

Continuous professional development: continuous learning and clinical practice

Recertification/revalidation – a tool to detect poorly performing doctors?

Hans Asbjørn Holm, MD PhD
AEMH Conference 2005 in Athens, Greece
hah@legeforeningen.no

Director Department of Professional Affairs

Norwegian Medical Association

My background related to education

- Substitute teacher secondary school 1960-61
- Medical student and “teacher” 1961-67
- Clinical work and teaching (small group teacher and lecturer internal medicine) 1970-85
- Norwegian Medical Association – medical education and quality improvement
 - 1985-
- Married to a teacher > 40 years
- Since 1986 worked closely
 - with professional educators

Aims of a doctors’ CPD

- Enabling the doctor to deliver evidence based health care
- Enabling the doctor to organise and administer health care in a just and cost-effective way
- Enabling the doctor to lead and develop health care teams for continuous improvement of care and reduction of errors

3

Why is CPD high up on the agenda?

- A fast changing professional environment poses an unprecedented tough challenge to professionals who want to stay abreast
- Better structure and planning emerge as a “must” if we shall succeed in filling the competence gaps facing us every day
- The issue of recertification as a means to maintaining competence is a challenge to the profession
- As more doctors gain insight in education the traditional way we think about doctors’ learning is challenged at every level of education (undergraduate>graduate>CME)
- Competence building outside the formal education system is just as important – or more – than that resulting from formal educational events
- Understanding interdisciplinary learning and working and quality improvement as part of CPD is a prerequisite for effective and safe health care delivery
- The ability of the working place to create an environment conducive for learning is crucial for building of competence

4



George E Miller (1918 - 1998)

5

“Perhaps the time has come to face up to the fact that many of us do not know what we are doing as teachers, and those of us who do, learned it accidentally and cannot communicate it to others.”

George E Miller

6

George E Miller about teaching-qualifications

“In all of higher education, including medicine, a degree and a clean collar are looked upon as adequate preparation for the heavy responsibility of teaching.”

7

George E Miller and his colleagues about learning

“We recognized very early that **people learn when they want to learn.**”

“A closely related principle reminds us that **knowledge and learning are different**true learning is largely an **emotional experience.**”)

“We also reached agreement that **true learning implies changes.**”

“If the three first principles are sound, the fourth, that **true learning requires freedom,** follows naturally.”

8

Traditionally, formal CME-courses have been perceived as the most important part of a doctor’s activity to stay updatet in his or her chosen area of medicine. About 20 years ago the first publications appeared taht challenged this assumption:

9

Mandatory CME - does it work?

Mandatory CME, which focuses on attendance at courses, may have impeded development of other types of CME that would be more individualized and would aid physicians to learn more from their clinical experiences as well as directly benefit patient care.

PR Manning and DW Petit. JAMA 1987

10

Impact of Formal Continuing Medical Education:

Do Conferences, Workshops, Rounds, and Other Traditional Continuing Education Activities Change Physician Behavior or Health Care Outcomes?

Dave Davis, MD; Mary Ann Thomson O'Brien, MSc; Nick Freemantle, PhD; Fredric M. Wolf, PhD; Paul Mazmanian, PhD; Anne Taylor-Vaisey, MLS

YAMA
Vol. 282 No. 9,
September 1, 1999

11

Conclusions:

”Our data show some evidence that **interactive** CME sessions that enhance participant activity and provide the opportunity to practice skills can effect change in professional practice and, on occasion, health care outcomes. Based on a small number of well-conducted trials, **didactic sessions do not appear to be effective in changing physician performance.**”

JAMA. 1999;282:867-874

12

**Phil R. Manning
Lois DeBakey**

**MEDICINE
PRESERVING
THE PASSION**

Phil Manning knows more about continuing medical education than anyone else. Lois DeBakey is the unchallenged champion of the proper use of medical English. Here they are together in a book on the preservation of excitement in medical education and practice. Certain success!

George D. Lundberg, M.D., Editor,
The Journal of the American Medical Association

From Lois DeBakey, renowned as an exemplar of clear, forceful writing, and Phil Manning, a pioneer in continuing medical education, we now have a splendid reader's manual of how to nurture and enhance the highest level of inspired medical practice.

C. Rufus Heston, M.D., Formerly Director,
American College of Surgeons

Motivating forces

"A driving force among the outstanding physicians whom we interviewed is their pride in performance - a desire never to be (or to be seen as) professionally inadequate".

Manning and DeBakey 1989

13

**Changing
and
Learning
in the
Lives of
Physicians**

Edited by
Robert D. Fox
Paul E. Mazmanian
R. Wayne Putnam

Qualitative study based
775 changes reported
from 340 doctors in
USA and Canada
(1989)

14

**Why do doctors engage in CPD? -
Carrot or Stick?**

I Personal, professional and social forces → **II** Develop mental image of change → **III** Judge present level of knowledge and skill compared to required knowledge and skill

→ **IV** Plan for learning → **V** Implement change

The Physician Change Study (1989)

15

Some examples of redirection of medical education:

- 1999 Accreditation Council for Graduate Medical Education (www.acgme.org) in the US adopted general competences - "outcome project"
- 2000 American Board of Internal Medicine (www.abim.org) changes its Recertification program based on the principles of continuing quality improvement
- 2001 Association of American Medical Colleges (www.aame.org) initiates the Medical School Objectives Project addressing (among others) two fundamental questions:
 - What should medical school students learn about quality issues?
 - What kinds of educational experiences would allow students to achieve those learning objectives?

16

**Graduate Medical Education &
Specialty Certification: "General
Competencies"**

1. Patient Care
2. Medical Knowledge
3. Practice-Based Learning and Improvement
4. Interpersonal and Communication Skills
5. Professionalism
6. Systems-based Practice

www.acgme.org/Outcome/

17

"Much of the thinking underpinning traditional CME and recertification rests on wrong assumptions."

18

THE **WRONG** ASSUMPTIONS

(from Professor Janet Grant, Joint Centre for Education In Medicine)

- qualified doctors do not continue to learn
- doctors do not assess their learning needs
- doctors ignore service needs in their CPD planning
- doctors are passive learners
- there are acceptable and unacceptable ways of learning
- improving practice is not a normal part of professional behaviour
- making doctors learn in approved ways will improve their practice
- doctors do not demonstrate the benefit of CPD undertaken

THE **RIGHT** ASSUMPTIONS

(from Professor Janet Grant, Joint Centre for Education In Medicine)

- Doctors:
- are lifelong learners
 - do improve and change their practice
 - work in a rich learning environment
 - have many ways of identifying their learning needs
 - have many ways of learning
 - are increasingly involved in business planning for the service
 - can show the benefit of CPD undertaken

Characteristics of effective adult learning



- adults are self-directed in their learning
- experience is a resource for learning
- participants look for practical learning
- adults learn by choice; learning is voluntary
- learning is more effective when adults are actively involved
- feedback is a critical part of learning (outcome of learning)

From Nancy L. Bennett: Adult Learning: Uses in CME
In the book: Continuing Medical Education. A Primer

21

CME or CPD Does it matter?

22

The Competence Grid

Otto Brun Pedersen and Kristin Prestegaard

Clinical task: Knowledge types	Area of competence			
	Medical	Managerial	Social	Personal
Theoretical knowledge	Causes, symptoms, prevention, treatment and prognosis of disease	Organisational, administrative and legal knowledge	Psychology of individuals and groups. Principles of communication	Ethical and political norms and values
Practical knowledge	Skills of procedures of examination and treatment	Skills of administration and management	Skills of communication and role performance	Ethical virtues, e.g. empathy, trust flexibility thoroughness
Situational knowledge	Familiarity with patients and clinical phenomena.	Awareness of organisational culture of staff and of local community	Familiarity with language and roles of patients and of other professions	Familiarity with norms and values of patient and of local environment

All competence areas and knowledge types are needed in effective CPD

23

From the CPME policy on CME/CPD 2001

Modern learning methods are many and diverse. Some degree of formalisation and, in particular, appropriate documentation of CME/CPD is necessary both for the doctors themselves in their individual competence development and as a way to demonstrate to the general public that the necessary up-dating of competence is accomplished in a proper way.

Individual competence development plans, regularly reviewed, are recommended for this purpose.

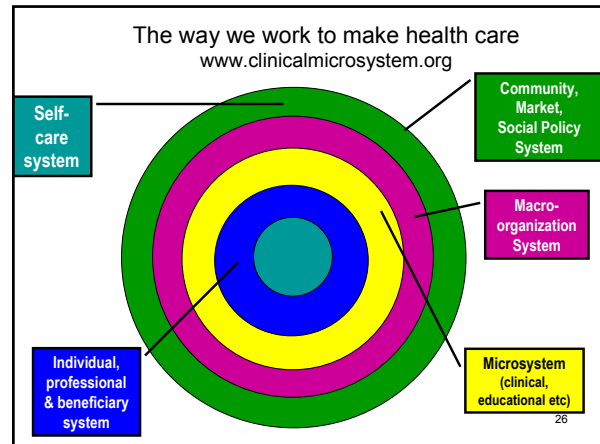
24

Learning within a context

Competencies and skills are most effectively attained where they are practised (contextual learning) – therefore we must focus on how we organise our work and the practice place.

The “Microsystem” - a place for effective practice-based learning!

25



What is a clinical microsystem?

A health care clinical microsystem can be defined as the combination of a *small group* of people who work together in a defined setting on a regular basis—or as needed—to provide care and the *individuals* who receive that care (who can also be recognized as members of a discrete *subpopulation of patients*.)

It has clinical and business *aims*, linked *processes*, a shared *information* environment and produces services and care which can be measured as performance *outcomes*. These systems evolve over time and are (often) *embedded* in larger systems/organizations.

As any living adaptive system, the microsystem must: (1) do the work, (2) meet staff needs, (3) maintain themselves as a clinical unit.

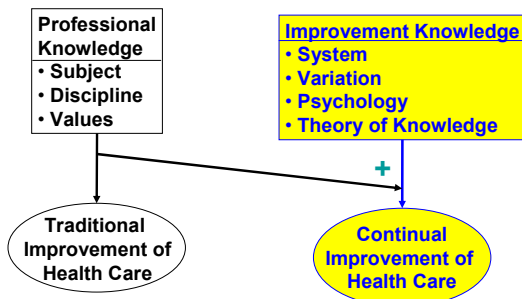
Integrating Continuing Professional (CPD)
and Continuous Quality Improvement (CQI)

or

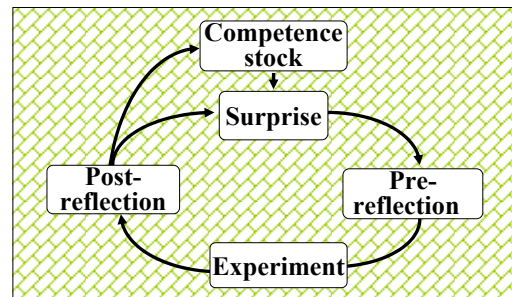
Why should doctors bother learning about
IMPROVEMENT KNOWLEDGE
as part of their CPD?

28

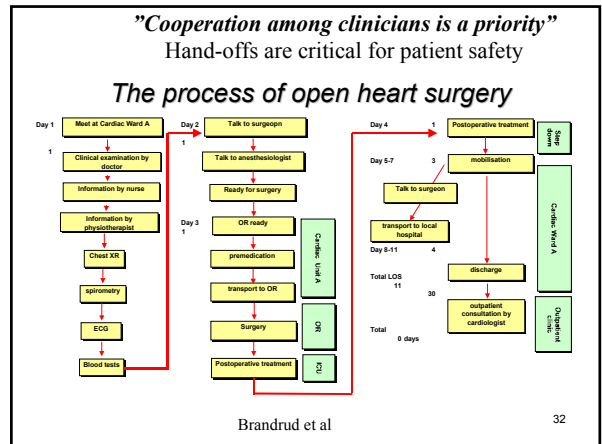
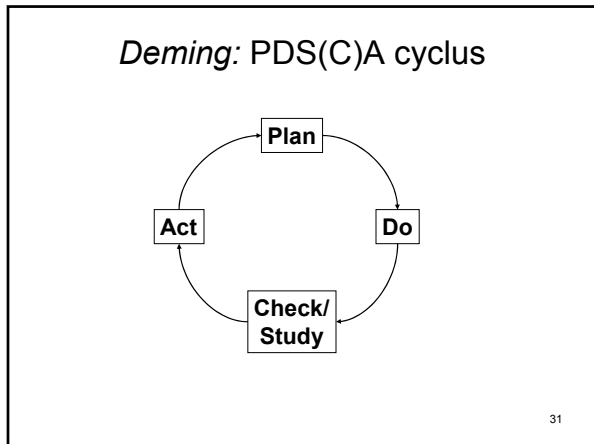
Traditional & continual improvement (Batalden and Stoltz 1993)



Experiential learning



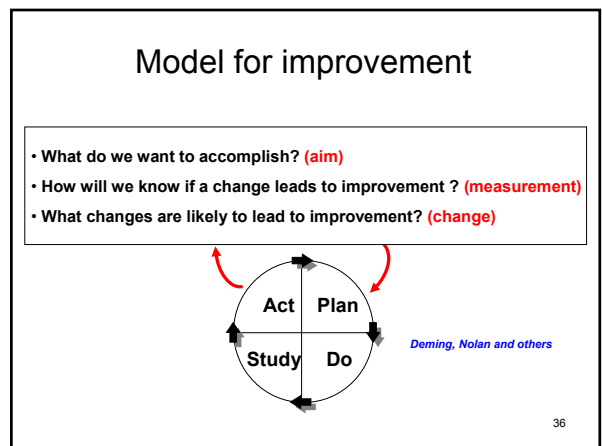
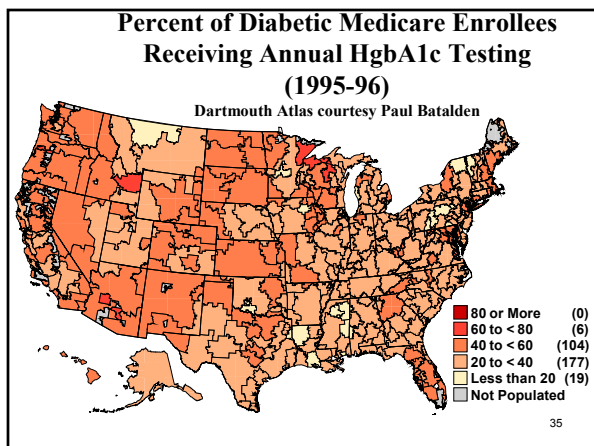
From Kolb, 1987³⁰



Paul Batalden
Center for Evaluative
Clinical
Dartmouth Medical
School

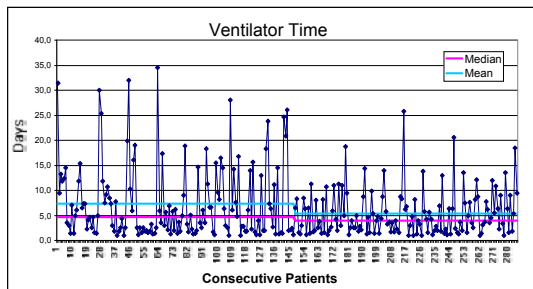
**"Every system is perfectly
designed
to get exactly the results it gets"**

33



Gjennombrudd kan også være vitenskap:

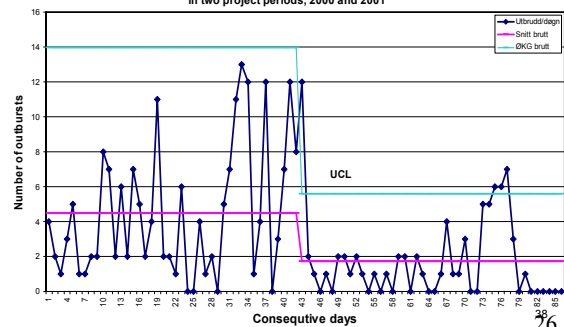
Time on ventilator



37

Monitoring intentional change (Brandrud & De Grève)

XmR-diagram: Number of aggressive outbursts pr. day
in two project periods, 2000 and 2001



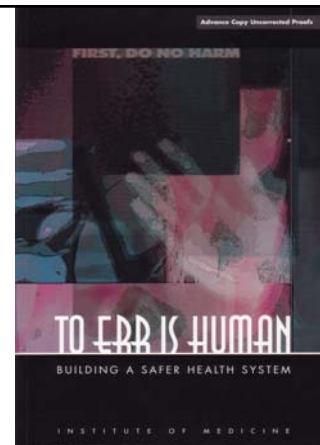
26

CPD must address patient safety

One of the most important challenges to doctors today is raising the competences needed to reduce harmful care.

And improvement knowledge is essential for analysing system properties leading to errors and monitoring change designed to reduce errors.

39



40

The Institute of Medicine Report: *To Err Is Human (1999)*

1. Injuries from care are common.
2. Injuries are not generally caused by individual carelessness or incompetence. Blame won't help.
3. Injuries from care are "system" properties.
4. "Blame-free," safe reporting systems are needed.
5. Public accountability requires transparency ...open reporting of the most serious injuries.
6. A strong research agenda will be helpful.

41

Injuries from Care Are Common IOM report "*To Err is Human 1999*"

- "Adverse Events" occur in 3.7% of hospitalizations
 - Definition: "AE" = One extra day of hospitalization or one extra week of disability
 - 20% are medication errors
 - 14% are fatal
- 2/3 are "Preventable Adverse Events"
- 44,000 to 98,000 preventable hospital deaths per year in USA

42

To Err Is Human.....

”Most patient injuries are not to blame worthy clinicians, but rather to systemic factors, such as:

- > *unrealistic reliance on human memory*
- > *poor communication systems*
- > *unrealistic demands on human vigilance*
- > *too little respect for the consequences of fatigue*
- > *reliance on handwriting in a computer age*

....exhortation, blaming, and “trying harder” are not acceptable plans for improving patient safety; rather, we should be pursuing the much more scientifically valid plan of substituting new, reliable system designs for old, unreliable ones.”

43

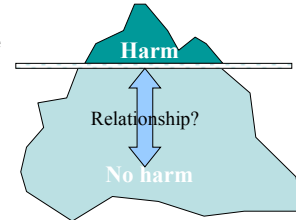
Similar or identical errors do not always harm the patient because they are discovered and corrected before harm is done

Iceberg model:

What is the relationship between errors that have consequences for the patient and those who don't?

We can learn from them all!

Therefore report systems are essential



44

Individuals Are Not Generally at Fault ... Blame won't help

- **Blame leads to.....**
 - Hiding information on errors
 - Unfair punishment
 - Accepting current safety levels
 - “Gaming”
 - Feelings of guilt and demoralisation
 - Fragmentation of efforts

45

Luxembourg declaration on patient safety 5 april 2005:

> *To include patient safety in the standard training of health professionals*

> *To create a culture that focuses on learning from near misses and adverse events as opposed to concentrating on “blame and shame” and subsequent punishment*

> *To implement work place projects focusing on patient safety and to establish an open culture to deal with errors and omissions more effectively*

http://www.opme.be/content.php?c=patient_safety_declaration

46

But, after all, what about the impaired physician?

We know there are some bad apples out there who may hurt their patients!

47

“I never met a guy who went out there to do a bad job!”

*John Premi, professor emeritus
McMaster University, Canada*

48

Why things go wrong

- Illness (somatic or psychiatric)
- Burnout
- Psychosocial impairment
 - distressing social events (disrupted family life , divorce)
 - "pathogenic" working environment

Doctors –like other workers – can benefit from occupational health arrangements

49

Examples from Norway

- All doctors are listed with a primary care physician (like all Norwegians are)
- In every county the local branch of the Norwegian Medical Association have a group of voluntary doctors that are ready to assist a doctor in trouble on request from the troubled doctor or his family. This is not a doctor- patient relationship, but a "collegial support system".
- A special clinic with psychiatric competence treat doctors and offer individual and group-based counselling to doctors and their families.
- NMA has in its bylaws delegated the local (divisional) boards to take action if they suspect that a doctor practice is below standard for some reason or another .

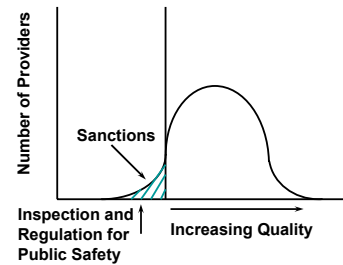
50

Norwegian Medical association bylaws:

"If it comes to the knowledge of a Divisional Board that a member has a health problem or is conducting himself in a manner harmful to his own work or detrimental to the profession, the Divisional Board shall take the matter up with the colleague in question and make sure that he is offered assistance if this has not been seen to by another institution. The Divisional Board must follow the matter up and bring it before the Divisional medical ethics committee or other authority if the regrettable activity does not cease.:"

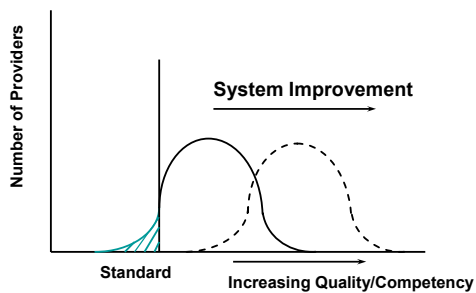
51

Inspection Focus (Is competency an all or none phenomenon?)



After Paul Miles

Improvement Focus



After Paul Miles

Main conclusions

Successful CPD is likely to occur if

- we understand and nurture adult self-directed learning based on actual patient-needs and outcomes,
- we build a supportive learning environment and network with easy access to updated information
- we apply systems for improvement linked to patient needs and outcome and based on inter-disciplinary collaboration and learning

Substantial improvement of health-care can only be achieved by system improvement, and focusing too much on individuals may impede real improvement

54