in the short- to medium-term future. For example, the framework is designed to be used easily by professional bodies other than specialist medical colleges that are members of the CPMC, and could be adapted for use as a framework on which a revalidation process such as that currently being introduced in the United Kingdom could operate.

As an adjunct to the framework, the creation of a universal system of recognising the participation of medical practitioners in appropriate CPD is advanced. Such a system (based upon the issuing of what has been called a *Certificate of Continuing Medical Professionalism* [CCMP] by participating bodies) could offer a mechanism to indicate to statutory bodies, as well as consumers and other stakeholders, that individual practitioners are participating and in good standing in a CPD program sanctioned by the issuing body. The practical issues and difficulties associated with this initiative are recognised and acknowledged; however it would appear to associated with sufficient advantage to merit consideration.

The framework has been constructed on the premise that participation by medical practitioners, or any other health professional, in CPD can help to maintain and increase the knowledge, attitudes and skills associated with practice; i.e. contribute to an individual's ability to practise in a manner that is considered 'professional' in modern medicine. The framework has taken a wide view of

medical professionalism, akin to the ‘new professionalism’ that has underpinned reform of the health system in the United Kingdom. It acknowledges the obligation for individuals to take responsibility for their own professionalism development, without mandating compulsory participation, and makes no claim as to the existence of an absolute causal link between participation in CPD and a guarantee of competence. CPD is seen as a means of helping a self-regulating profession to maintain and improve standards. The framework is an instrument that attempts to facilitate that process.

Future Directions

The framework for CPD for medical practitioners and the associated issues outlined in this report represent a timely opportunity for stakeholders involved in ongoing specialist medical education and registration in Australia to move forward in collaborative ways to develop integrated processes aimed at improved health care outcomes. Participation in CPD is an aspect of practice for medical practitioners that is increasingly being recognised as a basic professional expectation of and by all involved in the profession and it is appropriate that dialogue ensue to enable agreed attitudes toward, and standards of, CPD to be developed across the medical specialties in this country.

Those involved in the work described in this document hope that the framework as outlined can make a significant contribution to the ongoing process and debate relating to CPD for medical practitioners and look forward to any progress made as a result of its publication.

Continuing Professional Development – A Definition

According to Crampton and Wilkinson,¹

Doctors' performance and the maintenance of competence throughout their careers are issues of increasing importance for the profession, governments and communities. In addition, there is increasing public expectation that the medical profession will be pro-active in protecting patients from under performing doctors.

They further assert:²

Without structured programs it is difficult for doctors to remain up to date with their knowledge and skills. Documented participation in a PDP offers a learned medical college the opportunity to demonstrate to government, peers and communities that members are working to maintain standards.

Continuing professional development assists medical practitioners to optimise safety and quality of the health care they deliver to the community. Through participation in activities to improve practice, medical practitioners demonstrate their commitment to some of the principles and responsibilities of what it means to be members of the medical profession. The expectation is that medical practitioners will maintain high professional standards throughout their careers. CPD programs that are educationally coherent and convincing will support medical practitioners in this endeavour.

Peck et al.³ typify definitions of continuing professional development when they describe it as:

... the process by which health professionals keep updated to meet the needs of patients, the health service, and their own professional development. It includes the continuous acquisition of new knowledge, skills, and attitudes to enable competent practice.

¹ Crampton, M, Wilkinson, D. The Professional Development Program of the Australian College of Rural and Remote Medicine. *Australian Family Physician* 2002; 31 (10): 952.

² id.

³ Peck, C, McCall, M, McLaren, B, Rotem, T. Continuing medical education and continuing professional development: international comparisons. *British Medical Journal* 2000; 320: 432 - 435.

They advise that there is “no sharp division”⁴ between *continuing medical education* (CME) and CPD, and acknowledge that the term *continuing professional development* encompasses the medical and clinical knowledge and expertise required of health practitioners, as well as those aspects of medical practice that, traditionally, have received only tacit recognition as being important in the practice of medicine, such as managerial, social and personal skills.

The evolution of the RCPSC CPD program is a good example of the sea change in medical continuing education from CME to CPD. In discussing the program, Parboosingh comments that:

Continuing professional development extends beyond traditional CME, which is perceived to be teacher driven and focused on updating medical knowledge. In CPD, practitioners define competencies that they see as relevant to their practice needs. As well as traditional educational themes, CPD education covers subject matter such as doctor-patient communication, interdisciplinary team skills and risk management, as well as other competencies ... CPD activities use a wide variety of educational formats and delivery methods, including self-directed learning, traditional courses and self-assessment programmes.⁵

In its *Global Standards for Quality Improvement* document devoted to CPD⁶, the World Federation for Medical Education (WFME) sees the evolution from CME to CPD as reflecting “both the wider context in which this part of medical education takes place, and that the responsibility to conduct CPD rests with the profession and the individual doctor”.⁷

CPD, besides being a professional imperative of every doctor, is also a prerequisite for enhancing the quality of health care. ... CPD implies self-directed and practice-based learning activities rather than supervised training. CPD aims to maintain and further develop competencies regarding knowledge, skills and attitudes of the individual doctor to meet the changing needs of patients and the health care delivery system, new challenges as result of the scientific development in medicine and requirements of licensing bodies and society, as well as serving a need for personal professional development.

Within this climate of a developing acceptance of the need for ongoing learning in areas beyond traditional medical and clinical knowledge, the term *continuing professional development* is

⁴ id.

⁵ Parboosingh, J. CPD and maintenance of certification in the Royal College of Physicians and Surgeons of Canada. *The Obstetrician and Gynaecologist* 2003;5: 45.

⁶ Continuing Professional Development (CPD) of Medical Doctors WFME Global Standards for Quality Improvement. Result from Task Force Seminar 25 – 27 October 2002. World Federation for Medical Education, 2003.

⁷ *ibid.*, p.4.

understood in this project to encompass other terms, such as CME and *Maintenance of Professional Standards* (MOPS). Coupled with the acknowledgment that the practice of medicine is a *profession*, and all that this implies (see later discussion on Medical Professionalism), a succinct definition of CPD for medical practitioners can be developed as:

The ongoing maintenance, acquisition and development of knowledge, skills and attitudes to enable a medical practitioner to constantly improve as a practising professional.

Rationale for Reform

When considering the drivers that underpin the rationale for this project, five are key.

1. The proposal for a nationally consistent approach for medical registration.
2. The Australian Medical Council (AMC) accreditation of specialist education and training and professional development programs.
3. The current situation in regard to medical indemnity insurance.
4. Social factors that have seen patients become more aware of their rights as health care consumers.
5. The motivation of individual practitioners for continuous improvement.

The impetus for reform to medical registration arises from a number of recent developments. Since the early 1990s, following passage of the Commonwealth mutual recognition and associated enabling legislation, work has been undertaken to develop a nationally consistent approach to medical registration arrangements. In 2001, the New South Wales Medical Board noted, independently, growing advocacy among the medical profession for maintenance of professional standards and continuing professional development to be linked to registration of medical practitioners. In response to the proposal, the Australian Health Ministers Advisory Council (AHMAC) established a working party to consider reform, which includes linking re-registration to ongoing competency, but with evidence of continued professional development and recent practice as the basic measure. The work of this group is ongoing, with an announcement due shortly. Clearly, of the five drivers listed above, a nationally consistent approach to medical registration and re-registration that requires evidence of ongoing CPD has the greatest likelihood of sustaining incentive for participation in CPD programs. With renewal of medical registration

linked to participation in continuing professional development and evidence of recent practice, medical practitioners should welcome access to CPD programs that meet criteria for medical board re-registration, AMC accreditation, insurer endorsement, and consumer approval.

The AMC standards for accreditation of specialist medical college professional development programs describes such activities as “...an important component of self-regulation by the medical profession”.⁸ Accordingly, re-registration should continue to occur as a self-declaration or statement of fitness to continue to practise as a medical practitioner. Specifically, the AMC accreditation standards, which concern the processes of specialist education and training, require the training organisation (medical college) to:

- Have professional development programs that assist its members in maintaining their knowledge, skills and performance so they can deliver adequate and safe medical care
- Monitor participation in all areas in which the practitioner is currently practising
- Have processes to counsel fellows who do not participate in such programs when they are not compulsory
- Have processes in place for retraining and remediation of its fellows who are under-performing.⁹

There are unprecedented implications for medical practitioners and their colleges arising from sources such as reforms to medical registration, AMC accreditation requirements for organisations such as medical colleges offering specialist education and professional development programs, and effects of the medical indemnity situation flowing from government and bodies such as medical defence organisations (MDOs). This is particularly so in the context of an already significant and growing awareness of patients of their rights as health consumers. One clear implication is that medical practitioners can no longer practise in an environment where CPD is optional or ad hoc. This is clearly appreciated by some observers who are calling for a renewed examination of what it means to be a member of the medical profession per se (see later). The conducting of this project to propose a uniform framework for conducting the CPD of medical practitioners in this country would appear timely.

⁸ Accreditation of Specialist Medical Education and training and Professional Development Programs-Standards and Procedures, Australian Medical Council Incorporated, p. 34, October 2002.

⁹ *ibid.*, pp. 34-35.

Conceptual Platform

In regard to the CPD programs operating until now in Australian specialist medical colleges, it is interesting to note the almost complete absence of attempts to articulate categories that define or describe domains of practice for medical practitioners. In relation to its accreditation process, the AMC talks of the expectations on training bodies having “processes for deciding on the broad roles of practitioners in their disciplines”,¹⁰ and of the specialist training programs providing trainees with “an understanding of the importance of maintaining and enhancing his/her knowledge, competence and performance of them”.¹¹

On the whole, it would seem colleges have appeared content with the situation of an almost tacit understanding of what being a practitioner in their particular specialty entails once a Fellow is practising. The priorities for CPD program planners appear to have rested in grouping and accrediting activities, and mandating the requirements of programs.

For a CPD framework to have applicability across a range of medical specialities, and to consist of more than simply a guide to acceptable activities and program rules, a platform that has utility across the specialities involved is required. Such a platform must have relevance to the specialities involved, and should also be able to add to the framework in terms of strengthening the articulation of the purposes and aims of practitioners undertaking CPD.

One possible method of constructing a platform for a CPD framework is to formulate or utilise existing descriptions of practitioner roles or competencies. The most well-known example of an articulation of the perceived roles of specialist doctors is, of course, the CanMEDS specialist role descriptions as outlined by the RCPSC.¹² Indeed, it is to this set of roles that two colleges have recently indicated they will turn in an attempt to articulate areas of practice for their Fellowship.

¹⁰ *ibid.*, p. 9.

¹¹ *id.*

¹² Report of the Societal Needs Working Group, CanMEDS 200 Project, The Royal College of Physicians and Surgeons of Canada, 2000.

The report of the *Societal Needs Working Group* of the *CanMEDS2000* Project¹³ has been widely embraced. Its use as the basis for reforms in specialist medical education is acknowledgment of the increasing awareness of the holistic nature of medical practice in the areas of medical specialties. The document describes the generic competencies of medical specialists as comprising seven roles.

Medical Expert - The specialist must be able to demonstrate diagnostic and therapeutic skills for ethical and effective patient care; access and apply relevant information to clinical practice; and demonstrate effective consultation services with respect to patient care, education and legal opinions.

Communicator – The specialist must be able to establish therapeutic relationships with patients/families; obtain and synthesise relevant history from patients/families/communities; listen effectively; and discuss appropriate information with patients/families and the health care team.

Collaborator - The specialist must be able to consult effectively with other physicians and health care professionals; and contribute effectively to other interdisciplinary team activities.

Manager - The specialist must be able to utilise resources effectively to balance patient care, learning needs, and outside activities; allocate finite health care resources wisely; work effectively and efficiently in a health care organisation; and utilise information technology to optimise patient care, lifelong learning and other activities.

Health Advocate - The specialist must be able to identify the important determinants of health affecting patients; contribute effectively to improved health of patients and communities; and recognise and respond to those issues where advocacy is appropriate.

Scholar - The specialist must be able to develop, implement and monitor a personal continuing education strategy; critically appraise sources of medical information; facilitate learning of patients, house staff/students and other health professionals; and contribute to development of new knowledge.

¹³ id.

Professional - The specialist must be able to deliver highest quality care with integrity, honesty and compassion; exhibit appropriate personal and interpersonal professional behaviours; and practise medicine ethically consistent with the obligations of a physician.

In addition to the CanMEDS role descriptions, the AMC also makes reference to the six general competencies defined by the United States Accreditation Council for Graduate Medical Education (ACGME), listed below.¹⁴

Patient care – Provision of patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Medical knowledge – Demonstration of knowledge about established and evolving biomedical, clinical and cognate sciences and the application of this knowledge to patient care.

Practice-based learning and improvement – The ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve patient care practices.

Interpersonal and communication skills – The ability to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families and professional associates.

Professionalism – A demonstration of commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-based practice – Demonstration of an awareness of and responsiveness to the larger context and system of health care and the ability to call effectively on system resources to provide care that is of optimal value.

In the United Kingdom, the General Medical Council (GMC) has produced the document *Good Medical Practice* to guide the practice of doctors alongside the recently introduced revalidation requirements. The document “describes values and standards commensurate with what the public expects”. The Medical Council of New Zealand (MCNZ) has adapted the original *Good Medical*

¹⁴ Accreditation of Specialist Medical Education and training and Professional Development Programs-Standards and Procedures, Australian Medical Council Incorporated, pp. 13, 92 - 95, October 2002.

*Practice*¹⁵ to compose its “domains of competence” for doctors registered with that body. The domains and the areas that comprise them are listed below.

Medical care: Good clinical care; Treatment in emergencies.

Communication: Maintaining trust; Ending a professional relationship; Providing information about your services; If things go wrong.

Collaboration: Working in teams; Arranging cover; The central role of the general practitioner; Delegation and referral; Working with colleagues.

Management: Decisions about access to medical care.

Scholarship: Teaching; Making assessments; References; research; Keeping up to date; maintaining your performance.

Professionalism: Signing certificates and other documents; Your duty to protect all patients; If your health may put patients at risk; Integrity in professional practice; Financial and commercial dealings; Conflicts of interest – hospitality/gifts and inducements; financial interests in medical organisations.

Clearly there is more than one existing description of the roles or expectations of medical practitioners that could be used to create a conceptual platform for a CPD framework. The choice of which is the most suitable is not obvious, and is not helped by the current situation where some medical colleges are currently independently composing or re-working curricula for their training program or CPD program. In addition, many of the colleges in Australia that constitute membership of the CPMC, and which are eligible for AMC accreditation, are not simply Australian, but Australasian, and notice must be taken of the MCNZ requirements for CPD (recertification) in the construction of any framework developed through this project.

What is clear, however, is that whatever platform is used, it must reflect the essence that is common to all such documents currently in existence and already described, i.e. the recognition of the medical practitioner as involving more than the possession of knowledge and clinical expertise. This is concordant with the previously discussed move from CME to CPD. The appropriate concept that would appear to be able to do this, and which itself has recently undergone the type of shift reflected in the new philosophy of CPD would be *medical professionalism*. Indeed, a ‘new

¹⁵ Good Medical Practice The Medical Council of New Zealand, July 2003.

professionalism' is the guiding principle behind the GMC's *Good Medical Practice* document and associated reforms in the United Kingdom. The absence of 'professionalism' as a label for any of the principles of good medical practice outlined in that document is testament to the ability of the concept to underpin a framework for the "standards of competence, care and conduct expected of ... [doctors] ... in all aspects of ... [their] ... professional work". In the absence of any other consensual description, it would appear suitable also for use as the conceptual platform for a framework for continuing professional development for medical practitioners.

Medical Professionalism – A Background

Literature contributions related to the concept of professionalism in medicine and its meaning and implications for members of the medical profession have been steadily growing in number since the mid-1990s. That the plenary session of the RCPSC annual conference was entitled "Professionalism in a Changing Health Care System" is perhaps testament to the importance being attached to developing an awareness and understanding of the concept.

Writing in the *Medical Journal of Australia*, Van Den Weyden¹⁶ asserts that, for of the journal's readership,

The word "professional" conjures up an image of an individual with expertise in a discrete area of knowledge and a commitment to use this expertise judiciously. The word "doctor" has similar connotations, but also suggests the altruism of service to patients and society.

He goes on to advance the premise that the medical profession has not been insulated from or immune to the wholesale change that has occurred in the industrialised world, asserting that the changes and resulting uncertainty have awakened an interest in medical professionalism in various regions of the world, notably North America and the UK. This interest, he writes, "has yet to reach Australia".¹⁷

Van Den Weyden writes in the context of introducing to his readership the *Charter on Medical Professionalism*.¹⁸ Intended to be applicable to different cultures and political systems, the charter

¹⁶ Van Den Weyden, MB. *Medical Journal of Australia* 2002; 177: 263.

¹⁷ id.

¹⁸ www.professionalism.org. *Medical Journal of Australia* 2002; 177: 263-265.

is the outcome of the *Medical Professionalism Project*, a combined initiative of the European Federation of Internal Medicine, the American Society of Internal Medicine Foundation and the American Board of Internal Medicine Foundation.

The charter describes professionalism as “the basis of medicine’s contract with society”.¹⁹

It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust, which depends on the integrity of both individual physicians and the whole profession.

Acknowledging the vast range of settings in which medicine is practised, the charter advocates that common themes of medical professionalism emerge from these settings, and that medical professionalism in medical practitioners can be defined through three fundamental principles and a set of ten definitive professional responsibilities.

Fundamental principles

- Primacy of patients’ welfare – a dedication to serving the interests of the patient; altruism; and a realisation that external factors such as market forces, societal pressures and administrative exigencies must not compromise this principle.
- Patients’ autonomy – a commitment to honesty with and empowerment of patients, within the bounds of ethical practice and appropriate care.
- Social justice – a commitment to the promotion of justice in health care, including the fair distribution of resources and an active role in the elimination of discrimination in health care.

Professional responsibilities, i.e. commitment to:

- professional competence – a commitment by individuals and the profession to assuring its members are competent.

¹⁹ *ibid.*, p. 263.

- honesty with patients – a commitment to fully informing patients and obtaining informed consent, to promptly informing patients where medical errors occur, and to reporting and analysing medical mistakes to provide for prevention and improvement strategies to be developed.
- maintaining patients' confidentiality – a commitment to appropriate safeguards to ensure patient confidentiality, as well as a realisation that there may be times where this commitment must yield to other considerations.
- maintaining appropriate relationships with patients.
- improving quality of care – a dedication to continuous improvement in the quality of health care, involving the maintenance of individual clinical competence, as well as working collaboratively with other professionals to produce improvements at all levels of the health care system.
- improving access to care – a commitment to ensuring the objective of a uniform and adequate standard of care. An individual and collective working towards reducing barriers to equitable health care. The promotion of public health, as well as public advocacy, without concern for self-interest.
- a just distribution of finite resources – a commitment of the profession to develop guidelines for cost-effective care, including avoidance of unnecessary tests and procedures.
- scientific knowledge – the upholding of scientific standards, the promotion of research and the creation of new knowledge and its appropriate use.
- maintaining trust by managing conflicts of interest – an obligation to recognise, disclose to the public and deal with conflicts of interest that arise.
- professional responsibilities – at an individual and collective level, the expectation that doctors work collaboratively to maximise patient care, are respectful of one another, and participate in the processes of self-regulation (including remediation and discipline of members who have

failed to meet professional standards). Defining and organising the educational and standard-setting processes for current and future members of the profession. An obligation to engage in internal assessment, and the acceptance of external scrutiny of all aspects of professional performance.

The charter acknowledges the challenges of practising medicine in the modern era and advocates the reaffirmation of a dedication to the principles of professionalism by the medical profession as the mechanism of maintaining the fidelity of medicine’s social contract during what are seen as turbulent and uncertain times. This dedication is seen to entail a personal commitment on the part of practitioners to the welfare of patients, as well as collective efforts to improve the health care system for the welfare of society.

Cruess, Johnston and Cruess²⁰ echo the views expressed through the *Charter on Medical Professionalism*, acknowledging the huge changes that have taken place in the environments in which medicine is practised. They acknowledge the practice of medicine as a ‘profession’ and describe membership in a profession as involving a social contract whereby members of the profession (professionals) are granted:

... a monopoly over the use of a body of knowledge, as well as considerable autonomy, prestige and financial rewards – on the understanding that they will guarantee competence, provide altruistic service, and conduct their affairs with morality and integrity.²¹

They list the characteristics of a profession as they outline it, with obligations acquired by the profession as a result of this social contract (Table 1).

Characteristic	Associated obligations
Complexity of the profession’s knowledge base	Responsibility for the integrity of specialist knowledge, its proper application, expansion, and transmission to future practitioners, patients and the general public.
Service	The serving of society as a whole, as well as individual patients, involving issues such as access to health care and the just distribution of finite resources.

²⁰ Cruess, SR, Johnston, S, Cruess, RL. Professionalism for medicine: opportunities and obligations. *Medical Journal of Australia* 2002; 177: 208 – 211.

²¹ *ibid.*, p. 208.

Altruism	A commitment to placing the interests of individual patients above their own, as well as a devotion to the public good.
Autonomy	The setting and maintaining of standards for education and training, entry into practice, and the standards of practice. A guarantee of competence of practitioners, and the discipline of unprofessional, incompetent, or unethical conduct.
Professional associations	The balance between guaranteeing the quality of health care provided by members, and the protection of the interests of members.
Accountability	Accountability for patient care and self-regulation, along with the financial impact of decisions and for the health and well-being of populations.
Morality and integrity	Morality and virtue integral to the rules, processes and procedures by which practitioners operate, and medicine governs itself.
Codes of ethics	Guide practitioner behaviour and form an important part of public expectation of the profession.

Table 1 Characteristics and obligations of a profession

Cruess, Johnston and Cruess discuss the literature relating to professionalism and point to a change of societal attitude over time towards the medical profession, a change that the literature has helped to shape. They express the view that a public mistrust of the medical profession as a whole has developed; a mistrust that represents a threat to medicine’s professional status. Two major factors are thought to contribute to this mistrust.

- A perception that medicine has failed to self-regulate in a way that can guarantee competence.
- A perception that the profession has put its own interests above those of patients and the public. Here they cite examples that, in spite of more rigorous and increasingly open regulatory procedures being put in place, “have contributed to the belief that medicine has protected incompetent or unethical colleagues in the name of collegiality”.

The dual role of medical associations, acting as expert advisers on matters of health as well as representing their members, is cited as a factor that may be counterproductive to maintaining the medical profession’s “reputation for altruism”.

Cruess, Johnston and Cruess ask the question, “Can the ideal represented by medical professionalism be preserved in a way that will give continued meaning to the practice of medicine?” They respond that there are “reasons for hope” in this regard, and talk of an

opportunity for the profession “to rebuild trust”, outlining a range of opportunities of which they feel the profession should avail itself.

- Due to its perceived position at the core of medicine’s social contract, professionalism must be taught to, understood and sustained by practitioners.
- Professional associations must be cognisant of the public good when negotiating for their members.
- The obligation to ensure competence of practitioners and the rigorous and open disciplining of unethical or incompetent practitioners must be supported.
- Altruism and ethical conduct must serve as the backdrop against which medicine is practised.
- Health care systems should be such that they can actively promote desirable behaviour in practitioners that encourages and supports the preservation of professional values.

In summary, Cruess, Johnston and Cruess assert that, “Without question, the medical profession itself wishes to function within a system dominated by a healthy and flourishing professionalism”,²² and that “both society and the profession should wish for the same type of physician – competent, moral, idealistic and altruistic. This is best guaranteed by a healer functioning as a respected professional”.²³

The concept of medical professionalism being grounded in the nature of a profession and in the nature of the work of a practitioner is addressed also by Swick.²⁴ Swick emphasises the importance of a clear understanding of what medical professionalism entails, a definition that can be used by a variety of interest groups. For Swick, professionalism in medicine

... consists of those behaviours by which ... [practitioners] ... demonstrate that we are worthy of the trust bestowed upon us by our patients and the public, because we are working for the patients and the public’s good. Failure to demonstrate that we deserve that trust will result in its loss, and, hence, loss of medicine’s status as a profession.²⁵

To Swick, medical professionalism comprises the following set of behaviours.

²² *ibid.*, p. 211

²³ *id.*

²⁴ Swick, HM. Toward a Normative Definition of Professionalism. *Academic Medicine* 2000; 75(6): 612 – 616.

²⁵ *ibid.*, p. 614.

- Subordination of self-interest to the interest of others.
- Adherence to high ethical and moral standards.
- Response to societal needs, with behaviours that reflect a social contract with the communities served.
- Demonstration of core humanistic values, including honesty and integrity, caring and compassion, altruism and empathy, respect for others, and trustworthiness.
- Exercise of accountability for self and colleagues.
- Demonstration of a continuing commitment to excellence.
- A commitment to scholarship and to advancing the field.
- Ability to deal with high levels of complexity and uncertainty.
- Reflection upon actions and decisions.

Swick acknowledges the need for professionalism in medicine to be considered on two levels: individual and collective, advocating that many of the elements of the set of behaviours listed above, which comprise his ‘normative’ definition of professionalism, “apply equally well to the profession of medicine as a collective body”.²⁶ As with Cruess, Johnston and Cruess, the need for the profession as a whole to promote and adhere to professional values and behaviours that “can help maintain the distinction between medicine as a profession and medicine as a commodity”²⁷ is important. An understanding of what professionalism means in the everyday practice of medicine is important in this regard. Swick warns:

Serious negative consequences will ensue if physicians cease to exemplify the behaviours that constitute medical professionalism and hence abrogate their responsibilities both to their patients and to their chosen calling.²⁸

Writing from a United Kingdom perspective, Irvine outlines^{29 30 31} the basis for a ‘new’ professionalism and its relationship to the revalidation process now in operation. Based around the

²⁶ *ibid.*, p. 616.

²⁷ *id.*

²⁸ *id.*

²⁹ Irvine, D. The performance of doctors, I: professionalism and self regulation in a changing world. *British Medical Journal* 1997; 314: 1540 – 42.

³⁰ Irvine, D. The performance of doctors: the new professionalism. *Lancet* 1999; 353: 1174 – 77.

public expectation of doctors and the responsibility of the profession to secure public confidence and trust, the need for the profession to commit to ensuring quality patient care is stressed. The principles of the new professionalism are embodied in the General Medical Council document *Good Medical Practice*³², described by Irvine as “an explicit statement of duties, responsibilities, values, and standards for doctors, based on a strong public and professional consensus about the qualities that are important”.³³ The guiding principles of the modern professional medical practitioner in the United Kingdom can be gleaned from the description of “The duties of a doctor registered with the General Medical Council”,³⁴ which forms the introduction to *Good Medical Practice*.

Patients must be able to trust doctors with their lives and their well-being. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care and to show respect for human life. In particular as a doctor you must:

- Make the care of your patient your first concern;
- Treat every patient politely and considerately;
- Respect patients’ dignity and privacy;
- Listen to patients and respect their views;
- Give patients information in a way they can understand
- Respect the rights of patients to be fully involved in decisions about their care;
- Keep your professional knowledge and skills up to date;
- Recognise the limits of your professional competence;
- Be honest and trustworthy;
- Respect and protect confidential information;
- Make sure that your personal beliefs do not prejudice your patient’s care;
- Act quickly to protect patients from risk if you have a good reason to believe that you or a colleague may not be fit to practise;
- Avoid abusing your position as a doctor; and
- Work with colleagues in the ways that best serve patients’ interests.

In all these matters you must never discriminate unfairly against your patients or colleagues. And you must always be prepared to justify your actions to them.

³¹ Irvine, D. Doctors in the UK: their new professionalism and its regulatory framework. *Lancet* 2001; 358: 1807 – 10.

³² General Medical Council. *Good medical practice*, 3rd edn. London: GMC, 2001.

³³ Irvine, D. Doctors in the UK: their new professionalism and its regulatory framework. *Lancet* 2001; 358: 1808.

³⁴ General Medical Council. *Good medical practice*, 3rd edn. London: GMC, 2001.

A subcommittee of the *CanMEDS 2000* Project Committee that was formed to address how teaching and education on the *professional* role could be incorporated into residency programs in Canada acknowledge that “There are no simple and short answers” to the questions, “What is a professional” and “What is professionalism?”

Specifically, the *professional* role ascribed to a medical practitioner encompasses three competencies.

- The ability to deliver highest quality care with integrity, honesty and compassion. This implies an awareness of racial, cultural, and societal issues that impact on the delivery of care and an ability to maintain and enhance appropriate knowledge, skills and professional behaviours.
- An ability to exhibit appropriate personal and interpersonal professional behaviours. This implies being accountable for personal actions, having a high degree of self-awareness, maintaining an appropriate balance between personal and professional roles, and addressing interpersonal differences in professional relations.
- An ability to practise medicine ethically consistent with the obligations of a physician. This implies an understanding of and adherence to legal and ethical codes of practice, the recognition of ethical dilemmas and the need for help to resolve them when necessary and the ability to recognise and respond to unprofessional behaviours in clinical practice, taking into account local and provincial regulations.

Based on the outlines of these three competencies, objectives for residents to achieve upon completion of specialist training are then outlined.

In calling for a move from CME to CPD for gastroenterologists, hepatologists and endoscopists toward the end of the previous decade (century/millennium), Meryn³⁵ advocated all “honorable”³⁶ societies representing practitioners in these areas to “further define professionalism”³⁷ as a way of

³⁵ Meryn, S. Changes in Professional Development. Educating the Gastroenterologist for the Year 2000. *Digestion* 1998; 59(5): 619 - 623.

³⁶ *ibid.*, p.619.

³⁷ *id.*

advancing the transition. From the discussion above, there would appear to be broad areas of agreement about what medical professionalism entails in the climate in which specialist practitioners are currently operating. This definition of professionalism for medical practitioners forms the conceptual platform of the framework developed in this project. The definition is outlined in the following section.

Medical Professionalism as a Platform to Underpin a CPD Framework for Medical Practitioners

In a review of the professionalism literature from the past thirty years, Arnold³⁸ notes the existence of definitions that are both empirically and prospectively derived, with the existence of prospective definitions for both medical schools and professional organisations. In the case of definitions associated with professional organisations, she writes that the organisations “largely agree on the elements that define”³⁹ professionalism. These elements she lists as altruism; respect for other people; additional humanistic qualities; honour, integrity, ethical and moral standards; accountability; excellence; and duty/advocacy. These would appear logical, given the origins of the concept of a ‘profession’ as such.

Of interest is the inclusion of professionalism as one aspect of descriptions that aim to profile medical practitioners through the use of competencies. The well known and influential *CanMEDS 2000* document of the RCPSC and the competencies developed for the Outcomes Project of the Accreditation Council on Graduate Medical Education (ACGME) are examples of this that have already been discussed. Such descriptions acknowledge the increasing awareness of the nature of practice in the medical specialties, yet treat the professional aspect as arbitrarily distinct from other areas. In order to use the concept of medical professionalism as the basis of a CPD framework for medical practitioners, a profile of what medical professionalism involves is required. The profile that has been developed for this project is presented in the next section. As with the normative definition offered by Swick,⁴⁰ the profile attempts to “account for the nature of the medical profession and ... [to be] ... grounded in what ... [medical practitioners] ... actually do and how they act, individually and collectively”.⁴¹ It draws liberally from discussions and definitions

³⁸ Arnold, L. Assessing Professional Behavior: Yesterday, Today and Tomorrow. *Academic Medicine* 2002; 77: 502 - 515.

³⁹ *ibid.*, p. 503.

⁴⁰ Swick, HM. Toward a Normative Definition of Medical Professionalism. *Academic Medicine*. 2000; 75: 612-616.

⁴¹ *ibid.*, p. 614

already published in the literature, and is a conceptualisation that considers the possession and application of expert knowledge to be a component of professionalism in the medical specialties. As such, it represents an attempt to balance the expert and social trustee aspects of medical professionalism, an issue raised by Swick⁴² through his reference to the work of Brint.⁴³

This project, to develop a Framework for CPD of Medical Practitioners in Australia, has drawn on the literature sources previously discussed, as well as others, and will consider *medical professionalism* to encompass three strands of practice: *clinical expertise*; *risk management*; and *professional values and responsibilities*. Each of these strands can be “unpacked” into a series of components, and guided by adult learning concepts to enable the provision and selection of learning activities for and by an individual practitioner. Consideration of safety and quality principles makes a patient-centred approach to practitioner CPD possible. Along with a description of relevant adult learning concepts, the three strands and their components are discussed below. The resulting conceptual platform of the CPD framework is illustrated as Figure 1.

Clinical Expertise

Expertise as a medical practitioner depends on the possession of a large body of knowledge and procedural skill.⁴⁴ Experts have the ability to access, retrieve and use the information that they possess. They are able to integrate new with existing knowledge and discern critical features and fundamental issues when presented with clinical and diagnostic problems. The use of *medical informatics*, “the management and use of information in health and biomedicine”,⁴⁵ has an increasing role to play in the face of the rapidly expanding knowledge base of all areas of medicine. This strand of medical professionalism comprises three components, two of which are supported and informed by the clinical applications of medical informatics. The three components are *Medical Expertise*; *Clinical Judgement*; and *Medical Informatics (Clinical)*, each of which is briefly described on page 29.

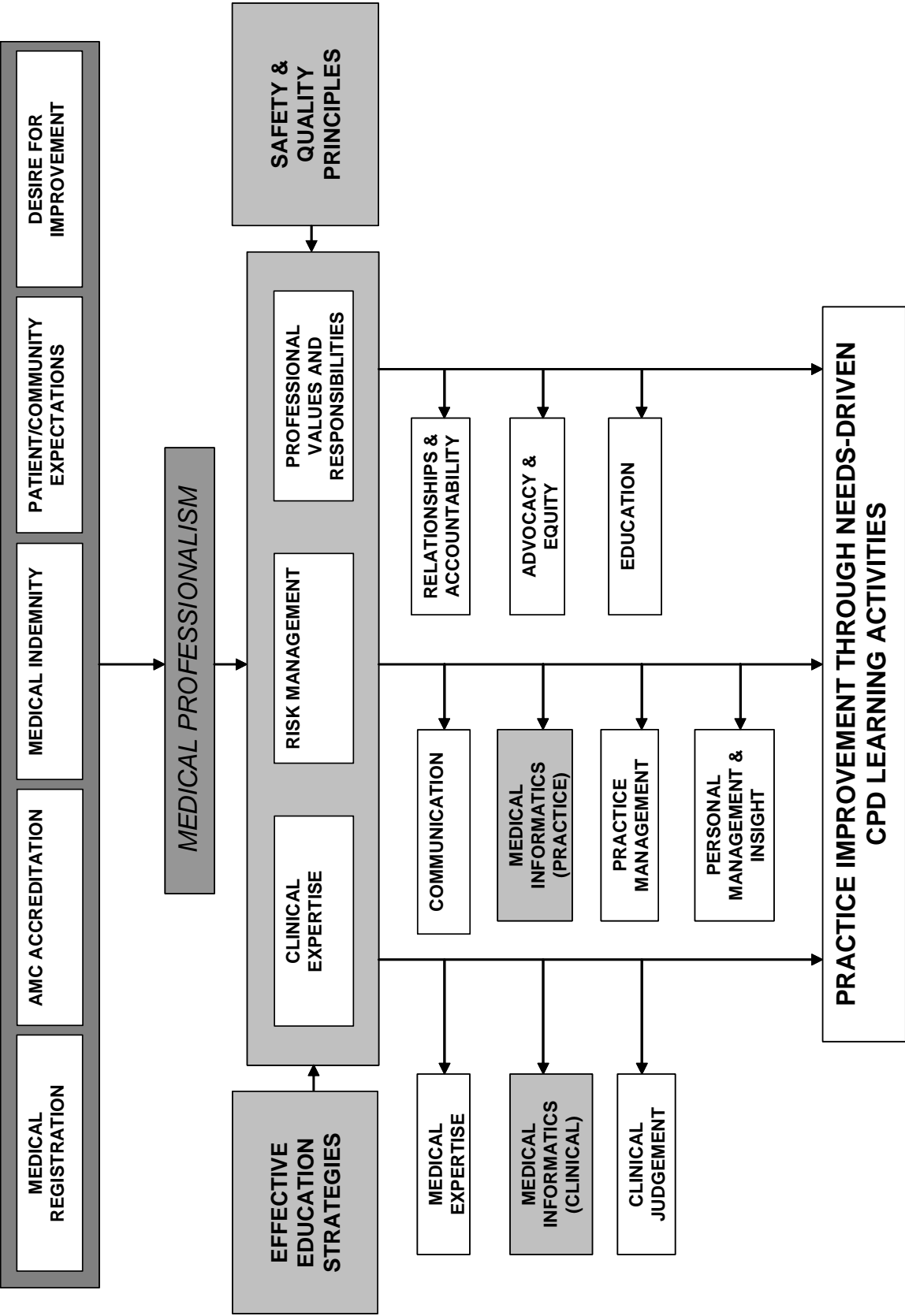
⁴² *ibid.*, p. 613

⁴³ Brint, S. *In an age of Experts: The Changing Role of Professionals in Politics and Public Life*. Princeton, NJ: Princeton University Press, 1994.

⁴⁴ Swick, HM. Toward a Normative Definition of Professionalism. *Academic Medicine* 2000; 75(6): 615.

⁴⁵ Hersh, WR. Medical Informatics. Improving Health Care Through Information. *JAMA* 2002, 288: 1955.

Figure 1 CPD Framework Scheme 1 – theoretical platform of CPD for medical practitioners



Medical Expertise

The medical practitioner possesses and maintains the requisite body of medical and procedural knowledge necessary to conduct the clinical aspects of their professional practice.^{46 47 48 49 50 51}

Clinical Judgement

The medical practitioner is able to apply their knowledge and procedural skills to make an informed, accurate diagnosis and provide appropriate treatment from the range of options available.^{52 53}

Medical Informatics (Clinical)

The medical practitioner is aware of the range of technologies available to them to assist in the maintenance and extension of their medical and procedural knowledge base, as well as their diagnostic skills.⁵⁴ They make use of these technologies as appropriate and required, both as a user and as a provider of information to other professionals and stakeholders in the health care system.^{55 56 57}

⁴⁶ Swick, HM. Toward a Normative Definition of Professionalism. *Academic Medicine* 2000; 75(6): 615.

⁴⁷ Cruess, SR, Johnston, S, Cruess, RL. Professionalism for medicine: opportunities and obligations. *Medical Journal of Australia* 2002; 177: 209.

⁴⁸ Welling, RE, Boberg, JT, Russell, TR. Professionalism: Lifelong commitment for surgeons. *Archives of Surgery* 2003; 138(3): 262 – 264.

⁴⁹ Rothman, DJ. Medical Professionalism – Focussing on the real issues. *The New England Journal of Medicine* 2000; 342(17): 1284.

⁵⁰ Irvine, D. The performance of doctors: the new professionalism. *The Lancet* 1999; 353:1175.

⁵¹ Benson, JA. Professionalism: Reviving or redrawing the Social Contract. *Annals of Allergy, Asthma and Immunology* 2002; 89(2): 115.

⁵² Cruess, SR, Johnston, S, Cruess, RL. Professionalism for medicine: opportunities and obligations. *Medical Journal of Australia* 2002; 177: 209.

⁵³ Swick, HM. Toward a Normative Definition of Professionalism. *Academic Medicine* 2000; 75(6): 612 – 616.

⁵⁴ *ibid.*, p. 615.

⁵⁵ *id.*

⁵⁶ Cruess, SR, Johnston, S, Cruess, RL. Professionalism for medicine: opportunities and obligations. *Medical Journal of Australia* 2002; 177: 209.

⁵⁷ Medical Professionalism Project. *Medical Journal of Australia* 2002; 177: 264.

Risk Management

Risk management can be defined as "... the identification, investigation, analysis and evaluation of risks and the selection of the most advantageous method of correcting, eliminating or reducing identifiable risks".⁵⁸ The medical practitioner is cognisant of the importance of an awareness of those aspects of their practice that contribute to less than optimum patient outcomes. As with the *medical expertise* strand, the use of medical informatics has a role to play in the minimisation of risk in medical practice. This strand of medical professionalism includes the following components: *Communication; Practice Management* and *Personal Management and Insight*, the first two supported and informed by the practice applications of medical informatics. Each of the components is briefly described below.

Communication

The medical practitioner ensures honest and open communication with patients and their families.^{59 60 61}

Patients are fully advised of the range of treatments available to them, and any associated risks so that valid consent can be obtained for treatment. Medical practitioners are effective listeners who demonstrate empathy with their patients in order to elicit all information relevant to making an effective diagnosis.^{62 63} Cultural and other factors that contribute toward the individuality of specific patients are appreciated and accommodated in the communication methods employed. In the event of outcomes that are considered sub-optimal, appropriate communication is undertaken with patients.⁶⁴

⁵⁸ *Risk management . . . and your practice*. United Medical Protection, September 2001.

⁵⁹ Medical Professionalism Project. *Medical Journal of Australia* 2002; 177: 264.

⁶⁰ Irvine, D. The performance of doctors: the new professionalism. *The Lancet* 1999; 353:1175.

⁶¹ Irvine, D. Doctors in the UK: their new professionalism and its regulatory framework. *The Lancet* 2001; 358: 1807.

⁶² Benson, JA. Professionalism: Reviving or redrawing the Social Contract. *Annals of Allergy, Asthma and Immunology* 2002; 89(2): 114 – 117.

⁶³ Irvine, D. The performance of doctors: the new professionalism. *The Lancet* 1999; 353: 1175.

⁶⁴ Medical Professionalism Project. *Medical Journal of Australia* 2002; 177: 264.

Practice Management

The medical practitioner is aware of the factors that contribute to effective practice management and strives for best practice in this area.⁶⁵

**Medical Informatics
(Practice)**

The medical practitioner is aware of the range of technologies available to them to help attain best practice in their practice environment. They make use of these technologies as appropriate and required, in order to optimise patient outcomes.

**Personal Management and
Insight**

The medical practitioner constantly reflects on all facets of their professional practice in order to optimise patient outcomes.⁶⁶ Part of this reflection involves an awareness of their own suitability for practice and a monitoring of self.

Professional Values and Responsibilities

As a member of a profession, it is incumbent on medical practitioners to exhibit beliefs and behaviours that reflect the expectations of those they serve (society) and those with whom they interact as part of their profession. Individual practitioners are no longer immune from the gaze or expectations of either of these groups. They need to be sensitive to cultural and linguistic diversity and responsive to the cultural needs of their patients and families. This strand of medical professionalism in the CPD framework acknowledges this. The strand comprises three components: *Relationships and Accountability; Advocacy and Equity; and Education.*

**Relationships and
Accountability**

This strand acknowledges that the medical practitioner is dedicated to serving the interests of the patient, respecting patient autonomy and enabling patients to make informed decisions about their treatment.^{67 68 69}

70 71

⁶⁵ Haskell, CM. In Letters: Comments and responses. Charter on Medical Professionalism: Putting the Charter into Practice. *Annals of Internal Medicine* 2003; 138(10): 852.

⁶⁶ Swick, HM. Toward a Normative Definition of Professionalism. *Academic Medicine* 2000; 75(6): 615.

⁶⁷ Medical Professionalism Project. *Medical Journal of Australia* 2002;177:264.

⁶⁸ Benson, JA. Professionalism: Reviving or redrawing the Social Contract. *Annals of Allergy, Asthma and Immunology* 2002; 89(2): 114 – 177.

Medical practitioners possess a knowledge and understanding of the legal and ethical framework in

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- ⁶⁹ Reiser, SJ., Banner, RS. The charter on Medical Professionalism and the limits of medical power. *Annals of Internal Medicine* 2003; 138: 844-846.
- ⁷⁰ Cohen, JJ. *Annals of Internal Medicine* 2003; 128(10): 855.
- ⁷¹ Irvine, D. The performance of doctors: the new professionalism. *The Lancet* 1999; 353:1175.
- ⁷² Cruess, SR, Johnston, S, Cruess, RL. Professionalism for medicine: opportunities and obligations. *Medical Journal of Australia* 2002; 177: 209.
- ⁷³ Swick, HM. Toward a Normative Definition of Professionalism. *Academic Medicine* 2000; 75(6): 614.
- ⁷⁴ Benson, JA. *Annals of Allergy, Asthma, and Immunology* 2002; 89(2): 114 – 117.
- ⁷⁵ Cruess, SL, Cruess, RL. *Annals of Internal Medicine* 2003; 128(10): 853 – 854.
- ⁷⁶ Cruess, RL, Cruess, SL. Professionalism: an ideal to be sustained. *The Lancet* 2000; 356: 158.
- ⁷⁷ Rothman, DJ. Medical Professionalism – Focussing on the real issues. *The New England Journal of Medicine* 2000; 342(17): 1284.
- ⁷⁸ Wynia, MK, Latham, SR, Kao, AC, Berg, JW, Emanuel, LL. Medical Professionalism in Society. *The New England Journal of Medicine* 1999; 341(21): 1612-1616.
- ⁷⁹ Medical Professionalism Project. *Medical Journal of Australia* 2002; 177: 264.
- ⁸⁰ Reiser, SJ, Banner, RS. The charter on Medical Professionalism and the limits of medical power. *Annals of Internal Medicine* 2003; 138: 844-846.
- ⁸¹ Irvine, D. Doctors in the UK: their new professionalism and its regulatory framework. *The Lancet* 2001; 358:1807.
- ⁸² Medical Professionalism Project. *Medical Journal of Australia* 2002; 177: 264.
- ⁸³ Benson, JA. Professionalism: Reviving or redrawing the Social Contract. *Annals of Allergy, Asthma and Immunology* 2002; 89(2): 114 – 117.
- ⁸⁴ Medical Professionalism Project. *Medical Journal of Australia* 2002; 177: 264.
- ⁸⁵ Swick, HM. Toward a Normative Definition of Professionalism. *Academic Medicine* 2000; 75(6): 615.
- ⁸⁶ Medical Professionalism Project. *Medical Journal of Australia* 2002; 177: 264.
- ⁸⁷ Cruess, SR, Johnston, S, Cruess, RL. Professionalism for medicine: opportunities and obligations. *Medical Journal of Australia* 2002; 177: 210.
- ⁸⁸ Benson, JA. Professionalism: Reviving or redrawing the Social Contract. *Annals of Allergy, Asthma and Immunology* 2002; 89(2): 114 – 117.
- ⁸⁹ Irvine, D. Doctors in the UK: their new professionalism and its regulatory framework. *The Lancet* 2001; 358: 1807
- ⁹⁰ Irvine, D. The performance of doctors: the new professionalism. *The Lancet* 1999; 353:1174.
- ⁹¹ Cruess, RL, Cruess, SL. Professionalism: an ideal to be sustained *The Lancet* 2000; 356: 158
- ⁹² Rothman, DJ. Medical Professionalism – Focussing on the real issues. *The New England Journal of Medicine* 2000; 342(17): 1284
- ⁹³ Welling, RE, Boberg, JT, Russell, TR. *Archives of Surgery* 2003; 138: 263.
- ⁹⁴ Wynia, MK, Latham, SR, Kao, AC, Berg, JW, Emanuel, LL. Medical Professionalism in Society. *New England Journal of Medicine* 1999; 341(21): 1614.
- ⁹⁵ Swick, HM. Toward a Normative Definition of Professionalism. *Academic Medicine* 2000; 75(6): 615.
- ⁹⁶ Arnold, L. Assessing Professional Behavior: Yesterday, Today and Tomorrow. *Academic Medicine* 2002; 77(6): 503.
- ⁹⁷ Wynia, MK, Latham, SR, Kao, AC, Berg, JW, Emanuel, LL. Medical Professionalism in Society. *New England Journal of Medicine* 1999; 341(21): 1613.

which they and their profession operate. They contribute to and abide by the Code of Ethics of their appropriate professional body. They appreciate the competing interests that can arise in the modern practice setting, and that they must practise in a manner that is without compromise in pursuing the interests of their patients and society- compromise that could result from interest group or stakeholder pressures.^{72 73 74 75 76 77 78}

The medical practitioner works collaboratively with other health professionals to maximise patient outcomes.^{79 80 81} They demonstrate appropriate personal and interpersonal behaviours in all interactions with patients and others involved with their treatment.^{82 83} Patient confidentiality is respected, but balanced with public interest considerations.⁸⁴

The medical practitioner has a responsibility for assisting in the creation and implementation of continuous improvement initiatives in the profession. Individually and collectively, they have a responsibility for ensuring the competence of practitioners in their field, and for ensuring that rigorous mechanisms are in place for dealing with colleagues who are found not to be so.^{85 86 87 88 89 90 91 92 93 94}

Medical practitioners evince core humanistic values such as honesty, integrity and compassion in their relationships with others at all times, ensuring that patients and others are never exploited for the personal gain of the practitioner.^{95 96 97}

Advocacy and Equity

The medical practitioner works actively to promote equity and justice and the elimination of

discrimination in the health care system.^{98 99 100} They are aware of the factors that contribute towards demands on the health care system, recognise the finite resources that are available and work toward a fair distribution of these resources.^{101 102}

The medical practitioner is an advocate for consumers of healthcare, being particularly cognisant of disadvantaged groups in the community,¹⁰³ as well as providers of healthcare, i.e. their fellow practitioners, and work toward improving the circumstances of both, recognising the fine balancing act that can be involved.^{104 105 106 107} There is a dedication to continuous improvement in the health care system, with an awareness of the need for collaboration with health care stakeholders, such as government, insurers, private-sector provider organisations, allied health professionals and consumer groups.^{108 109}

Education

The medical practitioner has a commitment to lifelong learning for themselves and others in the profession.¹¹⁰

¹¹¹ To this end they are involved in the education and

⁹⁸ Medical Professionalism Project. *Medical Journal of Australia* 2002; 177: 264.

⁹⁹ Swick, HM. Toward a Normative Definition of Professionalism. *Academic Medicine* 2000; 75(6): 614.

¹⁰⁰ Cruess, SR, Johnston, S, Cruess, RL. Professionalism for medicine: opportunities and obligations. *Medical Journal of Australia* 2002; 177: 210.

¹⁰¹ Van Den Weyden, MB. *Medical Journal of Australia* 2002; 177: 264.

¹⁰² Swick, HM. Toward a Normative Definition of Professionalism. *Academic Medicine* 2000; 75(6): 614.

¹⁰³ Wynia, MK, Latham, SR, Kao, AC, Berg, JW, Emanuel, LL. Medical Professionalism in Society. *New England Journal of Medicine* 1999; 341(21): 1612-1616.

¹⁰⁴ *ibid.*, p.614.

¹⁰⁵ Medical Professionalism Project. *Medical Journal of Australia* 2002; 177: 264.

¹⁰⁶ Brennan, T. *Annals of Internal Medicine* 2003; 138(10): 851.

¹⁰⁷ D'Ambrosia, R., Kilpatrick, JA. Professionalism. *Orthopedics* 2002; 25(4): 382.

¹⁰⁸ Reiser, SJ., Banner, RS. The charter on Medical Professionalism and the limits of medical power. *Annals of Internal Medicine* 2003; 138: 844 - 846.

¹⁰⁹ Feldman R. *Annals of Internal Medicine* 2003; 128(10): 854.

¹¹⁰ Van Den Weyden, MB. *Medical Journal of Australia* 2002; 177: 264.

¹¹¹ Swick, HM. Toward a Normative Definition of Professionalism. *Academic Medicine* 2000; 75(6): 615.

training of medical students, early postgraduates and new practitioners in ways that demonstrate an understanding of appropriate teaching and learning theories and practices,^{112 113} and act as role models for these.^{114 115 116} They actively promote and are involved in credible scientific research to validate existing and generate new knowledge, and possess a desire to share the knowledge of their profession with others, including colleagues and other health professionals, and more widely in society.^{117 118 119 120} They have a responsibility to ensure that new knowledge generated from the profession is appropriately used.

Adult Learning Principles

There is a growing expectation that medical professionals must take on the role of lifelong learners if they are to remain abreast of their field and maintain their expertise throughout the span of their careers, succinctly captured below.

Medical practice is evolving rapidly as new information supplants old. Gone are the days when newly graduated doctors were armed with most of the information they would need for a

¹¹² id.

¹¹³ Welling, RE, Boberg, JT, Russell, TR. *Archives of Surgery* 2003; 138: 263.

¹¹⁴ Quraishi, SA., Khalid, AN. *Annals of Internal Medicine* 2003;128(10): 851 – 852.

¹¹⁵ Welling, RE, Boberg, JT, Russell, TR. *Archives of Surgery* 2003; 138: 263.

¹¹⁶ Irvine, D. The performance of doctors: the new professionalism. *The Lancet* 1999; 353:1174.

¹¹⁷ Swick, HM. Toward a Normative Definition of Professionalism. *Academic Medicine* 2000; 75(6): 615.

¹¹⁸ Van Den Weyden, MB. *Medical Journal of Australia* 2002; 177: 265.

¹¹⁹ Benson, JA. Professionalism: Reviving or redrawing the Social Contract. *Annals of Allergy, Asthma and Immunology* 2002; 89(2): 115.

¹²⁰ Cruess, SR, Johnston, S, Cruess, RL. Professionalism for medicine: opportunities and obligations. *Medical Journal of Australia* 2002; 177: 209.

lifetime of practice. Today's clinicians are required to be lifelong learners so that they continue to adapt to the changing ecology of the medical environment.¹²¹

Continuing professional development is the tool by which this learning is accessed. That systems and programs of CPD should acknowledge and incorporate principles of adult learning is generally considered so obvious as to be almost an axiom of the field.

The central question of how adults learn has occupied the attention of scholars and practitioners since the founding of adult education as an acknowledged area of educational practice in the 1920s.¹²² Since that time a myriad of models, theories, ideas and frameworks have developed in what is a burgeoning field of education. Merriam¹²³ concludes that there are at least three ways in which these approaches are contributing to our understanding of adult learning.

First, the *adult learner* is seen holistically. The learner is more than a cognitive machine processing information. He or she comes with a mind, memories, conscious and subconscious worlds, emotions, imagination and a physical body, all of which can interact with new learning.

Second, the *learning process* is much more than the systemic acquisition and storage of information. It is also making sense of our lives, transforming not just what we learn but the way we learn, and it is absorbing, imagining, intuiting, and learning informally with others.

Finally, *the context* in which learning occurs has taken on greater importance. Not only can we see learning as situated in a particular context, but we can examine how race, class, gender, power and oppression, and concepts of knowledge and truth shape the context in the first place and subsequently the learning that occurs.

¹²¹ Shaughnessy, AF and Slawson, C. Are we providing the right tools for lifelong learning? *British Medical Journal* 1999; 319: 1280.

¹²² Thorndike, EL, Bregman, EO, Tilton, JW and Woodyard, E. *Adult Learning*. New York: Macmillan; 1928.

¹²³ Merriam, SB. *New Directions for Adult Learning and Continuing Education*, 2001; 89: 96.

The contribution of learning theory to improve the effectiveness of medical practitioners' everyday practice is indicated by the growing literature on adult learning^{124 125 126 127 128} and the doctor as learner and reflective practitioner.¹²⁹

The approach to adult learning that has clearly the greatest prominence in regard to the training and ongoing CPD of medical practitioners is that developed by Knowles in the early 1970s. Kaufman¹³⁰ summarises the work of Knowles as being based on five assumptions.

1. Adults are independent and self-directing.
2. They have accumulated a great deal of experience, which is a rich resource for learning.
3. They value learning that integrates with the demands of their everyday life.
4. They are more interested in immediate, problem-centred approaches than in subject-centred ones.
5. They are more motivated to learn by internal than external drivers.

Of clear concern to some is the lack of empirical evidence available to support these assumptions and the principles of adult learning that were developed from them. Despite this, however, these principles retain much currency in the field of medical education, acting, as Kaufman describes them, as “guidelines on how to teach learners who tend to be somewhat independent and self-directed”.¹³¹ Kaufman outlines these principles as follows.

¹²⁴ Knowles, M.S. *Andragogy in Action: Applying Modern Principles of Adult Learning*. San Francisco: Jossey-Bass, 1985.

¹²⁵ Candy, PC. *Self-Direction for Lifelong Learning*. San Francisco: Jossey-Bass, 1991

¹²⁶ Brockett, RB and Hiemstra, R. *Two Decades of Literature on SDL: A Content Analysis*. Paper presented at 14th International SDL Symposium, Boyton Beach, Florida, 2000.

¹²⁷ Merriam, S. . and Caffarella, RS. *Learning in Adulthood* (2nd ed.). San Francisco: Jossey-Bass, 1999.

¹²⁸ Mezirow, J. and Associates. *Learning as Transformation: Critical Perspectives on a Theory in Progress*. San Francisco: Jossey-Bass, 2000.

¹²⁹ Holm, HA. Quality issues in continuing medical education. *British Medical Journal* 1998; 316: 621 – 624.

¹³⁰ Kaufman, DM. ABC of learning and teaching in medicine. Applying educational theory in practice, *British Medical Journal* 2003; 326: 213 - 216.

¹³¹ *ibid.*, p. 213.

1. Establish an effective learning climate, where learners feel safe and comfortable expressing themselves.
2. Involve learners in mutual planning of relevant methods and curricular content.
3. Involve learners in diagnosing their own needs as an aid to internal motivation.
4. Encourage learners to formulate their own learning objectives as a means of providing control of learning.
5. Encourage learners to identify resources and devise strategies for using their resources to achieve their objectives.
6. Support learners in carrying out learning plans.
7. Involve learners in evaluating their own learning as an aid to developing skills of critical reflection.

It is the application of these principles to CPD for medical practitioners that is of interest and relevance to this project. If it is accepted that CPD for medical practitioners is the province of adult education principles, then the application of these principles needs to be considered in the context of the environments in which medical practitioners practise and how learning is undertaken in these practice environments.

Doctors' Learning and Change

Fox and Bennett¹³² discuss the role of CME in facilitating change in practitioner performance and patient outcomes. They write of the influence that studies of adult learning have had on medical education, CME in particular, and comment that:

The observation that it is not teaching but learning that leads doctors to change their practice has resulted in a shift in perspective: rather than education being regraded as instruction, it is regarded as the facilitation of learning. This paradigm shift has been based on research into how and why doctors change their practice and into the role of learning in that process.¹³³

¹³² Fox, RD and Bennett, NL. Continuing medical education: Learning and change: implications for continuing medical education. *British Medical Journal* 1998; 316: 466-468.

¹³³ *ibid.*, p.466

Fox and Bennett acknowledge that many factors influence the clinical practice of doctors. They cite a study of how and why doctors change¹³⁴ as describing change in doctors' practices resulting from a confluence of forces impacting on the doctor.

The forces emerged from their personal lives, their professional aspirations, and the social and cultural milieu of their practice settings. They included curiosity, sense of personal and financial well-being, stage of career, desire for new or enhanced competence, pressure from patients and colleagues, and pressures from the health care institutions in which they worked.

Different forces seemed to scatter doctors in different directions. Personal forces were associated with larger and more complex changes, professional and social forces with smaller and simpler changes. Regulations were associated with only small accommodations, which were usually made with resentment.¹³⁵

Fox and Bennet assert that doctors begin the change process once they sense forces for change at work. An image of change is obtained, the clarity of that image varying with the magnitude of the change involved. Once the image of change is obtained, it is used to self-assess the personal need of the doctor to change. This process involves four stages.

1. An estimate of where the doctor ought to be in terms of knowledge, skill and performance related to the change.
2. An estimate of what the doctor already knows or is able to do in terms of the change image.
3. An estimate of the discrepancy between (1) and (2) above.
4. The experience of a level of anxiety because of the existence of a discrepancy between the desired and the present state.

The discrepancy is an estimate of learning 'need'; the drive to reduce the anxiety associated with the need is the motivation to learn and change.

¹³⁴ Fox, R.D, Mazmanian, PE and Putnam, RW. (eds.) *Change and learning in the lives of physicians* New York: Praegar, 1989.

¹³⁵ *ibid.*, p.467

Fox and Bennett note:

This model of need and motivation shows that altering doctors' perceptions of where they are, where they believe they ought to be, and the size of the discrepancy can alter their perception of need and the extent of their motivation to learn and change.¹³⁶

Fox and Bennett assert that research into the effects of continuing education on doctors' behaviour has fuelled research into how learning explains changes in practice. They conclude that "two different facets of practice-based learning have emerged"¹³⁷ from this research.

1. Self-directed learning – the need for learners to understand how they learn and their learning strategies is emphasised by Fox and Bennett, as well as the need for educators to understand the natural patterns of doctors' learning to maximise the effects from this process.
2. Organisational learning – the uniqueness of individual health care settings as organisations is acknowledged.

Fox and Bennett conclude that "future, comprehensive CME systems will incorporate what we know about learning and change into three interlocking components".¹³⁸

1. A self-directed curriculum designed by each doctor to incorporate new knowledge and make use of their own experience.
2. The strategy of learning in groups.
3. Learning within learning organisations.

Contributions to the issue of doctors' learning by Slotnick¹³⁹ ¹⁴⁰ provide confirmation of prior research conducted by others, as well as the advancement of an integrated

¹³⁶ id.

¹³⁷ id.

¹³⁸ *ibid.*, p.468

¹³⁹ Slotnick, HB. How Doctors Learn: Physicians' Self-directed Learning Episodes. *Academic Medicine* 1999; 74, 10: 1106 - 1117.

¹⁴⁰ Slotnick, HB. Physicians' Learning Strategies. *CHEST* 2000; 118: 18S - 23S.

theory of doctors' learning in clinical practice. The theory stems from work conducted under the auspices of the Royal College of Physicians and Surgeons of Canada (RCPSC) and is acknowledged as being drawn on "heavily"¹⁴¹ in the construction of the recently implemented CPD program of that College. The work involved qualitative analysis of interviews with thirty-two physicians about past learning experiences. Slotnick describes the areas of practice of his cohort as:

Eleven of the physicians were psychiatrists, six were in internal medicine and its subspecialties, three specialised in obstetrics and gynaecology, and there were two each in geriatrics and ophthalmology. The sample included one doctor each from community medicine, dermatology, medical microbiology (a medical specialty in Canada), occupational medicine, pediatrics, and radiology.¹⁴²

The research of Slotnick confirmed previous work that two types of problems (*specific problems* and *general problems*) precipitate learning in doctors, and concluded that doctors learn via *learning episodes* that follow four definite stages:

1. scanning for problems;
2. deciding whether to take on the problem;
3. learning the required skills and knowledge; and
4. gaining experience.

A complete description of the theory of doctors' learning proposed by Slotnick is prohibitive in terms of the space required, however, a summary is presented below.

The two types of problems that initiate learning episodes for doctors are distinguished via their origin, the type of learning they invoke, and the changes that are produced. *Specific problems* arise from particular patients, are associated with *semi-structured learning*, and result in incremental additions to a doctor's knowledge and skills (adjustments). *General problems* arise from a more widely recognised need for identified gaps in knowledge and/or skills to be filled; the perceived need is not

¹⁴¹ Parboosingh, J. CPD and maintenance of certification in the Royal College of Physicians and Surgeons of Canada *The Obstetrician and Gynaecologist* 2003; 5: 45.

¹⁴² Slotnick, HB. How Doctors Learn: Physicians' Self-directed Learning Episodes. *Academic Medicine* 1999; 74(10): 1108.

precipitated by a specific case. General problems are associated with *formal learning*, and produce larger changes in knowledge and skills, as well as changes in perspective (redirections).

Table 2 (below) summarises the four-stage theory of Slotnick for each of the problem types.

STAGE	Specific Problems	General Problems
Stage 0 Scanning for potential problems	The physician is aware that problems are ‘out there’ and alert for problems that might need to be solved; when they are encountered, the physician moves on to the next stage.	
Stage 1 Deciding whether to take on the problem	The physician senses a need for immediate action and decides on the spot whether to take on the problem; alternatively, the physician reads a bit, talks briefly with others, and decides quickly.	The physician feels uneasy about a gap in knowledge or skills and asks: Is this really a problem? Is there likely to be a solution to the problem? Are resources available so I can do the required learning? Am I prepared to make the changes in practice required by the learning?
Stage 2 Learning the required skills and knowledge	The physician reads (journals that are received, less often texts) and consults with experienced colleagues.	The physician reads comprehensively and takes available and appropriate courses.
Stage 3 Gaining experience	The physician applies the learned solution to the problem and sees what happens	The physician tries the new skills and knowledge in a range of settings and gains experience as a result. They continue to read, although the purpose is not to gain new skills but to see what kinds of similar experiences colleagues have had.

Table 2 The four-stage theory of physicians’ self-directed learning episodes, by problem type (from Slotnick¹⁴³)

Slotnick compares each of the four stages in terms of the stage’s *goal*, the *discrepancy* resolved during the stage, the way *learning resources* are used, the *reflection* the doctor does during the stage, and the *criteria* to be satisfied for the stage to be complete (Table 3, facing). The criteria for completion of a stage are described as being “of particular interest because they bear on whether a doctor is justified in exiting ... [the] ... learning episode before ... [he/she] ... completes the last stage”.¹⁴⁴

¹⁴³ *ibid.*, p. 1109.

¹⁴⁴ *ibid.*, p. 1108.

	Stage 0: Scanning for potential problems	Stage 1: Deciding whether to take on the problem	Stage 2: Learning the required skills and knowledge	Stage 3: Gaining experience
Goal	To identify potential problems AND to note resources that might be useful in the future.	To decide whether to learn what is necessary to resolve the precipitating problem.	To learn the knowledge and skill necessary to begin resolving the precipitating problem.	To apply and practice what has been learned in resolving the precipitating problem and related problems.
Discrepancy	The physician needs problems to solve or satisfy Maslowian security, affiliation, and self-esteem needs.	The physician lacks sufficient information to decide whether to pursue the problem's solution.	The physician lacks the skills and knowledge necessary to begin resolving the precipitating problem.	The physician lacks experience with and/or confidence in what he is doing.
Resources	The physician reviews all aspects of practice and daily life in light of prior experience.	Specific problems: the physician looks to his clinical situation, reads available literature, discusses with colleagues. General problems: the physician reads broadly (eg journals available through the medical library), converses, and seeks information at meetings.	Specific problems: the physician reads available literature, and consults with colleagues. General problems: the physician reads broadly, consults, and takes courses.	In addition to the sources he has used already, the physician practises what he has learned and learns from other physicians' experiences in similar and related situations.
Reflection	The physician considers how problems fit their life generally and her practice specifically. They reflect on how problems, information, and issues relate to their practice.	Specific problems: the physician focuses on the patient and on immediate available reading and consultation; reflection varies from clinical and immediate to consultative and deliberate. General problems: the physician focuses on skills and knowledge to be learned; reflection is consultative, deliberative, and occurs whenever the doctor has time to consider the issue.	Specific problems: the physician considers what knowledge and skill she needs to resolve the problem; reflection is typically clinical and immediate. General problems: the physician reads, attends courses, consults colleagues; does hands-on learning; reflection is deliberative.	For both specific and general problems, the physician conducts a "post mortem". The physician focuses on her experience, prior knowledge, and experiences, as well as the experiences (both personal and published) of colleagues; reflection is deliberative and may or may not be at the site of the action.

Criteria for completion	The physician feels that the problem, issue or information is interesting or important enough to consider further.	The physician answers the questions: Is there really a problem? Is there a solution to the problem? Are resources available to learn what is required to solve the problem? Is it practical to do the learning?	Criteria specific to the precipitating problem: The problem requires action, resources were exhausted, others (e.g. instructors) told the physician it was time to act, there was nothing more to study. Criteria the doctor employed: An acceptable plan existed, the doctor felt ready; the doctor was clear on what was to happen next; the doctor felt there was no value in additional learning.	All criteria were specific to the precipitating problem in the sense that the doctor gained enough experience to be confident with the new learning. This was evidenced by the doctor's no longer consciously considering his actions, or the doctor's attention shifting to other issues. The stage could also end because the precipitating problem resolved and the doctor lacked further interest.
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Table 3 Attributes of each stage in a learning episode learning (from Slotnick¹⁴⁵)

As part of the implications flowing from his research, Slotnick lists three concerning CPD.¹⁴⁶

1. A proper needs assessment must collect information about (1) the problems doctors wish to solve; (2) the type of problem (specific or general); and (3) the stages doctors have reached in resolving the problem. The significance of this is emphasised because the research literature suggests that the functional unit of learning for doctors is an identified problem, not, for example, a general topic selected as part of a survey of doctors' interests as part of more traditional CME activities.
2. Since doctors can exit at varying stages in the learning process, evaluation of the success of CPD activities must look beyond change in clinical practice and consider both physicians' movement from one stage to the next, as well as whether early exits can be justified.
3. CPD activities should offer different learning formats for participants, depending on the nature of their problems and the learning needs associated with the stages they have reached in the learning episodes.

¹⁴⁵ Slotnick, HB. How Doctors Learn: Physicians' Self-directed Learning Episodes. *Academic Medicine* 1999; 74(10): 1110.

¹⁴⁶ *ibid.*, p. 1111.

The four-stage learning model developed by Slotnick is employed by the Royal College of Physicians and Surgeons of Canada (RCPSC) in their CPD program in a slightly modified format (Figure 2; over page). Its relationship to the CPD program can be summarised as:

The model ... proposes that Fellows engaged in a CPD activity, such as attending a CME meeting, reading a journal article or reflecting on a specific practice experience, are constantly on the look out for new ideas and practical tips that may enhance their practice. Having learned of a new way of investigating a clinical problem from reading an article, for instance, the Fellow may validate it by critically appraising the literature and discussing it with a colleague (Step 2). Finally, he or she explores the practical issues that must be addressed before the new investigation can be applied to practice (Step 3).¹⁴⁷

Parboosingh¹⁴⁸ writes of the program that:

The emphasis on reflective learning in practice ... recognises the need for Fellows to be competent in the management of clinical situations of uncertainty, ambiguity and conflict as well as in the practice of evidence-based medicine. CPD required to maintain skills in these competencies is as much tacit as it is explicit, and is largely acquired by practice reflection, communication with colleagues and the critical reconstruction of practice.

More will be written in regard to the RCPSC CPD program in a later section that examines current CPD programs in Australia and overseas. For now, attention is turned to a discussion of studies that have looked at the connection behind CPD for medical practitioners and changes in practice and/or patient outcomes.

¹⁴⁷ Parboosingh, J. CPD and maintenance of certification in the Royal College of Physicians and Surgeons of Canada. *The Obstetrician and Gynaecologist* 2003; 5: 46.

¹⁴⁸ id.



Figure 2 A staged model of learning (from Parboosingh ¹⁴⁹)

Continuing Professional Development – The Evidence

There is no shortage of voices citing the virtues of participation in CPD as being both a necessary and a fundamental part of on-going medical practice. The driving forces behind this have been discussed. It is reasonable for a report such as this to address the issue of what is known about the effectiveness of CPD in medicine. What follows is a synopsis of what is known of the effectiveness of CPD in influencing practitioner behaviour and patient outcomes.

In a contribution that discusses the evidence attached to the effectiveness of CME from both an overall perspective and in regard to general practitioners specifically, Cantillon and Jones ¹⁵⁰ note the following:

¹⁴⁹ id.

¹⁵⁰ Cantillon, P and Jones, R. Does continuing medical education in general practice make a difference? *British Medical Journal* 1999; 318: 1276 – 1279.

Systematic reviews of the educational literature found that although there were comparatively few rigorous evaluations of educational interventions, there were sufficient studies showing that continuing medical education could improve clinical performance and patient outcomes, indicating which methods were best at bringing about change in doctors' behaviour.¹⁵¹

They cite the most effective methods as including learning linked to clinical practice, interactive education meetings, outreach events, and strategies that involve multiple educational interventions. They cite the least effective as being:

... also the most commonly used in general practice continuing medical education - namely, lecture format teaching and unsolicited printed material (including clinical guidelines).¹⁵²

In regard to CME effectiveness in general practice, Cantillon and Jones write that:

Reviews of effective educational methodologies in primary care generally concur with the findings of wider literature reviews of continuing medical education. Combinations of educational interventions were found to be better than single interventions. ... organisational and management support were ... [found to be] ... important additional factors in changing behaviours. Several authors highlighted the importance of relating educational activity to the work that doctors do. Peer review and group learning models were proposed as particularly relevant in general practice settings.¹⁵³

Cantillon and Jones comment that "The most striking feature of this review is the lack of robust evaluations of general practice based educational interventions".¹⁵⁴ They conclude, however, that:

General practice educational activity should be based on the work that doctors do. Standard (and significant event) audits have been shown to be effective strategies for behaviour change if they include targeted feedback. This review has highlighted the importance of building reinforcement strategies into educational planning. Group and peer review type interventions have also been shown to be feasible and effective.¹⁵⁵

¹⁵¹ *ibid.*, p. 1277.

¹⁵² *id.*

¹⁵³ *id.*

¹⁵⁴ *ibid.*, p. 1278.

¹⁵⁵ *ibid.*, p. 1279.

The Cochrane Library houses reviews of the effects of a variety of CPD interventions on professional practice and health care outcomes. Specifically, the reviews of interventions currently available are:

- Continuing education meetings and workshops;¹⁵⁶
- Audit and feedback;¹⁵⁷
- Audit and feedback versus alternative strategies;¹⁵⁸
- Educational outreach visits;¹⁵⁹
- Local opinion leaders;¹⁶⁰ and
- Interprofessional education.¹⁶¹

The effect of printed educational materials on professional practice and health care outcomes¹⁶² has also been reviewed, however the review is currently not available.

Relevant findings from each of these reviews are presented briefly below.

¹⁵⁶ Thomson O'Brien MA, Freemantle N, Oxman AD, Wolf F, Davis DA, Herrin J. Continuing education meetings and workshops: effects on professional practice and health care outcomes (Cochrane Review). In *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software.

¹⁵⁷ Thomson O'Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Audit and feedback: effects on professional practice and health care outcomes (Cochrane Review). In *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software.

¹⁵⁸ Thomson O'Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Audit and feedback versus alternative strategies: effects on professional practice and health care outcomes (Cochrane Review). In *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software.

¹⁵⁹ Thomson O'Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Educational outreach visits: effects on professional practice and health care outcomes (Cochrane Review). In *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software.

¹⁶⁰ Thomson O'Brien MA, Oxman AD, Haynes RB, Davis DA, Freemantle N, Harvey EL. Local opinion leaders: effects on professional practice and health care outcomes (Cochrane Review). In *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software.

¹⁶¹ Zwarenstein M, Reeves S, Barr H, Hammick M, Koppel I, Atkins J. Interprofessional education: effects on professional practice and health care outcomes (Cochrane Review). In *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software.

¹⁶² Freemantle N, Harvey EL, Wolf F, Grimshaw JM, Grilli R, Bero LA. Printed educational materials: effects on professional practice and health care outcomes (Cochrane Review). In *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software.

**Continuing
education meetings
and workshops**

Description: Thirty-two studies were reviewed, involving mainly randomised controlled trials. Studies judged to be “of moderate to high quality, although methods were generally poorly reported”.¹⁶³ There was substantial variation in the complexity of targeted behaviours and characteristics of interventions; heterogeneity of results is best explained by differences in interventions. Studies reviewed involved the participation of qualified health professionals or health professionals in postgraduate training, not undergraduate students; most involved physicians. All but one measured health professional behaviour; eight measured a patient outcome. Nearly all the targeted behaviours involved learning “a fairly complex set of skills”,¹⁶⁴ such as management of a clinical problem, prescribing or prescribing counselling and preventive care. Four studies were focused on communication skills.

Conclusions/Discussion: Interactive workshops can improve professional practice. Lectures alone are unlikely to change professional practice. The review provides support for offering and attending interactive workshops rather than lectures, to the extent that the aim is to improve professional practice. Although there may be other reasons for offering and attending lectures, interactive workshops are more likely to result in improvements in health care, either alone or in combination with other interventions. The review findings do not indicate whether or not didactic presentations improve knowledge, but that they do not improve performance. Studies that use small group discussion and practice sessions to enhance skills were more likely to be effective in improving practice. This finding was not consistent across all such studies reviewed, however; some studies that used interactive or mixed activities reported small effects or non-significant differences between comparison groups, especially if the behaviour to be changed was

¹⁶³ Thomson O’Brien MA, Freemantle, N, Oxman AD, Wolf F, Davis DA, Herrin J. Continuing education meetings and workshops: effects on professional practice and health care outcomes (Cochrane Review). In *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software, p. 1.

¹⁶⁴ Thomson O’Brien MA, Freemantle, N, Oxman AD, Wolf F, Davis DA, Herrin J. Continuing education meetings and workshops: effects on professional practice and health care outcomes (Cochrane Review). In *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software, p. 6.

complex. The studies included in the review did not provide helpful evidence regarding the importance of the size of the group, the length or number of sessions, practising skills or achieving a local consensus. Due to the general lack of long-term follow-up in the studies reviewed, it is uncertain if any effects of the reported interventions were long lasting.

Audit and feedback **Description:** Thirty-seven studies were reviewed, with the reporting of study methods “inadequate for almost all studies”.¹⁶⁵ Studies were randomised trials of audit and feedback (defined as any summary of clinical performance of health care over a specified period of time). Participants were health care professionals responsible for patient care. A variety of behaviours were targeted in the studies reviewed. Eight studies involved trials of “multi-faceted interventions”¹⁶⁶ where the additional intervention was a reminder given at the time of the patient encounter. In five trials the subjects also received a patient-mediated intervention. Two trials included an outreach visit and one of these also included a local consensus process where the participants were involved in discussing and modifying criteria for care.

Conclusions/Discussion: Audit and feedback can be effective in improving the performance of health care providers. The effects are generally small to moderate (“but potentially worthwhile”¹⁶⁷), with or without educational materials or educational meetings. It is not possible to determine the optimal characteristics of feedback generally or in specific situations from the review. The evidence does not support the widespread use of audit and feedback; it should be targeted where it is likely to effect change, not be

¹⁶⁵ Thomson O’Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Audit and feedback: effects on professional practice and health care outcomes (Cochrane Review). In *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software, p. 1.

¹⁶⁶ Thomson O’Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Audit and feedback: effects on professional practice and health care outcomes (Cochrane Review). In *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software, p. 6.

¹⁶⁷ Thomson O’Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Audit and feedback: effects on professional practice and health care outcomes (Cochrane Review). In *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software, p. 2.

generally used for all problems: “Those attempting to enhance professional behavior should not rely solely on this approach”.¹⁶⁸ At the time of the review, decisions about the likely efficacy of audit and feedback, as well as the design of interventions based on it, must rely on good judgement. There are many sources of variation in the components of audit and feedback. Audit and feedback may be more effective in situations where the targeted behaviour is fairly complex or naturally occurring feedback is inadequate, and feedback serves to make the health professional aware of current performance. The review found insufficient data to clarify when the effects of audit and feedback are most likely to deteriorate after feedback stops. Contrary to what was expected, the results of the review indicated that more improvement occurred for tasks with moderate-low motivation. The reviewers suggest that the issue of provider motivation should be investigated further, since several theories of behaviour change suggest that this is an important component of the change process.

Audit and feedback versus alternative strategies

Description: Twelve studies were reviewed. Studies were randomised trials of audit and feedback (defined as any summary of clinical performance of health care over a specified period of time) compared with other interventions. Participants were health care professionals responsible for patient care.

Conclusions/Discussion: The review concluded that it is not possible to recommend a complementary intervention to enhance the effectiveness of audit and feedback. The reviewers “did not find sufficient evidence to strongly support or refute”¹⁶⁹ the hypothesis that interventions that combined audit and feedback with a complementary intervention were more effective than audit and feedback alone. Reminders might be more effective than audit and feedback to improve the delivery of some preventive services (e.g.

¹⁶⁸ id.

¹⁶⁹ Thomson O’Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Audit and feedback versus alternative strategies: effects on professional practice and health care outcomes (Cochrane Review). In *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software, p. 7.

mammography¹⁷⁰), but the results are not striking. Few trials investigated the effects of varying different characteristics of the audit and feedback process, although the reviewers noted the potential importance of some or all of these characteristics. At the time of the review, the selection of specific components of audit and feedback cannot be based upon evidence from the randomised trials investigated.

Educational outreach visits

Description: Eighteen studies were reviewed. In thirteen trials the behaviour targeted was prescribing practices. Three trials involved preventive services as the targeted behaviour, while the general management of a variety of common problems encountered in general practice was that targeted in two. Studies were randomised trials of outreach visits (defined as a personal visit by a trained person to a health care provider in his or her own setting). Participants were health care professionals. All of the visits consisted of several components, including written materials and conferences; reminders or audit and feedback complemented some visits. All studies examined physician behaviour and in three studies other health professionals such as nurses or health care workers were targeted.

The studies reviewed involved four types of outreach visits. Two attempt to influence a change in practice through persuasion. One of these involves a *social marketing* approach to behaviour change where participants are interviewed to assess the motivation for current practice and barriers to change and matching the intervention to the stage of the individual in the change process. Other steps are developing programs for specific physician targets and their “opinion leaders”; developing objectives; establishing credibility; encouraging physician participation; using concise educational materials; repeating key messages; and ideally providing reinforcement through subsequent visits.¹⁷¹ In the second type of outreach visit, an

¹⁷⁰ McPhee, S.J., Bird, J. A., Jenkins, C. N. and Fordham, D. Promoting cancer screening. A randomized controlled trial of three interventions. *Archives of Internal Medicine* 1989; 149: 1866 - 1872.

¹⁷¹ Thomson O'Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Educational outreach visits: effects on professional practice and health care outcomes (Cochrane Review). In *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software, p. 11.

assessment of barriers to change is not specifically reported. The third type of visit may not use persuasion as such, but may work by decreasing administrative barriers, for example, streamlining office procedures, and the fourth involves participants using practice-enabling strategies such as role play with feedback from simulated patients to develop skills.

Conclusions/Discussion: Educational outreach visits, when combined with additional interventions, particularly social marketing, appear to be a promising approach to modifying health professional behaviour, especially prescribing. The cost-effectiveness of outreach visits is not well evaluated, and it is not known how performance deteriorates over time and whether subsequent visits are cost-effective. The reviewers note that the preliminary interviews in the social marketing approach may be important in identifying barriers to change.

**Local opinion
leaders**

Description: The review evaluated randomised trials of the use of local opinion leaders (health professionals nominated by their colleagues as being educationally influential) on the practice of health professionals or patient outcomes. Eight studies that targeted a variety of patient problems were evaluated.

Conclusions/Discussion: Using local opinion leaders results in mixed effects on professional practice; however, it is not always clear what local opinion leaders do and it was felt that replicable descriptions were needed. Lack of clarity of the role of the opinion leader makes interpretation of these trials difficult. Six of seven trials that measured health professional practice demonstrated some improvement for at least one outcome variable; in two trials the results were statistically significant and clinically important. In three trials that measured patient outcomes, only one achieved an impact upon practice that was of practical importance: an improvement in the rate of vaginal birth after previous caesarean section.

**Interprofessional
education**

Description: The review had the objective of assessing the usefulness of interprofessional education (IPE) interventions compared to education in

which the same professions were learning separately from one another. The selection criteria were randomised trials, before and after studies and interrupted time series studies of IPE interventions designed to improve collaborative practice between health/social care practitioners and/or the health/well-being of patients/clients. The outcomes included objectively measured or self-reported (validated instrument) patient/client outcomes and reliable (objective or validated subjective) health care process measures.

Conclusions/Discussion: Despite finding a large body of literature on the evaluation of IPE, the studies found lacked the methodological rigour needed to begin to convincingly understand the impact of IPE on professional practice and/or health care outcomes. The reviewers point out that “although we found no evidence of the effectiveness of IPE, this does not imply that there is evidence of ineffectiveness of IPE”.

**Printed
educational
materials**

Review currently unavailable for access.

Mazmanian and Davis¹⁷² present a succinct summary of the issue of CPD effectiveness in regard to CME interventions covering such concepts as audit and feedback, chart-based reminders, clinical practice guidelines and formal lectures. They write:

Defined as interventions to change the behavior of physicians, the effects of those strategies were inconsistent across practitioners, settings and behaviors. As a result, in the midst of contemporary discussions about quality improvement and the effects of continuing education, there is no singularly effective method for improving physician performance. Physicians must accept responsibility for their own continuous learning: setting goals and selecting educational activities to achieve those goals.¹⁷³

Mazmanian and Davis describe the perceived evolution of CME to CPD in the past decade on the basis of the capacity of activities to produce change as a result of the

¹⁷² Mazmanian PE and Davis DA. Continuing Medical Education and the Physician as a learner. Guide to the Evidence. *JAMA* 2002; 288: 1057 - 1060.

¹⁷³ *ibid.*, p. 1057.

publication of work by Davis, Thomson, Oxman and Haynes.¹⁷⁴ They report further work^{175 176 177} as revealing three major consistent findings.

1. Effects are inconsistent across practitioners, settings and behaviours; assessment of learning need is of high importance.

Regardless of ... [the type of activity involved] ... it is important for physicians to recognize the need to change their behavior, knowledge base or skills. Irrespective of hospital- or office-based practice, primary or specialty care, a change in physicians' knowledge or skills was associated with an identified reason for the change prior to its implementation. ... When gaps are demonstrated and educational resources are extended strategically to help the learner, change occurs more frequently within each type of intervention.¹⁷⁸

¹⁷⁴ Davis, D, Thomson, MA, Oxman, AD and Haynes, RB. Evidence for the effectiveness of CME: a review of 50 randomized controlled trials. *JAMA* 1992; 268: 1111 - 1117.

¹⁷⁵ Davis DA, Taylor-Vaisey A. Translating guidelines into practice: a systematic review of theoretic concepts, practical experience and research evidence in the adoption of clinical practice guidelines. *CMAJ* 1997; 157: 408 – 416.

¹⁷⁶ Davis, DA, Thomson, MA, Oxman, AD and Haynes, RB. Changing physician performance. *JAMA* 1995; 274: 700 - 705.

¹⁷⁷ Davis DA, Lindsay, EA, Mazmanian PE. The effectiveness of CME interventions. In: Davis DA, Fox RD, eds. *The Physician as Learner: Linking Research to Practice*. Chicago, Ill: American Medical Association; 1994: 245 – 280.

¹⁷⁸ Mazmanian PE and Davis DA. Continuing Medical Education and the Physician as a learner. Guide to the Evidence. *JAMA* 2002; 288: 1057.

Of interest is the conclusion by Mazmanian and Davis that

Continuing medical education providers can improve the prospects for change by helping physicians integrate systematic quality improvement efforts with CME, including the assessment of need and evaluation of progress toward clinical goals.¹⁷⁹

2. Interactive learning and opportunities to practise skills can effect change.

Mazmanian and Davis outline the importance of educational strategies that are interactive and allow two-way communication between physician-learners and CME teachers. They emphasise the lack of efficacy of activities that are traditionally most easily recognised as CPD activities in promoting desired change, writing:

While lectures, conferences and short courses may predispose physicians toward change, didactic lectures by themselves do not play a significant role in immediately affecting physician performance or improving patient healthcare. ... Interactive workshops can result in changes to knowledge or skills; didactic sessions alone are unlikely to change professional practice.¹⁸⁰

3. Sequenced and multifaceted activities can effect change in practice and patient outcomes.

CME strategies designed to use more than one intervention can lead to change in practice. Physicians should choose educational activities with clear goals and the opportunity to progress incrementally toward achievement of those goals.

Table 4 provides a summary of the implications of the three findings outlined above both for practitioners involved in CME and the providers of CME.

¹⁷⁹ *ibid.*, p. 1058.

¹⁸⁰ *id.*

Study finding	What practitioners can do as learners	What CME providers can do
Effects are inconsistent across practitioners, settings, and behaviours: assessment of need is required	Set learning goals based on practice performance data Select educational activities needed to achieve a goal or that help you identify what is needed	Provide reliable data to enable physician-learners see present levels of performance compared with optimum performance Provide the physician-learner with an opportunity to reflect upon present levels and desired levels of performance
Interactive learning and opportunities to practice skills can effect change	Select educational activities designed to meet the clinical performance needs of the practitioner and those they may work with as members of a health care team Seek seminars, workshops, or activities with leaders who build knowledge and skills as resources into the educational sessions Select activities that enable the learner and others to observe new knowledge and skills and to use them in their practice setting	Offer consultation to help physicians specify goals that are achievable and measurable Enable comfortable communication among individuals or teams involved in the educational activity Enable physicians or teams to try in practice what is learned, with limited fear of failure Enable physicians to reflect upon their relative success and to choose what might be learned next
Sequenced and multifaceted activities can effect change in practice and patient outcomes	Participate in learning activities with instructional objectives clearly stating what the learner will know or be able to do as they progress from one level of knowledge or skill to another Choose educational activities that enable the learner to progress incrementally (e.g. over a period of days or weeks in reading, seminars or skills application sessions)	Design activities with the cumulative goal of helping physicians or teams of learners to adopt change incrementally, assuring there is compatibility with present systems and advantage over present behaviours Measure the results of educational activities intended to improve clinical care Assess the effects of educational and clinical improvements including budgetary performance

Table 4 Findings from reviews of Continuing Medical Education: what learners can do to improve the effectiveness of Continuing Medical Education (From Mazmanian and Davis¹⁸¹)

Whilst Mazmanian and Davis acknowledge the difficulty inherent in evaluating outcomes associated with CPD, they point out that changes in clinical practice can be measured through chart audit with feedback, remarking that the strategy is “central to

¹⁸¹ *ibid.*, p. 1059.

continuous quality improvement in health care”.¹⁸² Whilst they acknowledge the role of randomised controlled trials to examine the effects of learning and the performance of clinical behaviours, they write also that “minor clinical actions often have major consequences remote in space and time”.¹⁸³

Mazmanian and Davis conclude by noting that medical practitioners “should participate in educational activities that offer personal involvement in thinking about professional practice and in identifying learning needs”¹⁸⁴.

To achieve its greatest potential, CME must be truly continuing, not casual, sporadic, or opportunistic. Physicians must recognize the ongoing opportunities to generate important questions, interpret new knowledge, and judge how to apply that knowledge in clinical settings. Essentially, this means that CME itself must be self-directed by the physician, including management of the content of and context for learning. In turn, the opportunities for self-directed learning must enhance the knowledge and skills required for critical reflection on practice and measurement of improvement.¹⁸⁵

The Question Of Mandatory CPD

Although not expressly a requirement of this project, a discussion of the issue of the mandatory or voluntary nature of CPD would seem to be relevant for inclusion in this document. This is approached from the perspective of attempting to provide a description of the issues relating to CPD for medical practitioners, rather than from the perspective of recommending for or against the adoption of mandatory CPD, a task that would seem more appropriate for statutory bodies and/or government. That said, this is an issue that is clearly of much interest and relevance to the profession at present, being part of the current debate relating to possible changes to medical registration, as well as the desire to assure the public in regard to the competency of the medical workforce.

Regarding this latter issue, it is worth noting that this project takes the approach that CPD, particularly in its more frequent manifestations at the present time, cannot, of itself, guarantee the competence of all medical practitioners in all settings on all

¹⁸² id.

¹⁸³ id.

¹⁸⁴ id.

occasions. Indeed, this view is echoed in some responses received in consultations undertaken in relation to this project (see later). Also, there would appear to be little difficulty in sourcing anecdotal reports of practitioners who are apparently heavily involved in CPD on a points/hours basis, where that involvement is not clearly reflected in their perceived levels of competence or professionalism.

What is clear from previous sections of this document, however, is the following.

- That properly constructed and targeted CPD can affect change in clinical behaviours and practices of medical practitioners, and improve patient outcomes.
- That the current environment in which medical practitioners operate is dynamic; “the rate of change is increasing every year”.¹⁸⁶
- As members of a profession that possesses a highly specialised knowledge and skills base that is increasing as a result of research and technology advances, “doctors have an ethical obligation to keep up to date”.¹⁸⁷

The knowledge base is part of being a professional and it should be continually updated and replenished.¹⁸⁸

The final point above is, perhaps, crucial. The importance of quality health care to a society is obvious. The status and privileges traditionally afforded those who are charged with its delivery reflect this. In this context, the requirement to remain up to date with developments in a specialist field of medical expertise would also appear obvious.

Donen¹⁸⁹ provides an overview of the arguments for and against mandatory CME (Table 5).

¹⁸⁵ *ibid.*, pp. 1059 - 1060.

¹⁸⁶ Calman, K. The profession of medicine. *British Medical Journal* 1994; 309: 1140.

¹⁸⁷ *id.*

¹⁸⁸ *id.*

¹⁸⁹ Donen, N. No to mandatory continuing medical education, Yes to mandatory practice auditing and professional educational development. *CMAJ* 1998; 158: 1044 - 1046.

Arguments for mandatory CME
• Ongoing professional education of physicians is necessary to protect the public
• Involvement of every practitioner in educational programs is guaranteed
• Continued practice licensure accountability is guaranteed
• Mandatory CME is a transition phase into more effective systems of professional accountability
• An informed professional awareness is maintained
• Physicians will engage in education to address needs they might otherwise ignore
• Well-designed programs can influence effective practice
• Performance of the “reluctant” practitioner is improved
Arguments against mandatory CME
• Professionals should be accountable for their own effective performance, not participation; mandatory CME removes this individual responsibility
• All that can be mandated is attendance; mandatory CME does not guarantee change in attitude, motivation, ability to learn or change in current practice patterns
• Principles of adult learning are violated; mandatory CME is punitive to those who participate voluntarily
• Physicians will depend on traditional programs rather than self-responsibility for learning
• Mandatory CME is needed only for the few uncommitted physicians; most physicians continue their own self-education
• Performance of the incompetent physician will not be improved
• Evidence that it results in improved practice is lacking
• Programs delivered are not consistent and may lack relevance to practitioners’ needs
• Proliferation of programs of questionable quality may result
• Policy of mandatory CME is expensive
• Use of more valid and reliable measures of competence is reduced

Table 5 Arguments for and against mandatory CPD

The nature of the arguments advanced in Table 5 clearly indicate that this is difficult to adjudicate on this issue using on empirical evidence alone. Donen, however, echoes the views of Queeny and English¹⁹⁰ almost a decade ago that professionals should move beyond the mandatory debate and focus instead on providing practice-oriented continuing professional education.

¹⁹⁰ Queeny, D.S. and English, J.K. *Mandatory Continuing Education: A Status Report*. Information Series No. 357. Columbus, Ohio: ERIC Clearinghouse on Adult, Career and Vocational Education, Ohio State University; 1994. ERIC N.: ED372306. (From Donen, N. No to mandatory continuing medical education, Yes to mandatory practice auditing and professional educational development. *CMAJ* 1998; 158: 1044 - 1046. Abstract obtained from www.askeric.org 1 July 2003.

In the current environment, then, the relevant issue, would appear not to relate to the justification of mandatory CPD for medical practitioners, but to the justification of allowing medical practitioners, should they wish, to opt out of a properly constituted program that demonstrates, at the very least, improvement of a baseline measure of the knowledge, skills and attitudes needed for practice as a medical practitioner.

Flowing from this, as Donen acknowledges, is the issue of how best to approach the construction and administration of medical practitioner CPD. For this project this translates to producing improvement in practice as defined by the theoretical platform of this framework, as distinct from providing a universal guarantee of the competence of practitioners, without resorting to mechanisms such as formal recertification examinations.

This question is addressed in the next section. Here, after considering in broad terms the current format of specialist medical college CPD programs, the essential characteristics of the CPD framework for medical practitioners, which builds on the theoretical platform previously described, are discussed and outlined.

The Current Situation of Medical Practitioner CPD in Australia

As previously mentioned, an international comparison of medical continuing professional development systems by Peck et al¹⁹¹ has highlighted the international move from continuing medical education to continuing professional development. There is now clear acknowledgment of the need for medical professionals to continuously acquire new knowledge, skills and attitudes to enable practice that meets the needs and demands of patients and health services. As a result, over the past decade continuing education has come to include managerial, social and personal skills, as well as the traditional clinical medical subjects. This is a trend notable also at the undergraduate and postgraduate levels of medical training.

¹⁹¹ Peck, C, McCall, M, McLaren, B, Rotem, T. Continuing medical education and continuing professional development: international comparisons. *British Medical Journal* 2000; 320: 432 - 435.

The findings also reveal that the demonstration of participation in CPD is becoming an integral part of revalidation or recertification of practitioners. Peck et al claims that legislated revalidation and recertification of practitioners is driving the need for mandatory professional development programs that cover a spectrum of clinical, professional and managerial activities. Perhaps of most note in this regard is the requirement of revalidation for doctors in the United Kingdom, based around the document *Good Medical Practice*.

Another key finding from the comparison is that, despite variation between health care systems in different countries, there are many features of content and process common to systems of CPD in operation.

An overview of the current CPD situation in Australian medical colleges has been compiled from the current CPD matrix, an overview document that circulates between college CPD coordinators, as well as other documents sourced from the individual colleges.

Overview

The main aspects of the system as it currently operates are as follows.

- Although program titles differ, all colleges have a form of CPD in place.
- CPD is seen as important and a focus (core business) area of Australian medical colleges. In some colleges it is seen as a key element or a way to achieve an objective of the college strategic plan.
- Generally, the goals of CPD programs at the different colleges are relatively similar. The key focus is to ensure that medical practitioners are providing the highest quality of health care to patients by continually improving appropriate knowledge, skills and practices.

Program Structure

- Many of the programs have either recently undergone, or are in the process of, review. This is perhaps a reflection of the perceived need by Colleges to have a program that can be considered rigorous and defensible, yet achievable by their Fellowship.

- Enrolment of College Fellows in their relevant CPD program is not mandatory for the majority of the colleges. However, the following colleges require compulsory enrolment for all or some of their Fellowship: RANZCOG, RACS (for procedural Fellows), RACGP (compulsory for vocational registration), RANZCP and ACEM. Informal correspondence would suggest that an emerging issue for some of these colleges is what to do when Fellows do not participate as required.
- Program expectations are measured by some form of a points/hours credit system. There is no clear consistency between points definition and allocation for activities across colleges, although most have minimum points required per year in different category of activities and per cycle. The basis for the allocation of points for each activity is variable across the colleges, but appears to include factors such as: perceived/assessed educational value, a desire to encourage participation, and the amount of time spent on the activity.
- Program requirements are spread across 'cycles'; either three or five years, except for one college that has an annual cycle.
- All colleges incorporate CPD program costs into their Fellowship fees, whilst most of the colleges allow non-Fellows to participate in their CPD at a cost set by the individual college.
- Reporting mechanisms used by the colleges – self-reporting with most colleges conducting a yearly random audit of participants; yearly points/hour claim form / activity summary submitted.
- The data submission process and the substantiation requirements are relatively similar for all of the colleges. Tools used for recording CPD activities - diary/activity records - paper and online requirements/availability vary between colleges.
- Processes for endorsement of educational activities/meetings exist, but are not standard across colleges. The initial accreditation of activities and the process for requesting acceptance on a non-accredited activity is college-specific and there would appear to be significant variation in requirements between colleges.
- Most colleges appear to have acknowledged the shift from CME to CPD for their Fellows. Only one college appears to overtly state that courses or meetings related to business or management cannot be used for CPD credit purposes.

- Self Direct Learning (SDL) activities are a component of all of the college CPD programs. However, it appears that only a few of the college programs are using tools such as individual professional learning plans or practice profiles as an activity to actually direct the individual's current choice of SDL activity.
- The sanctions currently used across the colleges if the program is not completed reflect whether the program is compulsory or voluntary. The severest sanction for voluntary programs is not issuing a certificate, whilst colleges with compulsory programs can potentially terminate a Fellowship.

College CPD Activities

Colleges currently have CPD programs consisting of activities set up around four or so categories, with a predominant focus on CME. Typically, the categories can be described as:

- Group activities (e.g. group meetings, workshops, journal clubs, etc.)
- Individual self-education activities (eg. short/refresher courses, formal postgraduate courses, etc.)
- Education/training/research activities (teaching, presentations, training supervision, examining, mentoring, formal research, etc.)
- Practice improvement/QA type activities (audits, practice reviews, etc.)

Every college, however, appears to have their own way of grouping activities that they see as valid CPD activities, and the above are broad generalisations that serve only to give a feeling for the type(s) of activities that medical practitioners typically undertake in their college CPD programs. Almost inevitably colleges offer a mix ranging from passive learning activities to higher-level, more active learning activities that require high levels of assessment, planning, implementation and review. The credit systems in place in some cases reward the active learning activities with high points/hour allocation; however, the programs' credit systems are not all set up to encourage active learning.

Guiding Principles for the Framework for Continuing Professional Development for Medical Practitioners

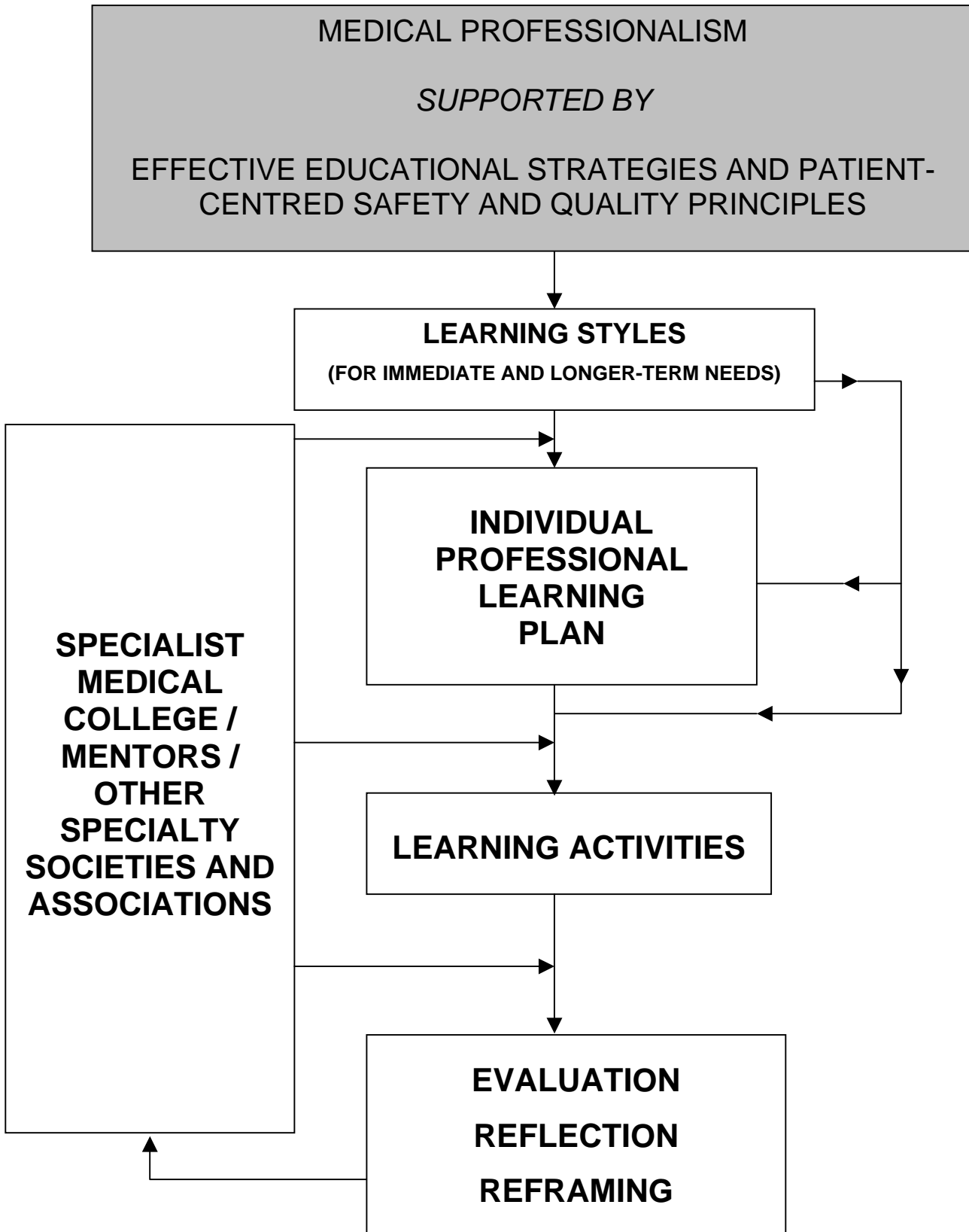
Consideration of the material presented thus far leads to the formulation of the following guiding principles for the framework being developed from this project.

1. The framework should be based on a theoretical platform that can provide a rationale for CPD that enables flexibility for use with practitioners in a variety of fields and practice settings.
2. The framework should acknowledge that the objective of CPD is improved health care and patient outcomes.
3. The framework should acknowledge the view that maintenance/improvement of clinical skills and knowledge is seen as a central purpose of CPD, whilst incorporating the increasingly accepted view that the role of a medical practitioner involves more than simply clinical knowledge and skills.
4. The framework should recognise that practitioners learn via two major approaches, with preferred learning styles for individuals within those approaches; consequently, both planned and unplanned CPD can be considered valid.
5. The framework should acknowledge that a range of activities can be involved in medical practitioner CPD, whilst acknowledging that some are demonstrably more effective than others in changing practitioner behaviour and patient outcomes.
6. The framework should acknowledge the apparent benefits of needs analysis in relation to CPD, at an individual practitioner and group level.

7. The framework should acknowledge the demands of medical practice, without abrogating the professional responsibility of practitioners in regard to their individual and collective accountability.
8. The framework should acknowledge the multiple roles of the specialist medical colleges and other relevant professional bodies in medical practitioner CPD; roles that specify more than a simple passive involvement in the administrative aspects of the framework.
9. The framework should acknowledge the contextual nature of the learning involved in a medical practitioner CPD program.
10. The framework should incorporate an avenue for acknowledgment of/reflection on learning by practitioners as a result of the learning activities undertaken.

Figure 3 (over page) provides a basic outline of the nature of the framework as envisaged in its operation. The drivers of change in the way CPD is considered, along with the theoretical platform of the framework (professionalism; 3 strands, adult learning principles and safety and quality considerations) feed into two possible learning paths for medical practitioners.

Figure 3 CPD Framework Scheme 2 – learning cycle of improvement through continuing professional development for medical practitioners



The Framework and CPD Activities: A Classification

What the description of medical professionalism developed as the theoretical platform for this project framework enables is the description of professional medical practice, regardless of the specialty involved. This is, of course, not sufficient in itself to act as the practical crux of the framework; essentially a matrix of components of professionalism with activities to develop these domains is required.

To this end, it is proposed that the framework developed in this project involve three categories of learning activities being offered for each of the ten components of medical professionalism contained in the theoretical platform. These three categories of activities would reflect, essentially, a hierarchy of CPD activities, based on the ability of the activity to effect change in practitioner behaviour and patient outcomes.

The three categories would acknowledge, and extend, the classification of Davis, Lindsay and Mazmanian,¹⁹² where CME interventions were classified as “primary” and “secondary” interventions. Essentially, one end of the hierarchy would involve traditional, passive, relatively low-effectiveness activities such as lectures and conferences, while the other end would involve Quality Assurance/Practice Improvement activities where the practitioner evaluates the impact of an activity or intervention. At this level it would not suffice simply to conduct an activity that measures a parameter; what is important in a Level 3 activity is that an intervention or adjustment is made to address a problem, and the effect measured. Such activities can vary in the degree of planning and evaluation involved, ranging from small-scale follow-up to issues arising from involvement in other CPD activities, to larger-scale, longer-term involvement in formal quality assurance projects or targeted interventions. The discerning feature of

¹⁹² Davis, D, Lindsay, E, Mazmanian, P, *The Effectiveness of CME Interventions*. In Davis, DA, Fox, RD (eds), *The Physician as Learner*. American Medical Association, Chicago: 17-24. (From Shakespeare, T. P., *Evaluation of Audit with Feedback as a Continuing Medical Education tool for Radiation Oncologists*. Unpublished Project for Master of Public Health degree, University of New South Wales, 2003.

these activities is the alteration to practice and the effectiveness of such changes, rather than the need for practitioners to be involved in activities that may be perceived as time-consuming and/or burdensome.

Table 6 lists activities that are currently used in Australian medical college CPD programs, categorised according to the three levels proposed for the framework. Clearly it is possible for activities that a practitioner undertakes from those listed in Level 1 to lead to a Level 2 activity, and then to a Level 3 activity. Activities have been obtained by reference to material from each of the medical colleges describing their CPD programs, as well as the literature generally.

Level 1 Focus on knowledge, skills	Level 2 Change-facilitating activities	Level 3 Change-evaluating activities
Local, national, international meetings, symposia, workshops: attendance, presentation, chairing Hospital grand rounds Formal: postgraduate courses (Masters, Ph.D) Short courses Self-assessment tests Journal clubs Individual reading: journals, texts Trainee supervision Mentoring Teaching Presentations to community groups College/professional association/hospital involvement: committee membership, examiner, publication reviewing/editing Writing and publishing Grant application reviews Literature searches Representative activities Expert witness/medico-legal activities Video/audiotapes: production and use Computer-based learning Overseas aid trips/pro-bono work	Key factors are collection of data related to a particular question/issue or the ability to demonstrate an improvement in practice resulting from increased knowledge or skill Critical incident monitoring Criteria auditing Morbidity/mortality meetings Clinico-pathology meetings Practice review/opinion leader visits Simulator/skill centre sessions Primary clinical research Patient/family, carer satisfaction studies Retrospective peer review of cases Quality control studies Development of clinical practice guidelines Benchmarking studies arising from clinical indicators	Learning projects resulting from involvement in Level 2 activities. Key factor is the measurement of effect(s) of selected intervention(s) Outcome studies Collaborative outcome projects Evaluation studies – techniques, processes, therapies

Table 6 CPD activities grouped according to proposed Framework levels

The Framework in Operation

If colleges chose to operate a CPD program on a points basis, the three categories of activities would accrue points at different rates. This is not a new approach; indeed, the CPD program of the Canadian RCPSC currently does this to encourage Fellows to undertake more beneficial CPD activities. Decisions would be made regarding the appropriate number of points (or hours) required from each of the three professionalism strands. Colleges are familiar with conducting this process; however, it is possibly more appropriate for the framework composition to include such guidelines.

A college could also choose to operate a CPD program using a portfolio approach where a minimum requirement of activities of certain types across the strands is designated as a requirement for a medical practitioner across a CPD cycle. A record of participation in any other activities recognised as CPD should then be maintained.

A balanced approach between the points and portfolio approaches is probably the preferred mode of operation and could be undertaken whereby the requirements of a program are specified within a minimum number of rules or guidelines. Essentially, the program could be structured around the following.

- Completion of an individual needs analysis, including an outline of how the identified need(s) are to be met. This would, most likely, involve the selection of planned activities in response to general problems and involve formal learning strategies.
- A requirement of a minimum amount of time (say 100 hours over two years) to be spent on CPD activities.
- A required minimum amount of time to be spent on activities related to Strands 2 and 3 (say 10 hours over two years).
- A required minimum amount of time to be spent on Level 3 activities (say 20 hours over 2 years).

- Completion of an evaluation of the activities undertaken as a result of the needs analysis.
- An audit by the college of a percentage of Fellows (say 5%) through a formal process that involves interviewing the practitioner and acts as the mechanism for on-going evaluation of the program.

As it is developing the framework would offer a highly flexible CPD program to colleges and practitioners, with three different classes of learning activities available for selection across ten different components of medical professionalism. That is, a practitioner could tailor a program to reflect their practice setting and preferred learning modes.

The framework could also be easily used by professional groups and organisations outside the formal college structure to supply members with a CPD program.

The Certificate of Continuing Medical Professionalism

Adoption of a common framework for medical practitioner CPD provides an opportunity to issue a common certificate that acknowledges on-going participation in an accredited CPD program; the *Continuing Certificate of Medical Professionalism*. The certificate would be common to all specialities, issued by the relevant college or other body and indicate satisfactory participation in their CPD program. Such a certificate, which is essentially a form of ‘common currency’ that indicates good standing in a CPD program, could offer synergies between the issuing body and other statutory bodies.

Project Consultations

Summary Of Views Of Organisations Invited To Comment On Priorities For Continuing Professional Development Of Medical Practitioners

Consultations relating to the purposes of CPD and priority areas of CPD for medical practitioners were undertaken by inviting State and Territory medical boards and health complaints bodies, medical defence organisations, and consumer and workforce bodies to comment on these issues. Invitations were sent to twenty-nine organisations (for list of organisations, see Appendix B). Written responses were received from sixteen of the organisations, while individuals associated with two other organisations were interviewed. Note that the term 'specialist' was used in these consultations, rather than 'practitioner', the two having the same meaning in the context of the consultations.

The questions to which replies were sought were as follows.

1. What does your organisation see as the purposes and perceived benefits of medical specialists' participation in a continuing professional development program?
2. What areas of continuing professional development are considered by your organisation to be priorities for medical specialists?
3. Does your organisation consider that participation in a continuing professional development program should be mandatory for medical specialists?
4. Does your organisation consider that continuing registration for medical specialists should be conditional upon participation in a continuing professional development program?
5. Does your organisation see a connection between participation in a continuing professional development program and competence for medical specialists?

Summaries of responses to the five survey questions are presented below.

1. What does your organisation see as the purposes and perceived benefits of medical specialists' participation in a continuing professional development program?

Generally, the purpose of CPD for medical practitioners is seen by the organisations as being to develop, maintain and update their clinical skills and knowledge, and ensure the delivery of competent and safe health services.

The perceived benefits of CPD can be clustered in terms of the recipient of the benefit.

- Patient-centred, ie. patient/client and the public/community as a whole:
 - provision of a high standard of medical care; and
 - consumer reassurance that up-to-date skills and knowledge are being used
 - to allow practitioners to better incorporate consumer participation in health care systems and service delivery

- The practitioner as an individual and the medical practitioner's profession:
 - an aid to practising competently;
 - reduces professional isolation and increase of potential support provided by colleagues
 - fostering lifelong acceptance of the need for professional development;
 - maximised learning & evaluation opportunities
 - awareness of patient expectations;
 - better management of risk – promotion and adoption of best practice in clinical matters; lower incidence of serious error, poor judgement (which result in formal complaints lodged) and thus less litigation. As source of information about legislative changes and changing standards.

In general, most organisations either concurred with or complemented each other.

2. What areas of continuing professional development are considered by your organisation to be priorities for medical specialists?

The updating and development of clinical skills and knowledge in the speciality area was seen a key priority by all organisations.

However, the following non-clinical areas were also highlighted as being of importance. In particular, the health care consumer complaints/insurance organisations stressed the following areas as priorities.

- Communication:
 - Doctor/patient and relative
 - Doctor/colleagues and other health professionals
 - Explanation of complex issues simply to patients especially for "informed consent" (clinical and financial)
 - Collaborative and participatory relationship between doctor and patient in terms of decision making and management of consumer expectation of the medical service
- Management of conflict and adverse situations/complaint handling
- Awareness of impacting legislation - privacy, child abuse reporting etc
- Information management:
 - Standardised note taking
 - Record keeping
 - Disclosure of information
 - Accessing of medical records and responsibilities of record storage post closure of practice etc.
- Ethical issues, legal issues, clinical governance and risk management
- Development of medication and other technologies, and an understanding of the associated research
- New developments generally

- An appreciation of local and global sociological changes and their impact on health care of the community and the individual
- Recognition and respecting of professional/personal boundaries
- Understanding of specific population groups, particularly those most currently disadvantaged

The general view of these organisations indicates that a medical practitioner CPD program would need to cover a broad range of issues, beyond the traditional updating of knowledge and clinical skills and practice.

3. Does your organisation consider that participation in a continuing professional development program should be mandatory for medical specialists?

Eight of the sixteen organisations responding supported mandatory participation in CPD programmes. Two of these organisations supported mandatory participation to ensure participation by all practitioners, especially those who do not see CPD as a priority. One of the medical boards cited mandatory participation as a way to reduce professional isolation. Two of these organisations noted that, whilst it is ideal to have voluntary participation, it is those who choose not to participate under a voluntary approach that need such programs the most.

Four of the sixteen organisations believed that CPD programmes should be voluntary, although strongly encouraged. One of the medical boards suggested that mandatory participation would be unworkable due to geographic and practical constraints.

Four of the sixteen organisations (health care consumer complaint organisation/insurance organisation/medical board/nursing body) declined to give an opinion, although two of these organisations also noted that social or legislative pressures may well result in mandatory participation.

4. Does your organisation consider that continuing registration for medical specialists should be conditional upon participation in a continuing professional development program?

Nine of the sixteen organisations believed that medical practitioner registration should be conditional on participation in CPD. Health complaints bodies were particularly strong in this view. Most of the organisations that support mandatory CPD participation support it being a condition of medical practitioner registration. Five organisations (two health care consumer complaints organisations/two medical boards/insurance organisation/nursing body) indicated they had no opinion or gave no response. Two of these thought it inevitable that this would occur; one thought it likely.

5. Does your organisation see a connection between participation in a continuing professional development program and competence for medical specialists?

A majority of the organisations (13/16) see a connection between participation in a continuing professional development program and competence for medical practitioners. There was, however, acknowledgment in some responses of the anecdotal nature of their judgement in this regard, as well as the realisation that CPD cannot, of itself, guarantee competence.

In summary, the prime purpose of CPD for medical practitioners is seen by these organisations as being to develop, maintain and update the clinical skills and knowledge required to ensure the delivery of competent and safe health care. The nature of the responses received also supports the framework as it has been developed, i.e. with its broad focus on practitioner improvement and quality outcomes for patients, along with an acknowledgment of the range of components that constitute professionalism in medical practice.

Summary of Views of Practitioners and Trainees Invited to Comment on Priorities for Continuing Professional Development of Medical Practitioners

Consultations relating to priority areas of CPD and the effectiveness of CPD for medical practitioners were undertaken by inviting practitioners and trainees to attend one-hour forums at nine public hospital sites selected from Victoria and regional Queensland (Table 7).

The forums were conducted along the lines of interactive presentations. Participants were taken through an overview of a draft version of the CPD Framework (as outlined in the project interim report). They were invited to comment on any aspect of CPD they wished, whether or not it came from or related directly to the framework as presented. Participants were given a copy of the interim report that was distributed to the specialist medical colleges in September and were invited to respond to the Project Manager after the forum (e-mail, etc) about any aspect of the Framework (comments, questions). Three participants did this. Participants were also invited to complete a simple survey related to CPD priorities and perceived effectiveness of activities (Appendix C). Thirty-six participants (31 practitioners, four trainees/residents, one other) did this; the results are presented and discussed below.

Site	Location	Date
Geelong Hospital (Barwon Health)	Regional Victoria	October 1 2003
Monash Medical Centre Clayton (Southern Health)	Metropolitan Melbourne	October 7 2003
Wodonga Base Hospital (Wodonga Regional Health Service)	Regional Victoria	October 16 2003
Dandenong Hospital (Southern Health)	Metropolitan Melbourne	October 21 2003
Mildura Base Hospital	Regional Victoria	October 23 2003
Mt Isa Hospital	Regional Queensland	November 4 2003
The Townsville Hospital	Regional Queensland	November 5 2003
Maroondah Hospital (Eastern Health)	Metropolitan Melbourne	November 6 2003
Mackay Base Hospital	Regional Queensland	November 7 2003

Table 7 Sites and dates of consultation forums

Site selection

The decision to conduct consultations via hospitals, rather than via forums within or across the specialist medical colleges was made by the Project Reference Group. It was felt that avoiding the college structures would provide a greater opportunity to elicit a diversity of opinions, hopefully avoiding a monoculture perspective. It was also felt that an unofficial grouping may perhaps be more effective and more inclusive than working through the colleges.

The decision was made to involve hospitals in Victoria and rural Queensland. Rural Queensland was cited by the Project Reference Group as being an area where opinions on CPD may differ from elsewhere in the country. Thus, in order to capture as complete and relevant a range of views as possible, a number of rural Queensland sites were included.

The Project Reference Group further decided that contact be made with the Australian Medical Association (AMA) to gauge their opinion regarding the most effective way to organise of the forums. Project staff met with the Director of Policy Development at the AMA Victoria and spoke to the Policy Officer at the AMA Queensland.

Dr Woodhouse was of the opinion that a mix of regional and metropolitan hospitals of varying sizes would provide the best way to capture diverse views. Therefore, both large metropolitan (e.g: Dandenong and Monash) and smaller metropolitan (e.g: Maroondah) hospitals were approached in Melbourne. Regional hospitals were chosen on the basis of size and geographic coverage; Geelong, Wodonga and Mildura hospitals were approached. The AMA provided contact details for key hospital staff, including the Chairmen of the Senior Medical Staff Association, the Director of Medical Services and the Medical Superintendent.

Establishing forums at the sites

Where possible, initial contact was made with the Chairman of the Senior Medical Staff Association. Where this was not possible, (smaller locations and rural locations owing to the lack of contact information), initial contact was made with the Director of Medical

Services or the Medical Superintendent. At the Queensland sites, the Medical Superintendent of each hospital served as the initial contact person.

The aims of the project and the forums were explained verbally to these individuals. Most then requested further written information about the project, such as the following.

- The aims of the project
- The importance/significance of the project, as well as the project's scope
- The purpose of the proposed forum
- Practical information about how the forum would be conducted
- What would be required from the hospital in an administrative sense

A form letter was sent to all hospitals that expressed an interest in learning more about the project. Without exception, the hospitals were all receptive to the proposed forum and happy to provide the administrative support needed to organise the events.

Advertising the forums to hospital medical staff was coordinated through the hospitals in consultation with a project staff member. The three methods used were via the following.

- Senior Medical Staff Association meetings
- Flyers posted on notice boards
- A series of global emails to relevant staff

Many hospitals used combinations of these approaches. Generally, the hospitals were very willing to promote the event and were keen to see that it was successful.

Divisions of General Practice

In order to involve General Practitioners (GPs), use was made of the various Divisions of General Practice. For each site that was visited, the Division in which it fell was contacted and asked to promote the event to its members. This was seen to be the most

efficient and effective way to promote the event to GPs as approximately 94% of GPs are members of their local division.¹⁹³ In each identified Division, a staff member responsible for the Division's publications or educational programmes was contacted by telephone. They agreed to promote the local forum in their "Friday Fax", a regular weekly communication and/or their monthly (or bimonthly) newsletters.

Attendance at forums

Attendance varied from site to site and is shown in Table 8.

Site	Practitioners	Trainees	Other	Total
Geelong Hospital (Barwon Health)	5	-	-	5
Monash Medical Centre Clayton (Southern Health)	5	-	2*	7
Wodonga Base Hospital (Wodonga Regional Health Service)	6	1	-	7
Dandenong Hospital (Southern Health)	2	-	-	2
Mildura Base Hospital	3	-	-	3
Mt Isa Hospital	6			6
The Townsville Hospital	4	-	-	4
Maroondah Hospital (Eastern Health)	3	1	-	4
Mackay Base Hospital	1	1	2**	4
Total	35	3	4	42

* One education officer and one research officer

** One hospital administrator and one resident

Table 8 Attendance at consultation forums

Attendance could be seen as depending on a number of factors such as:

- Size of the hospital/number of medical specialists
- Effectiveness of advertising
- Enthusiasm of senior hospital staff
- Enthusiasm and effectiveness of promotion by General Practice Divisions
- Timing of the meeting

¹⁹³ Australian Divisions of General Practice, <http://www.adgp.com.au/site/index.cfm?display=293> (accessed 6/11/03)

Regardless of the reasons, attendance in some cases was perhaps somewhat disappointing. The reasons for this will not be speculated upon here, as the only function of this section is to describe the arrangement process and the outcomes of the consultation forums. During the consultation there was attendance from at least one Fellow from each of the specialist medical colleges, excepting the College of Psychiatrists and the College of Emergency Medicine.

Forum Outcomes

Summaries of notes taken during the forums, along with comments written on the completed survey sheets returned from the consultations indicate little in the way of constructive comment regarding the draft version of the framework that could be incorporated into the framework per se. It is difficult even to garner whether or not there was support for the framework in general; however, there is no recollection on the part of those involved in running the forums of any forum generating openly negative views that would suggest the framework did not have merit. Some comments were made that render valid a reconsideration of the components related to *Medical Informatics* being subsumed to other components of the framework, the need to retitle Strand 2 as something different to *Risk Management*, as well as the difficulty or lack of relevance of the proposed Level 3 activities for some specialties. Also, the issue of the framework requirements being mindful of already very busy and committed practitioners was reinforced, as well as the hesitancy with which the proposed learning plan and reflection aspects of the framework will be approached, not so much from a lack of worth, but from a practicality perspective and the associated perspective of value-adding.

The issue of cost to practitioners of attending CPD activities was also raised. This is clearly an issue that requires examination and resolving by appropriate bodies; however, recommendations in this regard are beyond the boundaries of the work described by this report and are not attempted herein.

The task of obtaining information that could help give an insight to participant perceptions of the framework was perhaps complicated by the reality that one aspect of the framework that may cause controversy is the detailed description of the components for each strand. It is also the most tedious to work through in a forum where the main aim is to elicit comment from participants regarding their views on CPD priorities, the types of activities that are most beneficial to them, and any other matters regarding medical practitioner CPD that they see as relevant to the project. These descriptions were supplied to forum participants in the form of the interim report document and were talked about in general terms during the forums. Any questions relating to them were answered and a standing invitation to contact the Project Manager regarding any aspect of the forum presentation or the interim report document was given. As previously mentioned, only three participants did so.

In general, the forums were well received by those who attended. As their main purpose was to elicit views regarding priority areas of CPD for medical practitioners, along with an indication of the type(s) of activities considered to be of benefit to medical practitioners, an examination of the results of the surveys returned from the forums (see Appendix C) is now addressed. These were designed as a simple method of obtaining information that could directly address the main purposes of the forums. again, note that the term 'specialist' was used in these surveys, rather than 'practitioner', the two having the same meaning in the context of the consultations. Whilst it is acknowledged that the numbers of practitioners (and trainees in particular) that attended the consultations render the results obtained from this instrument of little value from a statistical viewpoint, it represents the views of almost 100 per cent of the practitioners and trainees who attended the forums.

As the numbers involved are not sufficient to allow a breakdown of information according to specialty, global results for questionnaire items 2 and 3 are presented as Tables 9 and 10 respectively.

	Practitioner responses (N = 30)	Trainee/ resident responses (N = 4)
	n (%)	n (%)
Clinical and diagnostic developments in the relevant specialty	29 (97)	4 (100)
Applications of technology to clinical practice	25 (83)	3 (75)
Patient – specialist relationships	17 (57)	1 (25)
Professional relationships	17 (57)	1 (25)
Advocacy and equity in health care	12 (40)	1 (25)
Medico-legal matters	18 (60)	4 (100)
Education and teaching	28 (93)	1 (25)
Professional ethics	18 (60)	1 (25)
Communication skills	24 (80)	3 (75)
Practice management (including the use of relevant technology)	15 (50)	2 (50)
Time and lifestyle management	15 (50)	1 (25)

Table 9 Responses to Item 2 of questionnaire (CPD priorities)

Essentially, as with the information obtained from the interest group consultations conducted earlier in the project, the results in Table 9 lend support to the scope of the theoretical platform of the framework. There is a clear emphasis on the areas of clinical and diagnostic developments, along with the associated applications of technology, and a recognition of the importance associated with effective communication skills. Education and teaching activities were afforded a high priority, and the remaining categories that were offered gained support that must be acknowledged within the limitations of the overall numbers involved. Of interest was the ability of all categories offered to gain acknowledgment from at least one of the four trainees/residents who attended the forums. The area of "Public Health" was the only "other" category cited by one participant. It can reasonably be assumed that activities in this areas could be covered by components of the *Professional Values and Responsibilities* strand of the framework, most appropriately through the *Service and Relationships* or the *Advocacy and Equity* components.

The nature of the responses to Item 3 (Table 10) would seem simply to reflect the importance of practitioners having a wide range of activities that they can count as 'valid'

CPD. There would appear to be a desire to be able to meet CPD requirements largely through activities associated with the normal course of employment. Whilst this is understandable, it does lead in theory to the situation of practitioners involved with large metropolitan or regional public hospitals having a far easier task of meeting their CPD requirements than, for example, isolated rural colleagues in solo private practice. Whilst this is neither a new dilemma, nor an easy one to solve, there would not appear to be much point in erring on the side of making the task of meeting CPD requirements equally as difficult for all to meet. Clearly the logistics of attending some CPD activities is a difficult issue and one that needs to be addressed. Initiatives such as the Support Scheme for Rural Specialists (SSRS) and the Rural Advanced Specialists Training Scheme (RASTS) are attempting to do this.

Other activities named by practitioners in response to this item were grand rounds; case discussions with peer groups; familiarisation with clinical practice guidelines and evidence-based summaries; and medical internet sites and bulletins.

	Practitioner responses (N = 30)	Trainee/ resident responses (N = 4)
	n (%)	n (%)
Lectures	18 (60)	3 (75)
Workshop demonstrations	20 (67)	4 (100)
Interactive (hands-on) workshops/simulations	21 (70)	3 (75)
Journal clubs	12 (40)	2 (50)
On-line forums	7 (23)	-
Research	9 (30)	1 (25)
Peer review activities	21 (70)	4 (100)
Clinical audit activities	15 (50)	2 (50)
Journal reading	15 (50)	2 (50)
Participation in college examinations	13 (43)	-
Trainee supervision	24 (80)	-

Table 10 Responses to Item 3 of questionnaire (CPD activity effectiveness)

Response to Interim Report from Specialist Medical Colleges

An interim report on the project was sent to all specialist medical colleges (attention of the Chief Executive Officer) that are members of the CPMC in the first week of September. The report essentially consisted of a draft version of the framework that outlined the main principles, along with a full description of the theoretical platform as it stood at the time. A covering letter that accompanied the report requested that it be disseminated to relevant people at the colleges, and that comment on the framework be made. This could be via three possible avenues: a written response to the Project Manager; a verbal response to the Project Manager; or via a meeting of CPD managers from the colleges that was set down for Friday, 17 October. Combinations of these methods were, of course, possible, and some colleges chose this route. The Colleges (and associated chapters and faculties) listed below provided written responses to the report.

- The Australian and New Zealand College of Anaesthetists (ANZCA)
- The Royal Australasian College of Physicians (RACP) (also Chapter of Palliative Medicine Education Committee and Board of Continuing Professional Development, RACP New Zealand)
- The Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
- The Royal College of Pathologists of Australasia (RCPA)

In attempting to construct a framework for medical practitioner CPD that is applicable to all specialties and, thus, acceptable to all of the relevant colleges, it is perhaps inevitable that some aspects of the resultant proposal will be less acceptable to some colleges than others, these aspects differing from college to college. This would seem to be the case with the framework as described in the interim report document and commented upon by the colleges. For example, one college expressed concern with the reflective nature of the framework, commenting that this type of model was rejected by their Fellowship in an earlier iteration of their CPD program, while a response from a member of the CPD committee of another college saw this as one of the more worthwhile aspects of the

framework as outlined. Some of the issues raised during the consultations are addressed below.

The concerns expressed by the ANZCA and RANZCO regarding the work that they have undertaken based on the CanMEDS 2000 competencies is valid. Revisions to training and CPD programs require much time and effort and, as previously discussed, the CanMEDS 2000 document of the Royal College of Physicians and Surgeons of Canada (RCPSC) does provide a framework that can be used to underpin an educational program. Whether or not it represents the most suitable framework for the purpose of CPD programs for Australasian medical colleges is not straightforward to assess. The AMC Accreditation Standards require that an accredited training organisation has processes to determine the broad roles of practitioners in the discipline and that these roles are addressed by objectives of the training program. It gives the CanMeds 2000 and the six general competencies defined by the USA Accreditation Council for Graduate Medical Education, slightly modified for Australian conditions, as examples. Currently, the AMC, RCPSC and the ACGME are collaborating in the production of a document bringing together these various statements.

Overall, the formal written responses and other less formal responses that have been made by individuals at the college level lead to the conclusion that the framework as outlined would appear worthy of trial to ascertain its validity. This is not a simple process to pontificate on; however, formal and informal college input would seem to indicate that the framework is capable of absorbing current college CPD programs and acting as the basis of medical practitioner CPD. Whilst it is recognised that some aspects of the framework do not have a universal acceptance (most notably perhaps the three 'levels' of CPD activities), neither do the same aspects appear to have universal rejection.

Of interest was discussion generated by the proposal of the creation and introduction of the Continuing Certificate of Medical Professionalism (CCMP). Generally, colleges seem willing to consider such a universal system of CPD recognition. The crux of the matter appears to be agreement between the colleges on what constitutes an acceptable

standard (amount ?) of CPD to enable the certificate to be awarded. Given the possible advantages of such a certificate, there would appear to be scope for further exploration of this concept. The practicalities of implementation are not a matter for discussion in this document.

Overall, the nature of the responses (formal and informal) received from the colleges and individuals make a definitive evaluation of the suitability of the framework for all specialist medical colleges problematic. What the diversity of views does reinforce is the need for the framework to be flexible, and for it to cater to the needs of the users in terms of any statutory requirements under which they operate.

Assessment and Evaluation of CPD Activities and Programs

The prime issue to address when discussing evaluation in any field is that of the purpose of the evaluation. In the case of a CPD framework such as that which this project aims to develop, the purpose of CPD is reflected in the working definition proposed in the early part of this document.

The on-going maintenance, acquisition and development of knowledge, skills and attitudes to enable a medical practitioner to constantly improve as a practising professional.

The purpose of evaluating the framework is to determine the success or otherwise of the framework in achieving this. This logically entails evaluation of the individual components of CPD undertaken by individual participants.

As part of a review of the MOPS program conducted by The Royal Australasian College of Physicians (RACP), the issue of evaluation of CME is discussed through a review of key literature to the time.¹⁹⁴

Reference is made to the contribution to the field made by the evaluation paradigm outlined by Dixon in the late 1970s.

This provided the basis for the development and expansion of the evaluation process in continuing education in the health professions. Even today the Dixon paradigm continues to drive the evaluation process within Continuing Medical Education.¹⁹⁵

The Dixon paradigm describes four levels of evaluation against which both activities and programs can be evaluated.

1. Perception/opinion
2. Changes in knowledge, skills and attitudes, with the aim of assessing competencies within these areas
3. Impacts on practitioner performance and behaviour as a result of (2)
4. Impacts on health care outcomes relative to patient or health status

The methods used can be both quantitative and qualitative.

The RACP review also discusses other models of evaluation that are described as being “dominant in earlier decades and still have some relevance and reference within the literature today”.¹⁹⁶ in order to allow a description of “how the evaluation process has evolved over the years”.¹⁹⁷ These include Tyler’s paradigm,¹⁹⁸ Stake’s Countenance¹⁹⁹ and Responsive²⁰⁰ Models, and the models of Scriven²⁰¹ and Stufflebeam.²⁰²

¹⁹⁴ *Review of the Maintenance of Professional Standards Program*. The Royal Australasian College of Physicians, August, 1999.

¹⁹⁵ *ibid.*, p. 9.

¹⁹⁶ *ibid.*, p. 10.

¹⁹⁷ *ibid.*, p. 11.

¹⁹⁸ Tyler, RW. *Basic Principles of Curriculum and Instruction*. University of Chicago Press, 1950.

¹⁹⁹ Stake, RE. The Countenance of Educational Evaluation, *Teachers College Record* 1967; 68: 523 - 540.

The RACP document addresses other issues related to evaluation of CME programs; including the merits of internal and external evaluation, a description of the key aspects that need to be considered before an evaluation can be carried out, and issues related to outcomes of the evaluation.

The issue of evaluation in CME and CPD is addressed by Brigley, Littlejohns, Young and McEwen,²⁰³ whose work is referred to by the RACP review. They contrast the nature of CME with the then relatively new CPD and the educational rationales and ideologies of the two approaches to continuing education in medicine. In regard to the issue of evaluation, they write that:

... approaches to evaluation of CME ... will differ markedly in aims, methods and outcomes from approaches to the evaluation of ... CPD. This dichotomy in turn is underpinned by contrasting curricular ideologies which condition policy and practice in CME and CPD.²⁰⁴

Brigley et al discuss the nature of scientific and humanistic evaluation in relation to continuing education in medicine. In both cases “the main rationale for evaluation is to support educational change”;²⁰⁵ however the comparison is drawn between the somewhat rigid “before and after”²⁰⁶ nature of scientific evaluation and the process-orientated nature of humanistic evaluation that focuses on the learning experience itself. Consistent with the desire to empower individual learners according to their particular requirements and context, the humanistic model advocates “no predictable and universal frameworks for

²⁰⁰ Stake, RE. *Program Evaluation, Particularly Responsive Evaluation*. CIRCE: University of Illinois at Urbana, November 1975.

²⁰¹ Scriven, M. *Goal-Free Evaluation*. In House, ER. (ed.) *School Evaluation*, Berkeley, CA: McCutcheon, 1973.

²⁰² Stufflebeam, DL. *An Introduction to the PDK Book*. In Worthen, BR and Sanders, JR. *Educational Evaluation: Theory and Practice*, Worthington, OH: Charles A. Jones, 1973.

²⁰³ Brigley, S, Littlejohns, P, Young, Y and McEwen, J. Continuing medical education: the question of evaluation. *Medical Education* 1997; 31: 67 - 71.

²⁰⁴ *ibid.*, p. 68.

²⁰⁵ *id.*

²⁰⁶ *id.*

continuing education: its evaluation has to be related to the particularities of the learning context”.²⁰⁷ This is not to say, however, that scientific, quantitative methods should be abandoned in the conduct of the evaluation of continuing education activities or programs. Rather, the message that can be gleaned is that, given the complexities of the issues involved, in order to achieve a rigorous evaluation of a CPD program, a variety of methods may well need to be applied.

The issue of outcome measurement in the educational processes of individual clinicians is discussed by Grant in the context of the move to prominence of CPD in the UK.²⁰⁸ Grant cites the results of studies commissioned by the Chief Medical Officer in the UK as showing that effective CPD is “not characterised by time spent in an apparent educational activity”.²⁰⁹ Rather, writes Grant, “effectiveness is associated with a series of managed steps”,²¹⁰ including:

- Defining a reason or need for undertaking CPD that can be based on formal or informal needs assessment
- Linking the educational activity to that reason or need. The activity can take any format: there is no best learning method or approach
- Following up the activity to reinforce it and bring it into practice. This includes many types of outcome measurement

In the context of the then developing move to revalidation in the UK (which culminated in the *Good Medical Practice*-based process), Grant comments that “outcome measurement ... [in CPD] ... will be a crucial issue for revalidation”.²¹¹

²⁰⁷ *ibid.*, p. 69.

²⁰⁸ Grant, J. Measurement of Learning Outcomes in Continuing Professional Development. *Journal of Continuing Education in the Health Professions* Fall 1999; 19 (4); 214 - 221.

²⁰⁹ *ibid.*, pp. 214-215.

²¹⁰ *ibid.*, p. 215.

²¹¹ *id.*

In discussing issues that are related to outcome measurement in CPD, Grant notes that:

Experienced clinicians are likely to have highly individual educational needs. This individuality of experienced clinicians' educational needs is implicitly recognised by the recommended needs assessment process, which might yield specific needs or a general need to keep up to date and to communicate with colleagues in the speciality. Outcome measurement therefore must be tailored to the individual and to a range of learning needs of varying specificity. If outcome measures are required to be specific and objectified, this will both limit the types of learning undertaken and adversely affect the types of learning needs that are identified.²¹²

She further asserts that:

... outcome measurement in CPD is not the same as assessment of a student's learning achievement. Outcome measures must apply not only to what the doctor knows, thinks, or can do, but to the resultant clinical practice, effects on patients, and deployment of health service resources.²¹³

Grant acknowledges the complexity associated with attempting to measure outcomes from education interventions generally. Moreover, whilst she acknowledges that the "ultimate outcome"²¹⁴ for CPD must be improvement in patient care, she points to the difficulties involved in this, "because of the number of uncontrollable variables that intervene"²¹⁵ (between the CPD intervention and the outcome).

Hazell, Mowbray and Cole²¹⁶ offer the scheme illustrated in Figure 4 to conceptualise the possible impacts of a CPD program. Based on this scheme, evaluation can focus on:

- process – evaluation that provides information relating to practicalities and impressions; or

²¹² *ibid.*, p. 217.

²¹³ *ibid.*, p. 218.

²¹⁴ *ibid.*, p. 219.

²¹⁵ *ibid.*, p. 220.

²¹⁶ Hazell, T, Mowbray, G and Cole, A. *Keys to Successful Evaluation*. Presentation at workshop for Support Scheme for Rural Specialists. Sydney, 31 October 2003.

- outcomes – short-term changes in knowledge, attitudes or performance/skills, as well as longer-term changes that are integrated into practice.

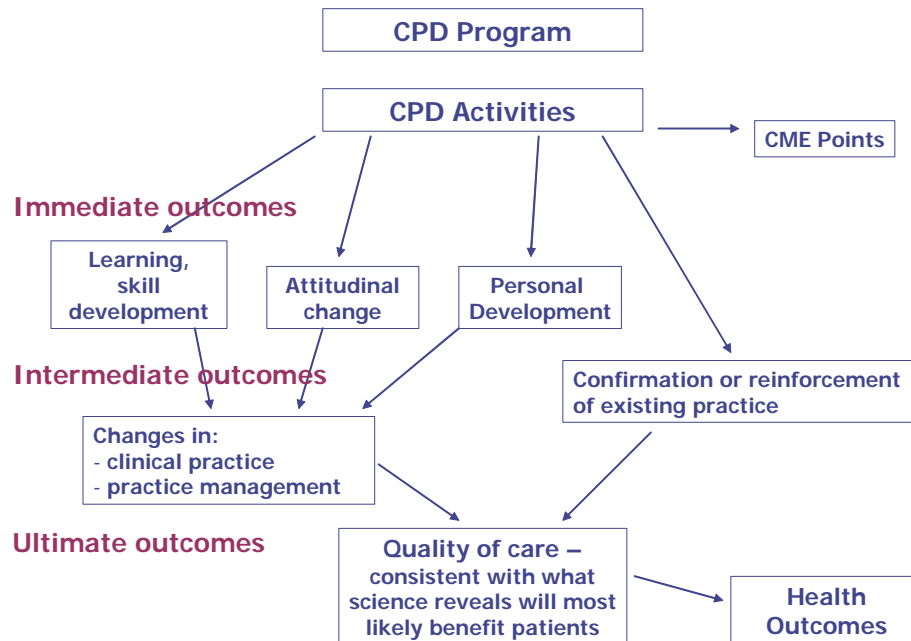


Figure 4 Scheme for conceptualising possible outcomes of a CPD program (From Hazell, Mowbray and Cole)

Hazell et al describe the factors that must be considered when planning an evaluation: budget, time, expertise, numbers of participants involved - and advocate conducting an evaluation in ‘SMART’ terms, i.e. an evaluation that is:

- Specific
- Measurable
- Achievable
- Realistic
- Time-framed

It is this approach that perhaps best describes that to be taken in evaluation of CPD programs based on this framework. The framework sees the maintenance and development of skills, knowledge and attitudes related to practice as a medical professional as the purpose of medical practitioner CPD. To that end, the ideal in terms of evaluation is the assessment of changes in practitioner behaviour and effects on patient

outcomes; i.e. evaluation at Levels 3 and 4 of the Dixon paradigm. The difficulties associated with this have already been discussed in terms of the assignment of causality; the time and expense associated with such measures in relation to what is possible in terms of college infrastructure and capacities are other factors that must be borne in mind. A range of methodologies that can be employed are discussed by Jordan in the context of continuing professional education (CPE) and CPD programs for health care professions in the UK.²¹⁷

Saidi and Weindling²¹⁸ provide an indication of the way in which such a process could be developed in the context of a recent evaluation of the CPD program of the Royal College of Paediatrics and Child Health (RCPCH) in the UK. Using focus group methodology, the following issues were explored in relation to the program in question.

- Ease or difficulty of achieving CPD requirements
- Whether a personal professional development plan enabled the planning process for CPD
- Whether CPD participation facilitated changes in practice.
- Participant views on the CPD system in operation at the time of the study

The study found that participants perceived CPD as having positive effects on their clinical practice, acknowledging, however, that self-evaluation is “subject to recall bias and it is not possible to validate the expressed views”.²¹⁹ Further, they write:

Further research in this area is needed to measure the effect of participation in CPD on health care outcomes and to investigate the extent of actual change in clinical practice that follows active

²¹⁷ Jordan, S. Educational input and patient outcomes: exploring the gap. *Journal of Advanced Nursing* 2000; 31(2): 461 - 471.

²¹⁸ Saidi, G and Weindling, M. An evaluation of a national scheme for continuing professional development (CPD) for career grade doctors: the Royal College of Paediatrics and Child Health’s programme for paediatricians evaluated by focus group methodology. *Medical Education* 2003; 37: 328 - 334.

²¹⁹ *ibid.*, p. 334.

participation in a CPD programme and the effects of such a programme's constituent parts, for example the PDP (professional development plan).²²⁰

Evaluation at the Levels 1 and 2 of the Dixon paradigm is readily conducted by Australasian medical colleges through summative assessments of the involvement and satisfaction of the Fellowship. Focus group interviews or surveys to measure participation and satisfaction are routine, and pre-and post-tests to measure changes in practitioner knowledge are not uncommon in relation to specific activities.

The trend toward QA activities in CPD can perhaps facilitate some evaluation of activities and, by extension, CPD programs at the higher levels. The conduit for such an evaluation could be via the audit process that is currently undertaken by a majority of colleges, primarily at the present time to assess compliance with program requirements. What would be required is an extension of the audit process to assess not just compliance, but also to enable reflection by individuals as to the effectiveness of the activities undertaken throughout a CPD cycle, as well as their learning plan for that cycle.

As already mentioned, there are logistic and resource implications associated with this. College infrastructure would have to be able to provide suitably skilled people to undertake interviews with Fellows selected for audit, as well as then be able to analyse the material obtained through interviews and other instruments. These considerations should not, however, deter colleges from attempting to progress in this area. Despite the difficulties involved, the ability to demonstrate positive effects from participation in CPD programs should be high on the agenda of colleges. As with the documentation and administration of programs discussed briefly in the next section, there are perhaps gains to be made in this area through collaboration between colleges.

²²⁰ *ibid.*, p. 333.

Administration of CPD Activities and Programs

Currently the administration of CPD programs in Australian specialist medical colleges is a matter for the individual colleges; this is, logically, how it should remain. The caveat to this is that, as with the situation relating to the evaluation of CPD programs, there may well be synergies available to groups of colleges through a pooling of resources in one way or another.

Most notably, colleges vary in the way in which they have embraced information technology in order to administer current CPD programs. It is not the intention of this document to advance such technology as the universal panacea for program administration. Indeed, initiatives in this area can be expensive and take time to implement properly in a reliable manner that does not defeat the intention of their use.

The above notwithstanding, however, it would seem appropriate that medical practitioners undertaking CPD based around the sort of framework proposed in this document be encouraged to develop their literacy and capacities in this area, and be supported in undertaking the requirements of such a program. The development of tools and systems that aid practitioners to develop and record learning plans, source learning activities, communicate with colleagues and then evaluate their CPD experiences would appear to be a desirable enabling step in this regard. Colleges should, then, be encouraged to develop such tools and systems, and program participants should be encouraged in their uptake of the same. Colleges who have not yet moved in this direction should be encouraged to take note of, and learn from, those who have developed experience and expertise.

A further area relating to CPD program administration in which colleges should be encouraged to consult is that of the approval or accreditation of activities and providers. An informal system currently exists whereby college CPD administrators meet twice a year to discuss issues related to CPD in medical colleges. With support to ensure the attendance of people who can have input into policy that can effect change at college

level, this forum should be able to address a range of matters relating to CPD in specialist medical colleges. There is much on the college CPD agenda where such a forum could go some way to encouraging dialogue and cooperation.

Summary

Continuing professional development (CPD) for medical practitioners is an area that is currently receiving much attention and is capable of stimulating spirited debate. This report has discussed some issues relating to the area, and has proposed the basis of a framework that may have utility in the specialist medical colleges.

The framework has proposed the application of the concept of *medical professionalism* as a theoretical platform to enable its use across medical specialties. Other platforms are acknowledged as potentially valid and this point in itself is one that could be the subject of much debate.

The framework advocates the use of a wide range of activities as being appropriate for use as CPD for medical practitioners and recognises the literature that does exist in the areas of the way in which doctors learn, as well as that which identifies the relative benefit of one type of activity over another. As well, the concepts of practitioners identifying learning needs at the start of a CPD cycle and evaluating the effects of their CPD at the end of a cycle are encouraged.

The framework attempts also to recognise the pressures under which medical practitioners work and to balance this with the desire to ensure, as far as is possible through the use of CPD alone, the quality of health care offered to consumers and the safety of practitioners.

The framework has attempted to recommend some guidelines along which the evaluation of CPD programs should be developed, and areas in which colleges could collaborate in order to reduce the variation in operation of programs from one college to another. As

such, however, it recognises that colleges are independent entities who are responsible for the operation of programs for their constituents. A common certificate that simplifies recognition of current satisfactory participation in a CPD program is advanced for consideration by the specialist medical colleges through a body such as the CPMC.

Appendix A: Project Reference Group Membership

Dr Jack Sparrow (Chair)	Committee of Presidents of medical Colleges
Ms Christine Ashley-Coe	Manager – Membership Programs, Royal College of Nursing, Australia
Dr Geoff Dobb	Intensive Care Specialist, Royal Perth Hospital
Associate Professor Jill Gordon	Associate Dean, Medical Education Head, Department of Medical Education, Faculty of Medicine, University of Sydney
Dr Debra Graves	Chief Executive Officer, The Royal College of Pathologists of Australasia
Ms Valerie Jenkins	Manager, Fellowship Services, The Royal Australian and New Zealand College of Gynaecologists
Dr Russel Jones	Director of Education, Australian and New Zealand College of Anaesthetists
Dr Eleanor Long	Chief Executive Officer, Director of Education, The Royal Australian and New Zealand College of Gynaecologists
Ms Sheryn Payne	National Professional Development and Risk Manager, United Medical Protection
Professor Peter Phelan	Emeritus Professor of Paediatrics, University of Melbourne Immediate Past Chairman, Australian Medical Council Specialist Education Accreditation Committee
Ms Beth Slatyer	Director, Specialist and Prevocational Workforce Section, Australian Department of Health and Ageing
Mr David Weeden	Health Workforce Branch, Australian Department of Health and Ageing
Dr Heather Wellington	Member, Australian Council for Safety and Quality in Health Care
Dr Peter White	Project Manager, Manager, Assessment Services, The Royal Australian and New Zealand College of Gynaecologists
Dr Andrew Wilson	Department of Medicine, St Vincent's Hospital, Melbourne

Appendix B: Organisations Invited to Submit Replies to Project Consultations

- Medical Board of Australian Capital Territory
- Medical Board of Northern Territory
- Medical Board of Queensland
- Medical Board of South Australia
- Medical Board of Western Australia
- Medical Council of Tasmania
- Medical Practitioners Board of Victoria
- New South Wales Medical Board
- Medical Indemnity Protection Society
- The Medical Defence Association of Victoria Limited
- Medical Defence Association of South Australia Limited
- MDA National
- NSW Health Care Complaints Commission
- Office of the Health Complaints Commissioner (Tas)
- Health and Community Services Complaints Commission (NT)
- Office of the Health Services Commissioner (Vic)
- Health Rights Commission (Qld)
- The Australian Capital Territory Community and Health Services Commissioner
- South Australian Ombudsman's Office
- Office of Health Review (WA)
- Australian Medical Workforce Advisory Committee
- Australian Nursing Federation
- National Nursing Organisations
- National Enrolled Nurse Association
- Health Issues Centre
- Consumers' Health Forum of Australia
- Australian Consumers' Association
- Rural Doctors Association of Australia
- Royal College of Nursing Australia
- Mayne Health

Appendix C: Consultation Forum Survey

On behalf of the Committee of Presidents of Medical Colleges (CPMC), the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is currently conducting a project to develop a framework for Continuing Professional Development (CPD) of medical specialists that will be applicable to a wide range of specialties and will account for the diverse roles that medical experts undertake.

Funded by The Commonwealth Department of Health and Ageing (DHA), the Project is designed to encourage worthwhile CPD programs in all medical colleges through the development of a framework that can be considered 'best practice' based on the evidence available during the life of the project.

As part of the Project, information is sought from practising specialists and trainees regarding their views on priority areas of CPD for medical specialists, and the activities and modes of learning that best develop and maintain their skills. Your assistance in contributing to this through the completion of this questionnaire is greatly appreciated.

PLEASE REPLY TO THE FOLLOWING QUESTIONS BY TICKING ALL RELEVANT BOXES OR COMMENTING AS DESIRED.

1. Are you a practising specialist or a trainee?

Practising specialist

Trainee

What is your area of specialist practice / College Affiliation(s)

2. What areas of continuing professional development do you consider to be priorities for medical specialists?

Clinical and diagnostic developments in the relevant specialty

Education and teaching

Applications of technology to clinical practice

Professional ethics

Patient – specialist relationships

Communication skills

Professional relationships

Practice management (including the use of relevant technology)

Advocacy and equity in healthcare

Time and lifestyle management

Medico-legal matters

Other (please outline)

PLEASE TURN OVER

Appendix C: Consultation Forum Survey

3. What activities and methods of learning do you find most effective for developing and/or maintaining the knowledge and skills required for your professional practice?

Lectures	<input type="checkbox"/>	Peer review activities	<input type="checkbox"/>
Workshop demonstrations	<input type="checkbox"/>	Clinical audit activities	<input type="checkbox"/>
Interactive (hands-on) workshops/simulations	<input type="checkbox"/>	Journal reading	<input type="checkbox"/>
Journal clubs	<input type="checkbox"/>	Participation in College examinations	<input type="checkbox"/>
On-line forums	<input type="checkbox"/>	Trainee supervision	<input type="checkbox"/>
Research	<input type="checkbox"/>		
Other (please outline)			

4. Please make any other comments that you feel are relevant to CPD for medical specialists, either as it currently operates, how you feel it should operate, or regarding the framework outlined to you tonight.

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS
QUESTIONNAIRE**