for opioid-related disorders: A systematic review and network meta-analysis of randomized controlled trials. *PLoS One* 2022;**17:**e0266142.
4 O'Brien C, Cornish JW. Naltrexone for probationers and parolees. *J Subst Abuse Treat* 2006;**31:**107–11.
5 Washton AM, Gold MS, Pottash AC. Successful use of naltrexone in addicted physicians and business executives. *Adv Alcohol Subst Abuse* 1984;**4:**89–96.

Vrinda Kabra
Muhammad Jadeer
Siddharth Sarkar
Department of Psychiatry
National Drug Dependence Treatment Centre
All India Institute of Medical Sciences
Ansari Nagar, New Delhi, India
sidsarkar22@gmail.com

[**To cite:** Kabra V, Jadeer M, Sarkar S. Opioid use disorder: Long-term use of oral naltrexone for promoting abstinence. *Natl Med J India* 2024;**37:** 358–9. DOI: 10.25259/NMJI_950_2024]

Continuing Medical Education (CME): The experience from Hong Kong

We read with interest the article by Bhattacharya *et al.*[1] about the loopholes of the existing continuing medical education (CME) system in India. The main concerns expressed were credit hours, subspecialty relevance, disproportional participation for earning each CME credit point, whether for physical attendance to educational events or academic writing for journal publications. We would like to share our experience on CME in Hong Kong (HK).

In HK, specialists' CME are mainly regulated by the HK Academy of Medicine (HKAM).[2] Each subspecialty has her own college within HKAM, e.g. HK College of Obstetricians and Gynaecologists (HKCO&G),[3] HK College of Physicians (HKCPhy), *etc.*[4] Each college has assigned different categories of CME, namely active (non-passive) and passive participation. Attending conferences purely as audience is the only passive item. Otherwise, non-passive ways of obtaining CME include being the presenter (3 points for poster versus 6 points for oral presentation), invited speaker, moderator or panelist in conferences; continuous quality improvement projects for improvement of patient care; development of CME materials such as courses and workshops; development of new technologies or services such as artificial intelligence usage in clinical practice; serving as the examiner for professional qualification examinations including the membership and fellowship examinations; teaching undergraduate or postgraduate courses; enrolling in hands-on clinical attachment programme (more applicable to surgical specialties) in other training centres; publishing scientific articles and research in indexed peer-review journals; performing quality assurance, audits and activities for improvement of medical care; and self-study of scientific publications.

The minimum CME requirement is 90 points in a 3-year cycle, with the additional requirement of at least 15 active CME points. A point of CME activity is equivalent to 1 hour of participation as an attendee in a Formal College Approved Activity (FACC). Therefore, a specialist could not purely attend 90 hours of lectures to complete the cycle. She/he needs to be the speaker or chairman for at least 15 hours in FACC, conferences or publish manuscripts in indexed journals, etc. to acquire adequate active CME points in a 3-year cycle to sustain the specialist registration and practicing license.

For non-regular FACC, each educational event needs to seek respective colleges' approval for qualification of CME, and the number of points would be accredited according to the relevance of content to that specialty. For example, in the Primary Healthcare Summit 2024 organized by the University of Hong Kong's Medical Faculty,[5] HKCO&G awards 5 CME points for each day of event, and a maximum of 5 CME points for the whole 2-day function; whereas HKCPhy awards 2 CME points for each day of event, but a maximum of 4 CME points for the whole function. This arrangement would allocate relevant CME as per one's specialty without loopholes.

Concerning publications, PubMed indexed journals are the entry requirements, thus low-quality or predatory journals' publication would not be counted. Publications of original research articles or higher level of medical literature, e.g. meta-analysis, would be awarded 10 CME points each; whereas case report, editorial, letter to editor, etc. would only be awarded at most 5 CME points. Only first and corresponding authors would be awarded the full number of CME points, otherwise the remaining authors would just be awarded at most half of the CME points per publication. Peer-reviewers would also be awarded, with 1 CME point for each manuscript reviewed for an indexed journal, here there is no further subdivision on the type of manuscript reviewed.

Besides, undergraduate and postgraduate teaching could not contribute to >15 CME points within the 3-year cycle, while being an examiner of the college's professional examinations could not occupy >10 CME point. No system is perfect, and each one has its flaw. In the era of artificial intelligence, even with post-CME examinations, one could still cheat to pass.

REFERENCES

1 Bhattacharya S, Bhattacharya K. Credit hours and continuing medical education (CME) programmes. *Natl Med J India* 2024;**37:**153–4.
2 So HY, Li PKT, Lai PBS, Chan ACL, Chan KKL, Chan TM, *et al*. Hong Kong Academy of Medicine position paper on postgraduate medical education 2023. *Hong Kong Med J* 2023;**29:**448–52.
3 Cheung KW, So PL, Mak LLY, Yu FNY, Cheung WL, Mok SL, *et al*. 2024 Hong Kong College of Obstetricians and Gynaecologists guideline on antenatal screening and management of hepatitis B for prevention of mother-to-child transmission. *Hong Kong Med J* 2024;**30:**400–8.
4 Chan KK, Szeto CC, Lum CCM, Ng PW, Kong APS, Lau KP, *et al*. Hong Kong College of Physicians Position Statement and Recommendations on the 2017 American College of Cardiology/American Heart Association and 2018 European Society of Cardiology/European Society of Hypertension Guidelines for the Management of Arterial Hypertension. *Hong Kong Med J* 2020;**26:**432–7.
5 Primary Healthcare Summit 2024, CME/CNE/CPD. Available at *https://phcsummit2024.hk/cme-cne-cpd/* (accessed on 19 Oct 2024).

Sunny Chi Lik Au
Department of Ophthalmology
Tung Wah Eastern Hospital, 9/F, MO Office
Lo Ka Chow Memorial Ophthalmic Centre
Eastern Hospital Road, Causeway Bay, Hong Kong
kilihcua@gmail.com

[**To cite:** Au SCL. Continuing medical education (CME): The experience from Hong Kong. *Natl Med J India* 2024;**37:**359. DOI: 10.25259/NMJI_1342_2024]

Clinical linguistic proficiency programme: An approach to achieve multilingual proficiency

The article on medical education in indigenous languages raises critical concerns about the future of medical training in India.[1] While the debate continues, we present the clinical linguistic proficiency program (CLPP), at present trilingual, developed at National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru for residents in psychiatry as an innovative and practical solution that

addresses many of these issues while maintaining the global competitiveness of Indian medical graduates.[2]

Initiated in September 2020, CLPP aims to bridge the communication gap between doctors and patients in psychiatry, a field where nuanced language comprehension is crucial. Unlike the wholesale shift to regional languages proposed by some, CLPP takes a balanced approach. It equips psychiatry residents with essential skills in Kannada, the local language, while maintaining English as the primary medium of instruction. This preserves the benefits of English-medium education while enhancing students' ability to interact effectively with local patients.

The CLPP curriculum is built on the following principles: (i) adult learning models that prioritize active participation; (ii) peer teaching, leveraging the diverse linguistic backgrounds of residents; (iii) a trilingual approach (Kannada, Hindi, English) reflecting India's linguistic diversity; (iv) focus on speaking skills first, followed by deeper language understanding; and (v) need-based learning tailored to common clinical encounters.

The program structure includes: (i) fortnightly one-hour classes in the first semester of psychiatry training; (ii) role-playing exercises in virtual classes to practice real-world scenarios; (iii) live clinical encounters for hands-on experience; (iv) a comprehensive manual with practical scripts and phrases in Kannada, complemented by Hindi and English translations.

What sets CLPP apart are its innovative features. These include: (i) an audio-integrated PDF manual enabling real-time pronunciation support during live consultations for on-spot live interaction with patients;[3] (ii) emphasis on the 'right question' approach for effective clinical communication; (iii) plans for an interactive video series to bridge gaps in understanding patient responses; and (iv) future integration of AI-enhanced learning using ChatGPT for personalized language practice.

This model effectively addresses many concerns raised by Garg.[1] It maintains the standardization of medical education, preserves opportunities for international collaboration and career progression, and ensures effective communication in diverse healthcare settings. Importantly, it does so without compromising the quality or global relevance of medical education.

A key strength of CLPP is its potential for scalability and adaptation. It's framework can be easily modified to incorporate other regional languages, making it a viable solution for medical institutions across multilinguistic India. This adaptability ensures that the benefits of enhanced doctor–patient communication can be realized nationwide while still maintaining a standardized core curriculum in English. Such an approach could improve patient outcomes and satisfaction, particularly in regions where language barriers have historically hindered effective healthcare delivery.

As we continue to debate the role of language in medical education, programmes such as CLPP offer a pragmatic middle ground that deserves serious consideration. It demonstrates that linguistic competence and cultural sensitivity can be seamlessly integrated into medical training, enhancing patient care without the need for a radical overhaul of the existing system.

We propose that the CLPP model be considered for wider implementation across medical institutions in India. Its adaptable framework could be tailored to different regional languages, providing a nationwide solution to the language barrier in medical education while maintaining India's competitive edge in the global medical community.

REFERENCES

1 Garg R. Medical education in Hindi and indigenous languages in India: Issues and challenges. *Natl Med J India* 2024;**37:**95–9.

2 Suhas S, Basavarajappa C, Korwar M, Shamanna V, Mittal A, Kumar N, *et al*. Clinical linguistic proficiency program: An innovation to bridge language incompatibility in the training of psychiatric residents. *Indian J Psychol Med* 2024;**46:**480–4.

3 Manjunatha N, Basavarajappa C, Harbishettar V, Ghadigaonkar D, Satish S (eds). *Clinical linguistic proficiency program: A handbook for psychiatric residents.* Bengaluru:Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bengaluru, India; 2024.

Manik Inder Singh Sethi
Narayana Manjunatha
Department of Psychiatry
National Institute of Mental Health and Neurosciences
Bengaluru, Karnataka, India
manikindersingh@gmail.com

[**To cite:** Sethi MIS, Manjunatha N. Clinical linguistic proficiency program: An approach to achieve multilingual proficiency. *Natl Med J India* 2024;**37:**359–60. DOI: 10.25259/NMJI_1146_2024]