Review of the GMC’s Role in Doctors’ Continuing Professional Development: Final Report

September 2011
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Executive summary

Doctors’ have a duty to keep their knowledge and skills up to date. This continuing professional development (CPD) is an integral part of doctors’ professionalism. Although it should be rewarding in its own right, CPD is not an end in itself. Its purpose is to enable doctors to continue to provide high standards of care for their patients throughout their career.

As the regulator, the GMC has responsibility for ensuring that doctors maintain those high standards and that their participation in CPD activities supports the better care of patients and the public.

This review has focused on how doctors should approach their CPD, how employers and others can create a culture and environment which supports appropriate CPD and the GMC’s role in promoting awareness of relevant CPD.

Unlike undergraduate and postgraduate training, there is no formal CPD curriculum for all doctors to follow. Nor should there be. Each doctor’s CPD needs will be different, depending on the role they are undertaking, the needs of the service in which they are working and, above all, the needs of their patients and the community. The identification of those learning needs and agreement on how they are to be addressed should therefore be the responsibility of the individual doctor in discussion with the individuals, teams and organisations with which they work. The principal mechanisms for this are personal development plans, job planning and appraisal.

The GMC’s role in regulating doctors’ CPD is not to prescribe what CPD doctors must do or how they must do it, but to provide a framework of principles around which doctors should plan, undertake and evaluate their CPD activity. The guidance which accompanies this report provides that framework of principles. To have their full effect they must be embedded in the processes for appraisal and in the way appraisal is quality assured. By using appraisal to confirm that doctors are practising to the appropriate standards revalidation will provide assurance that they are participating properly in CPD.
Primary responsibility for doctors’ continuing learning rests with doctors themselves. But they must be supported in this by a workplace culture which provides opportunities for all staff to maintain and develop their skills. This applies not just to consultants but equally to groups which sometimes struggle to access resources for their CPD, such as locums, sessional GPs and staff grade doctors. A number of recent reports have recognised the importance of institutional support for CPD\(^1\). The framework provided by our guidance offers a proportionate approach which balances the legitimate interests of employers and contractors of doctors’ services with the needs of doctors.

The GMC is not a provider of CPD and apart from in those areas where it has particular expertise related to its role as the regulator, it should not become one. However, the GMC’s unique position makes it well placed to bring to the notice of doctors trends and issues affecting their professional practice and key developments in medicine which are relevant for all doctors. It has already begun to do this in isolated instances and the introduction of revalidation will make this more important in the future. This will help doctors to reflect on their learning needs and decide what CPD will be most valuable for them in meeting the needs of their patients.

**Section 1: Background**

1. Lord Patel’s March 2010 report *Recommendations and Options for the Future Regulation of Education and Training* examined how the GMC’s role would need to develop in the light of the responsibilities it was about to take on for regulating postgraduate medical education and training\(^2\). That report also recognised that doctors’ learning does not end with the completion of formal postgraduate training and nor does the responsibility of the GMC.

2. Once out of training doctors still have most of their careers ahead of them. During that time what they learned at medical school and in postgraduate training will need to be updated to reflect changes in practice and technology, and in society’s expectations of the way doctors’ practice.

3. Doctors anticipate and respond to those changing demands through CPD. The onus is on them to show that they are maintaining appropriate professional standards. Revalidation will provide the public with assurance that they are doing so and evidence of participation in CPD will be part of that assurance.

4. The challenge for the GMC is to regulate doctors’ CPD activity in a way which serves the interests of patients, while also supporting doctors and recognising the needs of those who employ or contract their services.

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5. Lord Patel noted that the GMC had issued CPD guidance for doctors in 2004\(^3\). But he was mindful that much had moved on. His report therefore recommended that:

‘The GMC should update its 2004 CPD guidance and re-examine how the regulatory role in CPD should be exercised so as to support doctors in meeting the requirements of revalidation and providing high quality care for their patients, whilst preserving the value of CPD for individual professionals.’

6. Lord Patel’s recommendation provided the impetus for a review of the GMC’s role in doctors’ CPD. This report sets out the conclusions of that review.

Section 2: Defining CPD for doctors

7. The first problem for any regulator becoming involved in CPD is being clear about what it is trying to regulate and why.

8. There is no universally agreed definition of CPD for doctors. However, it is generally understood to refer to all the processes and activities pursued by doctors following their completion of formal postgraduate training that enable them to maintain and continually develop their professional practice. Building on this and with reference to the definitions used by others\(^4\) our review has used the following definition:

A continuing learning process, outside formal undergraduate and postgraduate training, which enables doctors to maintain and improve their performance across all areas of their medical practice through the development of knowledge, skills, attitudes and behaviours. It covers all learning activities, both formal and informal, by which doctors keep up to date.

9. We have also been clear that CPD is not an end in itself. Its purpose is to help improve the safety and quality of care provided for patients and the public. It is therefore linked to doctors’ performance as individuals and as members of teams in the organisations where they work.

\(^3\) Ibid, review recommendation 20

\(^4\) World Federation for Medical Education, Continuing Professional Development (CPD) of Medical Doctors: WFME Global Standards for Quality Improvement, WFME Office, University of Copenhagen, Denmark, 2003, p6.
Academy of Medical Royal Colleges, Continued Professional Development; Guidelines for recommended headings under which to describe a College or Faculty Scheme, 2010, p3
10. As we will see in sections 7 and 8 of this report, this definition and purpose of CPD shaped the way the working group felt CPD should be regulated.

**Section 3: Remit and objectives of the review**

11. The terms of reference for the review are reproduced at Annex A. Our task was to examine and make recommendations on the GMC’s role in CPD.

12. The required outputs were:

   a. A report to the Continued Practice, Revalidation and Registration Board and to Council setting out recommendations for the role of the GMC in CPD.

   b. Following consultation on the report and draft guidance, an updated version of the GMC’s 2004 CPD guidance.

13. To support our terms of reference and aid our developing thinking we established some underlying principles for the review. These provided a template against which we could test our developing ideas (Annex B).

**Section 4: Working methods**

14. A small working group, chaired by a lay member of the GMC, was established to undertake the review. The group comprised medical and lay members from the GMC, as well as representatives from the Academy of Medical Royal Colleges (AoMRC), NHS Employers and the Committee of General Practice Education Directors (COGPED). The full membership is shown at Annex C.

15. The working group recognised that its thinking needed to be informed by a wider range of views. These were sought in several ways. On 30 March 2011 we held a stakeholder seminar on our emerging ideas. The seminar brought together doctors (including consultants, GPs, SAS grade doctors, and trainees), employers, academics, representatives of the medical Royal Colleges, Departments of Health in England and Scotland, deaneries, professional associations and the independent sector, as well as medical and lay members of the GMC’s reference community.

16. Issues arising from the review were also among the topics discussed at two further seminars organised by the GMC for SAS grade doctors and new consultants in May 2011.
17. From March to mid July 2011 we ran an online survey asking doctors’
their views of the GMC’s role in CPD. Details of the survey were widely trailed
in the GMC’s e-bulletins to doctors and in the communications of other
organisations such as the medical Royal Colleges. The survey elicited 1872
responses.

18. As well as considering the regulation of CPD as it relates to medicine in
the UK, we also looked at other professions both within and outside the health
sector. This was supplemented by a literature review of how regulators
worldwide approached this issue.

19. We have also benefited from the results of research into the
effectiveness of doctors’ CPD commissioned by the GMC and the AoMRC.5

20. Details of the learning from the seminars, survey, literature review and
research are provided in section 6 of this report.

21. To supplement the research and engagement activities already
undertaken, we also commissioned longer term research looking at the links
between doctors’ participation in CPD and their practice and performance.
That research will not be completed before this review reports its conclusions.
However, we anticipate that the learning derived from the research will help to
inform the GMC’s future work.

22. The working group met on four occasions between November 2010
and July 2011. The recommendations in this report represent the group’s
conclusions. They are intended to provide the basis for a full public
consultation on our future role.

Section 5: Regulatory context and drivers for change

23. To understand our possible future role in the regulation of CPD, it is
first necessary to say something about the context within which we operate
and the drivers for change.

The GMC’s locus

24. Section 5 of the Medical Act 1983 gives the GMC the ‘general function
of promoting high standards of medical education and co-ordinating all stages
of medical education’. These general functions have not, until recently, been
accompanied by the sort of specific powers which might give the GMC direct
regulatory purchase on doctors’ CPD.

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5 Schostak J, Hanson J, Schostak J, Brown T, Driscoll P, Starke I, Jenkins N, The Effectiveness of
Continuing Professional Development, College of Emergency Medicine, 2010
25. Revalidation will provide the GMC with new legal powers\textsuperscript{6} and a focus for doctors’ future CPD activity.\textsuperscript{7} This is because evidence of participation in CPD will be part of the supporting information that doctors will bring to their annual appraisals to show that they are keeping up to date and working to enhance the quality of their practice.

26. For this reason, doctors need clear guidance from the GMC about what is expected of them in relation to CPD and revalidation.\textsuperscript{8} Our 2004 guidance, \textit{Continuing Professional Development}, was well received at the time it was published but, as Lord Patel recognised, it is now out of date.

27. More generally, \textit{Good Medical Practice} (2006) imposes a duty on all doctors to ‘keep [their] knowledge and skills up to date throughout [their] working life’ and ‘regularly take part in educational activities that maintain and further develop [their] competence and performance’. Doctors fulfil that duty through their participation in CPD. How they have done that has been largely left to individual doctors, the medical Royal Colleges and other providers to get on with.

\textit{External drivers for change}

28. Revised CPD guidance is one element, but revalidation has also prompted calls for ‘a more rigorous approach’ to CPD and ‘reforms…to the oversight of continuing professional development to support doctors in meeting the requirements of revalidation’\textsuperscript{9}. Importantly for our review, the calls for more rigour have been balanced by recognition that ‘[E]ffective CPD schemes are flexible and largely based on self-evaluation’ and the importance of the link between CPD and appraisal\textsuperscript{10}. These considerations have shaped our thinking about how the GMC can add value without introducing rigidity and disproportionate burden.

29. There have been other reports concerned with the challenge of embedding in medicine a culture of life-long commitment to personal and professional learning\textsuperscript{11}. These have recognised the risk that professional values fostered during a doctor’s 10 -15 years of education and training might atrophy during the much longer period of established practice that follows.

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\textsuperscript{6} Amendments to the Medical Act 1983 in relation to revalidation (not yet in force) will enable the GMC to set the requirements for retaining a licence to practise. One of these requirements will be participation in CPD.

\textsuperscript{7} This existence of legislation to support revalidation means that separate statutory powers specifically relating to CPD are not required at the present time.

\textsuperscript{8} GMC, Response to our revalidation consultation, 2010, pp32-33

\textsuperscript{9} Government White Paper, Trust, Assurance and Safety – The Regulation of Health Professionals in the 21\textsuperscript{st} Century, HMSO, 2007, p71


\textsuperscript{11} Royal College of Physicians, Doctors in Society: Medical professionalism in a changing world, 2005 and R Levenson, S Dewar, S Shepherd, Understanding doctors: Harnessing professionalism, Kings Fund, 2008
30. Government proposals have also sharpened the focus on who has responsibility for CPD. The Department of Health (England) consultation Liberating the NHS: Developing the Healthcare Workforce stated that ‘the current system lacks clarity about the responsibility for continuing professional development and this leads to underinvestment and wasted opportunities for staff to develop and respond to change...In the new NHS the responsibility for investing in the existing workforce and ensuring sustainability of specialist skills will sit where it should – with employers’\textsuperscript{12}. This view has been reinforced recently by a report from the NHS Future Forum which recommended that ‘employers should prioritise the provision of CPD’\textsuperscript{13}. The Government has welcomed this recommendation, noting that the NHS Constitution commits all employers supplying NHS funded services to provide staff with personal development and access to appropriate training for their jobs\textsuperscript{14}.

31. Yet this current emphasis on the importance of CPD occurs in an economic climate which places considerable pressure on the resources available for CPD. This has informed our guidance to doctors as to the focus of their CPD activities and our thinking about how the guidance might be embedded in the workplace.

The roles of others

32. Examination of the regulatory context must recognise the roles of others in doctors’ CPD.

33. Primary responsibility for remaining up to date and fit to practise rests with the individual professional. But, as we have seen, employers have a responsibility to support doctors in this. The medical Royal Colleges and Faculties, trade bodies, professional associations and others also support their members by operating CPD schemes, producing guidance for their members and providing CPD. The AoMRC has done much to introduce a common approach to the recording, organisation and quality assurance of CPD schemes across the different specialties\textsuperscript{15}.

34. In medicine there is both a culture of CPD participation and an infrastructure to support it. This necessarily affects the nature of the regulatory interventions required. We need to make sure that we add value and do not duplicate or usurp work that is carried out more appropriately and effectively by others. This is what the Council for Healthcare Regulatory Excellence refers to as ‘right-touch regulation’\textsuperscript{16}.

\textsuperscript{12} Department of Health (England), Liberating the NHS: Developing the healthcare workforce, December 2010, p24
\textsuperscript{15} See Academy of Medical Royal Colleges, Ten Principles for College/Faculty CPD Schemes and Guidelines for recommended headings under which to describe a College or Faculty CPD scheme
\textsuperscript{16} Council for Healthcare Regulatory Excellence, Right Touch Regulation, August 2010
Section 6: Understanding the needs of others

35. An unpublished 2010 survey of doctors about the content of GMC Today showed that CPD was the area of the GMC’s work in which doctors were most interested. This indicated an opportunity for us both to add value and satisfy an unmet need.

GMC stakeholder seminar

36. Our stakeholder seminar on 30 March 2011 (see paragraph 15 above) helped us to understand how we might begin to meet that need. The key messages were:

- CPD should be directed towards improving the care provided for patients and the delivery of the service.
- Doctors should be encouraged to take responsibility for their own learning.
- Reflection drives change in performance and is the key to good CPD.
- The GMC should take a light touch, setting a framework of high level principles supported by clear guidance.
- The GMC should avoid micro-management of doctors’ CPD and duplication of the work of others.
- Annual appraisal in the workplace is central to the identification of doctors’ CPD needs and to monitoring the effectiveness of CPD activity.
- There is a need for more advice on the use of CPD in appraisal.
- Revalidation will make doctors more accountable for their CPD activity, but it must not reduce CPD to a tick-box exercise.
- It is important to recognise that some aspects of CPD can be valuable even if their outcomes are difficult to measure.
- The GMC should sign-post CPD that might be relevant for doctors.
- Consideration should be given to the needs of doctors in less than full time practice and those returning to medical practice.
- Research was required on how CPD (or the lack of it) is linked to poor performance and concerns with fitness to practise.
37. These themes are reflected in the draft CPD guidance that the working group has developed.

GMC online survey

38. Some of the messages from the seminar have been reinforced by the results of our online survey of doctors (see paragraph 17 above). As this was not a scientific study of doctors' views we must be cautious about what we infer from the responses received.

39. Nevertheless, among the 1872 respondents there was a clear view that primary responsibility for doctors' professional development rests with doctors themselves (86%). 81% of respondents said they had the opportunity to discuss their CPD needs and personal development at appraisal, but that this was not necessarily followed up. For many there were concerns about the quality and effectiveness of appraisal at the present time.

40. Encouragingly, 79% of respondents said that their CPD activity over the last five years had helped to improve the quality of the service or care given to their patients. Feedback on what CPD activities had influenced or changed practice yielded a wide range of responses. This points to the importance of flexibility in the way CPD activities are understood and regulated. Responses also highlighted the value for many doctors of learning undertaken with other members of the healthcare team and with peers.

41. In terms of the GMC's role, doctors saw value in the development of high level principles and guidance, but did not want detailed or prescriptive requirements imposed on them. Many saw a role for the GMC in working with employers to support access to CPD. This was a particular concern for SAS grade doctors and those in part-time practice. Not surprisingly, many wanted clarity about the CPD requirements for revalidation.

42. Many of these themes are covered by our proposed guidance.

43. A more detailed account of the survey results is on our website.

Effectiveness of CPD report

44. The study commissioned by the GMC and AoMRC into the effectiveness of CPD has provided important insights into our future regulatory role and some helpful notes of caution.

45. The report looks at how doctors view their learning or the learning of others within their organisations, how this relates to conceptions of CPD, its provision and uptake, and what constitutes effective CPD.
46. The report shows a culture in which doctors participating in the study viewed CPD as a natural part of professional life, necessary for patient safety and rewarding\(^{17}\). There is no single, correct way of doing CPD\(^{18}\) but it was seen as more likely to be effective when doctors were able to determine their own learning needs through reflection within the totally of their practice\(^{19}\). There was a tension between the value of informal, opportunistic learning that happens on the job and the demands for increasing accountability for CPD activity and the quantification of learning\(^{20}\).

‘There was a perceived danger that the tick-box method evoked a feeling of “being regulated” and that this in turn fostered an autopilot response to attain the “credit rating” rather than a reflective learning experience that led to a deeper and more enriched understanding of practice\(^{21}\).

This was neatly encapsulated in the fear of revalidation leading to the ‘industrialisation of CPD…failing to capture many individual’s learning needs’\(^{22}\). Since CPD aims to improve the care provided for patients, it is imperative that this does not happen.

**Lessons from other regulators**

47. We spoke to a range of regulators and other bodies in the UK about their approaches to CPD\(^{23}\). We also reviewed the systems operated by medical regulators worldwide. A summary of the approaches considered is at Annex D. A detailed report on international models is on the GMC’s website.

48. How CPD is regulated varies widely and it is likely to be shaped by a range of different factors. These include the underlying culture of the profession, the nature and complexity of the regulated activity, history and societal expectations, the purpose of the regulatory intervention (to ensure compliance or foster excellence, or both), the regulatory risk to be addressed and the extent to which CPD serves as a proxy for revalidation. Just as there is no single, right way of doing CPD, so there is no single right way of regulating it.

49. In the next section we look at the feedback we have received and what the learning from other regulatory models should mean for our role.

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\(^{18}\) Ibid p 20

\(^{19}\) Ibid p 9.

\(^{20}\) Ibid p 41

\(^{21}\) Ibid p 41

\(^{22}\) Ibid pa 57

\(^{23}\) General Dental Council, Nursing and Midwifery Council, Health Professions Council, Solicitors Regulation Authority, General Teaching Council for England, Bar Standards Board, Royal Institute of British Architects, Institute of Chartered Accountants of England and Wales. We also reviewed the approaches to CPD of each of the other UK health regulators through the information on their websites.
Section 7: The role of the GMC

50. In defining our role we first needed to understand what it is we are trying to regulate and why.

51. The definition of CPD which we offered in section 2 (paragraph 8) makes clear that CPD is not simply a matter of courses and conferences. It covers ‘all learning activities, both formal and informal, by which doctors keep up to date’.

52. The definition also emphasises that CPD is not an end in itself. Its purpose is to help improve the safety and quality of care provided for patients and the public. It is therefore linked to doctors’ performance as individuals and as members of teams in the organisations where they work.

Supporting the purpose of CPD: some notes of caution for the regulator

53. It is a truism that CPD is about individual development. Professional regulation seeks to promote good practice. It does so by setting standards and requirements, defining outcomes, measuring compliance and taking action in cases of non-compliance. Our first challenge is to ensure that our regulatory tools do not distort professional development in a way which undermines the goal of enhancing patient care.

54. What we have learned from our seminars, surveys and research is that for many doctors the most effective CPD is the sort of experiential learning that occurs naturally in the workplace, almost as a by-product of practice, rather than through activities formally designated as CPD. Inevitably, this ‘informal’ CPD activity is hard to measure and resistant to providing the sort of assurances a regulator might seek.

55. Measuring the effect on performance is even more elusive. For this reason, many regulatory models tend to record activity rather than impact on practice. Typically, they require the accumulation of CPD hours over a specified period. These models are helpful in professions where there is no established culture of CPD because the regulator can audit a sample of CPD returns to monitor basic compliance, although these may say little about the CPD’s effect on a practitioner’s actual performance. Counting CPD hours or credits may also be relevant where there are no intermediate structures between the regulator and regulated practitioner which support the CPD.
56. In medicine, those structures do exist, for example through the work of the medical Royal Colleges and Faculties (which require members to undertake 250 hours CPD over five years) and professional associations, through the role of annual appraisal, job planning and doctors’ personal development plans. Above all, revalidation will give the GMC an insight into doctors’ performance which makes our detailed scrutiny of the level of individual CPD activity superfluous.

57. Regulatory models differ in the extent to which they are prescriptive about the CPD professionals must undertake. The GDC, for example, currently requires dentists to undertake a minimum of 250 hours’ CPD across a five year cycle, of which 75 hours must be verifiable by the regulator. The verifiable CPD should include medical emergencies, disinfection and decontamination, radiography and radiation protection. Failure to comply results in removal from the GDC’s register\textsuperscript{24}. In the USA several jurisdictions take a similar approach for doctors. California requires all physicians and surgeons to ‘complete mandatory continuing education in the subjects of pain management and the treatment of the terminally ill and dying patients’\textsuperscript{25}.

58. Our working group did not favour such approaches. Although prescriptive regulatory models provide certainty for the practitioner and the public, medicine is too diverse, and the regulator too far from the coal face of actual practice, to be able to determine what CPD is most relevant for each doctor and for the service within which he or she works. There would be a real risk of diverting doctors’ energies and resources from more valuable learning simply to comply with regulatory requirements.

59. The working group was clear that the CPD needs of individual doctors are best determined by the doctors themselves in discussion with their colleagues, teams and the service within which they work. The effective use of job planning, annual appraisal and personal development plans should be central to this. The role of the GMC is to provide a framework of principles and guidance within which those discussions should take place.

The role of revalidation

60. Revalidation is fundamental to our regulation of CPD, but it is important that doctors do not regard it as the impetus for, or the goal of, their CPD. An individual’s CPD must be directed towards improving and maintaining practice. Revalidation is simply a by-product of that process.

\textsuperscript{24} Continuing Professional Development (CPD) for Dentists, General Dental Council, December 2009.
\textsuperscript{25} American Medical Association, State Medical and Licensure Requirements and Statistics 2006
61. The clear message from the GMC’s 2010 revalidation consultation, *The Way Forward*, was the need to simplify the model. Doctors will do what is necessary for them to get through revalidation, but the GMC must ensure that revalidation does not drive doctors towards a level of minimum compliance which adds no developmental value, only regulatory burden. Clear principles and guidance around CPD from the GMC, rather than detailed and prescriptive requirements, will support this.

62. Revalidation will also serve the important function of enabling the GMC to look at doctors’ performance rather than at the CPD which contributes to performance. If a doctor is practising to appropriate professional standards there is no need for GMC regulatory scrutiny of the CPD input into that performance. Such scrutiny is more appropriate locally in the context of workplace annual appraisal.

*Quality assurance and accreditation of CPD*

63. We have considered whether the GMC should quality assure CPD provision or accredit specific courses, events or providers. It was suggested to us that the GMC should quality assure CPD in the same way that we quality assure undergraduate medical education and postgraduate training. The working group concluded that we should not do so.

64. As this report has already noted, the most effective CPD activity is often the sort of informal, experiential learning that occurs in the workplace in the normal course of medical practice and which is least susceptible to measurement.

65. Quality assuring or accrediting more ‘formal’ CPD – that is structured courses or programmes – would inevitably result in the creation of preferred providers and preferred types of activity even though the activities themselves may be the least relevant to the individual. The resource implications are also likely to be formidable.

66. We also noted that whereas undergraduate and postgraduate training have set curricula or outcomes that everyone must meet and there is clear organisational responsibility for delivery and accountability to the GMC, this is not the case with CPD where doctors’ needs are more individualised. It is unclear what we would be quality assuring.

67. If the GMC is to be satisfied about high standards of medical practice (to which CPD is an important contributor) it is more relevant to look at the outputs of revalidation and the systems which will support it. Plans for the quality assurance and audit of revalidation are being developed. Within this work, the GMC will continue to engage with the systems regulators to ensure that organisations have in place systems which will support access to appropriate CPD for doctors.
68. Above all, the working group was mindful that, in contrast to our powers to regulate undergraduate education and postgraduate training, the GMC has no statutory powers to regulate employing or contracting organisations or the providers of CPD. We do not think the GMC should seek such powers and, at the present time, it is unlikely they could be secured.

69. We have therefore concluded that it must be a doctor’s responsibility to ensure that their CPD activities are relevant, effective and provide good value for money.

**Should the GMC provide CPD?**

70. The working group considered whether the GMC should be a provider of CPD for doctors. We noted, for example, that the *Good Medical Practice in Action: Interactive Case Studies* on our website\(^\text{26}\) offer something that looks very much like CPD. These provide the opportunity for users to apply the principles of *Good Medical Practice* to real life scenarios. We have particular expertise in this area that makes it appropriate for us to provide learning materials. We should be alive to other similar areas where our unique position will enable us to add value.

71. However, we considered that such examples are likely to be rare. In general, others will be better placed and have more relevant specialist expertise to provide CPD, and it is more appropriate that they should do this. Nevertheless, we are of the view that the GMC does have a role in drawing to doctors’ notice key developments which may be relevant to their learning needs. We discuss this further in section 8 which looks at where we can add value.

**Section 8: Adding regulatory value**

**GMC guidance on CPD**

72. One of the required outputs from this review was a new set of GMC guidance to doctors on CPD. The [draft guidance](http://www.gmc-uk.org/guidance/case studies.asp) is available on our website.

73. The guidance reflects the learning described in sections 6 and 7 of this report. In particular, this includes the need for the GMC to establish a framework of principles and behaviours to guide doctors in the way they organise their CPD rather than attempt to prescribe or micro-manage their individual activity. The guidance will provide online links to a range of organisations, tools and examples of good practice which should help doctors to manage their CPD effectively.
74. The guidance makes clear that doctors have a professional responsibility to identify and act on their individual CPD needs. But because CPD is aimed at improving the safety and quality of care provided for patients and the public, this must take account of the needs of the teams and organisations within which doctors work, and the needs of their patients and of the wider community.

75. The guidance recognises the importance of flexibility in what is treated as CPD and in how CPD needs are met. One size, one learning method, one curriculum, will not fit all.

76. The guidance also highlights the importance of planning. Although doctors need to be alert to the unexpected opportunities for learning that arise from their day to day practice, learning cannot be left to happenstance. *Good Medical Practice* requires doctors to reflect on their standards of medical practice. This includes reflecting on their learning needs and how they are to be addressed. Such reflection is key to good CPD outcomes. We highlight the importance of appraisal, job planning and personal development plans in this process.

77. Reflection is fundamental to evaluating the impact of CPD. The guidance suggests how the use of evidence, reflection and evaluation, and commitment to practice change as part of the learning cycle, are more likely to lead to changes in behaviour.

*Equality and diversity issues arising from the guidance*

78. The working group considered the position of doctors who are in less than full-time practice or who are planning, or returning from, a career break. We are clear that patients and the public have a right to expect that all licensed doctors remain up to date in all areas of their work, regardless of the circumstances of their practice. Doctors therefore need to take advice from their College, their employer and others to support them in this.

79. Our guidance also highlights the responsibilities of employers, contracting organisations and managers to ensure that all members of their workforce have the opportunity to maintain and develop their skills, including groups who sometimes struggle to access the resources that will support their CPD, such as sessional GPs, locums and staff grade doctors. Embedding our guidance in local processes and appraisal systems will help to reinforce this message.

80. By taking a flexible approach in our guidance to what constitutes CPD we have tried to ensure that those who may have less ready access to formal modes of CPD are nevertheless able to have their informal activities acknowledged.
As explained in paragraphs 86-92 below, we also see opportunities for the GMC to use its unique position to bring to doctors’ attention issues that may be relevant for their CPD. Particularly for doctors who are not part of a College, specialty or professional association network, this will provide another means of helping them to reflect on their CPD needs.

Some of those we spoke with during the course of our review felt the GMC should require Colleges, employers and others to provide resources for, or access to, the CPD they required. The GMC has no regulatory jurisdiction over other organisations and we cannot compel other organisations to follow GMC guidance. Nor can we require doctors to be members of those organisations or follow the standards that they set. However, our guidance to doctors sets out where we consider that others have a responsibility to support doctors in meeting their CPD needs. In the next section we consider what steps the GMC should take to embed its guidance in the practice of others.

**Embedding CPD in the practice of others**

Our guidance will only be effective if it is successfully embedded in the way doctors approach their CPD and in the way CPD is supported by organisations and medical managers, including Responsible Officers. The guidance makes specific links to appraisal and personal development plans so as to embed our CPD principles in workplace processes. It also makes reference to the roles of others in supporting doctors’ CPD. We note, for example, that the Responsible Officer Regulations impose a statutory duty on Responsible Officers to co-operate with the GMC in relation to the GMC’s revalidation functions. The GMC should reinforce this by setting out its expectations on CPD in its guidance to Responsible Officers. Links should also be made through the Responsible Officer guidance issued by the Health Departments and through the documentation being developed in England by the Revalidation Support Team.

The GMC must also work with the systems regulators to ensure that provision for CPD is properly reflected in the standards required of organisations across the UK and with accountable employers’ organisations to ensure that GMC guidance is embedded in local processes.

Some of those with whom we spoke wished us to go further and specify the nature of the CPD provision that Colleges, employers and others must make, particularly in relation to resources for, and access to, CPD. However, the working group was clear that the GMC has no legal power to impose requirements on other organisations in relation to CPD. It was also clear about the need to recognise the boundaries between the role of the regulator and that of employers, Colleges and other providers of CPD.
Sharing what we know

86. In paragraph 81 we state that the GMC should not, in general, be a provider of CPD. Nor should we attempt to prescribe the CPD that individual doctors must undertake. The GMC should, however, do more to use its unique position and relationship with doctors to help them identify areas of learning which may be relevant to them.

87. Until recently the GMC held very little information about either individual doctors or trends across the profession as a whole. That is changing. For example, our fitness to practise procedures provide a wealth of data which help us to identify trends and potential areas of regulatory risk. Research tells us that doctors pose a higher regulatory risk at key transition points in their careers. We also have research which highlights issues with prescribing errors, not just among trainees, but across all grades. We publish this sort of information on our website, but might do more to follow it up in ways which would encourage individuals or groups of doctors to reflect further on their own practice and their own particular CPD needs.27

88. For example, we know that international medical graduates are more likely to face challenges in making the cultural transitions necessary for UK medical practice. We have a responsibility to promote the sort of good practice which will help these transitions. At present, international medical graduates receive a copy of Good Medical Practice when they register and are then left, by the GMC at least, to get on with things. The current review of the PLAB test will look at this. But the GMC should do more to minimise the known regulatory risks by highlighting areas where reflection might be valuable. This is not to usurp the responsibilities of employers to provide suitable induction and support. However, the involvement of the regulator in drawing attention to the issues among relevant groups may provide impetus for action where that is needed.

89. During our work we saw a number of reports of concerns about deficiencies in medical expertise in particular areas of practice. Where these relate to specialties and where doctors are linked to Colleges or other specialist networks there are established mechanisms through which they can access the learning they need. Yet we saw examples of groups (notably locums, doctors on career breaks and those working part-time) who reported difficulty in accessing CPD. We also learned of rapidly developing fields of practice, such as genomic medicine, which are not specialty specific and with which doctors in all types of practice will increasingly need to become familiar.

27 In The State of Medical Education and Practice in the UK 2011 report published in September 2011, the GMC began the process of drawing upon the wide range of information it holds to provide a picture of today's medical profession and some of the key challenges it faces. The aim of the report is to initiate discussion about these challenges with professional bodies, patient groups, employers, educators, other regulators, and doctors themselves.
90. The GMC would not have the expertise to provide CPD in such areas, nor should it. However, the working group considered that the GMC should use its unique and authoritative position to highlight the importance of particular developments in medical practice or wider issues of professionalism. Particularly for doctors who are not part of a College, specialist association or other network, or who may be professionally isolated, the GMC is in a position to help them make the link to the information they need.

91. Revalidation will, over time, give the GMC much richer information about individual doctors than ever before. The GMC will know about their scope of practice; their specialty; grade; the stage they have reached in their career, whether they are new to UK medical practice or returning to practice. The working group noted that it may, in future, be possible for the GMC to use its unique database to make connections with individual doctors or groups of doctors by targeting information likely to be relevant for their professional development.

92. This would be a significant step for the regulator to take. The GMC would need to consider carefully any data protection and other legal implications. It would also need to be clear that its role was not to dictate the content of doctors’ CPD activity, but to facilitate doctors’ access to relevant learning or facilitate reflection on whether that learning would be useful. Doctors have told us that they are interested in receiving more information from the GMC about CPD. This would be a step towards meeting that need.

Section 9: Further work

93. This report sets out recommendations for the GMC’s future role in regulating doctors’ CPD. But it is not the final word. The healthcare landscape is constantly changing and the GMC’s role in CPD will need to reflect developments.

94. Future changes to the shape of postgraduate training and in technology may affect the way in which doctors need to develop their knowledge and skills once they have completed formal training and how those new skills need to be assured by the GMC. Other initiatives, such as the credentialing of medical practice outside of training may also require the GMC to update the way it regulates.

95. The GMC must also ensure that its approach continues to reflect research in the field, particularly the links between CPD and performance. The GMC should, for example, be able to use the learning from ongoing research to guide the sort of regulatory interventions discussed in paragraphs 86-92.

96. Despite the inevitability of further change, the working group considered that the principles set out in this report, and particularly in the guidance, provide a good basis for the future regulation of CPD.
Section 10: Conclusions and recommendations

97. In 2010 the GMC assumed responsibility for regulating the continuum of medical education and training. The way in which it does this must reflect the different nature of doctors’ education and training needs at different stages of their careers.

98. Once doctors have completed their formal postgraduate training their needs, the needs of their patients and of the service within which they work will be particular to the circumstances of their practice. The diversity of medical practice means there is no CPD curriculum for all doctors to follow.

99. The GMC requires all licensed doctors to participate in CPD in order to maintain and improve the standards of their practice. Doctors do so because they recognise that this is integral to their professionalism and their duty to their patients and the public. What CPD activities will be appropriate must be for doctors themselves to determine having regard to the needs of their patients and the service in which they work. Revalidation will show that they are doing so effectively. The task for the regulator, working with others, is to provide a CPD framework which helps them to do this effectively.

Recommendation 1: The GMC must provide a framework of principles and guidance to support doctors in planning, undertaking and evaluating their CPD activities [paragraphs 36, 41, 46, 53-59].

Recommendation 2: The effective use of job planning, annual appraisal and personal development plans should be central to the identification, content and evaluation of doctors’ CPD needs. [paragraphs 36, 56, 59, 62].

Recommendation 3: The GMC should endorse the principles and guidance provided at Appendix 5 to this report [paragraphs 72-77].

Recommendation 4: The GMC should work with the systems regulators, accountable employers’ organisations, the Health Departments and NHS Revalidation Support Team to embed its CPD guidance in local processes of appraisal and personal development planning [paragraphs 83-85].

Recommendation 5: The GMC’s revalidation guidance to Responsible Officers should highlight the relevance of our CPD guidance [paragraph 83].

Recommendation 6: The GMC should not quality assure or accredit CPD provision. Instead, its focus should be on the outputs of doctors’ revalidation, to which CPD is an input [paragraphs 63-69].
Recommendation 7: The GMC should explore how it might bring to doctors’ attention developments in medical practice or professionalism which may be relevant to their CPD. It will be for doctors to determine how those issues affect their practice and whether they should be addressed through their CPD [paragraphs 86-92].

Recommendation 8: The GMC should not, in general, be a provider of CPD for doctors except in those discrete areas where its unique position as the regulator enables it to add value [paragraphs 70-71].

Recommendation 9: The GMC should commission research on how CPD (or the lack of it) is linked to poor performance and concerns with fitness to practise [paragraphs 36, 95].
Appendixes

Appendix A: Terms of reference
Appendix B: Working principles for the review
Appendix C: Working Group Membership
Appendix D: Models for regulating CPD: international perspective
Appendix E: Draft CPD Guidance [available on our website]
Appendix A

The Role of the Regulator in Doctors’ Continuing Professional Development: Terms of Reference

Background

100. Under section 5 of the Medical Act 1983 the GMC has the ‘general function of promoting high standards of medical education and co-ordinating all stages of medical education’.

101. Good Medical Practice requires doctors to keep their knowledge and skills up to date throughout their working lives.

102. In 2004 the GMC published the guidance booklet Continuing Professional Development which made explicit ways in which doctors might identify their learning needs and undertake their professional obligation to keep up to date.

103. Since 2004, much has changed. The merger of PMETB with the GMC has caused us to look across the continuum of medical education and training and to consider our role at each stage. This includes consideration of how we fulfil our objective of ensuring proper standards in the practice of medicine once a doctor’s formal training is complete. Progress towards the introduction of revalidation has placed greater emphasis on doctors’ CPD activity as a means of demonstrating that they remain up to date and fit to practise throughout their careers. At the same time, the economic downturn is putting greater pressure on the resources available to support doctors’ CPD activities.

104. These and other developments make it necessary to update our 2004 guidance. In doing so we also need to look more broadly at the role of the regulator in relation to CPD. This was one of the conclusions of Lord Patel’s 2010 report setting out recommendations and options for the future regulation of education and training. Lord Patel recommended:

‘GMC should update its 2004 CPD guidance and re-examine how the regulatory role in CPD should be exercised so as to support doctors in meeting the requirements of revalidation and providing high quality care for their patients, whilst preserving the value of CPD for individual professionals.’
105. At its meeting on 13 July 2010 the Council of the GMC accepted this recommendation.

106. A review of the GMC’s role in CPD will follow the terms of reference set out below.

**Purpose**

107. To examine and make recommendations on the GMC’s role in CPD.

**Themes and issues for the review**

*Theme 1: understanding the terrain – what other regulators do*

108. The examination of the appropriate role for the GMC will be informed by a review of the respective regulatory approaches to CPD taken by other UK regulators and by medical regulators in other jurisdictions. This will include looking at how CPD activity is assured and how it fits within their wider regulatory regime.

*Theme 2: understanding the terrain - the role of the medical Royal Colleges and the AoMRC, and the responsibility of individual doctors.*

109. The review will consider the role of the medical Royal Colleges and Faculties and of the AoMRC as the setters of the principles and standards for, and as providers of, CPD. In doing so consideration will also be given to the provision and recognition of CPD outside of the College systems and how groups of doctors who are not members of Colleges are able to access quality CPD.

110. The review will also consider CPD as part of the professionalism of individual doctors and how it might be supported by employers.

*Theme 3: quality, consistency and improving medical practice*

111. The review will consider what steps the GMC should take to ensure the quality and consistency of CPD. Issues will include:

a. The CPD’s contribution both to improved medical practice generally and specifically revalidation.

b. The sufficiency of the CPD principles and criteria that were the subject of the GMC’s 2010 revalidation consultation.

c. The proper relationship between College CPD requirements and the requirements for revalidation.

d. How the transparency and accountability of CPD is assured through appraisal.
Theme 4: CPD and regulatory risk

112. The review will consider the role of CPD in helping to address areas of regulatory risk, such as moments of career transition, entry onto the GP or specialist registers or entry into UK medical practice by non-UK medical graduates. Issues will include:

a. Feedback loops from the GMC’s work on standards and fitness to practise and from research.

b. Whether there is a role for the GMC as a promoter or provider of CPD.

c. Whether the GMC has a role in supporting the CPD needs of particular groups who may not otherwise be sufficiently served by existing arrangements.

Theme 5: legislation and guidance

113. In the light of conclusions reached, the working group will make recommendations as to whether the GMC should seek specific statutory powers in respect of the regulation of CPD and/or update the GMC’s 2004 CPD guidance.

Outputs

114. The outputs of the review will be:

a. A report to the Continued Practice Board setting out recommendations for the role of the GMC in CPD.

b. Following consultation on the report and draft guidance, an updated version of the GMC’s 2004 CPD guidance.

Process: Review membership

115. The review will be undertaken by a working group drawn from members of Council and representatives from bodies relevant to CPD issues as listed below:

a. Working group chair appointed by the GMC’s Continued Practice, Revalidation and Registration Board.

b. Not more than three additional members of Council.

c. One representative from the Academy of Medical Royal Colleges Directors of CPD Group.

d. One representative from NHS Employers.

e. One representative from the Postgraduate Deaneries.

f. One representative from the Directors of Postgraduate General Practice Education.
116. The group may seek information and expertise from additional sources, as required.

**Working methods**

117. The work of the review will be taken forward through meetings of the group and by email, as required.

118. It will be for the group to identify what material it requires to support its work, such as discussion papers, research, surveys, questionnaires or focus groups.

**Accountability**

119. The review group will report to the Continued Practice Board of the GMC.

**Timescales**

120. The intention is for the group to submit its report and draft CPD guidance first to the Continued Practice Board of the GMC by May 2011 and then to Council.
Principles for the Review

1. The aim of the following principles is to help the Group identify what a successful outcome for the review might look like so that the soundness of our final recommendations can later be tested against the principles.

   a. CPD is a means to an end and not an end in itself. The regulation of CPD should be directed towards achieving improved performance and better patient care.

   b. All doctors have a professional duty to keep their knowledge and skills up to date and regularly participate in activities that maintain and further develop their competence and performance.

   c. The role of the GMC is to be flexible, facilitative and supportive. We should support doctors in identifying and participating in the CPD most relevant to them and to their healthcare organisations.

   d. CPD should be tailored to the needs of the individual. Our role should recognise the individual nature of doctors’ CPD needs.

   e. The GMC’s approach to the regulation of CPD should recognise personal reflection, appraisal and PDPs as the principle local mechanisms for evaluating and monitoring the CPD of individuals.

   f. Regulation must avoid imposing detailed and prescriptive requirements for CPD which risk diverting doctors’ CPD activity from their own professional needs, the needs of the organisations in which they work and the needs of their patients. However, this should not preclude the GMC from working with the specialties and others to identify developments in medical practice which may assist doctors in identifying their needs.
g. There must be national standards for CPD, but local delivery of those standards. The GMC should define the overarching principles governing CPD and set national standards. However, it is for doctors in consultation with their employers (or those who contract their services) and colleagues to determine their individual CPD needs having regard to those standards, the circumstances of their practice and the needs of their patients.

h. In setting the standards for CPD the GMC must provide sufficient clarity for doctors, and those appraising them, to know what is needed to meet the requirements of revalidation.

i. The GMC must work with others (including the Colleges and employers) to support the participation in CPD of all non-training grade doctors.

j. The GMC should not be involved in the delivery of CPD.
CPD Review: Working Group Membership

Mrs Suzanne McCarthy (Chair) - GMC lay member

Dr John Jenkins - GMC medical member

Professor Trudie Roberts - GMC medical member

Dr Mairi Scott - GMC medical member

Dr Claire Loughrey – Director of GP Postgraduate Education, Northern Ireland

Professor Alistair Thompson* – Chair, Academy of Medical Royal Colleges Directors of CPD Committee

Mr Bill McMillan – NHS Employers

*Dr Ian Starke – Vice Chair, Academy of Medical Royal Colleges Directors of CPD Committee, deputising for Professor Thompson
CONTINUING PROFESSIONAL DEVELOPMENT
the international perspective

August 2011
Foreword

This paper presents an up to date, international perspective of continuing professional development (CPD) programmes and requirements for doctors. It draws together international academic literature, regulatory guidance, legislation and other online material from around the world to form an overview of CPD that is far wider in scope, and more detailed, than other published studies.

Whether a legal obligation or an unregulated voluntary option, doctors in almost every country undertake some form of CPD. This paper considers CPD systems in a wide range of countries, from Japan and Kenya, to Ireland and Canada. Some, such as Pakistan, are taking their first steps towards establishing a national CPD programme. Others, like the USA, which began granting CME recognition awards to doctors over forty years ago, have a long history of CPD.28

The paper has involved extensive primary research in order to capture as current a picture of CPD as is possible. CPD systems evolve and change very quickly, which means that the information in published research can swiftly go out of date and cease to be factual. The only reliable sources of the latest data are the documentation from the regulatory bodies and professional medical societies, which can often be located online. Unfortunately but understandably, websites and documentation are often not provided in English.

Relevant information has been translated from French and German, and where possible, attempts have been made to translate information written in other languages. However, a comprehensible overview of a country’s CPD system can, on occasion, remain tantalisingly hidden behind a language barrier. The current CPD systems in Russia and South America are examples of this and, regrettably, details of the CPD schemes of these areas could not be verified.

Despite such obstacles, this examination of almost thirty countries’ CPD systems should serve to provide a full and fairly comprehensive global account of the way regulatory bodies, professional medical societies, and doctors are utilising CPD.

GBM

Search Methodology

The search was conducted using research databases and facilities at the General Medical Council, the Royal Society of Medicine Library and the British Library in London.

To locate published studies on CPD in the medical sector, a specific search syntax of CPD/CME and free-text terms associated with CPD, doctors, revalidation, recertification and international comparisons was applied across: Medline, EBSCO Academic Search Complete, Science Direct, Web of Science, Ingenta Connect, Project Muse, Cochrane Reviews and Social Science Citation Index.

Studies which were deemed irrelevant were removed during the study selection process. Forty-two relevant studies were selected from the literature database search and were annotated. Countries with clearly defined or unique CPD schemes were pinpointed. A search of websites was undertaken, using Google, Google Scholar and other search engines to determine whether information in the published literature was up to date.

It became apparent that much material was out of date, and so searches of regulatory bodies, medical societies and government websites were undertaken to attempt to locate up to date guidance and legislative information. Google and other search engines were used to locate such material.

Working on a country-by-country basis, a log of CPD systems around the world was built. Forty-seven countries were eventually searched, but information of relevance could only be gleaned from twenty-seven countries. Detailed research of these twenty-seven countries was undertaken. Relevant material in French, German and Spanish documentation was translated.

Another specific search syntax of [country name] and free-text terms associated with CPD, doctors, revalidation, recertification and international comparisons was applied across the research databases listed above was applied, to ensure no published literature had been missed in the initial search.
A Note on CPD/CME Terminology

The term CPD acknowledges the wide-ranging competencies needed to practice high quality medicine, including medical, managerial, ethical, social and personal skills. CPD therefore incorporates the concept of CME, which generally is taken to refer only to expanding the knowledge and skill base required by doctors.29

Although Continuing Professional Development and Continuing Medical Education can be, and are frequently used interchangeably, most literature has now defined CME as being an ingredient of CPD. As one academic has put it, ‘CPD is a process that includes continuing medical education’.30 Many countries are now moving from a ‘knowledge and skills base’ CME system, towards a system that seeks to promote the ‘the wide-ranging competencies needed to practice high quality medicine’ that CPD entails.

This research paper has not attempted to stipulate which countries’ systems may or may not constitute CME or CPD, but has followed the terminology each individual country uses to refer to its own systems.

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Introduction

Few published studies have provided a comprehensive overview or comparison of CPD systems, either in Europe or internationally. In 2003, the European Union of Medical Specialties released a paper which summarised, very briefly, CME/CPD systems in its member countries. A few years later there came the publication of three studies, which still remain fairly prominent and widely cited. An article by Merkur et al. (2008), whilst ostensibly focusing on revalidation, provided a concise outline of CPD in a number of European countries, including Germany, the Netherlands, Austria, Belgium, France and Spain. In 2009, a comparative analysis of CME in six European countries, written by Garattini et al, emerged which provided additional details of CPD in Norway and Italy. In the same year, Euro Observer published a collection of articles which again examined the CPD systems in Austria, France Germany, albeit in more detail.

Whilst such research is to be welcomed and has informed this paper, studies have, arguably, either repeatedly focused on the CPD systems in a small number of countries, or provided a concise review of others. In setting out to answer the following questions (below), this research paper attempts to bridge the gap, by providing a solid outline of CPD systems around the world, and, where relevant, more detailed accounts of these systems.

Research Questions:

121. Do other countries have or are they developing standards, guidelines or criteria on the use of CPD as a way for doctors to stay up to date? How detailed or prescriptive are the criteria? What kind of obligations do doctors have in following these guidelines and are there consequences if they do not?

122. In what way are other medical regulators ensuring that their doctors are undertaking CPD? How, if indeed they do, are they auditing individual doctors’ CPD activities? Does the regulator accredit or quality assure CPD activity, or provide CPD for doctors? What other bodies may undertake this role?

123. Are any of these jurisdictions developing or have developed a revalidation process? How does CPD fit into that process? Are there any emerging trends in the use of CPD in revalidation?

124. Are there any examples of regulators helping doctors identify areas where CPD may be useful through a facilitative or engagement role? For example, do they guide doctors towards, or direct or require particular types of CPD activity?
*Do other countries have or are they developing standards, guidelines or criteria on the use of CPD as a way for doctors to stay up to date? How detailed or prescriptive are the criteria? What kind of obligations do doctors have in following these guidelines and are there consequences if they do not? Do regulator guide doctors towards, or direct or require particular types of CPD activity?*

There have been several key changes to CPD systems recently. As of May 2011, it became compulsory for all doctors in Ireland to participate in a CPD scheme. In July 2010, sweeping regulatory changes in Australia brought about mandatory CPD for doctors. Provinces in Canada are in the process of rolling out compulsory CPD for doctors, which is also the case in Malaysia. Indeed, of the 22 countries in this study which require doctors to participate in CPD, over half have adopted the mandatory policy since 2001. It would seem that many governments and regulatory bodies are moving away from systems of voluntary CPD, although voluntary professional CPD processes exist in Belgium, Spain and Sweden.

Almost all the regulatory bodies in countries where CPD is mandatory have developed standards and guidelines on the use of CPD. Some, such as the Medical Council Ireland’s guidance on CPD set out the standards behind the CPD scheme – such as good medical practice – but only stipulate basic requirements: ‘as a minimum, doctors have to engage in fifty hours of CPD and one clinical audit per year.’ Others go much further. The Medical Council of New Zealand has issued some of the most detailed and unique CPD guidance, which requires non-specialist doctors to form collegial relationships, take part in CME, clinical audit and peer review. The Council also stipulates exactly how many hours must be spent on each of these activities.

Most regulatory bodies, at the very least, set the minimum number of credits doctors should gain (or hours doctors must spend) on CPD each year in order to fulfil requirements. It is worth noting that there is no international, standardised system of using CPD credits and although most countries, as a rule of thumb, award 1 credit for 1 hour of CPD activity, countries can award different amounts of credits for undertaking the same pursuit (e.g. publishing a research paper). The number of credits needed varies, even within particular countries. For example, in the USA, the State Medical Board of Kansas asks for 50 credits per year, whilst the State Medical Board of Alabama currently only asks for 12 credits. The highest number of credits required for CPD that this study uncovered is 80, in Canada. Whilst CPD is voluntary

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31 Of the countries not covered in this report, Saudi Arabia, UAE, Brazil, Argentina and Mexico have mandatory CPD. Nigeria, Turkey, Israel, Philippines, Thailand, Costa Rica and Peru have professional CPD.
32 It should be noted that some countries in Europe have redesigned their CPD schemes to match the UEMS EACCME framework of CME credits.
in Sweden, doctors are encouraged to spend ten days per year participating in CPD activities. At the other end of the scale is Kenya, where only five CPD credits – equivalent to five CPD hours – are required per year.

In various countries where CPD is mandatory, doctors must take part in particular CPD programmes. In Canada, provinces are beginning to require doctors to enrol in a choice of two CPD programmes, one run by the Royal College of Physicians and Surgeons of Canada, the other by the College of Family Physicians of Canada. In New Zealand, specialists must enrol and participate in a CPD programme run by their specialist association. Whilst the State Medical Boards in the USA where CME is compulsory do not specify that doctors participate in a specific CME programme, the type of activities which doctors can claim CME credits for is sometimes dictated and usually only formally accredited CME activities can be used toward CME credit.

Occasionally, regulatory bodies specify the subject matter for CPD, or the type of CPD that must be undertaken. In Slovakia, doctors must ensure that 60% of their CPD credits are earned through participating in or attending officially accredited medical education event (the remainder can be accrued through personal study). Specialists in Germany have to show that 70% of their vocational training has been on topics concerning their specialty. In Singapore, this figure is 20%. South African doctors must gain five credits per year (out a total of thirty) by studying subjects relating to ethics, human rights or medical law.

Are there consequences if doctors do not participate in CPD?

The consequences for non-compliance of compulsory CPD vary throughout the world and range in severity. Where CPD is linked to recertification or re-registration, the law often gives regulatory bodies the option to revoke the licences of non-compliant doctors, but locating evidence of whether or not this actually occurs – and to what extent – can be difficult.

Despite the requirement for compulsory CPD being part of legislation, the lack of robust regulatory frameworks in some countries makes it difficult for the law to be applied. For example, in Greece and Jamaica (and previously France) despite a mandatory system, there would appear to be no penalty for doctors who do not participate in CPD. In Greece this is because there is no agreed or formal system of certifying participants. Therefore, whilst the Greek Minister of Health lawfully has the right to revoke the licence of a doctor who does not accrue 100 hours of CPD each year, there is actually no way for the Minister to know which doctor has or has not fulfilled their obligation.
South Africa and the Netherlands have taken the decision to allow non-compliant doctors extra time to fulfil their requirements, as opposed to immediately imposing penalties. South African non-compliant doctors are given up to a year to accrue any outstanding CME points before they are referred to the Medical Board. Doctors who fail to fulfil their CPD requirements in some provinces in Canada are provided with a mentor, who will actively help the doctor accrue CPD credits. More serious consequences, such as revocation of a licence, are used as a last resort. In Croatia and Singapore, a number of doctors have indeed had their licences revoked, and have had to re-sit an examination (Croatia) or fulfil their CME requirements (Singapore) in order to gain their licences back. In Hungary, non-compliance can result in doctors losing their specialist status. The State Medical Board in Texas has the option to publicly reprimand and fine a doctor up to $500 should they fail to fulfil their CME obligations.

Though not necessarily a sanction, doctors in some countries may lose out financially through non-participation in CPD programmes. In Norway, specialist GPs who take part in the compulsory CPD scheme are able to increase their fees by 20%: those who are non-compliant may lose their specialist status, but also face losing the significant monetary benefits that come with participation. The system of CPD is entirely voluntary in Belgium, but because participation in it is linked to increased fees and one-off payments, over a three year period, doctors who participate in the voluntary scheme can end up earning almost €15,000. Unsurprisingly, this has resulted in around eight out of every ten doctors engaging in CPD.

In what way are other medical regulators ensuring that their doctors are undertaking CPD? How, if indeed they do, are they auditing individual doctors’ CPD activities?

As the CPD Institute has pointed out, ‘monitoring and compliance are the most difficult aspects of implementing CPD policy...In particular professions face difficulty in...ensuring compliance across the majority of membership [and] dealing with the increased complexity of monitoring the more varied and self-managed CPD being undertaken.’

This research has uncovered that the auditing of doctors’ CPD activities is widespread, and is the main method which regulatory bodies (or equivalent) use in order to ensure (a degree of) compliance. The number of doctors audited varies from country to country. The highest audit percentage this research found will be undertaken by the Medical Council Ireland, which seems likely to audit 15% of all doctors undergoing re-licensure in 2012. The New Zealand Medical Council audits

34 http://www.cpdinstitute.org/storage/pdfs/CPD_Research.pdf
10% of applications for recertification. In both these countries, the bodies which provide the CPD programmes, such as the specialist colleges, also audit CPD activities. The Australian and New Zealand College of Anaesthetists, for example, audits 5% of all doctors who complete their three-year CPD programme. Such ‘double auditing’ appears to be fairly common. Toward the other end of the scale is the Medical Council in Slovenia, which audits approximately 2.5% of CPD declarations.

In most countries, doctors who are audited are required to submit evidence of CPD activities to the relevant authority. This will usually consist of a CPD portfolio together with certificates of CME events – from conferences, for example – which provide evidence of attendance. For non-specialist doctors in New Zealand, all documents must be countersigned by a colleague, but this is unique.

Because of the audit schemes, doctors are therefore required to keep all CPD evidence for a number of years. In Canada, doctors have to retain a personal copy of proof of participation in a CPD scheme for a minimum period of 6 years in case they are selected to participate in audit. Many countries also require that the providers of CME also keep copies of event registers, so that doctors’ attendance can be corroborated. In Singapore, CME providers are required to keep hard copies of registers for a minimum period of two years, in South Africa three years, and in the USA, documentation setting out the credit awarded for certified activities must be kept by providers for a minimum of six years after the completion date of the activity.

*Does the regulator accredit or quality assure CPD activity, or provide CPD for doctors? What other bodies may undertake this role?*

There is extensive accreditation of CPD activities and providers. The Austrian Medical Chamber runs its own CPD programme, although this is uncommon. A few regulatory bodies, such as the Regional Chambers in Germany, the Medical Board of Doctors in South Africa and the National Institute in Belgium directly accredit CME events.

Most regulators delegate the responsibility of the running of CPD schemes to professional medical societies, such as specialist colleges, which then accredit CPD events themselves. Regulatory bodies tend to accredit the societies which provide CPD programmes and require CPD programme providers to meet a set of rules. In Australia, the Australian Medical Council (AMC) runs a very strict and active accreditation scheme for CPD programme providers, during which AMC expert assessment teams travel to the medical association to examine its CPD programme against standards set by the Council. In the USA, the Accreditation Council for Continuing Medical Education (ACCME) is responsible for accrediting organisations for CPD programmes.
which provide CME. It has a particularly lengthy accreditation process, which involves visits, interviews and two separate decision-making committees. Many State Medical Boards require CME activities to be ACCME accredited.

Are any of these jurisdictions developing or have developed a revalidation process? How does CPD fit into that process? Are there any emerging trends in the use of CPD in revalidation?

A number of countries have made the participation of CPD a condition for recertification. In order to re-register, GPs in the Netherlands must recertify every five years, in which time they must have performed clinical work for a minimum number of hours, undertaken at least 40 hours of CPD per year and taken part in at least two hours of peer review per year. In Norway, Specialist GPs must undergo re-certification every five years and CME requirements form part of the re-certification process. A mandatory six year re-certification cycle which is directly linked to CPD exists in Croatia. Doctors in New Zealand must apply for an Annual Practising Certificate (APC) each year, in order to practise medicine. The issuance of an APC is entirely dependent on the doctor declaring that they have taken part in a CPD programme, and providing proof of this if audited.

A number of CPD schemes are linked to re-registration. In order for doctors in Australia to re-register each year, they must affirm that they are participating in a CPD programme, and must provide proof of this if audited. This is a similar system to that in Ireland where doctors seeking to renew their professional registration are required to complete an annual declaration that they have enrolled in and are complying with the requirements of a specific competence scheme.

The Medical Council of Singapore has indicated that it is moving toward a system of revalidation. Perhaps most significantly, the Federation of State Medical Boards in the USA has released a new framework for maintenance of licensure rules, which should come into being in April 2012. If this system becomes mandatory, as looks likely, doctors would be legally mandated to participate in a ‘more robust program of continuous professional development that is relevant to their areas of practice, measured against objective data sources and aimed at improving performance over time.’

35 http://www.fsmb.org/mol.html
<table>
<thead>
<tr>
<th>Country</th>
<th>CPD Requirement</th>
<th>Credits / Year</th>
<th>CPD Scheme Delivered By…</th>
<th>CPD Activities Accredited By…</th>
<th>Sanctions</th>
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<tbody>
<tr>
<td><strong>EUROPE</strong></td>
<td></td>
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<tr>
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<td>Regulator</td>
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<td>Licence loss / fees reduced.</td>
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<td>Professional societies + Providers</td>
<td>Professional societies</td>
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<td>Medical Association</td>
<td>Loss of status + fees</td>
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<td>Regulator</td>
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<td>Australia</td>
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<td>Specialist societies</td>
<td>Societies or Regulator</td>
<td>Suspension from register</td>
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<td>Can suspend from register</td>
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<td>Regulator</td>
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