CME MCQs are coming in FNDV to help your CPD

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It has been decided that *Forum for Nordic Dermato-Venerology* is going to include Continuing Medical Education (CME) as a part of the journal. This will be done through multiple choice questionnaires (MCQs), already familiar from other journals. The plan is for the efforts to be linked to clinical reviews in *Acta Dermato-Venerologica*, but the material may come from other sources as well, and submission of unsolicited material is welcome. Following peer review, MCQs will be made available to the readers of *Forum*.

There are many aspects to the development of individual careers, so-called continuous professional development (CPD). In medicine, CME is one of the most important. CME is necessary not only because of the rapid general development in our understanding of biological phenomena and the subsequent developments in therapy and patient care, but also for simple psychological reasons. If CME does not become a natural part of professional life, a degree of stagnation in inverse proportion to the general development in the field is inevitable. This can subsequently affect an individual's CPD. CME is therefore a personal obligation and primarily a personal independent activity.

This aspect of CME is nothing new. On the contrary, it has been well known for thousands of years. As early as 370 BC, the Hippocratic oath included CME: 'I will impart the knowledge of the Art, ...' which is an explicit commitment to teaching and hence an implicit commitment to being taught. This individual recognition of the dynamics of acquiring and maintaining specialist knowledge has therefore always been a natural part of the professional life of doctors. However, as soon as structures grow and become more complex, such individual commitments are at risk. Other obligations to the organization, the group or society tend to infringe on one's CPD. To ward off the effects of such interference, a degree of extraneous systematic structure is often helpful in CPD as well. In spite of this, such an infringement on our perceived professional autonomy easily irks our sensibility as physicians.

Not all structures are a threat to professional autonomy. This is most easily exemplified by the founding of the Royal Colleges of Medicine and Surgery in England, created by Henry VIII to meet a perceived demand of formalized CME. The concept of formal CME is therefore neither new nor particularly alien to the CPD of individual physicians.

In consequence, there have been structures to promote CME on a national or local level for many years. It has been a core activity of universities, national societies, and other organizations, which have managed CME within an extended professional autonomy.

The new aspect of CME for Nordic dermato-venerologists is therefore not the concept itself, but the emerging structure that offers a framework for personal CME activities. These structures can be seen as a reflection of the increasingly complex knowledge now accumulated and of the increasingly complex health systems in which we function. The structures can also be seen as a reflection of the increased number of doctors and their potential mobility. Both of these factors require increased efforts to standardize the abilities of the individual physician in accordance with a given standard. The second factor in particular must be seen as one of the most important driving forces behind the development of CME in the US, where the concept of structured CME has evolved particularly extensively. In Europe and the Nordic countries, these driving forces are more recent and the concept of CME may therefore appear newer than it is.

On a pan-European level, structures have been provided for the promotion and monitoring of CME since 1959, when the UEMS was created to support free mobility of physicians within what was then the EEC. The UEMS constitutes an umbrella organization that brings together national societies of medicine, which can then become a forum for consensus anchored in national legislation. Policy rarely translates naturally into actual custom, however, so the UEMS created the EACCME in 1998. The goal of this organization is to promote and facilitate CME activities on the European level. This is done by accreditation through national authorities, because it is not

within the realm of the European institution to regulate national CME requirements. This means that the requirements for recognized CME vary considerably from country to country. In some countries, e.g. Belgium, recognized CME activities are required for maintaining certain billing rights vis-a-vis patients; whereas in other countries, e.g. Denmark, recognized CME activities are at the moment voluntary, albeit strongly encouraged. The perceived need for nationally recognized and formalized CME therefore vary similarly. This cannot be taken to suggest that the individual dermatovenerologist's sense of professional obligation is insufficient, but merely that the formal requirements differ. General modern societal development, however, appears to lean inexorably towards certification, transparency and standardization, which makes it highly likely that some degree of standardization of the CME requirements will be introduced, even if dermatovenerology is unlikely to be the first speciality to be affected.

By introducing CME in *Forum*, the Editors hope to help its readership prepare for this in a Nordic context and based on local experience. This is in complete agreement with the UEMS interpretation of CME activities as stated in the Dublin declaration. This declaration draws up the requirements for CME and unequivocally demands that CME should be under the control of physicians. It is therefore to be hoped that the readership will view this initiative positively and actively participate, not only in their own personal CME but also in that of others by contributing to this section.