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REVIEW ARTICLE

Overview of legal aspects of Continuing Medical Education/ Continuing Professional Development in Georgia

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Abstract

Improved patient safety and quality of health care are of great importance to the Continuing Medical Education/Continuing Professional Development (CME/CPD) system in Georgia. In particular, those involved in the delivery of frontline care have an inherent duty to ensure that they are competent and skilful in providing good care for patients. An effective system should support physicians across a number of key areas including:

• Providing patient care; • Promoting health improvement, wellness, and disease prevention; • Innovating and developing the role of the physician; • Managing and using resources of the health care system.

CME/CPD must become an integral part of a healthcare professional's practice experience. Practice must facilitate reflection on needs and on new approaches to care and on best practice in all healthcare settings. The value of effective practice and learning from practice through reflection is widely accepted.

Physicians should participate in CME to develop abilities to describe and critically analyse episodes of their clinical practice, illuminate and assess their own level of competence by applying competency standards as a benchmark, identify areas of strength and those requiring development and develop practice-driven clinical learning objectives. Patient care must be based on the latest evidence. The analysis of CME/CPD systems in the medical field in various European countries makes it difficult to directly pinpoint specific institutions having responsibility for providing CME/CPD. Medical professional organisations are the main suppliers and supporters of CME/CPD. Physicians themselves also play an important role in the CME/CPD process. It has become a life-long responsibility for all doctors to be involved in CME/CPD.

Keywords: Continuing Medical Education/Continuing Professional Development, Georgia, legislative regulation, WFME, UEMS.

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Introduction

Patient safety and quality of health care are of critical importance for any continuing medical education/continuing professional development (CME/CPD) system.[1] In particular, those involved in the delivery of frontline care have a duty to ensure that they are competent in their contribution to the care of patients. The goal of CME/CPD is to improve patient care through better clinical performance of healthcare professionals translating into improved clinical outcomes.[2] The importance of meeting the expectations

of the population by the providers of health care services is widely accepted as one of the indicators of a functioning system.[3,4] An effective system should support physicians across a number of key areas including:

- Providing patient care;
- Promoting health improvement, wellness, and disease prevention;
- Innovating and developing the role of the physician;
- Managing and using resources of the health care system.

Despite variations in detail, there are common features of content and process that allow international mutual recognition of activities in CME/CPD. CME is defined as any activity that serves to maintain, develop or increase the knowledge, skills and professional performance and relationships that a physician uses to provide services for patients, the public or the profession. The term CPD includes education methods beyond the didactic, embodies concepts of self-directed learning and personal development and considers organisational and systemic factors.[5]

It is desirable to demonstrate a clear effect of CME/CPD on patient outcomes.[6] There is a pressing need to demonstrate the ability of CME/CPD to improve health care and this requires the development of a research agenda to study the impact of CME/CPD on patient safety.

CME/CPD is considered essential to bridge the gap between medical education and practice. The non-enforcement of CME/CPD and the lack of incentives by the professional and regulatory medical bodies may account for the lack of physicians' involvement in CME/CPD in Georgia. In order to improve CME/CPD activities, cooperation between the health professionals, health organisations, government, NGOs and international organisations is needed. The key players in the CME/CPD process should be defined: professional medical organisations, employers or the state institutions.

CME/CPD should become an integral part of a healthcare professional's practice experience. Practice should facilitate reflection on needs and new approaches to best practice in all healthcare settings. The value of reflective practice and learning from practice through reflection are widely accepted. Recent studies suggest that physicians benefit from reflection on their progress and development of their next learning projects or questions.[7]

Physicians should participate in CME/CPD to develop abilities and competences; to describe and critically analyse episodes of their clinical practice; to elucidate and assess their own level of competence by applying competency standards as a benchmark; to identify areas of strength and those requiring development; and to develop practice-driven clinical learning objectives. Patient care should be based on the latest evidence-based practice.

Legislative basis on CME/CPD of Georgia

In Georgia health care is regulated by the following national legal acts:

Laws of Georgia on (i) Health Care, (ii) Medical Activity, (iii) Rights of Patients, (iv) Medical Insurance and (v) Drug and Pharmaceutical activity.

The Health Care Act defines CPD[6] as a subsequent period of higher medical education and post-graduate professional training, which continues throughout the entire professional activities of an individual.

Article 97 of the same law states that after receiving higher medical education, the professional training of physicians includes post-graduate professional training and CPD. Post-graduate professional training is directed at the doctors' specialties, whereas CPD aims to maintain the professional competence of a physician so that his/her theoretical knowledge and practical skills are consistent with the achievements and technologies of contemporary medicine.

According to Article 100 of the Health Care Act, the components of CPD along with the criteria and rules of evaluation of physician participation must be determined by the Law of Georgia on Medical Activity, which defines CPD differently from the Health Care Act – "Continuing Professional Development aims to ensure the consistency of theoretical knowledge and practical skills of an entity of independent medical activity with the contemporary medical achievements and technologies".

Pursuant to Article 29 of the Law of Georgia on Medical Activity, CPD components are as follows: (a) CME; (b) continuing medical practice; (c) professional rehabilitation; and (d) continuing improvement of the quality of medical care. The same law defines each of the listed components. In particular, in accordance with the definitions of the law:

> CME is the component of CPD, which includes self-education, as well as participation in formalised education/training programmes and also other activities promoting the enhancement and improvement of a physician's professional knowledge and skills (participation in congresses and conferences, publication of works, teaching, etc.);
>
> Continuing medical practice is the component of CPD which implies continuing practical clinical activities in a defined specialty and is evaluated by relevant data (number of patients, number of manipulations to be carried out, duration of practice, etc.);
>
> Professional rehabilitation is the component of CPD which implies undertaking a relatively long-term (1–5 months) education/training course and aims at restoring a physician's professional competence in a specific medical specialty;
>
> Continuing improvement of the quality of medical care is the component of CPD, which implies the periodic evaluation of the quality and results of a

physician's clinical activities and a gradual improvement of respective indicators.

In accordance with the same Article 29 of the Law of Georgia on Medical Activity, the separate forms of CPD's first component – CME – and the professional rehabilitation rules of the third component, as well as the rules and criteria of accreditation are developed by the Professional Development Council within the Ministry of Labour, Health and Social Welfare of Georgia and are approved by the Ministry. Pursuant to Article 20.7(e) of the same law, the Professional Development Council also carries out organisation, management and monitoring of the CME/CPD processes.

In 2005, the Georgian Association of Medical Specialties was established; and in 2006, it became a member of the European Union of Medical Specialists (UEMS). From 2010, it has been a member of the European Medical Association (EMA).

Internal regulations of the Georgian Association of Medical Specialties were approved on 16th May 2006 by Council Order. It is stipulated that the association carries out the following activities:

- Ensures the organisation, management and monitoring of the CME and CPD processes in Georgia;
- Examines the issues of CME and CPD and develops relevant recommendations to facilitate accreditation of these programmes;
- Ensures the harmonisation of the Georgian CME/CPD system with European countries based on the World Federation for Medical Education (WFME) and World Health Organization (WHO) recommendations;
- Carries out relevant measures and makes appropriate decisions in relation to CME and CPD, unless otherwise provided in the Health Care Act;
- Represents the Georgian Medical Society to the public administration agencies, delivers opinions and proposes new directions for the development of the health care system;
- Facilitates increased mobility of Georgian physicians; cooperates with all European and World Organisations engaged in Post-graduate Medical Education and CPD to ensure the highest level of professional autonomy and self-regulation of medical specialties.

In 2004 and 2005, two acts were adopted in Georgia in relation to CME and CPD requirements for recertification of physicians. However, the Law on Physicians Act does not provide for recertification for doctors in independent medical practice and allows a state certificate, once granted, to be valid indefinitely.

On one hand, the legislator recognises CME/CPD as an integral part of medical activity and an essential component of professional qualification of physicians almost amounting to mandatory CME/CPD; on the other hand, the legislator states that CME/CPD is not an obligatory requirement for physicians.

Thus, a physician in Georgia, who obtains the certificate of independent medical activity for his/her lifetime, participates in CME/CPD activities only on a voluntary basis. Although the legislator views such participation in activities as an integral part of this physician's activities, it is not legally mandatory.

Global standards in CME/CPD in the light of current practices in Georgia

The WFME, along with the WHO, has developed Global Standards for CME and CPD for medical doctors.[8] The material was published in 2003, and may be considered as universal recommendations. CME describes continuing education in the field of knowledge and skills of medical practice; CPD, a broader concept, refers to the continuing development of the multi-faceted competences inherent in medical practice, covering wider domains of professionalism (e.g. medical, managerial, social and personal subjects) needed for high-quality professional performance.

Although CPD relates to the period commencing after completion of post-graduate training, it has further ramifications. CPD activities start when the student is admitted to medical school and continue as long as the doctor is engaged in professional activities. The shaping, reshaping and development of a doctor involve responding to changing societal and individual needs in the context of evolving medical science and health care delivery. Independence is also implicated. In the Global Standards document, the term CPD is used and CME is considered as one of its components.[9]

Therefore, the former term of CME has been replaced by CPD. The new term both reflects the wider context in which this phase of medical education takes place and signifies that the responsibility for the context in which this phase of medical education takes place rests with the profession and the individual doctor. Law and jurisdiction seldom regulate CPD. Where regulations do exist, these are flexible, even in countries demanding re-licensure of doctors in practice.

Modern Trends of Legislative Regulation of CME/CPD

CME/CPD is legally regulated in many European countries; however, such regulation is usually flexible, even in countries where the repeated certification of physicians is established.

The analysis of CME/CPD systems in various European countries does not allow easy comparison and identification of specific institutions responsible for providing CME/CPD. The volume and interdependence of different organisations' and stakeholders' involvement in CME/CPD vary greatly in different countries

and their roles are usually not clearly defined.[10] In the majority of cases, medical professional organisations carry out the general planning and coordination of CME/CPD activities, including the registration and documentation of these activities.

In European countries, there are national bodies of CME/CPD accreditation. CME/CPD providers and activities are guided by the European consensus formulated in the charter of the European Union of Medical Specialists (UEMS) on "CME" and its annexes, as well as the guidelines developed by the UEMS. In addition, national accreditation authorities grant credits, accumulation of which is necessary where CME/CPD is a mandatory condition of re-certification and re-licensing. Further, the accreditation of international CME/CPD activities at the European level is carried out by the European Accreditation Council for CME (EACCME) created by the UEMS. Full accreditation also requires approval by the national accreditation authority of the host country of the CME/CPD activity.

Barriers to CME/CPD in developing countries

The primary goal of medical education is to produce physicians, who will deliver high-quality health care.

Recent calls for greater accountability in medical education and the development of outcomes research methodologies should encourage a new research effort to examine the effects of medical training upon clinical outcomes.[11] Increasingly, there is a demand for professional accountability through re-certification because of concerns about professional negligence and increased awareness of medical errors.[12]

In Georgia, the following factors have been considered as obstacles to CME/CPD. These can be summarised as follows:

- Motivation – there is no motivation except for self-improvement to participate in CME/CPD, or to gain admission to membership of some specialist medical association. The need for CME/CPD is not sufficiently appreciated in Georgia. There is no incentive for engaging in CME/CPD, nor sanction for non-participation.
- Time – doctors need time for study, reflection and to attend learning courses. Lack of time due to pressure of work and lack of funded study leave have been identified as major barriers to CME/CPD activities. Management considers allotting time for CME/CPD as a luxury.
- Finance – most doctors have to pay for their participation in external CME/CPD activities. In developing countries, salaries are just enough to meet basic family needs and many doctors have to work extra hours in private practice to supplement salaries. There is little to spare. In most health organisations, there are no budget lines for CME/CPD.
- Access – information about CME/CPD is not widely distributed, so many doctors, especially those working in rural areas are not aware of professional conferences until after the event.
- Acceptability – most CME/CPD activities outside teaching hospitals are based on attending professional meetings and national conferences. These activities are often not tailored towards individual needs. It is widely appreciated that professionals prefer a wide variety of activities that are vocational, flexible, and relevant, linking theory to daily practice, as opposed to college schemes that tended to favour academic activities over more practical and locally based ones.

Recommendations for development of CME/CPD in Georgia

The following are recommended as the way forward:

- Doctors should accept CME/CPD as a moral and ethical obligation to continue life-long learning in order to maintain and improve their competence and performance without waiting for government legislation to force the profession and professionals into mandatory CME/CPD.
- Health organisations should restructure their institutional practice so that protected time is provided during the working day for CME/CPD activities.
- CME/CPD should be given priority. In all health organisations, a respected senior colleague should be appointed and given full authority to set up and coordinate CME/CPD activities in each health institution. It is increasingly being recommended that CME/CPD be accepted as part of a doctor's employment.
- Organisational CME/CPD should involve all health professionals involved in patient care in the institution, and should be varied and structured around the practice in the institution. Activities should include interactive practice-based activities such as case presentations, seminars, invited lectures, skill-specific workshops, etc. Being inter-professional, these would foster better team work for the benefit of patients.
- Self-directed learning should be encouraged and organisations should support participation in external CME/CPD by establishing incentives related to promotion or selection for other benefits.
- Links should be developed with nearby teaching institutions or bigger centres, which could provide CME/CPD educators for specific topics or skills.
- Further regulation of CME/CPD – the responsibility for regulation should be moved towards professional organisations, so that they will develop the standards of CME/CPD and an accreditation system which would also deal with criteria for commercial support, etc. It is desirable that this process takes into consideration global standards and the experience of other European countries.

Conclusion

A self-governing multidisciplinary board or professional association should be the main provider and supporter of CME/CPD in Georgia. Physicians themselves should play an important role in the CME/CPD process. It has to become a life-long responsibility for all doctors to be involved in CME/CPD. It is recognised that mandatory CME, focusing only on attendance at courses, may have impeded development of types of CME/CPD that would help physicians to learn more from their clinical experience.

Declaration of Interest

The authors report no declarations of interest. The authors alone are responsible for the content and writing of the paper.

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