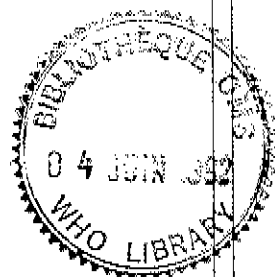


**SECOND CONSULTATION
WITH LEADING
MEDICAL PRACTITIONERS**

Geneva, 20 - 22 August 1990



WORLD HEALTH ORGANIZATION
1991



REPORT ON
SECOND CONSULTATION WITH LEADING
MEDICAL PRACTITIONERS

GENEVA, 20 - 22 AUGUST 1990

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SECOND CONSULTATION WITH LEADING MEDICAL PRACTITIONERS

GENEVA, 20 - 22 AUGUST 1990

The First Consultation with Leading Medical Practitioners was organized by WHO in Geneva on 23-24 August 1989. Participants in that meeting considered that a close relationship between WHO and the medical profession was important in order to achieve health goals, and a consultation was an appropriate means to improve communication between the two. It was also agreed that such consultations should continue, but with a focus on specific topics on each occasion. Subsequently it was decided that the Second Consultation should concentrate on the subject of Continuing Medical Education (CME), and its role in Quality Assurance.

1. OPENING

The Director-General, Dr H. Nakajima, opened the Second Consultation and called upon participants to consider the role of continuing education in achieving quality assurance. He pointed out, however, that other equally important goals of continuing education might include incentive strategies for preventive and promotive care, and the appropriate use and allocation of resources. The participants were challenged to look beyond the obvious value and benefits of CME and tackle the problem of developing CME programmes which satisfy rigorous educational criteria.

Dr Nakajima suggested that the deliberations be conducted within the framework of the environment in which health systems and health professions are currently operating, and crucial issues which will influence them in the future such as:

- (1) Continuing improvement of the efficiency and effectiveness of technical interventions;
- (2) Compatibility with national politico-socioeconomic realities and integration of the health sector into the national economy; and
- (3) Respect for basic human rights, such as the right to be informed, and the integrity of the individual, including freedom to decide, in the spirit of social justice and equity.

Dr Nakajima said that he had invited medical practitioners to participate in this consultation to work toward ensuring quality of care. For, without the involvement of the medical practitioner, quality of care cannot occur.

In closing, he reminded participants that the First Consultation had pointed to the need to improve the flow of information between WHO and national and regional medical associations. He therefore requested comments from those who had attended the First Consultation as to what had been achieved in this respect.

2. INITIAL DISCUSSIONS

2.1 Information Dissemination

Participants responded that progress had been made in improving the flow of information between WHO and the medical profession, but much remained to be done. There were specific examples of activities which had occurred as an outcome of the previous year's Consultation: senior WHO officials had been invited to speak and participate in regional meetings of medical associations, or to national groups of leading medical practitioners. Some medical associations had urged their governments to pay

WHO in full the dues they owed and had worked for the passage of legislation to achieve this goal. In other cases, WHO materials had been distributed, or translated and included in the publications of medical associations.

A number of participants urged WHO to provide simple, short and succinct articles on important matters that could be used as inserts in journals and newsletters for broad dissemination to members, ensuring coverage even in remote areas.

A need was expressed for the development of continuing education programmes for medical journal editors, as well as seminars for mass media journalists to improve the quality of medical information which is disseminated.

2.2 Continuing Medical Education

Three papers were presented addressing the issue of quality assurance through continuing medical education (CME) (outlines attached as annexes). These stimulated a wide-ranging discussion of what constitutes quality assurance. At one extreme it was defined as the best possible care using the most advanced technology to treat a specific patient. While no consensus was reached, in general participants agreed that quality assurance is increasingly centred on outcomes, rather than structure or process as in the past. Further, that lessons learned from any evaluation of outcomes may and ought to be used for educational purposes.

Participants agreed that it is for the medical profession to define the quality of medical care. Beyond these general assumptions, there were wide-ranging opinions. The suggestion was made that perhaps the term "quality assurance" is a misnomer, and that the profession should use, instead, "quality assessment".

In order to examine more closely the impact of CME on quality assurance, participants focused the remainder of the meeting on the following questions:

- (1) What is CME?
- (2) How can CME be developed to make favourable changes in behaviour?
- (3) Who should be involved in CME?

3. WHAT IS CONTINUING MEDICAL EDUCATION?

3.1 The general parameters of CME, though not definitive, which emerged from the discussions are: CME is applied education or learning experience, formal or informal, which takes place after initial qualification training and provides new or improved skills and/or knowledge that will better enable health care providers, whether they be physicians, nurses, midwives, or other health personnel, to meet, protect and promote the needs of their patients and/or the community in which they serve. CME is seen as a process of learning which takes place over the entire career of health personnel rather than being a finite, one-off or series of disconnected educational experiences. These experiences must be developed and take place within the context of the health care provider's own health system.

3.2 CME by its very nature is complex, not only conceptually but also in its development, implementation and evaluation. The complexity is evident in the range of key issues related to CME listed by the participants:

- Ethics
- Funding
- Human resources
- Recognition and accreditation for professional purposes (role of national medical associations and specialty societies)
- Relicensing
- Reaching all health personnel (especially those in remote areas)
- Appropriate learning tools (finding creative solutions to overcome constraints: lack of provider time, location)
- Relationship of CME to quality of care
- Control or oversight of CME process
- Dealing with variations in practice setting (rural, teaching hospital, group practice)
- Motivation of health personnel to participate
- Need for teachers to be trained educators and actively involved in practice in the appropriate discipline
- Relevance (must be related to real needs of practising doctor)

4. DEVELOPING CME TO MAKE FAVOURABLE CHANGES IN BEHAVIOUR

4.1 Process

The process of development of CME is critical because it embodies the basic philosophy and the manner in which many of the key issues identified above are dealt with in CME. The consensus was that CME would involve some part of all of the following activities:

- Develop appropriate procedures for identifying CME needs and interests
- Establish objectives to meet the specific needs of the target health care providers
- Determine instructional content in terms of outcome or changes in knowledge, skills and/or attitudes
- Design appropriate activities to meet needs of participants and ensure it is an "applied" situation
- Establish appropriate measurement tools to assess the effectiveness of the CME programme
- Create a structure to carry out the on-going assessment of needs, planning, implementation and evaluation of CME

4.2 Considerations

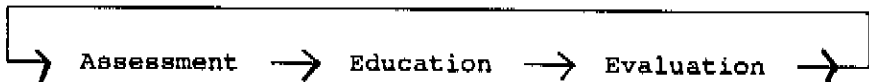
The professional development of health workers to promote quality of care is one of the primary objectives of CME. Since the development of CME must take place within the total context within which physicians or other health professionals

work, it is important that factors other than simply the educational content be considered. Additional factors which must be taken into account in the process of developing CME would include, but not be limited to:

- Incentives for doctors to embrace CME (e.g. getting them to see it as a life-long process)
- Role models in CME
- Individual needs of health professionals for CME
- Technical support to apply skills in practical situations

4.3 Summary

CME is an on-going, iterative process. It begins with an assessment of the needs of health professionals. This will determine the education content which is structured in terms of objectives, instructional content, and specific activities. The educational element is followed by evaluation to make the process complete. Evaluation leads back to the assessment of the process. Due to the fact that CME is progressive in its development, adequate time is required for it to develop properly. During this developmental process, incentives may be needed for health personnel to participate actively (e.g. recognition by peers, etc). The CME development process can be represented in a figure:



5. WHO IS INVOLVED IN CME?

It was generally agreed that all health personnel in the health system should participate in continuing education. Some of these activities would occur conjointly between different health personnel groups, while others would be offered solely within a particular group. Each country, and health personnel groups within it, must evaluate their situation and needs and develop the appropriate mechanisms and means to promote relevant CME.

6. WHAT IS THE ROLE OF NATIONAL, REGIONAL AND INTERNATIONAL GROUPS AND AGENCIES?

The role of the various groups represented at the meeting, in promoting and developing CME, was considered at three levels:

6.1 Role of National Medical Associations in CME

The medical profession through National Medical Associations must accept the primary responsibility for CME. However, implementation will vary depending on circumstances in each country. For example, some activities may be delegated to specialized colleges and societies, including those dealing with family medicine or general practice. The role of National Medical Associations might be, for example:

- To stimulate and ensure a professional approach and ethical attitudes in CME
- To encourage CME, with respect to the medical profession, specialist colleges and societies, and governments

- To publish or supply appropriate information on continuing medical education opportunities
- To arrange accreditation
- To be responsible for determining where deficiencies exist in medical education and to encourage training in such areas
- To organize quality assessment/evaluation studies, including studies on education models.
- To set standards on the training of teachers of CME
- To cooperate closely with other health professional organizations at country level
- To establish guidelines governing commercial support of CME
- To develop an appropriate recognition award system for physicians participating in CME
- To inform the public of organized medicine's efforts to provide CME activities that assist physicians in carrying out their professional responsibilities more effectively
- To encourage and foster self-directed learning in the sense that physicians should be actively responsible for their own CME

6.2 Role of Regional Medical Associations in CME

Whilst the activities and constitutions of regional Associations vary, they do play an important role in CME. It is in regional medical associations where a more accurate picture of

cross national developments in CME can be identified. These associations play an important part in helping nurture CME development at the national level by undertaking some or all of the following roles:

- To collect CME topics of regional interest
- To present country reports on CME
- To establish liaison with other international bodies, with governments and with funding agencies in designing CME activities
- To act as an intermediary between WHO and national medical associations
- To encourage regional cooperation in vocational and specialty training, including establishment of regional criteria for specialty training and CME
- To publish regional newsletters for continuous exchange of information
- To conduct continuing education programmes at each regional meeting
- To coordinate continuing education exchange visits between member countries which may include visits to medical schools, teaching hospitals and attendance at national CME programmes.

6.3 Role of WHO

The key role of WHO in facilitating the promotion of CME on a global basis was recognized due to its ability to transcend national and regional considerations in a unifying role. The key areas for WHO's role to be maintained and expanded are:

- Advocacy for CME, vis-à-vis governments and national health authorities
- Clearinghouse for appropriate information and exchange of experience. This would include providing a platform for exchange of information on activities in CME conducted by national associations
- Maintain a roster of experts/consultants
- Provision of manuals on methodology on CME, including its evaluation
- Seek ways to make appropriate teaching materials more widely available
- Identify areas in which CME appears to be deficient at present
- Establish a network of collaborating centres.

7. CONCLUSION

The issue of professionalism surfaced frequently during the discussions on quality assurance through CME. It was repeatedly stated that in the medical profession, the physician must take responsibility for life-time study to keep current with the accelerating rate of technological changes affecting medical care. Medical practitioners must be highly motivated to work for the highest standards of competency so that their knowledge and skills can be utilized for the welfare of their patients.

In his closing remarks, the Director-General expressed the view that the value of this type of consultation has been clearly demonstrated. The discussions had illustrated the importance of continuing education in achieving quality assurance, not only for physicians but all health professionals and health workers at all levels of each health system.

Dr Nakajima stated that he felt the process should be continued, with each consultation concentrating on a topic of relevance to the medical profession, with the aim of improving quality of health care and the health of the community. This was supported by all participants.

QUALITY ASSURANCE THROUGH CONTINUING MEDICAL EDUCATION

SYNTHESIS OF PRESENTATION AT

SECOND CONSULTATION WITH LEADING MEDICAL PRACTITIONERS

Dr Ian Field, Secretary, British Medical Association

Continuing Medical Education begins with undergraduate training and persists in a structured way through training for career posts. The system operating in the United Kingdom ensures that doctors selected for career posts are generally competent in their own clinical field. However, more needs to be done during this period of undergraduate and postgraduate training to encourage the philosophy and culture of audit, both self and group audit, and effective management of resources. It is important, therefore, that continued medical training in audit method must be available and that the profession ensures that medical audit remains under medical leadership and direction.

There has been increasing discussion on the need for standard setting and the prescription of protocols of practice in order to arrive at some criteria against which quality assessments can be made. Although it has not always been possible to arrive at consensus on these criteria, the process has in itself provided a form of continuing medical education for those who have participated. In fact, many quality assurance processes in medicine are themselves a form of continuing medical education. One of the major problems in this field at the moment is that there are no widely acceptable indicators of clinical outcome or of quality of life for patients. Much more research needs to be done in this area.

In the United Kingdom, the standard of medicine in the private sector is, on the whole, no different from that in the National Health Service, save that certain more advanced techniques are not available throughout the private sector. The two biggest groups working in the National Health Service are the general practitioners and the hospital doctors. The former are officially independent contractors, who have entered into a contract with the National Health Service but are not salaried. On the other hand, hospital doctors are employees who are salaried, although most of the specialists in established posts have contracts which permit them to do some private practice as well.

'Quality' in health care includes many perspectives but a number can be covered through medical education, particularly those relating to medical care and standards; effective use of resources; and most important of all those relating to the individual attitudes and approach of the doctors themselves.

Undergraduate Medical Training

In the United Kingdom, medical training rests with the individual medical schools of the universities, who are also responsible for admission procedures. As the demand for entry to medical school exceeds the number of places available, this control on numbers has inevitably caused the entry standards to rise. The overall control of quality of undergraduate medical education throughout the country lies with the statutory General Medical Council, the composition of which is largely medical, although there are some lay members. Thus, although the universities set their own examinations, there is a degree of standardization through this monitoring which ensures that no particular set of degrees in the United Kingdom is any better, nor any worse, than any other.

The system has worked well for many years but has tended to concentrate firstly on knowledge of the basic sciences and then very much on clinical knowledge and skills, in both the

general practitioner and the hospital setting. I believe there needs to be more emphasis on the need for some identifiable form of audit so that the individual learns to assess the quality of his or her own performance, and that students need to be made more aware of a requirement to manage resources effectively as part of the practice of medicine.

Postgraduate medical education

To become a principal in general practice in the United Kingdom, a doctor must undertake at least three years of vocational training to a satisfactory standard. One year will be spent in a series of approved hospital posts and two years on attachment to a recognized training practice in the community. The quality of training practices is monitored carefully by a joint committee on postgraduate medical training in general practice, which includes representatives from both the British Medical Association and the Royal College of General Practitioners, as well as other interests. The assessments carried out by the joint committee cover more than just clinical ability, they do include both the organizational arrangements of the practice and the degree to which members of the practice engage in quality assessments. In fact, although quality assessment has been encouraged in training practices in the past, it will shortly become a requirement for practices to include this element if they are to be recognized for training purposes. I would like to emphasize that this is a professionally-led change.

Continuing Medical Education

As in most other countries, doctors engage in continuing medical education by reading medical journals, and they will attend a variety of medical meetings organized at different levels. There are formal courses and conferences arranged by the royal colleges or by university departments, in addition to which many courses will be organized locally in the postgraduate medical

centres. On the whole, there is a postgraduate medical centre attached to each district general hospital in the United Kingdom.

In addition to these more formally organized courses, both general practices and specialty divisions within hospitals organize clinical-pathological conferences, death and morbidity meetings, and some variation of what used to be called "ground rounds". The contribution of all these arrangements to quality assurance is considerable, although the degree of participation across the country has been patchy in the past and hard to monitor. Be that as it may, the medical profession has provided the National Health Service with a generally high quality of service on this basis over many years.

It has now been decided that all doctors working in the National Health Service are to become involved in some type of formal clinical audit as part of their continuing education. This activity has been defined as:

"the systematic, critical analysis of the quality of medical care, including procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient."

The medical profession has insisted that formal clinical audit should be achieved by peer review, and be seen as something quite distinct from any form of financial audit. It has argued that quality assessment by the medical profession must be medically led and directed.

Wider clinical audits

Apart from the local audit procedures, there are a number of wider geographic audits that have been conducted in the United Kingdom. One of the longest running formal audits in the United

Kingdom is the confidential enquiry into perinatal deaths in English and Wales which was first established in 1952. All obstetric units voluntarily report cases involving deaths during the perinatal period to a central point, where they are analyzed and lessons drawn for future practice. This has produced a culture in obstetricians whereby reporting such cases, the analysis of them and the publication of that analysis with the lessons drawn is seen increasingly as the "norm". More recently, other audits have been established, both on a national and more limited geographical basis.

Undoubtedly, taking part in this formal style of audit provides a continuing education in itself and such "enquiries" need to be encouraged in other fields. However, there is also a need for continuing education in audit method itself to encourage personal audit and an interest in broader quality assessment.

It is vitally important that this type of quality assessment is seen as primarily educational, and does not become a medico-legal tool or take on a disciplinary or punitive function. Furthermore, there still needs to be a great deal of education if the exercise is to achieve its positive objective, which is to improve the quality of patient care. The danger is that if doctors are not properly briefed to understand the purpose of the exercise, it will drive them into entrenched positions. It is also true that the exercise requires a sensitive long-term approach and great commitment both in terms of time and money. In the British Medical Association our concern is that this requirement for additional time and money may not be fully appreciated either by administrators or by the Government.

The further development is an increase in the tendency of professional organizations to attempt to set standards, or to devise protocols and procedures, affecting various aspects of clinical practice. It has not always been possible to achieve consensus in the development of these standards or protocols, but

undoubtedly the effort of trying to reach a consensus has proved education in itself.

Last but not least, we must recognize that there is always a relationship between continuing education and research. In the field of quality assessment and audit much more work needs to be done on the indices for outcomes of treatment, both in terms of its clinical effectiveness and its effect on the general quality of life for the patient. The challenge of continuing medical education will then be to convert the lessons of this work into general clinical practice to the advantage of the patient.

**QUALITY ASSURANCE THROUGH CONTINUING MEDICAL
EDUCATION**

SYNTHESIS OF PRESENTATION AT

**SECOND CONSULTATION WITH LEADING MEDICAL
PRACTITIONERS**

John J. Ring, M.D.

Chairman, Board of Trustees, American Medical Association

Organized medicine has been concerned with quality assurance for a very long time. We need to improve the quality of medical care by standardizing and improving the education of physicians. By education is meant the full range of training from pre-medical to medical school, and on to formal post-graduate education.

Continuing medical education is becoming more and more important.

At the turn of the century physicians could graduate as physicians secure in the knowledge that whatever they learned in school would probably serve them for most of their professional careers. Forty or fifty years ago medical science began to advance more rapidly and much of what doctors learned in school became obsolete in a generation or so. In the near future it is more than likely that what physicians are taught in school will become obsolete before they finish their residency training!!

So although continuing medical education is not new, it is going to become even more important if we hope to keep up with

the increasingly rapid growth in knowledge and technology. Physicians of the future face a greater challenge than the mere acquisition and application of knowledge.

In this new era, it will no longer be sufficient to talk about quality assurance, we will have to focus on quality improvement. Institutions outside the profession of medicine will continue to intervene as society seeks to balance its resources with a wide variety of other needs. And physicians will be judged as much by their responsiveness to social imperatives as by their medical talents. That means their competence must be demonstrated.

Despite the rapid advances in science, doctors are still healers, not mere technicians. The U.S. health care system has produced marvellous medical training, outstanding scientific research, and fine patient care, but while the quality of care is high, there is always room for improvement. The medical profession needs to promote technology and leave science free to conduct research in the best interest of patients.

Concern, however, is not only with quality but with how quality is defined and by whom. Those are the real issues, as a profession, we need to continue to define and to improve the quality of health care.

In the past year, the AMA has sponsored or participated in a series of conferences, congresses and meetings to focus on enhanced clinical competence, explore potential interrelationships of state medical societies, quality assurance agencies and institutions and organizations with educational resources. Our 1988 policy for Focused Continuing Medical Education for Enhanced Clinical Competence has had a ripple effect in several states of the USA. The Third International Conference on CME held at Rancho Mirage, California, drew more than 120 participants from around the world.

There are many ways of improving quality including expanded development and use of practice parameters and the appropriate use of statistical data. The main concern is to assure that practice guidelines originate within the ranks of organized medicine. Likewise, continuing medical education can help improve quality of care. Here also, patients are best served by a system that keeps physicians in control. Only a small percentage of US physicians are deficient in their levels of expertise. Certainly the number is not great enough to warrant elaborate costly and questionable state-run programmes of continuing medical education. First of all, it would be difficult to establish that simply attending CME training leads to improved performance.

One also has to concede that, even though a physician knows a given subject area, he or she may not be proficient in it. So, continuing medical education in and of itself does not necessarily result in quality improvement. Still, it can be demonstrated that continuing medical education can be effective and can influence a physician's learning and can influence performance.

Medicine is in a continuing state of change and physicians must keep abreast of change by reading journals, attending conferences, peer discussions, viewing televised programmes and other learning activities. But whether the state can guarantee or assure competence through CME is another question. Both physicians and the institutions that produce them must maintain a strong sense of social responsibility for the health and medical care they provide. If doctors are expected to be lifetime learners, medical education must remain self-directed and personally exciting for practitioners. That is why although the policy of the AMA is to support voluntary continuing medical education, it opposes government-mandated CME programmes. Through its continuing efforts to upgrade undergraduate and graduate medical

education, and its support of licensure throughout the states, the AMA has done much to improve physician competency.

Continuing medical education is a significant part of our strategy. But it should be voluntary, a part of our professional responsibility and not something that is imposed upon us by the state or by third-party payers.

QUALITY ASSURANCE THROUGH CONTINUING MEDICAL EDUCATION

SYNTHESIS OF PRESENTATION AT

SECOND CONSULTATION WITH LEADING MEDICAL PRACTITIONERS

H. Lindsay Thompson, A.M., M.B., B.S., F.R.A.C.G.P., F.A.M.A.
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One of the main purposes of Quality Assurance (QA) is to define problems which can be corrected by Continuing Medical Education (CME). The processes of assessment, education and evaluation are part of a continuum of ongoing activity with a circular flow chart.

Whilst systems of peer review, quality assurance and hospital accreditation - the latter through the Australian Council on Health Care Standards - have become established, they are far from universal. Many are still sceptical, in particular the medical profession who are frequently in private practice and fear further intrusion from government into medical practice. Other health professionals are more enthusiastic, in some cases seeing the exercise of quality assurance as a way of improving their status.

No matter how one looks at the problem it is difficult to reconcile the interests in quality of the medical profession whose prime interest is in providing the best possible care to individual patients, with the intent of governments who have the collective responsibility to see that money for health care is available from private and public sources. In an era of growing population with the greying of this population in westernized countries, and

increasing technological development, governments must be primarily concerned with costs. The conflict between doctors and government will inevitably continue unless reasonable balances are achieved between quality, access and cost, which are the basic variables in health care delivery.

In Australia, State Governments have made quality assurance more or less compulsory for public hospitals, and the private sector has responded by making accreditation a qualification for private hospital association membership in some states. The Australian Council on Health Standards (ACHS) has placed effective quality assurance as a key criterion for health care facility accreditation. It is true, however, that the ACHS has made little progress as yet in the area of community services as distinct from hospital services.

However, outside the hospital accreditation areas developments have taken place in certain areas of medical practice with increasing interest being shown by the Australian Medical Association, as well as speciality colleges and societies.

Continuing Medical Education

Some observations need to be made re CME:

1. The following is quoted from a paper by Philip W. Shay, Executive Director of the Association of Consulting Engineers in New York, delivered in 1965:

- "1. Knowledge of the Profession, including its background, purpose, common body of knowledge, skills and practices.
2. A standard of conduct governing the relationships of the practitioner with prospective clients, colleagues, members of allied professions and the public.

3. A motive of service as distinguished from exclusive preoccupation with making money.
4. A continuing discipline of study and a sense of responsibility for assisting in the advancement and dissemination of professional knowledge and skills.
5. Professional pride. The true professional is imbued with a profound belief in the worthiness of his calling, and this conviction guides and dominates his actions. Professional pride inspires a man to continually strive for higher standards of competence and professional conduct."

With continuing growth in knowledge plus use of technology, all professions, but especially medicine, need to be taught and continually reminded about what a profession is all about. Physicians are not in business or trade. Those in private practice are not in small business despite the fact that they face similar economic problems. Being professionals, they have the obligation to behave in accordance with the above list of characteristics which includes a continuing discipline of study. This commences with undergraduate studies and should be a continuum for the rest of the medical professional life.

2. CME programmes - at least in Australia - are largely used by those who need them least.
3. CME should produce demonstrable changes in one's practice of medicine - reading journals, attending seminars, listening to tapes are not productive if one does not obtain useful knowledge.
4. There is a necessity to define practitioners' needs for CME - many pursue their interests rather than their needs.

5. There is a need to rationalize the vast number of programmes available to avoid wastage of resources.
6. Practising physicians need to be educated regarding the growing body of applied knowledge appropriate to their vocation otherwise the "knowledge explosion" leads to an inability to cope.
7. Clinical knowledge, skills and judgement are best learned in clinical practice rather than in a medical school. Medicine centres around the care of humanity and this cannot be learned in a lecture room.
8. Current criticisms of the medical profession, as well as other professions, are multifactorial in origin. CME will not act as a panacea to satisfy these criticisms unless it is allied with programmes to improve total professional performance including behaviour, ethics, and practice designed to provide cost-effective care.
9. Reassessment and recertification, whilst not acceptable to most practitioners at present, are inevitable in the not too distant future. With scientific knowledge and its technological expression continuing to grow exponentially resulting in a doubling time of about ten years public opinion will insist on this.
10. The central role in the provision of CME should be undertaken by appropriate medical organizations - associations, colleges and societies - and not by government. How this is to be done will vary according to differing national health care systems. It is highly desirable that National Medical Associations representing the medical profession as a whole should play a major role in coordinating CME.
11. CME should emphasize preventative medicine.

12. As health care involves many medical specialities as well as other health workers, education should include the understanding of the role of colleagues and the team approach.

The challenge remains to produce QA programmes which are confidential, privileged (in the sense that they cannot be used for medico-legal action), non-threatening to participants, sound educationally and effective.

Undoubtedly CME has a major role to play in correcting deficiencies. This is important as it overcomes a major criticism of CME in the past, namely lack of direction designed to correct deficiencies at both the collective and individual level.

Whilst activity to date has largely been in hospitals, there is growing usage of QA in the area of community services as illustrated in Australia by the RACGP initiatives already documented.

In my opinion physicians, either individually or in small groups, must develop the ability to assess, manage and plan their own CME. This may be easily achievable at unit level within a hospital but is a long way off for most practitioners in community practice, particularly if they are in solo practice.

SECOND CONSULTATION WITH LEADING MEDICAL
PRACTITIONERS
GENEVA, 20 - 22 AUGUST 1990

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