UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES

SECTION OF PSYCHIATRY

Due to the cancellation of the April 2020 Section Meeitng, this report is awating formal Section appriovaI but has been recived and acknowlesged by the Section's delegates.

Continuing Medical Education (C.M.E.) and Continuous Professional Development (C.P.D.)

The UEMS is a non-governmental organization representing the national associations of medical specialists at the European level. It promotes the free movement of medical specialists across Europe whilst ensuring maintenance of the highest level of training in order to promote and improve quality of care for the benefit of all European citizens. Particular areas of expertise include Post Graduate Training, Continuing Medical Education and Quality Assurance.
The Section of Psychiatry represents the specialty of Psychiatry and promotes the highest standard of care for those with Mental Health Problems. It conducts its work by:

- Setting standards for education and learning at all stages
- Contributing to the harmonization of standards across Europe
- Producing guidance on matters of training and service delivery
- Assisting with monitoring and assessment of standards when invited to do so
- Collaboration with relevant organisations

Context – The Working Group on CME/CPD (Continuous Medical Education/Continuous Professional Development

The objective of the Working Group is to review relevant documents and developments in relation to CME/CPD in order to assist the Section in the setting of standards for education and learning at all stages, which includes the lifelong learning required by the profession, and contributing to harmonization across member states. To specifically inform the Section on the current position in relation to CME/CPD in psychiatry, each member state was asked to provide information in relation to the requirements, content and governance of their CME/CPD programmes at this time. The table illustrating the responses received forms part of this review.
This document therefore updates the position of the U.E.M.S. Psychiatric Section which was initially expressed in a paper on "Continuing Medical Education" which was approved at the Lisbon Meeting in 1998 and revised at the Berlin Meeting in 2003. A number of documents have also been produced by the U.E.M.S. in relation to CME/CPD and the Psychiatry Section feels it necessary and important to make further comment and to elaborate in recognition of the specific requirements of psychiatry and the

expectations expressed in Chapter 6 of the UEMS Charter on CME (Approved in 1994). These include the role of the Sections regarding the provision of advice and stimulation of CME at a European level. It is expected they will include:

- Structure, professional input, availability
- Setting of standards
- Assessment and accreditation
- Quality Assurance
- Safeguarding and financial independence
- Coordination of programmes.

Relevant Documents

The following in particular have been considered in conjunction with recent presentations and research:

- UEMS Charter on CME 1994
- UEMS Charter on Quality Assurance in Specialist Practice in the EU 1996
- UEMS Psychiatry Section Report on CME Lisbon1998
- UEMS Charter on CPD - the Basel Declaration 2001
- UEMS Psychiatry Section Update Report on CME Berlin 2003
- UEMS Budapest Declaration 2006 - Ensuring the Quality of Medical care
- UEMS Declaration on Promoting Good Medical Care 2009
- UEMS EACCME (European Accreditation Council for Continuous Medical Education) Criteria for recognition of Live Educational Events (LEEs) - 2012
- Directive 2013/55/EU – Directive on the Recognition of Professional Qualifications

Definitions

CME or Continuous Medical Education in psychiatry is the acquisition of specialist knowledge and skills relevant for ongoing practice following initial specialist qualification. It generally refers to further developing medical knowledge, skills and attitudes.

Continuous Professional Development or CPD incorporates this concept but also includes additional competencies such as managerial, ethical, social and interpersonal skills.

Both involve the acquisition of information but increasingly the emphasis is on the application of this knowledge to change clinical practice and behavior resulting in improved outcomes for patients. More recent documents have favored the term CME/CPD to include both these aspects of lifelong learning.

Aims

CME/CPD ultimate aim is to contribute to the provision of the highest possible level of patient care and is therefore a necessary integral, ongoing and lifelong aspect of specialist professional practice.

Challenges to Harmonisation

The Section of Psychiatry considers the provision of up-to-date, evidence-based care to be a matter of public interest. Professional Competence schemes are a means by which it can be demonstrated that doctors are engaged in activities that facilitate CME/CPD This helps to ensure the maintenance of knowledge and skills but does not directly measure overall competence or performance. In order to provide for such schemes there will be a need to identify appropriate sources of funding.

Harmonisation of CME / CPD within Member states and others who participate in the UEMS will help ensure that all specialists in psychiatry can provide a comparable, high standard of care. This is particularly important as mobility of medical specialists increases. The UEMS is committed to the use of evidence-based practice in relation to all the components of CME/ CPD As can be seen from the documents already considered, the UEMS as a whole has already given considerable attention to this area of practice however the need for the Psychiatry Section to maintain a particular focus on CME/CPD is a valid role not only because learning and training are lifelong, but also because there are aspects of specific importance to this specialty requiring consideration.

A recent review of the practice of Member States in relation to current arrangements however, has revealed significant differences. The Working Group has considered the issues raised by inviting all members of the Board of Psychiatry to comment. In some cases CME /CPD is compulsory, in others not at all or only partially. Governance varies from state to state and the actual amounts of activity required or times involved differ significantly as do the methods of recording used. Funding is a major concern and likely to be a significant factor contributing to the variation of practice between states. Sanctions – even where they exist – are not uniformly applied and in some cases they are driven by insurers rather than a professional coordinating authority. The involvement of agencies – including pharmaceutical agencies or employers with vested interests may inappropriately influence the content of a C.M.E. /C.P.D. programme. Also whilst the aspiration is to have a strong evidence base it has been reported that the majority of recognition of CME/CPD is currently heavily weighted in favour of didactic, conference-based learning when, for example, involvement in teaching/examining has been shown to have a stronger impact on clinician behavior. Views on the inclusion of Peer Support are somewhat divided and the concept of formal evaluation or accreditation not, as yet, well developed.

There is also as yet no clear evidence that mandatory CPD systems can either identify poorly performing doctors or improve patient care.

Structure, Professional input and availability

CME should provide an opportunity to update current or previously acquired knowledge. It should also allow for the acquisition of new or novel information both in relation to areas of special interest as well as the broader base of general psychiatric knowledge. Practitioners have a duty to maintain and upgrade their competence relevant to their particular area of specialization and scope of regular practice but also to maintain a broad overview of developments in psychiatry as a whole.

Therefore a substantial amount of any comprehensive CME /CPD programme will be required to concern itself with the general aspects of psychiatry. A general principle is one of a balance between the constituent elements of psychiatry, namely the biological, psychological and social aspects. This will allow the practitioner to fulfill the obligation to maintain a broader view and remain up to date with developments in all areas of psychiatry that frequently interface. Psychiatrists working in one or more specialized areas will also need to ensure they remain up to date in those areas. Those working in the academic (teaching/research) or managerial fields will need to address these in aspects of their CME / CPD programme.

Standards, Assessment/Accreditation and Financial Independence

Ideally CME should be implemented by a National Professional Body or Association. This body will need to have the authority to accredit the contents of the syllabus. The syllabus will be required to be presented by suitably qualified and accredited persons and free from inappropriate extraneous influence. If external involvement is necessary or unavoidable it should be appropriately governed by the relevant European Guidelines. The General Principles described by EACCME in relation to potential commercial influence and bias are recommended. These include:

- The education provided must be free of any commercial influence or bias
- The education provided must be free of any form of advertising
- Sponsorship may only be in the form of an unrestricted educational grant

The National Professional Body should designate a body to oversee the structure of programmes, ensuring that general aspects of psychiatry form a major component of these but with due regard to the specialties nationally recognized by member states. This body should encourage members to participate in CME / CPD and facilitate the

collection of data in relation to this. CME /CPD has been shown to be most likely to be utilized where it is a compulsory aspect of continued practice or where there are negative consequences for non-compliance such as financial or regulatory. The financial cost of participating in a programme may however discourage compliance, whilst external funding – appropriately obtained- is likely to ensure better uptake.

International practice suggests that between forty and fifty hours per year of CME/CPD should be sufficient but the nature of the content may vary depending on specialization. Some countries require a balance of credits earned from differing activities such as "external" events (International/National congresses) and "internal" events (local in-house teaching programme). The requirements for Audit or Peer Review vary considerably.

Quality Assurance

Evaluation and quality assurance should also be the remit of a national body with periodic audit. A standardized form of data collection should include the various forms of participation involved. Examples of electronic "log books" are increasingly available. This allows for an overall review and comment on the CME programme itself as well as facilitation of individual feedback. Obviously where non-compliance may lead to penalty, the nature of the collection will require a clear and consistent system of credits or points related to the duration or complexity of the task ie one point per hour of activity is frequently used. There will also need to be an appeals process.

The 1994 UEMS Charter on CME (Article 4.6) advises the national body to decide on what sanctions should be applied should there be a failure to comply with minimum In some cases his may be a refusal to permit registration or continued practice.

Harmonisation and Coordination of programmes

Accreditation and the provision of a relevant and achievable programme will be the responsibility of the local service provider however the actual awarding of accreditation could be at European level. The UEMS Section of Psychiatry is competent in this respect though EACCME portfolio of activities.

There should be mutual recognition of acceptable CME between member states.

As member states continue to develop CME/CPD programmes with due regard to the principles and recommendations described harmonization will increase and the care and treatment of patients of psychiatric services will benefit.

Acquisition and Opportunities for Learning

CME should be conducted using the best educational methods and mirror changing presentations in psychiatric practice including those resulting from technological advances. It should generally be delivered in a defined setting which may be local, regional, national or international but some credit will need to be permitted for time spent in private or individual learning and in teaching and training others. Acquisition of information or skills may therefore be through self-study, attendance at presentation or demonstration, interactive participation or presentation by the individual themselves. Peer review may also be included as an allied contributing process. Evidence demonstrates the superiority of active learning as a means by which practice can be changed. Ideally participation through all the various forms of learning should be encouraged.

Conclusions and Recommendations

There remain significant differences between countries in relation to the implementation, structure, governance and funding of CME/CPD at present.
Much of current practice remains unstructured and retrospective and fears have been expressed in relation to funding which can be challenging. While CME/CPD appears to be becoming increasingly compulsory or financially imperative, it is clearly not possible for individual doctors and the profession to fund the diverse activities required. It will therefore be necessary for the state and employers to provide this support. It has been observed, also, that when CME/CPD becomes a necessary requirement to practice, it must also become more structured and more diversity in learning is encouraged.
Encouragingly, however, the need for CME/CPD and benefit to those we treat is well-recognised and the challenges are practical and financial rather than idealogical.

The Working Group Recommends:

1. Increasing harmonisation should include individual pre planning of CME/CPD activities, relevant to scope of practice and delivered by quality assured schemes with appropriate governance. The role of the pharmaceutical industry, government, employers, national specialist organisations and medical regulatory bodies needs to be recognized and defined by each member state with due recognition to the UEMS Charter. It will not be possible for the profession alone to fund this.

2. Ideally a practicing psychiatrist would identify relevant and specific objectives – possibly with the help of peer review – that should, if achieved, ultimately lead to improved quality in the service he/she provides.

3. Identification of targets can then be used to record participation in, completion of and learning from experiences related to those objectives.

4. A "Continuing Professional Development" or "Continuing Medical Education" Programme can facilitate a structure, promoting prospective goals (including the balance and nature of learning) with minimum or recommended standards of completion and a means by which this can be formally recorded and thus available for scrutiny and /or discussion. Transparency has been made increasingly possible by the ability to demonstrate compliance with CME/CPD to stakeholders including in electronic format.

5. Activities that may be recognised as contributing to CME/CPD can involve teaching, research and publishing, engagement with patients and carers, on line learning, peer review, audit, development of legal, managerial and economical skills as well as the more familiar attendance at congresses or courses. This diversity is to be encouraged.

6. The Psychiatry Section has now compiled a summary of the current position of CME/CPD for psychiatrists in Member States at this time which is summarized in the table that follows. We suggest that all Member States should update this table annually through submissions from National Delegates in relation to changes to CME/CPD requirements, practice or funding. In that way the Section can remain informed and continue to contribute to the monitoring, standard setting and harmonization of practice that are its objectives.

7. It may be possible for the twice yearly meetings of the Section to apply for recognition as CME/CPD events to recognize these as appropriate opportunities for lifelong learning.

8. Governance of the quality of CME related activities including sources of funding and formal recognition will require input from various bodies including EACCME. Potentially sanctions or consequences for those non-compliant are therefore possible but the emphasis should remain on encouraging and supporting psychiatrists in striving for professional excellence in the interest of our patients.

Addendum

Learning from the Pandemic

This document was initially developed following discussions in the working group with a view to finalise at the Spring Meeting 2020. The Covid 19 Pandemic, that necessitated that this Meeting required to be held virtually, has also had a significant impact on CME/CPD - both in relation to its absolute relevance and importance but also in how it has been achieved.

The need for psychiatrists to learn principles of infection control and to adapt rapidly to changing clinical situations - including changes to Mental Health Legislation - brought our need for lifelong learning and adaptability into focus in a manner we never could have foreseen.

The requirements to remain physically distant and to limit travel whilst needing clinically to learn and be informed, accelerated our use of the virtual world and a myriad of technological adaptations to facilitate remote assessments, meetings and education.

Those countries where CPD/CME is mandatory have had to adapt requirements to prevent doctors from becoming un registered through being unable to meet requirements. For example an increased allowance of "external" points to be gained "on line" or an enhanced time frame for collection of credits has been sanctioned. Others have allowed for a derogation request where the pandemic has interrupted all attempts at "formal" learning.

It is likely that, in the aftermath of this global challenge one change in relation to CME/CPD will be an enhanced focus and consideration of the importance of rapid adaptation and learning from clinical necessity. The use of alternatives to large congresses with their requirements for travel and proximity and the possibilities of "virtual" meetings will no doubt be much discussed. The value, however, of face to face contact, actual experiences of visiting and seeing other mental health services and the energy of direct discussion and group engagement we hope will not be lost.

Dr Rachael Cullivan Elliott

April 2020