



Continuing Professional Development in Primary Health Care

Quality Development integrated with Continuing Medical Education

Policy Document of EQUIP and EURACT

1. Purpose

Continuing Medical Education (CME) and Quality Development (QD) have the same ultimate objective: to provide optimal care for patients. CME and QD can support and strengthen each other in the process of improving care.

This policy document, prepared by both EURACT and EQUIP seeks to inform and support national/local authorities and national colleges in their efforts to improve their CPD activities.

The basic aim of this document is to give recommendations on the characteristics and conditions needed for effective integration of CME and elements of QD.

The document will formulate recommendations. It will not describe the different methods of CPD, but focuses on the place of QD initiatives in the newer definition of CPD.

2. Summary of recommendations

Basic principles.

- Patient and community priorities concerning health care should be central.
- Continuing professional development should be based on the learners daily work practices.
- Goals should be set by the GP and/or the practice.
- Integration of CME and QD is a continuing process.

Creating a new model for CPD.

- CPD should be planned and individually tailored.
- A needs assessment should be undertaken.
- Educational sessions should involve information on the philosophy and techniques of Quality Development.
- Active adult learning methods should be employed.
- Data should be collected to analyse performance.
- Start with simple and effective procedures.
- Integrate methods that use evidence based guidelines.
- Include practice enabling and reinforcing strategies.
- Organise discussion on barriers to change.
- Organise evaluation of the outcome of CME programmes.

Implementing the new model of CPD.

- Financial incentives must be available.
- Integrate both CME and QD in accreditation procedures.
- CME and QD organisers must work together.
- In QD procedures the need for CME should be defined and linked to the existing CME network.
- The organisation of peer review groups should be promoted.
- QD skills and the management of lifelong learning should be included in both undergraduate and GP specialist training programmes.
- National research centres should work together in an international network evaluating the methods and results of modern CPD.

3. Background

Contextual changes.

The medical scenery is constantly changing necessitating new concepts, strategies and options concerning services, education and quality. Science and knowledge, especially medical knowledge, change rapidly, leading to a limited lifetime for a "diploma". In every country governmental policies result in changes from "medicine by status" to "medicine by contract".

Modern high technology care, changes in demography, morbidity and social needs, growing expectations of patients, the demand of a humanistic approach and many other issues are going to impact on education and quality as well as on expectations of the medical profession. As doctors' change to part-time work, electronic communication develops further and free movement among countries becomes the norm further changes will take place. The pharmaceutical industry is also changing its marketing strategies with increasing use of scientific evidence to support its products.

Authorities stress the importance of basic knowledge and skills in the field of quality management for professionals in health care. Data should be collected and produced at local, regional and national levels in order to underpin assessment and decisions concerning policy and development.

Continuing medical education and quality development.

Until now, most formal Continuing Medical Education (CME) programmes have been offered as separate entities. Formal CME programmes have traditionally emphasised teaching rather than learning. Several quality improvement activities have also been developed, and are also mainly organised as separate activities. Quality development encompasses a larger area focusing on detection and analysis of practice performance and on the planning/implementation of improvement.

The emerging requirements of health care systems focusing on outcome and cost-efficiency combined with the new learning paradigms, focusing on knowledge, competence and performance, set the scene for Continuing Professional Development Planning. This involves integrating the more traditional options for CME and QD.

Professional development, continuously striving to enhance the competence necessary to meet the needs of patients and societies served, is a legal and ethical obligation. General practice should be open to evaluation. Quality assessment and development are essential, irrespective of the employment status of family physicians. CME can be an important instrument in Quality Assurance (WHO, 1998).

QD is a rapidly evolving discipline using specific methods and instruments. There is a need for education in QD methods and evaluation of the quality of current CME.

4. Motivation

Recent large-scale review work demonstrates that didactic CME lectures don't lead to changes in performance. Broadly defined interventions using practice-enabling or reinforcing strategies are needed. These strategies consistently improve physician performance and in some instances, health care outcomes. Inspiring new approaches to continuing medical education focus on active learning emphasising needs' assessment and learners' experiences.

"What are the characteristics of effective integration between CME and Quality Development initiatives?"

"Which actions support implementation of integrated interventions between CME and Quality Development?"

We asked these two questions to experts in 6 European countries.

This document reflects their opinion and the discussion in both EURACT and EQuIP.

You may find also several examples on the different issues mentioned in this document.

5. Basic principles

Patient and community priorities concerning health care should be central.

CPD initiatives can start from health problems detected by individual patients or by the community. Patient evaluation programmes may reveal quality problems. Guidelines can include patient perceptions. Patient empowerment can lead to improvement of care. (Example 1)

Example 1: Switzerland: Quali Doc: Learning from patients' experiences

Method: A step-by-step process is used to build up a model encompassing 4 dimensions: (1) patients' experiences with care and cure, (2) staff satisfaction including self-assessment and burnout signs, (3) clinical outcomes, and (4) financial performance. To underpin continuous improvement "Quali Doc" measures an organisations' current performance with a standardised European EuroPEP instrument against self-perceived performance and against a model, which represents a position of 'excellence'.

Results: The first two dimensions have been developed. Results are deployed as performance profiles monitored over time in comparison with standardised benchmarks of a reference group of providers that can be chosen accordingly. Standardised "outreach visits" to the evaluated practices by trained peers were introduced for feedback of data, allowing weighting of results, setting priorities and implementing change. The "Quali Doc" methodology enables providers learning and measuring from each patient using the information gleaned to test improvements.

Continuing professional development should be based on the learners daily work practices.

The use of learners experience is a powerful tool. Experience can be used in an intuitive way using case discussions, or in a more formal way by using data from medical records e.g. in discussions on prescription behaviour.

Goals should be set by the GP and/or the practice.

Planning professional development can start from perceived needs in individual practices; the goals are set by the physician or the practice team setting up a personal or practice professional development plan. All members of the Primary Health Care team should work together. QD offers various methods to detect, define and analyse these needs.

Integration of CME and QD is a continuing process.

CME and QD have common aims and require full integration in a continuing process rather than a series of sporadic projects. In order to be an effective tool for change, this process should be a routine part of clinical practice, ideally instilling lasting professional pride and drive toward improvement in each participant in the endeavour.

6. Creating a new model for CPD

CPD should be planned and individually tailored.

Personal development plans and portfolio learning help the individual professional to plan CPD.

A personal development plan is based on the results of an appraisal meeting (interview), which covers the areas most suitable for further professional development. The process covers the personal needs of the doctor and the needs of the service. The Personal Development Plan (PDP) must be a comprehensive document that records the outcome of the appraisal. The PDP describes the proposed CPD activities, how needs were identified, how CPD will be reinforced or disseminated and how effectiveness will be shown.

A learning portfolio is a comprehensive record of learning events, along with evidence of outcomes. It may contain logbooks, practice research and proposals, clinical data, "jottings" (ideas, thoughts, insights, challenges) and a reflective commentary in which the individual identifies what has been learned. The portfolio provides a way of assessing professional development.

A needs assessment should be undertaken.

There are different ways to define CPD needs. One of the key challenges health professionals face is establishing whether or not their current practice is up to date. Sackett and colleagues (*Clinical epidemiology: a basic science for clinical medicine*, 1985) refer to this as "the key to continued effectiveness as a clinician". Needs assessment techniques can be subjective (perceived needs) and/or objective (reflective needs). Several tools exist to help combine reflective or subjective needs assessment methods with use of objective methods, such as measures of competence, performance (for example, external audits), patient management problems, and health outcomes. Review or audit of medical records is a useful method of determining the extent to which our current practice is consistent with evidence-based principles.

Professionals need to be educated and motivated to start manageable procedures defining these needs.

Educational sessions should involve information on the philosophy and techniques of Quality Development.

Planning long-term integration of the newer quality techniques into CPD, basic knowledge about the philosophy, methods and techniques of QD is essential

Example 2: Germany: training program for moderators of peer review groups

Method: in two-day courses general practitioners are trained to lead small group work. Techniques of problem finding, communication in groups and conflict resolution are presented. In addition the participants learn to document and evaluate quality of care with documentation sheets and videotapes. Training materials and a handbook of instruction (in German) have been developed.

Results: crossing the borders of medical speciality, presently about 1,100 physicians in ambulatory care have been trained (and ca. 1,500 other physicians by other providers). An estimated 2,500 quality circles (= peer review groups) in different medical specialities have been established in Germany. Experiences and evaluations show that training in communication skills and techniques of quality improvement is of particular importance for general practitioners to tackle problems of quality in daily care.

Active adult learning methods should be employed.

It is not teaching but learning that leads doctors to change their practice. This paradigm shift has led to a situation where education is now viewed more as facilitation of learning rather than as instruction. From now on, CME programmes should be based on the principles of adult learning: facilitation of learning, using methods of active, self-directed and experiential learning. According to Knowles, adult learning is driven by the need to know (purposive behaviour), the learners self concept (self direction), the learners' experience (what they bring to learning), a readiness to learn (developmental appropriateness), an orientation to learning (task-centred or problem-based learning), and by motivation. Learning occurs most effectively when it takes place in the context of solving a problem, or finding a solution to a situation, that is of immediate relevance to the needs and interest of the learner. The acquisition of new knowledge is associated with activation of prior knowledge learned and is also based on active construction of new knowledge. These basic facts should be kept in mind when organising CME activities to get better results in the form of desired performance.

Example 3: The Netherlands: The GP peer group: A good method to learn palliative care.

Method: The design of the project originated from preconditions for effective learning. Core of the project is that general practitioners consult each other in a one-to-one situation following a strictly controlled procedure. This takes place during the peer group meeting. The project takes two years. Each year consists of a cursory part of 2x two days and seven meetings of two hours where peer groups of general practitioners come together. A peer group consists of people with the same education and experience who can support each other from this common background. Each peer group is joined by an expert in palliative care. Each peer group consists of five or six general practitioners. Once every six to eight weeks the members of the peer group meet. During the meeting one of the participants introduces a palliative patient from his practice who induced a particular question. In this way, each member of the peer group comes in contact with more patients than a sole practice would provide. Facilitated reflective learning: In facilitated reflective learning the general practitioners consult one another in a one-to-one situation. Initially the consultation takes place in the peer group between two participants; the GP-questioner and the GP-

consultant. This differs from the conditions in supervision where an expert is the group leader and the participants contribute in an equal way. The task of the GP-consultant is to clarify the question and the problem of the questioner and to facilitate introspection. The questioner prepares the meeting to such an extent that he can line out the case history and formulate a concrete question. The other participants of the peer group have the role of chairperson or observer. This strictly structured working procedure enables deepening of the issue. The general practitioner with a question receives various perspectives on the problem which enables him to proceed with his patient. If this is not the case, the other participants can be consulted for additional advice and suggestions. Finally the expert in palliative care can answer remaining questions. The expert in palliative care: An expert in palliative care participates in the peer group to ensure that consultation will become a self-evident part of the process.

Results: The benefits of the project are rated highly. 83% of the participants experience a large increase or even a very large increase in knowledge and 75% are certain that the satisfaction in palliative care has risen to the same extent. Two thirds say that partaking in the project has also had a positive impact on them as a person. The design of the project is appreciated largely among almost all participants. Elements that were also appreciated with percentage ranging from 76% to 85% included learning through repetition, to apply knowledge and skills in 'real situations' in the peer group, to consider topics from all angles, and to integrate various aspects of care. The participants hold the view that facilitated reflective learning has had a positive impact on the functioning as peer group and on the depth of the learning process. 92% feels that the project is worth the time investment, whereas 90% will continue to work in the peer group after the ending of the project. Noticeable changes were mostly a greater feeling of certainty, of feeling at ease with the situation and confidence due to the increase in expertise. Improved communication skills give room to listening and discussing the problems. A number of respondents mentioned that this resulted in a postponement of the request for euthanasia or even an abandonment.

Data should be collected to analyse performance.

Data collection tends to be the most time-consuming part, but it is essential. To evaluate how well we are doing, it's usually good to compare our own results with somebody else's data. The outcome of this action can set the goals for CME programmes.

Some methods of evaluating results are shown in the EQuIP handbook on "Tools and methods for QI in General Practice". One example: Quality circles in primary care (experiences from Germany and Switzerland): Some of the data sources used are case reports, chart review, computer records, documentation sheets and video analysis.

The analysis of figures and data is of paramount importance. Methods of data analysis and process analysis may help GPs in choosing the right decisions or actions to improve.

Good examples for analysing data are: structured brainstorming technique; nominal group technique, cause-effect analysis by Ishikawa, flow charts, etc.

Example 4: Finland: ROHTO: Changing prescription practices by training

In Finland, in the 1990' two consecutive national working groups recommended to set up a training programme on rational prescribing. The wide-ranging ROHTO programme (1998-2001) was supported by all medical associations and by national authorities. It had an aim to steer physicians' prescription patterns in a more rational direction. The main target group, general practitioners were encouraged to review critically their own prescription practices. Main tools in this encouragement were teamwork and information activities. Statistical data of treatment practices were available. The small group work was carried out in local teams led by regional contact persons trained for this task according to active learning methods. In addition, prescribing issues were discussed in medical journals, current guidelines were evaluated, conferences concerning rational prescribing organised and even parts of undergraduate medical education reorganised.

An external evaluation was organised concerning the project, but the practical results i.e. the change in the prescription patterns has not yet been studied sufficiently. The aim and the goal of the programme have been widely accepted and the programme had a positive image among all physicians and actors. The activities were visible and widely known in the country. The participants in the small-groups were satisfied and the self-steering of the teams increased the commitment and the attitudes were moulded. The evaluation group recommended to continue the activities and link ROHTO programme to the regional training organisations. Learning and performance change would benefit optimally from individual feedback and dealing with participants' own practices.

Start with simple and effective procedures.

Clinical incident analysis, audit on prescription patterns, care for specific patient groups and evaluation of organisational aspects of practice care are usually good starting points.

Integrate methods that use evidence based guidelines.

Developing, distributing and implementing useful guidelines pose a major challenge for family doctors and their organisations. Simple dissemination of paper guidelines do not guarantee change in practice. Combined methods using academic detailing, personal feedback and opinion leaders' messages based on key messages of these guidelines have greater chance to achieve success. In the Netherlands guidelines are combined with CME-packages for implementation.

The national CME tutor network in Ireland provides training of key persons to facilitate small groups in performing various Quality Development methods. (Example 5).

Example 5: Ireland: CME-groups with an emphasis on quality improvement

Method: CME in small groups involved in peer review, guideline implementation and audit. Groups are led by CME Tutors. These Tutors are local GPs who have been trained as group leaders and educators. Tutors are paid the equivalent of two sessions per week to allow them protected time for their activities.

Results: There are 120 small groups distributed throughout the country with an average of 10 members meeting at a local venue on a monthly basis. CME groups are promoted by the ICGP and at local level by individual CME tutors. The ICGP has produced a manual on small group facilitation and organisation. CME tutors attend three residential educational workshops per year to maintain and improve their skills. 90% of Irish General Practitioners are members of the ICGP, and 60% attend CME small groups on a regular basis. Improvement in skills and knowledge e.g. treatment protocols agreed. Supportive environment conducive to mutual support. Inter-referral between GPs encouraged e.g. Minor Surgery, Family Planning. CME tutors have an official ICGP visit every three years to evaluate all aspects of their work. A qualitative study addressing the issue "Does small group CME make a difference" has just been completed. Preliminary results suggest that participants have made changes in their clinical practice as a result of CME.

Include practice enabling and reinforcing strategies.

Figures about performance data on the subject of CME and reinforcing strategies may have considerable impact on implementation of guidelines. Well-structured feedback techniques may improve the quality of certain clinical procedures (cervical smears, laboratory requests).

Example 6: The Netherlands: Effect of routine individual feedback, over nine years general practitioners requests for tests.

Methods: The Diagnostic Coordinating Centre Maastricht has provided feedback continuously since 1985, resulting in a more rational use of tests and fewer requests. They report the effects of nine years of feedback. They also investigated its effects on requests for tests that were not advised but had a recommended alternative. Written feedback is given twice a year, with comments on inappropriate requests and suggestions for more rational testing. Rationality can be assessed because forms contain clinical data on patients.

Results: Annual data were analysed for each test and each doctor from 1983 to 1993. The effects of feedback are assessed by comparing trends in the number of requests for 44 common tests in our region and a control region. From 1984 to 1993 the mean annual decrease in the number of requests in the Maastricht region was 3.5%, leading to a total decrease of 29% from 1984 values in 1993. A transient increase occurred in 1989. Requests for individual tests decreased by up to 98%. The number of requests for the 44 common tests decreased by 45% between 1984 and 1993 (mean annual decrease 6%) in the Maastricht region, but it increased continuously in the control region (mean annual increase 3.2%) ($P < 0.001$, Mann-Whitney U test). If the trend in the Maastricht region had been the same as that in the control region the number of requests in 1993 would have been about double.

Organise discussion on barriers to change.

A discussion on barriers to change can reveal potential difficulties for implementing optimal care and facilitate acceptance of proposed change.

Potential barriers to effective practice can include:

- **structural** (e.g. financial disincentives, limitation of time)
- **organisational** (e.g. health care environment: health policies which promote ineffective or unproven activities)
- **individual** (e.g. knowledge, attitude, skills)
- **influence of opinion leaders or peer groups** (e.g. local standards are not in line with desired practice)
- **patient factors** (e.g. demands for care, perceptions/cultural beliefs about appropriate care).

Organise evaluation of the outcome of CME programmes.

There are many reviews of the effectiveness of CME. Davis et al (1995) concluded that short (1 day or less) CME events usually bring about little change. Wensing et al. (1998) confirm the effectiveness of multi-faceted interventions. Davis et al. (1994) conclude their review of the effectiveness of CME interventions by emphasizing the intensity and complexity of interventions with positive outcomes and the multi-faceted nature of the change process.

Evaluation procedures should include both the process of CPD and the outcome on practice level. Performance indicators are now constructed in a reliable way, and can be used to measure the process and outcome of clinical care. (Example 7)

Example 7: The UK: Quality indicators for general practice

Method: A reliable set of indicators for all the major clinical areas has been developed in the UK. A step-by-step procedure reviewing literature and appraisal by expert panels in a two-round data analysis.

Results: Quality indicators have been defined in 19 major clinical areas. The indicators allow comparisons between practices over time or against gold standards. They facilitate an objective evaluation of a quality improvement initiative.

Audit can play a paramount role in the evaluation of peer review group work.

Where practices are actively involved in audit, it seems logical to address gaps in practice by linking education programmes to clinical audit. An example of a programme, which has made such links, is the Australian QA and CME Programme (PITERMAN 1995); learning is evaluated by repeating the audit to see whether actual performance has changed. (Example 8)

Example 8: Australia: Clinical audit--linking continuing medical education (CME) and practice assessment (PA).

Method: The Quality Assurance (QA) Program of the Royal Australian College Of General Practitioners has required doctors to engage in practice assessment (PA) activities. Clinical audit is one of these activities and has been used as an assessment tool in the Graduate Diploma in Family Medicine at Monash University, in impact evaluation of educational programs as well as a means of pooling morbidity data for research purposes and peer review.

Results: Doctors participating in these audit activities have almost invariably described them as a valuable reflective educational exercise with changes in clinical practice occurring after the audit in a number of instances.

7. Implementing the new model for CPD

Financial incentives must be available.

Resources are needed to implement an effective system for CPD.

Integrate both CME and QD in accreditation procedures.

Accreditation procedures should integrate both CME and QD initiatives. Attendance at CME courses and attainment of specific goals in QD should be included. Therefore CPD time should be used for both QD programmes and CME.

A flexible system of accreditation is needed, covering re-certification (competency evaluation) and both practice and doctors accreditation (performance evaluation). The system should be designed to accommodate the diversity of adult learning with emphasis on the doctor as a self-directed learner.

A system of accreditation has to be supportive, transparent and overseen by national authorities, professional organisations and scientific organisations. Transparency encourages public trust. CPD should be constantly evaluated, prioritised and guided at a national level in terms of efficiency, potentiality, acceptability, etc.

Any point system using credits has to include the broad range of CPD interventions. Thus the organisers of CME/CPD can focus on real learning needs and how these can be met.

The legal consequences of various systems of mandatory re-certification for all specialists need clarification before introducing new systems.

Example 9: The Royal College of General Practitioners (UK): The Accredited Professional Development Programme

Concept: the programme is a flexible framework by which GPs can target their continuing professional development at striving to be the "excellent" GP described in Good Medical Practice for General Practitioners. The programme helps GPs to organise information and evidence collected over a five-year period for their annual appraisals and revalidation. A facilitator may support this process. The programme incorporates one continuous keeping up to date module and 5 rotating modules over a five-year cycle. GPs choose when and how often they study each module but they must all be undertaken once every five years. The other modules are: communication skills; medical record keeping; access and teamwork; referrals and prescribing; complaints and removals. The programme is adapted to any primary care setting in the world.

CME and QD Initiatives organisers must work together.

Colleges, universities, local authorities etc. involved in the organisation of CME meetings and those who organise Quality projects must combine their efforts in organising effective integration of Quality initiatives in CPD. The organisation of effective integrated interventions on this level has to be stimulated by knowledge and stepped planning. The establishment of a clinical task force with numerous areas of competence to produce theoretical, practical and situational knowledge is one way of achieving this.

Doctors themselves have to take the lead, using methodological guidance provided by experts.

Example 10: Israel: Diabetic care and quality assurance: Diabetes in the Community

History Starting in 1996 Clalit Health Services, Israeli largest HMO with 3,600,000 members started a quality assurance program for improving the care of diabetes patients in primary care clinics. One of the implementation methods was CME sessions in small, interdisciplinary groups of physicians and nurses. The CME was focused on changing attitudes, improving knowledge and teaching new skills in diabetes care. Working in small groups improved the communication between the members of primary care team and influenced positively the daily care of diabetes patients.

Method: The program "Diabetes in the Community" uses multifaceted interventions:

1. Structural such as:
 - interdisciplinary steering team of the program
 - opening various tests to primary care
 - improving dietician services.
2. Encouraging team work and shared care:
 - interdisciplinary steering team of the program
 - Establishing a clinical interdisciplinary pathway for care of diabetes patients in the community
 - encouraging shared care of primary care providers by shared electronically follow up sheet
3. QA methods as:
 - establishing guidelines based on international recommendations and tailored to the Israeli circumstances
 - Guidelines dissemination
 - Establishment of indicators of care in diabetes care
 - Follow up and feedback on performance to the primary care providers on continuous base
 - yearly feedback on performance to the districts
4. Partnership with the patients:
 - patients' empowerment
 - patients education changing the attitudes of the society towards diabetes patients (Arabic population)

In Quality Development procedures the need for CME should be defined and linked to the existing CME network.

Definitions of QD initiatives should include precise needs for CME and vice versa. Audit programmes could be used to define the educational needs for a CME programme. The APO audit method defines a clear place for CME, tailored and intensive (Example 11).

Example 11: Denmark: the APO method:

Method: The Audit (A) Project (P) Odense (O) methodology combines prospective data collection with peer review group discussion and presentation and discussion of guidelines in CME sessions. Evaluation and registration of changes. The APO method is an integrated quality development method, which follows the audit cycle, suitable for elucidating frequently occurring topics encountered by staff in the primary health care sector. An audit according to the APO method includes:

- 1) Prospective registration on a specially developed chart suitable for collection of data to study own practice.
- 2) Follow-up activities including analysis of the registration result, identification of quality problems and subsequent training courses with a view to quality improvement.
- 3) Final registration and evaluation 1-2 years after the first registration in order to see whether the project target has been achieved. As familiarity with the method increased, it was further developed to enhance the power to implement change. Tailored intensive CME activity has been integrated, and on a further stage APO registrations are combined with other data sources like administrative registers. Patient views will be considered via a questionnaire.

Results: The Project is well consolidated in Denmark and is now a resource centre for quality development and postgraduate training in general practice, and also relevant for other personnel groups in the primary health care sector. APO develops and carries out quality development projects, carries out research in quality development methods, and other research based on audit projects. In addition, APO has been involved in the development and implementation of clinical guidelines. Audit work is widespread in all counties in Denmark through a network of specially trained audit supervisors. Similarly, independent audit projects have been established in all the Nordic countries. APO has every year carried out an audit on diagnosis and treatment of infections, in several projects been able to demonstrate a significant reduction in the number of antibiotic prescriptions and a significant change in prescribing pattern towards more small-spectrum antibiotics. In addition, APO has carried out audits on allergy, which has resulted in the issue of national guidelines on the topic, audits on musculoskeletal diseases, where quality problems with regard to X-ray diagnostics and the use of NSAID have been demonstrated. In the last couple of years the APO method has been used at the implementation of the clinical guidelines on prevention of ischaemic heart disease of the Danish College of General Practitioners. More than 2/3 of all Danish general practitioners have once or several times participated in an audit project. APO method is developing in the direction of combining self-registration with a multi-faceted intervention strategy designed to provide the best possibilities of change.

The organisation of peer review groups should be promoted.

The organisation of peer review groups should be promoted as a useful structure as long as it is organised as a secure and open environment for adult learning. Small- group work offers the opportunity for interactive education in a trusting environment. Establishing a peer review network would facilitate these actions. A tutor-training program enhances the facilities of the individual groups.

Example 12: Norway: Peer group learning based on performance data improves practice

Method: Between 1995 and 1998 the Norwegian Medical Association carried out a project to develop and to assess a quality improvement tool for use in general practice (SATS). This method combines self-directed learning, documentation of practice and peer group support. SATS defined performance indicators for registration of practice by means of the computerised patient record. Groups of 4-10 general practitioners used their own consultation data as a basis for learning cycles. The participants saw the possibility to compare their own practice with that of others as a good source of learning. The group discussions gave support and constructive criticism, which are both important to the learning process. The participants discussed what they were actually doing with patients, not what they assumed that they did. The strength of the method seems to be that it is linked to own data, woven into the clinical everyday work, discussed with colleagues and is relatively simple to use. The participants provide the data themselves, independent of external support. This gives flexibility. The method presupposes full openness about data inside the group, but gives protection against the observation from outside. It is seen as crucial that the participants "own" their data and that they remain confident that the aim is professional development, not external control.

Results: The practice evaluations indicate significant improvement in clinical work. The confrontation with own-recorded practice in a supportive peer environment is found to be a major force for change. The participants reported satisfaction with the method, and expressed an interest in trying out new topics. However, the project demonstrated the need for simplification of terminology, further development of group process methods and computer software. There is furthermore a need for strong local support of peer review groups.

QD skills and the management of lifelong learning should be included in both undergraduate and GP specialist training programmes.

Skills to attain optimal CPD planning should be acquired in undergraduate teaching and during vocational training. A positive attitude towards lifelong learning, evidence- based practice, and the undergraduate and vocational training curriculum should encourage cost-effective outcome orientation.

National research centres should work together in an international network evaluating the methods and results of modern CPD.

Establishing national research centres for CPD, working together in an international network, should support research on effective CPD. The results and outcomes of CPD should be recorded and analysed.

The focus of the Cochrane Effective Practice and Organisation of Care Group (EPOC, www.abdn.ac.uk/hsru/epoc/) is on reviews of interventions designed to improve professional practice and the delivery of effective health services, including various forms of CME, QD, informatics and financial, organisational and regulatory interventions that can affect the ability of health care professionals to deliver services more effectively or efficiently.

CME and QD are the most important aspects of continuing professional development of physicians, but they can not exist in isolation. Physicians must be facilitated to partake in CPD through supportive structures in their health care systems, open discussion forums, access to professional and scientific organisations, active involvement in different stages of GP education and research and finally through international cooperation.

8. Terminology

CME : “any and all ways by which physicians learn and change in practice”.

Quality development : “a continuing process of planned activities based on performance review and setting of explicit targets for good clinical practice with the aim of improving the actual quality of patient care.”

Continuing professional development : “ a process of lifelong learning in practice. CPDs endpoint should be the quality of care. CPD must help to improve the quality of care, must try to demonstrate its effectiveness and must become a properly managed activity by both the physician and the profession.”

9. Literature

Literature search

Method:

- Medline selection 1996-2000, key words: Education, -Medical, -Continuing AND Quality of Health Care; only review articles were selected.
- Cochrane Library search (12/11/99)

Selected articles

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Interviews

Semi structured interviews were conducted in Belgium with Peter Dieleman and Piet Vanden Bussche; in Norway with Tor Carlsen and Dag Hofoss; in Israel with Prof Hava Tabenkin and Dr Samuel Reis; in the Chec Republic with Vaclav Benes and Bohumil Seiffert; in The Netherlands with Harry Geboers; in Ireland with Michael Boland and Henry Finnegan and in Italy with Prof Vettore and Dr Gadaleta.

Prepared for EURACT and EQuIP 2002

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Table of contents

Purpose	p 1
Summary of recommendations	p 2
Background	p 3
Motivation	p 4
Basic principles	p 5
Creating a new model for CPD	p 7
Implementing the new model of CPD	p 14
Terminology	p 19
Literature	p 19

(Footnotes)

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