

Maintaining competence: A professional challenge

Editorial

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In this article, André Jacques discusses the role of CME and some of the measures that have been introduced by the Collège des médecins du Québec (CMQ), in Quebec, Canada for the maintenance of competence of physicians. He points out that even without mandatory CME, the majority of the practitioners have been engaged in CME activities. He elaborates on the CMQ's scheme of monitoring and enhancement of the performance of physicians, which evaluates all practitioners and has provision to offer tailor-made training to those few who are identified as having specific difficulties. The author raises the issue of needs analysis in CME planning, and provides points that should receive the attention of CME planners who wish to move away from the ever popular lectures and seminars to more effective formats of CME/CPD.

Maintaining competence is, first and foremost, a personal responsibility. In certain countries, it is also a matter of the professional code of ethics. In Quebec (Canada), for example, the physicians' ethics codes mention it explicitly. This necessity of maintaining the competence exists for all the countries, and the tools they are using are different for each one of them. The goal of this text is to present a few solutions being used in Quebec in order to give the opportunity to the physicians active in their practice to maintain their performance, and to present the advantages and the inconveniences related to some of these solutions.

Pre-graduate education	Specialized studies	Professional practice
4-5 years	2-5 years	40-50 years

The knowledge, abilities or attitudes learned by the future physician during his education (four to five years before graduation, followed by two to five years of specialized learning in the province of Quebec) will necessarily have to be updated by the physician all along his professional work.

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We expect – and we have the right to – physicians to be competent and to maintain their competence in a world where knowledge evolves rapidly and where epidemiological data change, and where methods of treatment as well as technology are discovered regularly, thus changing the diagnosis and therapeutic approach. In such a context, the maintenance of competence is not only a matter of personal responsibility. It involves with, no doubt, a social character; the public expects that the professional assumes the responsibility to keep himself at the leading edge of knowledge and of the medical discoveries.

The physician, a continuous learner all along his professional life

Medical schools and medical organizations (professional associations, unions, scientific societies etc.) offer many options to the physician members to help them to maintain their competence up to date. Many organizations offer the physicians continuing medical education (CME) programs of various formats: scientific publications and literacy, self-learning programs, symposia, congresses, seminars, discussions with colleagues, workshops etc. Taking part in these programs is on a voluntary basis.

A study done in Quebec shows that more than 80% of the Quebec general practitioners voluntarily participate in group activities of CME, irrespective of the number of years of practice they have. In Quebec, to be accepted for continuing medical education credits, these activities must, however, satisfy the quality criteria of a CME activity adopted by the Council for Continuing Medical Education of Quebec.

Some professional associations and scientific societies, for which access to the physicians is on a voluntary basis, have chosen to involve the membership in a certain kind of mandatory CME. In Canada, for example, the

College of Family Physicians of Canada requires its members to participate in at least 50 hours of CME activities per year. The Royal College of Physician and Surgeons of Canada, on its part, requires from its members a participation of 80 hours of CME per year. However, this participation guarantees neither the enhancement of knowledge nor the transfer of training gained by the physician to daily practice.

Another option that is offered to physicians is the programs of assessment of professional practice by their colleagues, twinned with individualized improvement activities. In Quebec, this kind of evaluation is mainly done by the licensing authority. The advantage of this method is that it permits not only an evaluation of the strengths and weaknesses of the physicians' competence, but also proposes feedback and the means to update his knowledge regarding his patients. This feedback to the physician gives him the opportunity to correct his shortcomings identified. So, it gives an evaluation and an opportunity for improvement not only of the physician's competence, but also of his performance in his routine practice.

Mandatory Continuing Medical Education - Is it necessary?

For many years, the subject of mandatory CME has regularly been in the headlines. Can the physicians and the organizations representing them see in mandatory CME an additional means to guarantee the quality of the physicians' practice?

Would the member of the public be confident of obtaining a better service, by a more competent professional, if he has the assurance that physicians are forced to update their knowledge by participating in CME activities? And, beyond the initial impression, would he really get a better service?

In a new law adopted in June 2000 by the Government of Quebec, among the many measures proposed is the issue of mandatory continuing medical education. It gives the Board of Directors of a licensing authority, among which is the *Collège des médecins du Québec (CMQ)*, the right to adopt a regulation to determine continuing education activities or a framework of these activities that members of the organization or a group among

them must follow. It would include the justifications for continuing education activities as well as the methods of control, supervision or evaluation of such activities, the sanctions to be imposed for default and, if the need arises, the instances for granting exemption. The licensing authority then has the opportunity to make continuing medical education mandatory to their members.

The Board of Directors of the CMQ has not decided it is necessary to adopt such a rule. Many reasons support this decision.

PHYSICIANS' PROFESSIONAL OATH

On completion of his medical studies and of his residency program and at the moment where he receives his license to practice, the physician is being asked to pledge allegiance to a professional oath, which will remind him of the essence of his profession and the fundamental principles to which he will have to refer all along his professional life. Among the elements contained in the professional oath is one that asks the new physician to confirm solemnly that he will practice medicine according to the rules of the science and of the art, and that he will maintain his competence. Thus, from the first day of his professional life, the physician commits himself to a process of maintaining his competence and of CME that will end only with his retirement.

VOLUNTARY PARTICIPATION IN CME ACTIVITIES

According to the data held in the central file of CME activities, 86% of Quebec general practice physicians participate in formal CME activities. During the period 1995 to 1996, they had spent an average of 34.5 hours in CME.

QUALITY OF PRACTICE OF THE PHYSICIANS

A study, in which general practitioners chosen at random have been evaluated by their peers, has shown that 92% of general practice physicians allows enough time for their CME to guarantee a quality of care judged satisfactory.

These data allow us to conclude that the mandatory CME, in Quebec, would aim at only 4% of general practitioners or at not more than 8% if we compare these data to those related to general practitioners of Ontario (another province in Canada).

Moreover, no study indicates that physicians forced to attend these CME activities assimilate the new knowledge to their daily practice. Consequently, this required process would be contrary to the modern methods of teaching. Therefore, it is better to offer all physicians CME activities of quality answering their needs, invest in interactive workshops in smaller groups, where the potential of inducing change is greater, and give professional organizations the responsibility to identify physicians showing weaknesses and offer them CME activities that are tailor-made.

Role of licensing authorities: the protection of the public

In 1994, the Federation of Medical Licensing Authorities of Canada (FMLAC) defined four sectors related to the supervision of the physicians' performance:

1. Competence (knowledge and technical abilities);
2. Behavior (communication abilities, physician-patient relationship);
3. Mental and physical capacity of practicing medicine;
4. Use of the resources.

Competence is, in effect, the basis of the performance of physicians. But competence (knowledge of the scientific data and medical techniques) is not enough.

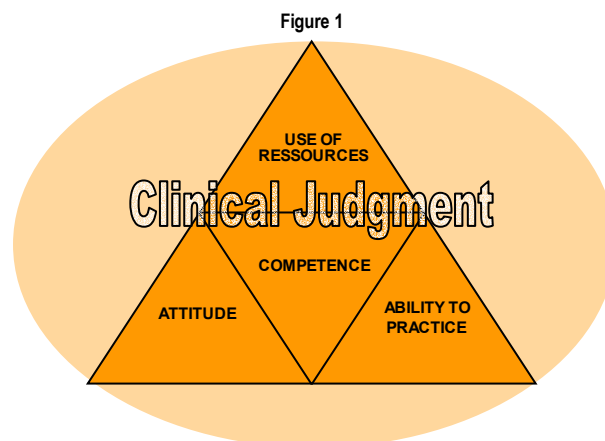
Indeed, a physician might be very competent but, at a moment or another in his professional life, he can have personal problems (financial problems, family problems or mental or health problems) and he might surpass his competence or be unable to make good diagnostic or therapeutic decisions pertaining to a patient.

Even if competent, a physician could have difficulties in establishing an interpersonal relationship fitting his patients, leading the latter to misunderstand the explanations or the directives delivered by the physician.

Finally, a physician might be asked to practice in a context where patients consult the doctor without having made prior appointments. This may force him to see a large number of patients within a short time. The pressure of functioning in such a setting could lead the physician, though competent,

to order too many diagnostic tests because of lack of time to question and examine the sick people whom he receives in consultation. In such a case, the use of resources would not be optimal.

To this "triangle of performance", we must add the element of judgment. In fact, in addition to the theory, the physician must integrate his knowledge to the practice and use his judgment to adopt good treatment. Therefore, it is not sufficient that a physician practices medicine relying on convincing data; he must also take into account the psychological, family, social and environmental context of the patient. Such an appreciation of his patient will give him the opportunity to apply his clinical judgment, to recommend the most appropriate treatment or intervention in a particular situation (Figure 1).



Performance is the result of a full integration of the knowledge, of the abilities and the attitudes with judgment by a physician, who enjoys all his mental and physical capacities, and adequately uses the resources at his disposal.

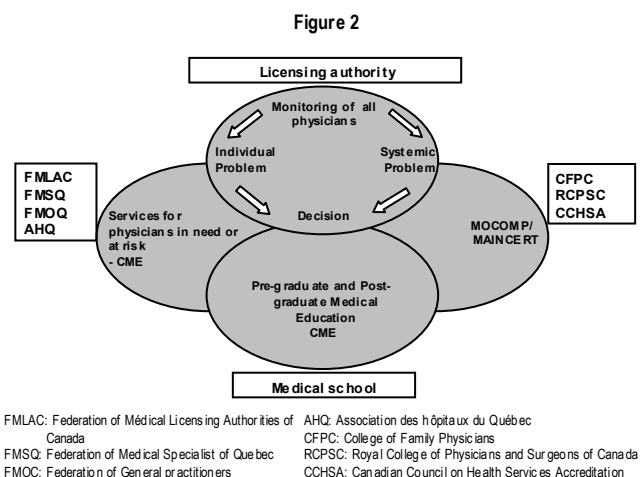
The preceding examples show well that the notion of 'maintaining the competence' goes far beyond the simple acquisition of knowledge. It must include the transposition of this knowledge to the daily professional practice.

The mission of a licensing authority is to protect the public, by making sure that its member physicians are competent at the moment when they obtain their license, and that their performance, all along their professional life, meets the population needs as well as the standards established by the profession.

The public expects this organization plays a proactive role in the surveillance and im-

provement of the physicians' performance. And when a physician encounters a problem of performance, the organization must decide what intervention is the best to deal with it.

It is obvious that such a system of surveillance of the performance and the improvement of the practice of the physicians cannot be spread out without the contribution from many organizations. That is why the FMLAC has proposed a model of collaboration that includes the participation and the support of the public, the profession and the government (Figure 2).



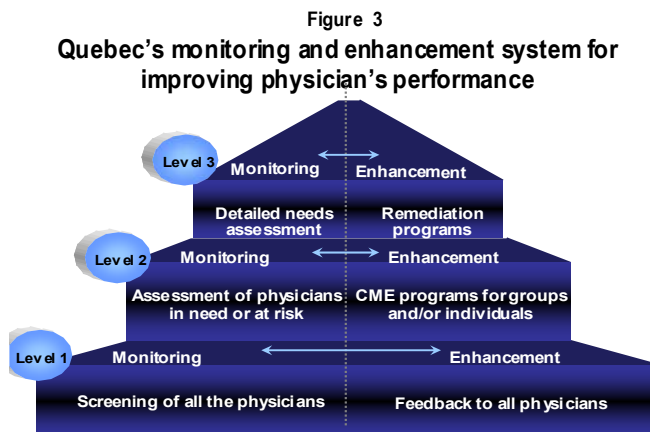
Quebec's system for monitoring and enhancement of the performance of physicians

The CMQ has adopted a model for monitoring and enhancement of the performance of physicians which aims at giving physicians all the information useful for improving the quality of the care they are giving. This monitoring and enhancement system consists of three levels of intervention. It suggests:

1. That all physicians be evaluated;
2. That these physicians be informed systematically at every level of surveillance;
3. That each tool of monitoring and enhancement be systematically validated before its application;
4. That these monitoring activities be systematically related to enhancing the professional practice activities.

The system set in place by the CMQ has the characteristic of being primarily oriented towards the improvement of the performance instead of the identification of deviant physicians. Thus, the surveillance of professional

practice of physicians is deeply related to a spreading of measures that should encourage the improvement of the performance, through the use of feedback at every step in the process (Figure 3).



• LEVEL 1 – SCREENING OF ALL THE PHYSICIANS

All the physicians covered by a program of monitoring are evaluated at the first level. Every tool used at this level must be simple, inexpensive, acceptable to the profession, valid, reliable and credible. For this, we review, for example, the bank of government's data (health insurance and drugs insurance) to obtain information on drug prescriptions, profiles of practice, or medical or surgical actions that have been taken.

For example, within a program of surveillance on the prescription of a particular drug, following a data compilation and analysis, each physician concerned could receive information on his individual profile of practice and on the general profile of physicians looked at in the program. In some cases, information on the standards of practice could also be given to physicians. This feedback should allow the physician to compare himself with his peers and with the data from the scientific literature. In the great majority of cases, this self-evaluation will give the physicians the opportunity, if need be, to make the necessary adjustments to improve their practice.

A few months after the intervention, a new data collection could be done to identify the physicians who could face specific difficulties.

- **LEVEL 2 – FURTHER EVALUATION OF THE NEEDS**

We estimate that 10 to 20% of the physicians evaluated at the first level will need additional evaluation information. Here, different tools, like the professional inspection visit, which consists of an overview of the hospital files or of the office, and a meeting with a colleague to complete the evaluation can be used.

Having completed the evaluation, a structured program of CME (seminars, symposiums, congress, readings etc.) targeted on the weaknesses identified could be recommended. A further evaluation could also be given after a few months, to verify the improvement.

- **LEVEL 3 – THOROUGH EVALUATION OF THE NEEDS**

Among all the physicians evaluated at level 1, a very few (1-2%) will need a thorough evaluation of his needs in training. Some tools like the structured oral interview (SOI), the OSCE, the concordance test scripts or training evaluation could be used to identify the weaknesses and establish, if necessary, prescribed training (mini-residency).

It is after these evaluations that a program with individualized training activities will be recommended or, if necessary, imposed on some physicians. These training activities could contain a tutorial or retraining period, with or without limitation of the professional practice of the physician who has been asked to participate.

Individualized training prescription

During the past years, the CMQ has shown its capacity to organize activities of individualized CME in order to answer specific needs of physicians having particular difficulties. In many cases these activities have been planned and organized in collaboration with the medical schools.

Between 1992 and 2000, the CMQ has offered individualized CME activities (tutorial, mini-residencies) to about 225 physicians (general practitioners and specialists). In these cases, the objectives of the activities have first been elaborated based on the difficulties identified with respect to a physician

within a program at level 1 or level 2, and specified at the time of an evaluation at level 3.

The format of educational activities offered to the physician during his training varies: direct supervision under unidirectional mirror or under video by the trainer, guided readings, presentation of clinical cases, indirect supervision, revision of patients' documents, literature review, educational courses etc. They are chosen by the trainer to achieve predetermined objectives.

At the end of the training session (and at the middle of the training period when the training periods last more than four months), the trainer prepares a report describing how the objectives have been reached and the success achieved by the trainee.

Depending on the weaknesses of the physician, the training period can be part-time or full time, and its duration will vary in relation to the learning objectives to be reached. The CMQ could also impose on the trainee a limitation of his regular clinical practice. In such cases, the physician could be constrained to limit his professional practice to training activities. The expenses incurred in this individualized training program will be borne by the trainee himself.

Conclusion

The maintenance of the competence is, first and foremost, the physician's personal responsibility. This individualized responsibility does not absolve the licensing authority at all of the responsibility of ensuring the competence of its members. The great majority of physicians maintain their competence and stay up to date by practicing medicine of quality. Unfortunately, some do not devote the required energy to their professional development; some others, though having good knowledge perform at a sub-optimal level because of various factors.

The mission of the CMQ is to promote a health care of quality, to protect the public and contribute to the improvement of the health of the Quebeckers. To realize this mission, the CMQ has put in place a system which aims not only to survey the Quebec physicians' practice but also to improve their performance.

Bibliography

1. Code of Ethics for physicians, Article 2.03.15. *Lois refondues du Québec*, chapitre C-26, article 87.
2. Goulet F, Gagnon R, DesRosiers G, Jacques A, Sindon A. Participation in CME activities; Family physicians in practice for more than 25 years versus those in practice for less than 25 years. *Can Fam Physician* 1998;44:541-8.
3. 'Organisateur d'EMC, Vol. 7, no2, page 3 – Juin 1994.
4. Miller GE. The assessment of clinical skills/ competence/performance. *Acad Med* (9 Suppl.) 1990;65:S63-7.
5. Goulet F, Jacques A, Gagnon R, Bourbeau D, Laberge D, Melanson J, et al. Performance assessment: Family Physicians in Metropolitan Montreal meet the mark! *Can Fam Physician* 2002;48:1337-44.
6. McCauley RG, Henderson HW. Results of the peer assessment program of the College of Physicians and Surgeons of Ontario. *Can Med Assoc J* 1984;136:557-61.
7. Jacques A, Sindon A, Bourque A, Bordage G, Ferland JJ. Structured Oral Interview, *Can Fam Physician* 1995;41:1346-52.
8. Miller F, Jacques A, Brailovsky C, Sindon A, Bordage G. When to recommend compulsory versus optional CME programs? A study to establish criteria. *Acad Med* 1997;72:760-4.