Continuing Medical Education  
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“I’ll know it when I see it”  
Justice Stewart (US Supreme Court 1964)

The practice of medicine is entering a new era, one based on fundamental changes in the structure of its own professional registration and regulation systems. Whilst these changes are imminent in the UK the implications of them are not only far reaching but reflect a worldwide shift in the relationship between doctors and society. In the UK, the General Medical Council (GMC) has begun to implement this change with the introduction of a requirement for all doctors wishing to remain in practice to have a license and also to submit to a system of regular renewal of that license. (GMC 2009)

The requirements of the new system are based on Good Medical Practice (GMC 2001) and in the 2001 version the educational component – maintaining Good Medical Practice refers to this as “keeping your knowledge and skills up to date”. This is what we currently understand by the term Continuing Medical Education (CME). In the AMEE Guide no 34 (Davis et al 2008) there is a comprehensive overview of CME along with details of the practical implications and a suggestion that Continuing Professional Development (CPD) is a similar term although broader.

In the revised version of Good Medical Practice (GMC 2006) the word “professional” was inserted to describe these knowledge and skills. This addition recognised that doctors must not only acquire new knowledge and skills but also locate them within their own professional experiences – Continuing Professional Development (CPD). (see Diagram) Although these two terms are often considered to be synonymous for reasons that are explained later in this article it is vital to ensure that CPD is inclusive of, but not limited to, or constrained by CME.
The profession has responded to these proposals so far and a working party led by the Royal College of Physicians has suggested that if we are to embrace the positive impact of these changes there must be the “emergence of a New Professionalism”. (Royal College of Physicians 2005)

There is however an abundance of definitions of “professionalism” and so we must be clear what is understood by the term collectively. Most definitions confine themselves to considering the behaviour of doctors in their approach to the care of individual patients and their ability to work with colleagues. The Kings Fund in its discussion paper (Rosen & Dewar 2004) define this “New Professionalism” as being patient centred, responsive to patient’s interest, having strong leadership and an effective relationship with managers. Although it does acknowledge that doctors have a role in developing service delivery in a way that promotes high standards it does not refer much to the importance of education for doctors throughout their careers.

The report produced by Royal College of Physicians working party gives a range of more extensive definitions. It begins to identify the wider context of societal change and the co-dependency of maintaining standards within medical care and education. It examines the need for professionalism to be taught within undergraduate curricula and suggest ways for this to be improved but does not consider in any detail how this might happen for doctors post qualification.

It can be argued that being a professional implies a commitment to lifelong learning and the essential part of that - to be able to reflect on one’s own performance. In a definition of professionalism as a whole Eurat (1994) indentifies five component parts - A moral commitment to serve the clients interests, the discipline to self-monitor and review personal practice, the will to expand one’s personal repertoire and reflect on one’s experience, to contribute to your organisation, and to reflect on and contribute to the profession’s changing role in society.

Whilst all of these definitions are important and helpful in the UK, it is perhaps the GMC’s definition as the regulator of the medical profession in the UK that will have the most impact when the systems for revalidation become operational. Similarly in other countries it will be the requirements of the individual national regulators that will provide the focus for activity.

**Professional context.**

Creuss (1997) suggests that the professional characteristics of the medical profession are based on long standing and traditional views. These views have led to not only the current “medical model” of care but also the creation of the very language we use to define and develop that model.

Health care and the delivery of that care takes place within an ever changing environment.

Some of the factors which are powerful drivers for change are;

- changes in demography and so stretched resources
- increase in demand due to more sophisticated and effective medical treatments
- changing societal expectations related to consumerist values,
- increased access to knowledge that was in the past traditionally held by doctors alone,
- public disillusionment with professional accountability and self regulation.
All of these and others factors have led to a plethora of systems designed to monitor health care processes and at times health care outcomes. There has been a huge expansion in activities designed to measure the measurable.

The consequences of this are a growing disillusionment amongst doctors concerned that the complexity of the tasks they do with patients individually is immeasurable and not only not recognised by these measurement tools but also damaged by them. (Spicer 2009) In general practice this complexity has been defined as the “essence” (Gillies et al 2009) and whilst not unique to general practice is a vital component of what patients expect whenever they consult with a doctor. Willis (2008) in an article comparing the difference between the measurable and immeasurable likens this to the difference between grey and red squirrels….the grey is the “how” of professional activity – and the red is the “why”. The grey are more prolific and clearly visible whilst the red are less visible and under threat of extinction.

“How” doctors conduct themselves will be the basis of professional regulation and CME is part of that. But the “why” is much more challenging. Doctors are individuals with differing knowledge, skills and behaviours all informed by their own unique qualities and characters. They also have their own personal values determined in part by their upbringing. As professionals they have to balance their profession’s ethics or code of conduct with their own personal values.

Aultman (Wear & Aultman 2006) suggests that ethics is a systematic approach for understanding ourselves as persons, and how we make moral decisions. Medical ethics has the additional overlay of requiring its professionals to elevate certain values or goals such as health or autonomy to the status of overriding consideration. All of this encompasses the “why” and CPD systems must be responsive to that.

**CME to Mastery: CPD to Generativity**

CME currently uses an evidence based approach that supports a structure of delivery around needs assessment, course design and style of delivery, adult learning principles, the improvement of not just knowledge but also doctor’s performance and increasingly based in and around the work place. Whilst this is an important component of “keeping up to date” it is not the whole picture.

Skilled professionals are reflective practitioners (Schon 1983) and when taking part in CME bring their own experiences, their own values, their own personal character, the inherent language of their discipline, and their own ethics all together whilst they assimilate new knowledge. This is how CME ensures that professionals become masters of their craft.

Zohar and Marshall (2004) define Mastery as rooted in wider interpersonal values and skills ….a system of shared understanding distinctive of some wider thinking or shared vision. A master “draws on his craft collective pool of wisdom and skills” and so “will see opportunities and possible innovations where others don’t.”

CPD however is the location of CME within the richer and complex adaptive environment that is achieved by being a reflective practitioner learning with colleagues. This type of learning not only helps individuals to develop but also allows the discipline itself to expand its boundaries. This is described by Zohar and Marshall as “creativity driven by love and passion….which gives people as sense of playfulness about their creativity….. they are often generative in many directions”. Masters are “leading expressers of a tradition” whilst “Generative people create new traditions, new paradigms”
An example of this is the work of Michael Balint in the 1960’s. By focusing on the doctor patient relationship and by analysing this extensively with many groups of experienced general practitioners he developed a new approach that not only allowed general practitioners to consider their own feelings about their patients and vice versa but to recognise that these feeling could hold the key to a enormously important therapeutic approach. This approach has become so enshrined in the way general practitioners and others within their team approach patient care as a recent article by Homes (2008) suggested we are “all Balintians now”. GP’s in those early and subsequent Balint groups extended their “mastery” to a higher level, to that of Generativity.

Conclusion

Professional Regulation will require all doctors to demonstrate their “learning” on a regular basis. They will mostly do this by active involvement in CME and so will be able to comply with the requirements of GMC and Professional Regulation. As James Willis says, the grey squirrel will grow and prosper. But what of the red squirrel? He suggests it will not survive without active intervention. To save the red squirrel he asks that those in high places must “open their eyes and their sensibilities as to why they (red squirrels) are so special and so vulnerable”.

The GMC as regulators, providers of education and doctors themselves must all “open their eyes and their sensibilities” and create a system not just for CME but for CPD. To do this will embrace “New Professionalism” and confirm its place in this new world of Professional Regulation. It will take the practice of medicine from an era of Mastery to an era of Creativity.

References


General Medical Council. Licensing and you: Information for Registered doctors. 209 Available at: http://www.gmc-uk.org/about/reform/Licensing_leaflet.pdf

General Medical Council. Good Medical Practice, 3rd ed. 2001 London; General Medical Council


Homes J. 2008. Are we all Balintians now? BMJ; 337; a1549. Available at; http://www.bmj.com/cgi/content/extract/337/sep03_1/a1549


Spicer R. 2009. Targets destroy morale and do not help patients. BMJ;338:b953. Available at; http://www.bmj.com/cgi/content/full/338/mar09_2/b953


Wear D, Aultman JM. 2006. Professionalism in Medicine Critical Perspectives. Springer


Notes on Contributor

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