Network organisation within WONCA Region Europe - ESGP/FM

Continuing Professional Development

Integration of Formal CME and Quality Improvement Initiatives

Policy Document of EQUIP[1] and EURACT[2]

1. Purpose of the document

Continuing Medical Education (CME) and Quality Improvement (QI) Initiatives have the same ultimate objective: to provide optimal care for patients.

We believe that formal CME and QI need and can even strengthen each other in the process of Continuing Professional Development (CPD).

This policy document, prepared by both EURACT and EQUIP is needed to inform and support national/local authorities and national colleges in their efforts to improve their CPD activities.

The document will outline an evolving model of Continuing Professional Development.

2. Aim

The basic aim of this document is to give recommendations on the characteristics and conditions needed for effective integration of formal CME and *elements of QI*. As a result of our evaluation of integration of formal CME and Quality Improvement initiatives we will identifiy characteristics and conditions needed for implementation.

These recommendations intend to outline an evolving model of Continuing Professional Development, combining QI interventions and more traditional forms of CME.

The document will not describe the different methods of CPD, but focuses on the place of Quality assurance in the newer definition of CPD.

3. Background

[1] EQUIP = European working party on Quality Assurance in Family Practice
[2] EURACT = European Academy of Teachers in General Practice

The medical scenery is constantly changing necessitating new concepts, strategies and options concerning services, education and quality. Science and knowledge, especially medical knowledge, change rapidly, leading to a limited lifetime for a "diploma". In each country Governments policies result in changes from "medicine by status" to "medicine by contract".

Modern high technology care, changes in demography, morbidity and social needs, growing expectations of patients, the demand of a humanistic approach and many other issues, as doctors' shift to part-time work, development of electronic communication and free movement between countries are going to have their impact on education and quality as well as on expectations towards the medical profession. In addition, the pharmaceutical industry is also changing its strategies with increasing use of scientific evidence.

Authorities stress the importance of basic knowledge and skills in the field of quality management for professionals in health care. Data should be collected and produced at local, regional and national levels in order to underpin assessment and decisions concerning policy and development.

Until now, most of the formal Continuing Medical Education (CME)[3] -programmes have been offered as separate entities. Traditional formal CME programmes have emphasised teaching. Inspiring new approaches to continuing medical education focus on active learning. Quality Improvement (QI) activities have also been developed, and are mainly organised as separate activities.

The emerging requirements of health care systems focusing on outcome and cost-efficiency combined with the new learning paradigms, focusing on knowledge, competence and performance, set the scene for integrating the more traditional options for Continuing Medical Education and Continuous Quality Improvement, and put more and more emphasis on Continuing Professional Development Planning.

General Practice should be open to evaluation. Quality assessment and development is essential, irrespective of the employment status of family physicians. Continuing medical education can be an important instrument in Quality Assurance. (WHO, Regional office for Europe, 1998)

A doctor's desire to be more competent in delivery of health care is the most important motivating factor for continuous learning and change. It is a prerequisite for achieving any improvements. Every doctor has a personal responsibility to participate in continuing professional development programmes, consisting of both formal CME and QI procedures. Professional development, continuously striving to enhance the competence necessary to meet the needs of patients and societies served, is a legal and ethical obligation. CPD should be based on the learners experiences. Effective CPD starts from perceived needs of the professional. The doctor should be seen as a self-directed learner(Hans A. Holm)

Recent large-scale review work demonstrates that didactic CME lectures don't lead to changes in performance. Broadly defined interventions using practice-enabling or reinforcing strategies are needed. These strategies consistently improve physician performance and in some instances, health care outcomes.

This document shows several ways to link traditional CME with Quality Improvement initiatives. Quality Improvement is a rapidly evolving discipline using specific methods and instruments. There is a big need for education in Quality Improvement. There is also a big need for evaluation of the quality of current CME.

[3] The terminology used in this document is described in addendum 1

4. Basic elements of integration of elements of QI in CPD

Patient and community priorities concerning health care should be central to CPD –activities.

QI initiatives can start from health problems detected by the community or individual patients.Quality Improvement methods use patient evaluation programmes. Guidelines can include patient perceptions. Patient empowerment can lead to improvement of care.

Integration requires a continuous process.

Formal CME and QI initiatives share common aims and require full integration in a continuous process rather than a series of sporadic projects. In order to be an effective tool for change, this process should be a routine part of clinical practice, ideally instilling lasting professional pride and drive toward improvement in each participant in the endeavour.

Continuing education should be based on the learners daily work practices.

The use of learners experience can be a powerful tool in CPD. Experience can be used in an intuitive way using case discussions, or in a more formal way by using data from medical records e.g. in discussions on prescription behaviour.

The goals are set by the GP or the practice.

Planning professional development can start from perceived needs in individual practices; the goals are set by the physician or the practice team setting up a personal or practice professional development plan. All members of the Primary Health Care team should work together. Quality assurance offers various methods to detect, define and analyse these needs.

Refocus CPD on the local professional environment.

There is a need to refocus CPD on the local professional environment as the proper main arena for QI and formal CME. QI should be combined with current local CME systems.

In Quality Improvement Initiatives the place for formal CME should be defined and linked.

Definitions of QI initiatives should include precise needs for formal CME and vice versa. Quality Initiatives should be organised in close relationship with formal CME programmes. For example audit programmes could be used to define the educational needs for a CME programme.

5. How to integrate formal CME and elements of QI ?

Education in the philosophy and techniques of Quality improvement

To enhance the process of change, formal CME can be used for education in the philosophy and training of QI techniques. Quality Improvement is a young discipline. Implementing will be facilitated if GPs learn about its philosophy, methods and techniques.

Elements of QI can be used for needs assessment in formal CME

There are different ways to define the needs for CME. One of the key challenges that health professionals face is knowing whether or not their current practice is up to date. Sackett and colleagues (Clinical epidemiology: a basic science for clinical medicine, 1985) refer to this as “the key to continued effectiveness as a clinician”. Needs assessment techniques can be subjective (perceived needs) and/or objective (reflective needs). Several tools exist to help combine reflective or subjective needs assessment methods with use of objective methods, such as measures of competence, performance (for example, external audits), patient management problems, and health outcomes. Review or audit of medical records is a useful method of determining the extent to which our current practice is consistent with evidence based principles.

QI has developed methods for analysing recorded performance

Data collection tends to be the most time-consuming part of the QI process, but it is essential. To evaluate how well we are doing, it's usually good to compare our own results with somebody else's data. Some methods of evaluating results are shown in the EquiP handbook on "Tools and methods for QI in General Practice". One example: Quality circles in primary care (experiences from Germany and Switzerland): Some of the data sources used are case reports, data analysis from charts, practice computers or documentation sheets, as well as video documentation. Other examples are: practice visiting and practice audit (UK, Netherlands, Sweden, Belgium), patient feedback or patient satisfaction (EUROPEP).

QI has developed methods to use evidence based guidelines in formal CME activities

The development of our work by QI is easier when based on solid clinical evidence. To develop a valid and reliable guideline is hard work. Developing, distributing and implementing useful guidelines should be a major challenge for family doctors and their organisations. Guidelines can also provide excellent material for clinical training as well as for CME. There are many experiences from the Netherlands about implementation of the Dutch Guidelines combined with CME-packages linked to the topic of the guidelines. The National CME tutor network in Ireland provides training of key persons to supervise small educational groups performing various QI methods.

Data and guidelines give direction to the process of planning actions for improvement.

QI has developed reeinforcing strategies enhancing the effects of formal CME activities.

Since formal CME activities such as lectures, conferences and educational materials appear to have little impact on practice, better use could be made of other approaches such as practice-based work in small-groups which incorporates the use of patient-specific reminders to health professionals. Dissemination of systematic reviews and evidence based guidelines could be integrated into the system of CME. Where practices are actively involved in audit, it seems logical to address gaps in practice by linking education programmes to clinical audit. An example of a programme which has made such links is the Australian QA and CME Programme; learning is evaluated by repeating the audit to see whether actual performance has changed.

QI and barriers to implementation.

Potential barriers to effective practice can be structural (e.g.financial disincentives, limitation of time), organisational(e.g.health care environment: health policies which promote ineffective or unproven activities), individual (e.g.knowledge, attitude, skills), influence of opinion leaders or peer groups (e.g. local standards are not in line with desired practice), patient factors (e.g. demands for care, perceptions/cultural beliefs about appropriate care). The focus of the Cochrane Effective Practice and Organisation of Care Group (EPOC, www.abdn.ac.uk/hsru/epoc/) is on reviews of interventions designed to improve professional practice and the delivery of effective health services, including various forms of CME, QI, informatics and financial, organisational and regulatory interventions that can affect the ability of health care professionals to deliver services more effectively or efficiently.

QI offers methods to evaluate the outcome of formal CME programmes.

There are many investigations concerning effectiveness of CME courses. Davis et al(1955) concluded that short (1 day or less) CME events usually bring about little change. Wensing et al.(1998) review of research on implementing guidelines and innovations in general practice confirms the effectiveness of multi-faceted interventions. He also noted that "many ineffective interventions involved the dissemination of educational materials or the provision of a short education programme". Davis et al.(1994) conclude their review of the effectiveness of CME interventions by emphasizing the intensity and complexity of interventions with positive outcomes and the multi-faceted nature of the change process.

Evaluation procedures not only have to check the process of CPD but also the outcome on practice level. Performance indicators are now constructed in a reliable way which can be used to measure the process and outcome of clinical care.

6. How to implement CPD ?

1. Financial incentives

Financial incentives must be available for both formal CME and QI initiatives. A better planned and managed system of CPD means visualising what resources are needed.

2. Accreditation procedures

Accreditation procedures must integrate both formal CME and QI initiatives. CME courses must be attended and specific goals in QI attained. Therefore CPD time should be used for both QI and formal CME.

A flexible system of accreditation is needed, covering re-certification (competency evaluation) and both practice and doctors accreditation (performance evaluation). The system should be designed to account for the diversity of adult learning and knowledge and acknowledge the doctor as a self-directed learner.

The system of accreditation has to be supportive, transparent and checked with the national authorities, the professional organisations and the scientific organisations. Transparency will encourage public trust. CPD should be constantly evaluated, prioritised and guided at a national level on efficiency, potentiality, acceptability, etc.

Any point system using credits has to include the broad range of CPD interventions. Thus the organisers of formal CME/CPD become less obsessed with the control aspect and more focussed on real learning needs and how these can be met.

The legal consequences of various systems of mandatory re-certification for all specialists need clarification before introducing new systems.

3. Formal CME and QI Initiatives organisers must work together.

Colleges, universities, local authorities etc. involved in the organisation of formal CME meetings and those who organise QI must combine their efforts in organising effective interventions. The organisation of effective integrated interventions on this level has to be stimulated by knowledge and stepped planning. The establishment of a clinical task force with numerous areas of competence to produce theoretical, practical and situational knowledge is one way of achieving this.
Doctors themselves have to take the lead, using methodological guidance provided by experts.

4. The organisation of peer review groups should be promoted.

The organisation of peer review groups should be promoted as a useful structure as long as it is organised as a secure and open environment for adult learning. Small- group work offers the opportunity for interactive education in a trusting environment. These actions would be facilitated by establishing a peer review network. A tutor training program enhances the facilities of the individual groups.

5. Education

Skills for integrated effective interventions should be acquired in undergraduate teaching and during vocational training. A positive attitude towards lifelong learning, evidence- based practicing, and cost-effective outcome orientation should be encouraged by the undergraduate and vocational training curriculum.

6. Research.

Research on effective CPD should be supported by establishing national research centres for CPD, working together in an international network.

EPOC :**NIKLAUS can you write something about EPOC here?**

The results and outcomes of CPD should be recorded and analysed.

7. Conditions for starting integrated CPD interventions

1. Pre-course needs should be assessed.

QI provides methods for pre-course needs assessment. Needs perceived by patients or other partners fe patients can be detected. Clinical audit can reveal areas needing attention. Evaluation of physician performance (according to stated indicators) can be the starting point for detecting areas requiring improvement.

2. Start from a need in the practice.
Personal engagement can be encouraged by allowing individuals to choose their own outcome topics. However patient, society and health care needs should also be addressed.
CME topics should focus on specific, well defined, problem-based topics, where improvement is possible and readily applicable in practice. CME topics should be suitable for Q work.
Formal CME programmes should not only consist of credit collection to fulfil the demands set by authorities etc, but be based on assessment of needs.

3. Personal development plans and~~;~~ portfolio learning help the individual professional to plan CPD . ~~Cf The good CPD guide (Janet Grant)~~
A personal development plan is based on the results of an appraisal meeting (interview) which discovers the areas most suitable to further professional development. The process covers the personal needs of the doctor and the needs of the service. The Personal Development Plan (PDP) must be a comprehensive document that records the outcome of the appraisal. The PDP decribes the proposed CPD activities, how the need was identified, how CPD will be reinforced or disseminated and how effectiveness will be shown.

A learning portfolio is a comprehensive record of learning events, along with evidence of outcomes. It may content log-books, research of practice, research proposals, clinical data, “jottings” (ideas, thoughts, insights, challenges) and a reflective commentary in which the individual identifies what has been learned.
The portfolio provides a way of assessing professional development.
4. Include practice enabling and reinforcing strategies in formal CME programmes.
Figures about performance data on the subject of CME and reinforcing strategies may have considerable impact on implementation of guidelines. Well structured feedback techniques may improve the quality of certain clinical procedures (cervical smears, laboratory requests).

~~Consequences for the accreditation procedure~~

~~To be elaborated~~

~~The basic understanding about lifelong learning and its three systems has been as follows:~~

	Formal CME	CPD	QI
Focus:	Knowledge	Competence	Performance
Accreditation based on:	Doctor Credits, sessions	Doctor and practice Involvement	Practice Outcome

Consequences for Basic Medical Education (BME) and Vocational training (VT)

Changes towards a more CPD- oriented policy will require basic changes in BME and VT,not only for the subject of General Practice, but also for other subjects. At the moment, there is a tendency to teach QI and EBM only in the time reserved for General Practice, whereas most of the topics mentioned below could belong to other disciplines in BME as well. All the elements have to be learned as early as possible, but some of the topics are particularly suitable for vocational training.

1) Preparation for life-long learning

- Basic principles of learning and studying; different learning styles and strategies, how do I learn best? What kind of learning strategies should I use in different situations? Self-knowledge is needed, and it has to be started during BME.
- Skills for continuously updating knowledge; how to do a literature search, how to use databases, how to read critically (critical appraisal, EBM), what kind of search-elements to use, how to make an overview of main results.
- Skills for identifying learning needs, how to assess learning needs, not only from an individual point of view but also taking patients and health care needs into account. Encouragement of positive attitudes towards QI during BME.

2) Skills for team-learning and multidisciplinary learning;

- To be able to work as a team member in task-orientated groups.
- Communication skills and leadership skills.

3) Basics of Quality Assurance (QA)

- What is quality, what is the place of QA in daily practice, terminology; basic philosophy of QA: the Plan Do Check Act cycle or quality cycle.
- Basic Procedures: peer review, practice visits, clinical internal or external audit, patient evaluation; feedback procedures etc.
- Quality indicators: definition, characteristics.
- Procedures and techniques to define and outline a quality problem.
- Value of guidelines, how to implement guidelines.
- Skills to assess one's own work: clinical incident analysis; structured case discussion; chart audit: clinical audit; video assessment of communication skills etc…
- Skills to analyse and interprete figures
- Skills to plan actions for improvement and to evaluate them
- QA management skills: change management, time management, leadership, annual report and planning QA . working as a team.

4) Working with a learning agenda (discover your own needs, evaluate your learning progress, record it in an individual portfolio).

Conclusion

A doctor's desire to be more competent in delivery of health care is the most important motivating factor for continuous learning and change. It is a prerequisite for achieving any improvements. Every doctor has a personal responsibility to participate in continuing professional development programmes, consisting of both formal CME and QI procedures.

Continuing Professional Development requires a planned integration of formal CME and QI initiatives. This will set the conditions to facilitate improvement in the process of day to day medical care.

This policy document shows the conditions and characteristics for such an integration.

Literature

Literature search

Method:

- Medline selection 1996-2000, key words: Education,-Medical,-Continuing AND Quality of Health Care; Only review articles were selected.
- Cochrane Library search (12/11/99)

Selected articles

1. D. Davis : Impact of formal Continuing Medical Education. JAMA, sept 1 1999
2. A.D. Oxman : No magic bullets: a systematic review of 102 trials of interventions to improve professional practice.Can. Med Assoc J, nov 15, 1995.
3. Frank Smith, ea. General Practitioners' continuing education: a review of policies, strategies and effectiveness, and their implications for the future. Brit Journal of General Practice, october 1998.
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12. Cathy Peck, Martha Mc Call, Belinda Mc Laren, Tai Rotem. Continuing medical education and professional development: international comparisons. BMJ 2000:320; 432-35.

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D Davis Effective Continuing Medical Education, Presentation on the EAMF conference, London, 1999.

The good CPD guide; a practical guide to managed CPD; J.Grant PhD, Elly Chambers MA.

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M.Mäkela et.al.- Family Doctor's Journey to Quality, The WONCA Working Party on Quality in Family Medicine, 2001, Stakes, Finland

Evidence Based Practice in Primary Care ed. Ch.Silagy, A.Haines, BMJ Books, London, 1998

Tools and methods for Quality Improvement in General Practice, V.Alles et.al., 1998, Stakes, Finland

Quality Indicators for General Practice, Martin Marshall, Stephen Campbell, Jenny Hacker, Martin Roland, sept 2001.

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1. Munck A. Audit Project Odense; in Tools and Methods for Quality Improvement in General Practice; 1998; 70-73.

ADDENDUM 1

Terminology

(FORMAL) CME = formal educational interventions: conferences, rounds, symposia and individualised training and teaching sessions. Knowledge is transferred by educational activities .

CME (definition AMA): "any and all ways by which physicians learn and change in practice"

QI = Initiatives for **Q**uality **I**mprovement, where registration and evaluation of performance data are essential. QI essentially consist of three steps of the quality cycle~~(should be defined somewhere !):~~ : planning, evaluation of practice performance and action. Documentation (data collection), a pending issue in the recertification debate, is a central part of the QI process.

Quality development = a continuous process of planned activities based on performance review and setting of explicit targets for good clinical practice with the aim of improving the actual quality of patient care.

Integrated activity = an initiative where formal CME and QI activities are integrated in a planned coherent intervention.

Continuing professional development = a process of lifelong learning in practice. CPDs endpoint should be quality of care. CPD must help improve quality of care, demonstrate ~~–~~ its effectiveness and become a properly managed activity by both the physician and the profession.

Method

The document is the result of a consensus procedure using semistructured expert interviews, literature reports and focus group discussions in the EQuiP and EURACT meetings from November 1998 to 2001.

The members of the EQuiP working party:
Dr Luc Seuntjens, Dr Margaret O' Riordan, Dr Niklaus Egli, Dr Margalit Goldfracht, Dr Angelo Campanini, Dr Kees in' t Veld, Dr Libuse Valkova, Dr Tomasz Tomasik, Dr Bohumil Seiffert, Prof Dr Per Hjortdahl.

The members of the EURACT working party:
Dr Paula Vainiomaki, Dr Jonah Yaphe, Dr Mladenka Vrcic-Keglevic, Prof Dr Jan Heyrman, Dr Dag Søvik, Dr Eva Jurgova, Dr Anasthasios Simeonidis and Dr Bernardina Wanrooij.

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ADDENDUM 2

Quotations illustrating different items of the policy document

Prof J Heyrman, Leuven

Conceptual background

The medical scenery is changing rapidly and constantly, and this is also changing many concepts, strategies and options.

- All knowledge, and certainly medical knowledge changes rapidly, there is only a limited lifetime for a "diploma".
- Governments changes : in each country there is a change from "medicine by status" to "medicine by contract". Health policy concepts starts from outcome, disease management, alternative solutions. General Practice is one of the options, with subsidiarity and low cost as main argument, but in competition with other options.
- pharmaceutical industry changes strategies : there is a growing claim on scientific evidence. Industries are focussed on providing the evidence. Selling strategies are adapted to this new situation.
- total quality management is the focus : each partner in health care is part of a in a total system that is governed in its totality.

In society, and thus also in medicine and general practice, the central emphasis in the learning programmes has been placed on "lifelong learning". With the venue of the "information-society", with the mundialisation and the acceleration of scientific and technical innovation, there needs to be a new emphasis on a broad general basic education, followed by lifelong learning of flexibility and adaptation. (Edith Cresson, *Teaching and Learning, towards the learning society,* EU report 1996)

Prof. Paula Vainiomäki, Finland

In EURACT, we have discussed CME in a more modern way, considering CME activity, including all the procedures which are directed towards effective learning (the attributes of which are: constructive, cumulative, collaborative, context-situated, feedback searching etc.) I suppose this old-fashioned definition is not easily accepted by EURACT as a definition of CME. For me it is not enough to transfer knowledge. CME also means aiming towards changes in performance. Learning is easily defined today as a change in a person, a thinking in a new way etc. Learning means that you will find some idea which is different than yours own one. You have to take a stand on the new idea, and accept it or not.

Tor Carlsen, general practitioner, Skien, and project leader, Quality assurance program, Norwegian Medical Association:

"CME and QI, two different approaches, but closely linked and partially overlapping, same final goal: "Providing better care for the patients". The elements of the adult learning theory can be found almost mirrored in the quality improvement circle. "They are twins, but not identical twins"."

Hans Asbjørn Holm MD PhD

" We felt we needed to know as much as possible to be able to establish a framework for doctor's CME/CPD that really could serve to support and nurture competence development"

"To illustrate the complexity and diversity of competences applied by doctors I often use what is called the Competence Grid, developed by Otto Brun Pedersen and Kristin Prestegaard after

working with continuous learning and professional development of general practitioners in the Norwegian county of Telemark."

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 Communi-Cation	Ethical and political norms and values
Practical Knowledge	Skills of procedures of examination and treatment	Skills of administration and management	Skills of communi-Cation 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

Otto Brun Pedersen and Kristin Prestegaard (1997)

"Between 1995 and 1998 the Norwegian Medical Association carried out a project to develop and to assess a quality improvement tool for use in general practice (SATS).

The confrontation with own recorded practice in a supportive peer environment is found to be a major force for change."

Bernardina Wanrooij, The Netherlands

Implementation of the things learned.

First of all we experience the strength of **repetition**. We try to plan more sessions about a specific topic, in this way giving time for the material to sink in. Moreover we give homework, that we handle next time, with tasks where people (are forced to) use the material we taught them. In the last part of a course we reserve time especially for the item "implementation". For instance each participant has to choose two items from the course that he plans to use. **He has to discuss with a colleague what he thinks will help him to really go and use it, and what he thinks will hinder him.**

I do agree that cooperation (between CME and QI) is a good thing. In fact learning and quality improvement should be the same kind of process. In learning you follow the learning cycle. The quality circle resembles this . The learning circle is focussed on the GP as learner, the quality circle on improvement of practice.

Literature

Literature search

Method:

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- Cochrane Library search (12/11/99)

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1. Munck A. Audit Project Odense; in Tools and Methods for Quality Improvement in General Practice; 1998; 70-73.

Appendix two

History of the document

November 1998, Reykjavik Iceland, EQuiP	"The connection between CME and quality improvement" is selected as the top priority for EquiP work. The selection was made after a careful selection procedure. The aims of the working party are : 1. Define the relation between QI and CME 2. Define efficient models of integration of CME and vice versa. A questionnaire is drawn up to gather information for writing~~te~~ a policy document. Aims of this questionnaire: - Examine the structures already in place for CME and QI in the different European members states. - Analyse who is responsable for the organisation, and whether sanctions are applied in case of non participation - Look at the links which already exist between CME and Quality assurance in individual countries - Analyse the perception of usefulness of these links - Look at evidence for the effectiveness of these links We decide to ask EURACT for their cooperation. John Yaphe and Paula Vainiomaki join the group.
December 1998-May 1999	A project plan is written by Dr L Seuntjens (Belgium) Literature search (EDUCATION,-MEDICAL,-CONTINUING+QUALITY OF HEALTH CARE) by Nicole Boffin (WVVH Belgium). Pilot version of the questionnaire is finished and distributed to the countries of the core group (Italy, Belgium, Israel, Ireland, Tchec Republic, Norway and Switz~~s~~erland). Following a suggestion of Yonah Yaphe we decide to organise a symposium during the WONCA regional Mallorca congress May 1999. A preliminar report of the results of the questionnaire is presented at the Mallorca WONCA congress by Margaret O' Riordan. Niklaus Egli presents a literature review and Mladenka Vriic-Keglevic and Paula Vainiomäki give~~s~~ an overview of the organisation of CME throughout Europe.
May 1999 Mallorca congress EquiP meeting at Palma	To get a proper answer to our key questions additional information is necessary. We decide to carry out semistructured expert interviews, using an interview guide. 2 experts/country are interviewed. The interview guide is written by Luc Seuntjens. We also decide about deliveries: a stepped approach: 1. A joined EQuiP- EURACT policy document. 2. An a~~A~~rticle describing the process and results. 3. A booklet with examples of effective integrated CME-QI The interviews are carried out in Belgium(2), Italy(2),Norway(2),Israel(2) and the Chec Republic. Literature is selected by Niklaus Egli.

November 1999 Kopenhague EQuiP meeting	Contact with D. Davis, EAMF We re- discussed the aims of the working group. The discussion is vital to obtain a firm base for the interpretation of the interviews, the literature and the presentations.

	<u>First aim</u> To describe the characteristics of effective integration between formal CME and QI initiatives <u>Second aim</u> To describe techniques that lead to implementation of integrated interventions between formal CME and QI. Terminology : discussion about definitions of CME and QI. Additional interviews are planned in Ireland, The Netherlands and Finland.
November 1999-June 2000	Interviews in the Netherlands (1), Ireland (2) and Finland (1) Update of the literature. A final report on the results of the questionnaire is made by Margaret O Riordan.
June 2000: Vienna EQuiP meeting, joined by Paula Vainiomäki of EURACT	The final report on the pilot questionnaire is discussed. Quotations suitable for the policy document are selected. The design of the policy document is decided. A selection procedure for the items in the interviews is stated.
July-September 2000	Selection of key elements of the interviews, on a prestructured preparation paper. Update of the literature.
October 2000	First draft of the policy document (Luc Seuntjens). This draft integrates comments of Margalit Goldfracht (Israel), Margaret O Riordan (Ireland), Angelo Campanini (Italy), Niklaus Egli (Switzerland),Jan Heyrman (Belgium), Paula Vainiomäki (Finland) and Tomasz Tomasik (Poland).
October 19,20 2000 EURACT meeting Kusadasi	Discussion and re-structuring of the document 1. Background of the position paper 2. Aim and objectives 3. Education, evaluation and research 4. Recommendations 5. Summary Rewriting of the document by Paula Vainiomäki as a contribution to the “core content” conference of Barcelona, October 11-12,2001. This conference, initiated by EURACT, aims to design the core content of the curriculum for General Practice. An EQuiP delegation is asked to join this conference.
November 2000	The importance of the Barcelona conference is stated.

EquiP meeting in Athens	The first draft document is discussed together with the document of Paula. The relation between Quality Improvement and CME is discussed. The global structure of the policy document is discussed. Terminology discussion.
January 2001	Comments by Janet Grant. Luc writes a 4th draft.
January 27 2001 EURACT executive board meeting Leuven	The document is discussed at the EURACT meeting. General comments are made - the relation of the document to the other documents of the core content conference - the relation of the document to more specific aspects of General practice care - The consequences of this document for basic medical education and vocational training The document is commented more in detail by Paula Vainiomaki. Luc Seuntjens writes a 5th draft for the ESGP board, February 2001.
EURACT council meeting Eger, April 4-7 2001	Consequences of the document for Basic Medical Education and Vocational Training were discussed. Furhter preparations for Tampere WONCA Europe Conference June 2001 and Barcelona meeting October 2001 were discussed. The Barcelona meeting is followed by London WONCA Europe conference June 2002, where the final document is supposed to be accepted/adopted by the societies. Niklaus Egli from EQUIP did come to Tampere conference instead of Luc Seuntjens to lead the session with Paula Vainiomäki. Paula Vainiomäki has a workshop with Hans Asbjørn Holm on the same topic during the meeting of Nordic Federation for Medical Education in Helsinki in May 2001. Hans Asbjørn Holm has confirmed his visit in the Barcelona meeting as an expert invited by EURACT.
May 2001	Language check by Margaret O Riordan. Discussion at the EQuiP workshop in Tuusela FINLAND.
July 2001	New draft after the Helsinki remarks worked out by Luc, Niklaus, and R Grol Successful workshop during Tampere WONCA meeting. Positive opinions among the participants to try to find links between formal CME and QI.
October 2001	EURACT council meeting. Discussion of the present state of the document.
November 2001	Abstract for a workshop during the London WONCA conference EQuiP meeting in Rouen. Several examples are defined to be included. Fiona s language check is accepted. Luc Seuntjens writes a new version, which will be discussed at the EURACT Maaastricht meeting. Margalit Goldfracht includes examples.