CONTINUING MEDICAL EDUCATION FOR PHYSICIANS

The concept of continuing medical education for all branches of the profession is not a recent philosophy. It has been advocated for more than thirty years as the means whereby standards of medical practice can be maintained and possibly improved. The main problem has been to ensure that such education is of advantage both to the medical profession and to patients whom the profession treats and that it is economically justifiable. Despite these problems, there can be no denial of the argument that increased knowledge, particularly in the practical field of clinical medicine, should offer advantages to the consumers.

In recent years there have been very significant changes in both the responsibilities and the activities of The Royal Australasian College of Physicians. The M.R.A.C.P. diploma has been abolished, and a one-stratum membership (Fellowship) created. Accreditation of basic and advanced physician training programmes has become firmly established, with the important emphasis on proper training in medicine rather than on the ability to pass examinations. Examinations measure the ability to pass examinations, with no guarantee that this will ensure competence to practise properly as a consultant physician. The College's decisions on proper advanced training, with a return to almost individual learning by apprenticeship, is an interesting change in emphasis. It cannot be denied that these rather revolutionary changes have created problems, in the time of transition, to those in positions of responsibility and also to those who are physicians-in-training. It is to be hoped that the final benefits will be found to have been worthwhile.

It is not surprising that these winds of change should have stimulated some members of The Royal Australasian College of Physicians to question its duty towards those who have achieved consultant status. The latter constitute a rapidly expanding body, and it was argued that responsibility does not end with the College's acting as an examining and certifying institution. In short, those once certified as competent to practise as consultants must be provided with the means whereby their continuing competence is assured and, it may be hoped, improved.

As the result of moves initiated within the College Council, an Ad-Hoc Committee reported on these important matters to Council. The latter accepted the basic recommendations of the Ad-Hoc Committee—acceptance of a responsibility to ensure maintenance, and improvement, of standards in all branches of internal medicine. An Advisory Committee on Continuing Education was established, with the task of advising Council on the practicality and feasibility of meaningful programmes of continuing medical education for physicians in Australia and New Zealand. This Committee received comments from within the College, as well as advice from interested bodies, and it considered a wide variety of experience from outside Australasia. Its original recommendations to the College Council indicated the necessity of creating a full-time Continuing Education Unit. The economic aspects of these recommendations, combined with some understandable resistance to change, caused Council to seek an independent assessment from an outside expert. Consequently, Professor D. R. Wilson—from the R. S. McLaughlin Examination and Research Centre of the Royal College of Physicians and Surgeons of Canada—accepted Council's invitation to assess the desirability, and necessity, of continuing medical education for physicians in Australasia, and also in certain areas of South East Asia.

Professor Wilson's inquiry extended over a period of six months. His Report1 was considered by the College Council, together with further recommendations from the Advisory Committee of Continuing Education, the latter being based partly on the Wilson Report. After careful and full discussion, the College Council accepted its responsibility to provide for continuing medical education.

1 A Report to The Royal Australasian College of Physicians on Continuing Medical Education, by Don R. Wilson, M.D., Guest Director of Continuing Education, February, 1976.
education, not only for all its members, but also for all physicians in Australasia and many others in the College's spheres of activity in South East Asia.

These decisions—made at a Council meeting in May, 1976—are of paramount importance in establishing a philosophy of maintenance of standards to the profession as a whole. Regardless of the economic implications, it was decided that a full-time Continuing Education Unit of The Royal Australasian College of Physicians should be established. It was decided that the College should, if necessary, bear the financial responsibility for establishing this Unit for a period of five years, with the hope that it might prove self-supporting after this time. Professor Wilson's Report indicated widespread enthusiasm and support for the concept of continuing, and efficient, education for physicians. One of the most important aspects was the need expressed by most "geographically isolated physicians". The latter are not only those practising in country areas, but include physicians within metropolitan cities who are not members of a teaching hospital.

It is to be hoped that The Royal Australasian College of Physicians, with the positive cooperation of its many affiliated societies in specialist medicine, will establish an exciting, attractive and full programme for all types of physicians. It is understandable that any type of change may meet with some initial resistance, especially from those who have a wide variety of programmes already available to them. However, it is reasonable to question whether these programmes could not be improved.

The Advisory Committee on Continuing Education has suggested certain broad guidelines for the activities of the Continuing Education Unit. It is reasonable to state these in detail:

1. To identify priorities for continuing medical education for physicians in relation to the community needs for their services.
2. To identify the needs and priorities for individual physicians, and for groups of physicians.
3. To identify, and make use of, existing educational facilities for physicians, and improve their efficacy.
4. To develop, and evaluate, pilot educational programmes.
5. To develop, and integrate, a bank of "test items" for use in self-assessment programmes, pre-testing and post-testing of educational meetings, advanced training programmes etc.
6. To liaise with all interested, and responsible, authorities in the fields of medical administration, undergraduate and postgraduate medical education etc., in an attempt to provide a continuum of medical education.
7. To pay particular attention to the development of continuing medical education programmes for "geographically isolated physicians".
8. To educate physicians towards more efficient, enjoyable and worthwhile methods of learning in their own specialized fields, and also in the broad field of general internal medicine.

After some years of inquiry and discussion at local and national meetings, The Royal Australasian College of Physicians has accepted its responsibility towards its corporate body. It is to be hoped that this decision will prove to be of far-reaching importance, especially in regard to improvements in medical care.

COMMENTS

THE HAZARD OF ASBESTOS

The only thing about pollution that is at all new is the understanding that we must do something about it, but this is often an uphill struggle against vested interest and entrenched practices. This is well illustrated by the case of asbestos, discussed in a paper by R. Barnes on page 600 of this issue. As noted by Barnes, an association between asbestos and disease was recognized by Roman physicians nineteen hundred years ago. Today asbestos is the basis of an extensive industry. Some six million tons of it are mined annually, and its industrial applications are legion.

Because of the fine, fibrous nature of the mineral, asbestos is inevitably a dusty material to work with, but the full extent of its hazards have been realized only slowly. The modern industrial use of asbestos goes back only to the last quarter of the nineteenth century, and the first death from asbestosis is stated1 to have been recorded in 1900. Asbestosis was at first considered as a dust disease like the other pneumoconioses, and recognition of the carcinogenic nature of the dust came later. In 1955 Doll2 reported a very high incidence of lung cancer in a group of asbestos workers. Interestingly, the next paper in the same journal3 reports the incidence of lung cancer in Welsh coal miners to be lower than in a comparable group of non-miners. But it was only after Godwin's delineation of pleural mesothelioma and asbestos exposure became evident.

One factor which may have delayed recognition of this association is the extremely long latent interval which frequently occurs between asbestos exposure and development of the tumour. The first case of pleural mesothelioma in an asbestos worker in Australia was described by McNulty in 1962,4 and during the past ten years we have published various papers by different authors in Queensland,5 Western Australia,6 Victoria7 and

1 Longley, E. O. Med. J. Aust., 1969, 2: 1063.
2 Doll, R., Brit. J. industr. Med., 1955, 12: 81.
3 James, W. R. L., ibid., page 87.
4 McNulty, J. C., Med. J. Aust., 1962, 2: 953.
5 Mortimer, R., and Campbell, C., ibid., 1968, 2: 70.
6 Elder, J. L., ibid., 1967, 2: 579.
7 Milne, J., ibid., 1969, 2: 669.