

**General  
Medical  
Council**

Regulating doctors  
Ensuring good medical practice  
Intelligence Unit Research

**CONTINUING PROFESSIONAL DEVELOPMENT**  
the international perspective

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## **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.<sup>1</sup>*

*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 CPD systems evolve and change very quickly, which means that the information in published research can swiftly go out of date and cease to be factual.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**

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<sup>1</sup> Marc A. Rodwin, 'Drug Advertising, Continuing Medical Education, and Physician Prescribing: A Historical Review and Reform Proposal', *Conundrums and Controversies in Mental Health and Illnesses* (2010) 807-815 (p.809).

## 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 pin-pointed. 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.<sup>2</sup>*

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'.<sup>3</sup> 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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<sup>2</sup> 'Charter on continuing medical education/continuing professional development approved by the UEMS Specialist Section and European Board of Anaesthesiology', *European Journal of Anaesthesiology* (2007) 483–485 (p.2007).

<sup>3</sup> Thomas Zilling, 'The Core of Continuing Professional Development for Physicians and its Relationship to the Pharmaceutical Industry and Legal Authorities', *Business Briefing: European Pharmacotherapy* (2005) 18 – 20 (p.20).

## 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:*

1. 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?
2. 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?
3. 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?
4. 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.<sup>4</sup> 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).<sup>5</sup> 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

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<sup>4</sup> 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.

<sup>5</sup> It should be noted that some countries in Europe have redesigned their CPD schemes to match the UEMS EACCME framework of CME credits.

Board of Alabama currently only asks for 12 credits.<sup>6</sup> The highest number of credits required for CPD that this study uncovered is 80, in Canada. Whilst CPD is voluntary 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

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<sup>6</sup> <http://www.ama-assn.org/resources/doc/med-ed-products/table16.pdf>

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.'<sup>7</sup>

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<sup>7</sup> [http://www.cpdinstitute.org/storage/pdfs/CPD\\_Research.pdf](http://www.cpdinstitute.org/storage/pdfs/CPD_Research.pdf)

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 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 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.'<sup>8</sup>

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<sup>8</sup> <http://www.fsmb.org/mol.html>

Country	CPD Requirement	Credits / Year	CPD Scheme Delivered By...	CPD Activities Accredited By...	Sanctions
<b>EUROPE</b>					
<b>Austria</b>	Voluntary	50	Regulator	Regulator	No sanctions
<b>Belgium</b>	Voluntary	20 + 2 PRs	Accredited Providers	Regulator	No sanctions
<b>France</b>	None	-	-	-	-
<b>Germany</b>	Compulsory	50	Accredited Providers	Regulatory Body (Regional)	Licence loss /fees reduced.
<b>Greece</b>	Compulsory	20	Accredited Providers Medical Assoc.	Medical Association	No sanctions
<b>Hungary</b>	Compulsory	50	Accredited Providers	Medical societies	Retake examinations
<b>Italy</b>	Compulsory	50	Accredited Providers	Regulatory Body (Regional)	-
<b>Netherlands</b>	Compulsory	40 inc. PR	Professional societies + Providers	Professional societies	Annual registration
<b>Norway</b>	Compulsory	40	Universities + societies	Medical Association	Loss of status + fees
<b>Poland</b>	Compulsory	40	Regulator (Regional)	Regulatory Body (Regional)	-
<b>Slovakia</b>	Compulsory	50	Accredited Providers + Council	Regulator	-
<b>Slovenia</b>	Compulsory	15	Accredited Providers	Regulator	-
<b>Spain</b>	Voluntary	-	-	-	-
<b>Sweden</b>	Voluntary	~50 (10 days)	Accredited Providers	Professional Association	-
<b>AUSTRALASIA</b>					
<b>Australia</b>	Compulsory	40	Specialist societies	Societies or Regulator	Suspension from register
<b>New Zealand</b>	Compulsory	50	Regulator or Specialist boards	Specialist boards	Can suspend from register
<b>NORTH AMERICA</b>					
<b>Canada</b>	Compulsory	80	Specialist Colleges	Specialist Colleges	Possible removal of licence
<b>Jamaica</b>	Compulsory	10	Accredited Providers	Regulator	-
<b>USA</b>	Compulsory	12 - 50	Accredited Provs/Specialty Boards	Medical Association / Committee	Varies – fine, reprimand
<b>AFRICA</b>					
<b>Kenya</b>	Compulsory	5	Accredited Providers	-	-
<b>South Africa</b>	Compulsory	30	Universities, Specialist societies	Regulator	Removal from register
<b>ASIA</b>					
<b>Japan</b>	Voluntary	-	Medical Association	Medical Association	-
<b>Malaysia</b>	Voluntary	-	-	-	-
<b>Pakistan</b>	Voluntary	-	-	-	-
<b>Singapore</b>	Compulsory	25	Accredited Providers	Regulator	Removal of licence

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# EUROPE

## ***Note on UEMS EACCME***

The European Union of Medical Specialties (UEMS) was established in 1958. It describes itself as a “non-profit organisation which promotes the free movement of medical specialists across Europe through the harmonisation of the highest level of training for European doctors. Through its activities at the European level, the UEMS attempts to...improve the quality of care provided to European citizens”. UEMS is run by an Executive, and is supported by several working groups, which includes the European Accreditation Council for Continuing Medical Education (EACCME)

The EACCME was established in 2000. It works with national accreditation bodies to facilitate the exchange and recognition of CME/CPD credits by offering independent European accreditation of events and seminars. It charges a fee for these services and the GMC understands that this is the main source of income for UEMS. The body also has a reciprocal agreement with the American Board of Medical Specialists. Several countries have signed agreements with the ACCME and recognise, without the need for accreditation, ACCME events or activities.

## Republic of Ireland

- In 2007 a new Medical Act was produced, which paved the way for compulsory CPD of health professionals in Ireland.
- Four years later, in May 2011, the Medical Council of Ireland (MCI) began to regulate a compulsory system of CPD, which is required for the annual retention of a licence to practise. Doctors seeking to renew their professional registration each year are required to complete an annual declaration form to confirm that they have enrolled in, and are complying with the requirements of a CPD scheme.
- The MCI has produced detailed regulatory guidance for the CPD system as a whole. The MCI has given formal recognition to thirteen training bodies to actually deliver specialty-specific CPD schemes, many of which are Faculties of the Royal College of Physicians Ireland (RCPI).
- In order to quality assure these schemes, the MCI undertook a lengthy accreditation process. To maintain the quality of the schemes, the training bodies must reports to the MCI every year on the operation of their schemes.
- Taking part in the professional competence process is self-directed and doctors must, as a minimum, engage in fifty hours of CPD and one clinical audit per year.
- Training bodies and the MCI will – in the future – audit a percentage of doctors' CPD activities by requesting they send in proof of their attendance at events, together with other documentation.
- The training bodies accredit CPD events themselves, and have frameworks for assessing whether CPD events can be recognised. There is no national framework for the accreditation of CME events.

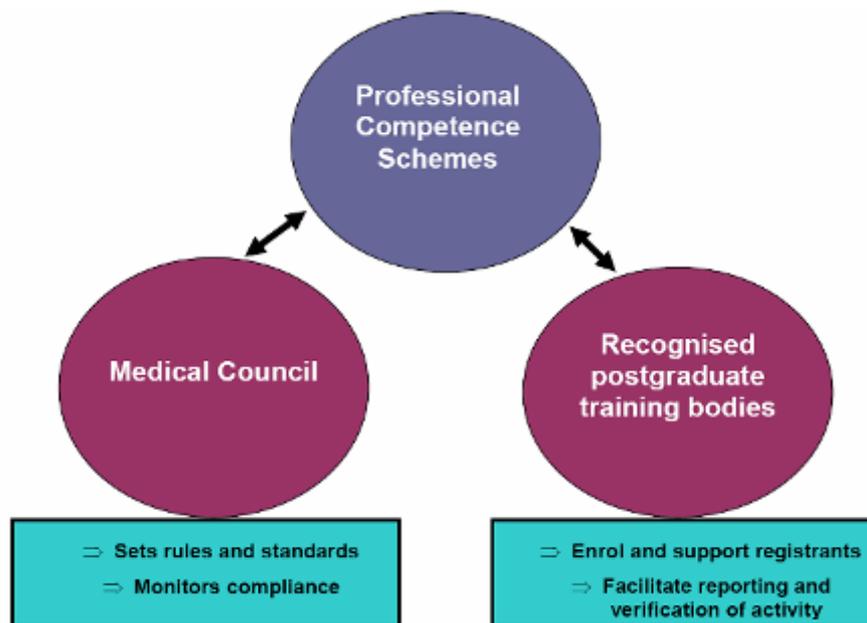
## Regulatory and legislative background

In 2007, the Department of Health and Children introduced the Medical Practitioner Act 2007, which 'radically reformed the regulation of the medical profession in Ireland'.<sup>1</sup> The functions of the Medical Council Ireland (MCI) were changed to include the responsibility for setting the national standards of medical education and training. Under Section 43 of the Act, a new Register of Medical Practitioners was set out, which established new criteria for doctor registration.

Significantly, requirements for the Maintenance Professional Competence of doctors practising in Ireland were also set out. Part 11 of the Act made it a statutory duty for the MCI to establish and oversee a professional competence system. The MCI was given the freedom to develop Standards for the system and the power to recognise bodies which would deliver specific professional competence schemes (PCS) on its behalf. The MCI has decided that the only providers of PCS are, at present, the official postgraduate training bodies (i.e. the medical Colleges of their specialist Faculties).

CPD is an integral part of the maintenance of professional competence system. Doctors must gain a certain number of CPD credits, as well as take part in one clinical audit each year. Part 11 of the Act made clear that the duty to maintain professional competence lies with the doctor: neither the MCI nor the body operating a PCS is responsible for ensuring that a doctor participates in a professional competence scheme. Indeed, the Act made it a legal requirement for all medical practitioners to maintain their professional competence. The MCI was given the option to make a complaint against a doctor (i.e. refer the doctor either to a preliminary proceedings committee or fitness to practice committee) for failure to maintain professional competence.<sup>2</sup>

Part 11 of the Act only came into force once the MCI had developed all necessary Standards for the Maintenance of Professional Competence system and the training bodies had fully developed their PCS. On 1 May 2011, Part 11 came into effect, and the participation in PCS became mandatory for all doctors in Ireland. Professor Kieran C Murphy, President of the MCI, commented that 'this development will positively impact on the quality and safety of healthcare delivery in Ireland as it will bring our systems in line with best international practice.'<sup>3</sup>

*Medical Council Ireland Professional Competence System outline*

The guidance issued by the MCI makes clear that the onus for enrolling in a professional competence scheme, developing a development plan and undertaking the activities lies with the doctor. Whilst training bodies provide opportunities (activities, e-learning systems, conferences) for doctors, they do not set individual curricula. Taking part in the professional competence process is therefore resolutely self-directed.

As of May 2011, all doctors, except for those in recognised training posts, had to have contacted the postgraduate training body most relevant to their day-to-day practice and enrolled in a professional competence scheme.<sup>4</sup> For example, a psychiatrist would contact the College of Psychiatry in Ireland, which would then enrol the doctor in its own professional competence scheme. Once enrolled, the training bodies should support the doctor's maintenance of his or her professional competence. The MCI is able to intervene if it feels, following audit, that a doctor is not registered in the correct scheme. The MCI is able to direct a doctor to take part in another scheme.

The maintenance of professional competence system is based on five general Standards. These Standards do not define a curriculum for doctors to follow, but instead set out 'targets for accrual of credits across different activity categories.'<sup>5</sup> The MCI has stated that maintenance of professional competence should be based on:

- **good medical practice** – the doctor maintains professional competence to achieve the outcome of good professional practice which contributes to patient safety and quality of patient care.
- **planned assessment needs** – the doctor plans the maintenance of professional competence based on current patient, practice and health system needs as well as anticipated future developments.
- **diverse and relevant practice based activities** – the doctor is responsible for maintaining professional competence through a diverse range of self-directed and practice-based activities relevant to assessed needs to achieve targets set out in Council's Framework for Maintenance of Professional Competence Activities (21)
- **reflection and action** - the doctor reflects on activity to maintain professional competence and takes action to ensure good professional practice that contributes to patient safety and quality of patient care.

and that the whole process should be

- **documented and demonstrable** - the doctor collects and documents evidence to demonstrate the maintenance of professional competence.

Good Professional Practice consists of eight domains (below), which the MCI deem 'describe a framework of competencies applicable to all doctors across the continuum of professional development from formal medical education and training through to maintenance of professional competence. Since they describe the outcomes which doctors should strive to achieve, doctors should refer to these domains throughout the process of maintaining competence in line with the Standards. For example, the domains can be used to assess needs and plan maintenance of professional competence, and they can be cross-referenced with specific activities for maintenance of professional competence.'<sup>6</sup>



Each doctor has the responsibility to develop their own development plan for maintenance of professional competence. The MCI gives doctors the freedom to put a plan in place, but emphasize that it should be informed by the individual needs of the doctor (in terms of the doctor's practice and health system) as well as the needs of the patients cared for by the doctor. Once a doctor has formulated a development plan, the doctor must engage in activities that the MCI recognises, or the relevant training body suggests or provides. The training bodies offer examples of, and guidance for activities. They also directly offer activities and accredit activities offered by other organisations.

As a minimum, doctors have to engage in fifty hours of CPD and one clinical audit per year. The clinical audit should account for a minimum of 12 hours of activity per year. Generally, an hour of CPD activity will generate one CPD credit. The MCI requires doctors to undertake a variety of CPD activities each year, which are set out in the following Framework for Maintenance of Professional Competence Activities:

Type of activity	Minimum credits per year*
External – maintenance of knowledge and skills	20
Internal – practice evaluation & development	20
Personal learning	5
Research or teaching	2 desirable
Clinical audit	1**

\*In general, 1 hour of activity accrues 1 credit \*\* In general, 1 clinical audit equals 12 hours of activity

The MCI has left it up to each postgraduate training body to define the types of activity that they will accept as CPD. Examples of external activities include conferences, academic seminars, postgraduate medical degrees and accredited online courses. Internal activities may include journal clubs, case conferences, peer review groups, or critical incident review meetings. Personal learning may involve reading journals, preparation for giving lectures or online learning. Research or teaching can include postgraduate examining or writing published articles.

#### *Accreditation of Professional Competence Schemes*

Following a lengthy process of accreditation, the MCI gave formal recognition to thirteen training bodies to provide PCS, many of which are Faculties of the Royal College of Physicians Ireland (RCPI).<sup>7</sup> The Medical Council held a formal ceremony on 30 March 2011 to announce details of these postgraduate training bodies.

The MCI has informed doctors that a PCS run by one of these training bodies will provide 'at least' the following services:

- Provide doctors with tools and guides to support the maintenance of professional competence.
- Allow doctors to record participation in maintenance of competence activities and a system which attributes credits to these activities.
- Offer doctors an annual statement of progress of their maintenance of competence activities.
- Make available activities for the maintenance of professional competence and will accredit activities provided other organisations.
- Provide verification of credits that are claimed by doctors, for instance following an audit.

In line with these commitments, the MCI's 'Arrangement...for the establishment and operation of Professional Competence Scheme(s) under Section 91 (2), Medical Practitioners Act, 2007' sets out, in detail, the standards through which a training body can become formally recognised and accredited by the MCI for the purpose of providing PCS.<sup>8</sup>

This 60-page document (which is effectively a contract) sets out in more detail the responsibilities of the training bodies. It includes details about the scope of the scheme, governance of the scheme, together with information governance, details regarding financial procedures (the training body must gain written consent to levy fees for involvement in schemes), quality and standards, monitoring and accounting for activities, as well as details regarding the referencing of the MCI in publications.

So that the MCI can quality assure the PCS, the training body must report annually to the MCI on the operation of the scheme. Should the recognised postgraduate training body fail to meet the requirements specified in the document, or cannot satisfy the Medical Council that it is meeting them at any time, the Council may revoke, suspend or cancel the postgraduate training body's recognition to operate PCS. Changes to the content or activities underpinning the professional competence schemes are also subject to agreement between the recognised postgraduate training body and the MCI.

#### *Case Study: College of Psychiatry Ireland Professional Competence Scheme*

The College of Psychiatry Ireland has introduced a five-year cycle for its PCS. Participants receive an annual statement of their credits. This statement may be requested from the individual doctor by the MCI at any time as part of the MCI audit. Doctors will be contacted by the College at the end of each year if their recorded credits are below the expected number of fifty. If the number of credits is still too low by the end of year two, the doctor will be automatically included in College's verification process. The College will provide support to the doctor in their efforts to address their difficulties in meeting the requirements. Should the doctor remain noncompliant for three successive years, the College will be share the information with the MCI. Follow up action will be taken by the MCI.<sup>9</sup>

As well as stipulating the types of activity which doctors can take part in, the College also 'strongly' recommends its members take part in peer review as part of their internal activities, though peer review is not mandatory. Drawing 'particularly on the Royal Australian and New Zealand CPD programme for our recommendations', the College has issued guidance to members on peer review (which can be found

[here](#)).<sup>10</sup> The College awards one internal CPD credit for one hour of Peer Review Activity. Interestingly, a number of the other training bodies, including the Irish Committee on Higher Medical Training, have included Peer Review as a Clinical Audit activity in their PCS guidance.<sup>11</sup>

Although doctors can enter the number of credits they have gained online, the College provides forms for the doctors to fill in to document their participation in PCS on paper. The information required is fairly basic. The Personal CPD log, for example, only requires the date, title of activity and a short 'reflective note' for each activity.

**CPD Log for Personal Learning Activities** **APPENDIX 3**



**CPD Log - Personal CPD** Name: \_\_\_\_\_

This log should be maintained by the Consultant as evidence of personal CPD activity, for which CPD credits can be claimed under the Personal CPD category. 1 hour = 1 CPD credit.

Date	Activity / Topic	Consultant Signature
	Reflective Note:	

..OC 14/01/09

Clinical Audit Guidelines to support clinicians in achieving their Clinical Audit requirement have yet to be produced by the College. The College has stated that these guidelines will be made available as they are developed and updated by the College's Clinical Audit Working Group. Clinical Audits will also be subjected to verification by the College. Once guidelines for the audit of Clinical Audits have been published, the process will be supported by the relevant expertise outside of the College's committees. Whilst other Colleges, Faculties or Institutes have produced slightly more detailed guidance on clinical audits, such as including example activities, it is clear that the development of guidelines on this activity is still at an early stage.<sup>12</sup>

In order to comply with MCI guidelines, the College's Professional Competence Committee will undertake a verification process of a percentage of the annual returns received. The specific percentage is not given, although this is the same with all the training bodies. The College does not charge members extra for PCS – the membership fee covers the PCS. Members of the Faculties and Institutes of the Royal College of Physicians are required to pay for enrolment in a PCS programme (currently €200 per year).

The College has introduced guidance for the accreditation of CPD events. Events which require accreditation include conferences, symposia, short training courses, workshops and seminars organised locally, regionally, nationally and internationally, long training courses, as well as degree/diploma and research projects. Applicants for CPD events must demonstrate that:

- The event is of relevance to the pursuit of a psychiatrist's clinical, educational and research activities.
- The event need not be confined solely to medical topics and improvements in patient care but can also include additional topics such as management, medical ethics
- The event should have educational objectives which are matched by the content and teaching methods based on the principles of adult learning.
- Where there is a commercial sponsor, presentations must not contain any promotional content.
- Promotional logos / branding cannot be included on any presentation slides or on meeting invitations, flyers etc.
- Speakers should include a declaration of interest slide at the start of their presentation.

- Learning objectives should be clearly outlined at the start and end of presentations.
- Publicity material should include a clear description of those for whom the event is primarily intended.
- Publicity material should not carry branding or logos of commercial sponsors.
- Events must incorporate a mechanism for evaluation so that the organisers, presenters and other participants can obtain feedback on the relevance, quality and effectiveness of the activity.
- Events must have a nominated organiser who will keep records of attendance and evaluation.
- Meetings should have a broad invitation list
- Meetings should be international or national conferences, or academic meetings.
- Unless the speaker / presenter is external to the service, meetings attended solely by consultants working within the same service would not qualify for External CPD credits – credits should be claimed under the Internal CPD category.<sup>13</sup>

Once an event has been accredited, it is added to the College's CPD credit calendar. The June 2011 calendar is given below. Notably, Lilly, a pharmaceutical company, has been granted permission to organise (and not just sponsor) an event.

JUNE 2011	Date	Location	Organiser	Credits
CAMHS North East - Regional Summer Conference	01/06/2011	Meath	CAMHS North East	5
Female Perspectives in Mental Health Care	08/06/2011	Cork	UCC Trinity Centre for Health Sciences	2
ADOS-G Clinical Training	09-10/06/11	Dublin		5+5
Mental Health, Practical Theology and Spirituality: Rediscovering Forgotten Dimensions.	10/06/2011	Dublin	All Hallows College	2
Lilly - Update on Professional Competence	15/06/2011	Dublin	Lilly	1
<b>BST Training Programme - Education and Assessment Objectives</b>	<b>21/06/2011</b>	<b>Dublin</b>	<b>Cpsychl</b>	<b>2</b>
La Touche - The Expert Witness Conference 2011	23/06/2011	Dublin	La Touche	5

The MCI has produced a patient leaflet explaining what professional competence is, what the doctor will have to do and how it will improve patient safety.

## **Audit of doctors' CPD by MCI**

Each year, the MCI will choose a random sample of doctors for more detailed inspection. According to the College of Psychiatrists of Ireland, this will be 15% of all registered doctors.<sup>14</sup> The MCI will take action if it is not satisfied that a doctor is maintaining professional competence. It has written guidance for doctors which states that: 'You must cooperate with any audit process applied by the Medical Council. You may be asked to provide supporting documentation regarding maintenance of professional competence. Doctors who maintain professional competence in compliance with Standards set by the Medical Council will find the quality control checks straightforward and easy to fulfil. If, however, the Medical Council becomes aware that a doctor is not satisfactorily maintaining competence, it may take action to promote confidence in the professional competence system from the perspective of the public and of other doctors.'<sup>15</sup>

In line with this, the MCI has stated that it may, at any time (from 2012 onwards), request that a doctor submits documentation relating to their maintenance of professional competence. The request will specify the form of documentation required, though it is not yet clear what types of documentation the Council may request. More guidance on this will be issued by the MCI in 2012.

When doctors register with the MCI or apply for retention each year (and pay the fees in order to stay on the register), they must also (by law) complete an Annual Declaration Form. From 2012, the Annual Declaration Form will include a section on professional competence. According to the MCI 'this will enable the MCI to satisfy itself about doctors' ongoing maintenance of professional competence.'<sup>16</sup>

## Belgium

- Legislation in Belgium states that specialists and GPs must maintain their clinical competence, but the formal participation in CPD programmes is not mandatory. Therefore, doctors are able to maintain their competence independently, in any way they see fit.
- A voluntary system of CPD accreditation for doctors exists, which includes participating in CME, as well as attending local medical evaluation groups to discuss clinical practice. The system runs on a three-year cycle and requires 60 CME credits every 3 years.
- Participating in the CPD accreditation system is financially beneficial for doctors: they can earn over €4,000 per year by taking part. Doctors are free to select the types of CME activity they take part in, but they must spend three hours each year participating in CME related to ethics and economics.
- CME programmes are not directly provided by the regulatory body for doctors, but it does, via its Committees, accredit (and therefore quality assure) CME providers. Commercial companies are not permitted to run CME activities, but may sponsor them under strict guidelines.
- It is unclear whether any audit or review of doctors' participation in the scheme is undertaken by the regulatory body or its Committees.

## Regulatory and legislative background

In Belgium it is a legal requirement for specialists and GPs to maintain various standards, including undertaking a minimum number of consultations per year, maintaining patient files and 'participating in their local on-call service'.<sup>17</sup> The maintenance of clinical competence is also a legal obligation for specialists and GPs, but the participation in a formal CPD programme is not.

To encourage doctors to take part in for CPD, a voluntary but financially beneficial system of CPD accreditation exists – overseen by the regulatory body and other professional organisation – which gives doctors the ability to claim back an increased fee for each consultation, thus 'boosting a physician's salary by about 4%'.<sup>18</sup> In 2003, some 80% of doctors in Belgium took part in accreditation; more recent figures do not appear to be available.<sup>19</sup> The participation in CME is a key part of accreditation, which operates on a three-year cycle. To gain and renew accreditation, a doctor must hold a certain number of consultations (1,250 per year for established GPs), retain their good standing and accumulate at least 60 CME credit points over a three year period. They must also participate in at least two medical evaluation meetings with peers each year. The participation in CME activities and the attendance at medical evaluation meetings comprise the CPD requirements for accreditation in Belgium.

The formal (but voluntary) CPD programme was first introduced in 1994 by the central regulatory body for health professionals – the National Institute for Health and Disability Insurance (Institut National d'Assurance Maladie Invalidité: INAMI-RIZIV). The Institute oversees compulsory healthcare and benefits insurance in Belgium and is in charge of formally regulating CPD. The Institute's CPD programme is informed by various committees. These help to ensure CME activities are quality assured:

- The Conseil National de la Promotion de la Qualité (CNPQ), which manages and coordinates the entire system of accreditation, including the CME programme.
- The Groupe de Direction l'Accréditation (GDA), which is a steering group given responsibility to determine which CME activities or events can be recognised for accreditation. Under the Royal Decree of 13 July 2001, its members are appointed by the King.<sup>20</sup>

- The Comités Paritaires (Joint Committees), which represent twenty-six medical specialties (including general practice) and consist of doctors and other scientific experts. The Comités Paritaires evaluate CME programmes for their own specialty and decide how many CME credit points are to be attributed to the CME activities recognised by the GDA.

### **The system of CME in Belgium**

Whilst it issues substantial guidance on CME, the Institute does not provide its own CME programme. Instead, its CME steering group, the GDA, accredits external CME providers. 'Universities, scientific and professional associations, public authorities and private training institutes' can all apply for accreditation to provide CME in Belgium.<sup>21</sup> In order to quality assure CME, providers must apply to the Institute for certification of a CME event or course, although it is not clear whether universities, for example, are granted automatic recognition. All CME providers must ensure that a register of attendance is kept and returned to the Institute following a course. Pharmaceutical companies are not permitted to run CME activities, but are able to sponsor events, except GLEMs (see below). No advertising is allowed within conference facilities but can be displayed in a reception hall, although it must be made clear that an event is being sponsored by a pharmaceutical company.<sup>22</sup>

Currently, there are eleven types of CME activities which are recognised by the GDA.<sup>23</sup> Activities include 'workshops, regional seminars, national symposia, international congresses, didactic publications, scientific presentations (courses, abstracts, posters), or acting as a moderator [of a CME activity]'.<sup>24</sup> As of October 2010, staff meetings in a hospital ceased to be recognised for CME accreditation.

Doctors must accrue at least 60 CME points over a three year period. A maximum of one CME credit point is awarded per hour for most activities. Exceptions include the allocation of six credit points for the first author of peer-reviewed publication, two credit points for secondary author. Two credit points can be gained by speaking at an accredited event. The Institute participates in the UEMS EACCME system and doctors who attend international conferences are awarded credit points. The Institute has automatically recognised accredited EACCME events since January 2007 and in the same year it changed its system of CME credits in order to align itself with the EACCME.

In 2005 the Institute began accrediting CME e-learning modules for doctors, which include specialty-specific modules. The Institute calls for organisations or companies to submit proposals for new e-learning modules when required. The GDA then votes

on which company to award a contract to. Currently, modules on dementia and urinary incontinence are in development, for which the Institute is providing funding of up to €175,000. E-learning CME is worth one credit point per hour and doctors must receive individual feedback on their e-learning performance from the e-learning provider.

Doctors are generally free to choose which CME activities they participate in, but they must accumulate at least twenty credit points per year, and at least sixty every three years. However, there are two activities which must be undertaken each year in order to gain accreditation:

- Firstly, doctors must gain at least three credit points per year by taking part in some form of CME related to ethics and economics.<sup>25</sup> According to one critic, this requirement is to 'encourage doctors to reflect on the non-medical consequences of their professional behaviour'<sup>26</sup>.
- Secondly, doctors must take part in at least two local medical evaluation group meetings per year (peer reviews), for which they must gain at least two credit points.

## **GLEMs**

Local medical evaluation groups – peer review groups – are undertaken by way of Groupement Local d'Evaluation Médicales (GLEMs). A GLEM is set up by doctors from the same locality and specialty, who must meet at least four times per year to evaluate clinical 'results, costs and guidelines' relevant to their practice.<sup>27</sup> The Institute states that GLEMs should lead to 'a critical review of the quality of care by physicians.'<sup>28</sup> A GLEM can comprise up to twenty-five doctors, at least eight of whom must be accredited. The doctors cannot all be from the same hospital or practice, but should be from the same discipline (specialty).<sup>29</sup> To set up a GLEM, an accredited doctor must be nominated as the GLEM's 'rapporteur' (secretary) and must ensure the proper management of the GLEM. The secretary has to register the GLEM with the Institute and provide the Institute with the names of the proposed GLEM's members. Details of each GLEM meeting must be entered onto the Institute's own online GLEM system.

Though four GLEM sessions must be held each year, a doctor only needs to attend two per year in order to fulfil accreditation requirements. One credit point is awarded

for meetings less than two hours, two credit points for meetings over two hours, and a maximum of eight credits can be awarded for GLEM activities per year.<sup>30</sup>

The Institute receives limited details of GLEMs via its online system. The Institute or its committees do not appear to attend or audit GLEMs. However, in 2003, the GDA undertook a survey of GLEM to 'assess the impact of accreditation as a system'.<sup>31</sup> The survey received responses from 1,611 doctors.<sup>32</sup> The survey showed high levels of satisfaction with the system, with over 90% agreeing that GLEM improved peer relations, and around 70% of doctors agreeing that involvement with GLEM had improved their practice.<sup>33</sup>

### *Accreditation of Doctors' Participation*

Doctors apply for accreditation by filling in and sending two forms to the GDA every three years. On the first form, the doctor must simply tick boxes to state that he/she has undertaken 1,250 consultations in the previous year, ensured continuity of care, assisted in quality assessment and not had their fitness to practise questioned. On the second form (found [here](#)) doctors must fill in various details about their CPD activities. These include disclosing the type of CME activity undertaken, the date of the course attended, the title of the course, the name of the organiser and the number of credit points received. The CME organiser must stamp the form to 'certify that the owner of the document has attended the CME event'.<sup>34</sup> It is uncertain whether the Institute or GDA perform any audit or check the returned forms.

By successfully accrediting, the Institute pays doctors a bonus of around €1,700 over three years (€556 per year in 2008). Doctors are also entitled to claim back higher fees for their consultations (currently about €3 per consultation). As each doctor must complete at least 1,250 consultations per year in order to accredit, doctors receive a minimum of an extra €3,750 each year. Doctors can also claim back tax for expenses related to CME. Therefore, the total financial gain for a doctor during each three year cycle is likely to be over €13,000. Whilst there are no sanctions for doctors who miss accreditation – the system is voluntary – the financial benefits no doubt make accreditation an attractive scheme for many doctors in Belgium.

## Germany

### *Key Points*

- CME is compulsory for the vast majority of doctors in Germany.
- The main body which issues guidance on CME is the German Medical Association.
- There are 16 states in Germany, each of which has a Chamber with its own ability to set standards on mandatory CME. However, the German Medical Association issues national guidelines in an attempt to standardise CME. Generally, CME is run on a five-year cycle.
- Specialists are required to undertake the majority of their CME in specialty-specific subjects. Doctors must gain 50 CME points per year.
- A system of accrediting CME events exists, but the robustness of this system has been questioned. Germany is the only country which has introduced a barcode system for doctors, through which CME providers can automatically scan doctors' attendance onto a database.

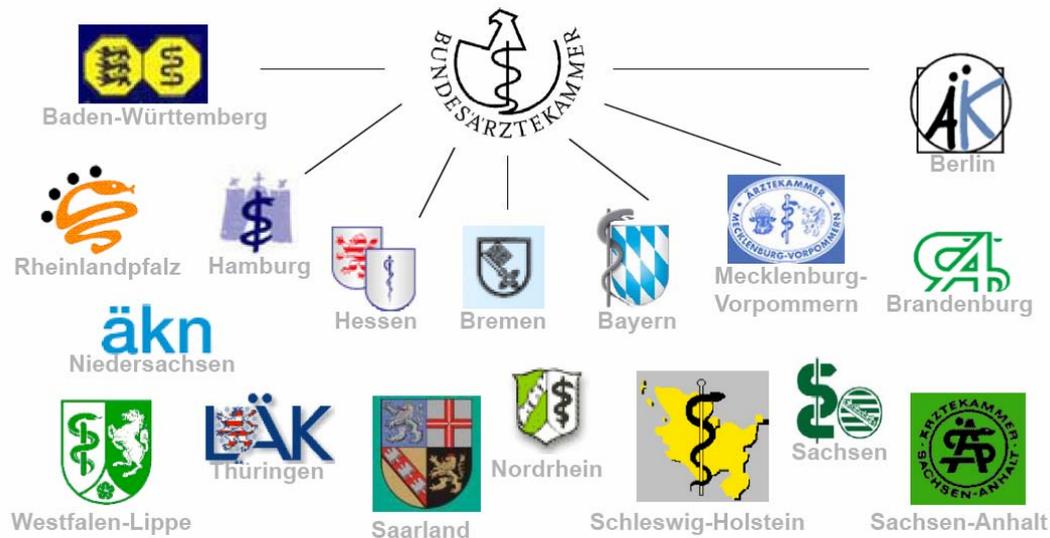
## Background

The German healthcare system is largely funded through statutory health insurance (SHI) contributions, which covers around 90% of the population. The remaining health care is paid for through private health insurance.<sup>35</sup> In 2008 there were over 300,000 doctors practising in Germany, 135,000 of whom worked in ambulatory care; the remaining 145,000 worked in hospital care.

In 2003, a major reform of quality management and CME took place in Germany (the Social Health Insurance Modernisation Act). Amongst other things, this Act made CME compulsory for all physicians, apart from those who are purely private (i.e. not funded by SHI whatsoever). Whilst CME is mandatory, the German CME system is a complex one, not least because there are various bodies which are involved in the management, implementation and quality assurance of CME. Due to the system of sixteen states (länder) in Germany there are actually seventeen (two in one of the largest states) primary organisations involved in overseeing CME, with some 500 professional CME providers.<sup>36</sup> Each state in Germany is able to issue individual standards on CME, although CME systems are fairly homogenous across Germany.

The Gemeinsamer Bundesausschuss (the Federal Joint Committee) which was founded in 2004, is the 'supreme decision-making body of the...self-governing system in Germany.'<sup>37</sup> 'The German parliament [specifically the Ministry of Health] sets the legal framework for health care provision in Germany. The mandate of the Joint Committee is to issue standardised and binding directives in order to translate the legal framework into practice. Therefore, the Joint Committee is called "little legislator".'<sup>38</sup> It delegates responsibility for CME/CPD to the German Medical Association.

The Bundesärztekammer – the German Medical Association – is the federal medical association with overall responsibility for issuing core guidance on the CME/CPD system. Under it are seventeen regional Medical Chambers of Physicians (Ärztekammer) which authorize their own CPD programmes, approve CME courses or seminars in their region, and decide how many credit points each CME activity can merit.



*The German Medical Association and its seventeen Medical Chambers.*

There are also seventeen 'regional associations of SHI physicians (Kassenärztliche Vereinigung, KV) in Germany (one in each of the 16 federal states, except for North Rhine-Westphalia, the most populated of the federal states, which is represented by two KVs). Membership in a regional KV is mandatory for physicians...to qualify for reimbursement through the statutory health insurance system ('SHI physicians'). The KBV is the national association of the KVs.<sup>39</sup> Ambulatory care doctors must report the CME that they have earned to their regional KV in order to maintain their licence to work within the social health insurance system, which suggests that those who do not will have their KV licence revoked.

### **CME in Germany**

In an attempt to standardise CME across Germany, the Bundesärztekammer – the German Medical Association – issued a model regulatory framework for CME, which serves as an example of CME for Germany's seventeen Medical Chambers. There is no requirement for the Medical Chambers to emulate the model, but most follow the core guidance.

Simply put, the German Medical Association's model guidance advocates a system of CME in which the doctor must gain 50 CME points each year, and prove (or as Schlette and Klemperer put it, 'display') that he or she has gained 250 CME points every five years. The Regional Chambers accredit CME activities and also issue CME certificates to doctors.

Doctors are often free to choose which activities they participate in, although there do appear to be exceptions. Merkur (2008) writes that 'specialists working in hospital have to show that 70% of their vocational training has been on topics concerning their specialty.'<sup>40</sup> A recent presentation by the director of the Regional Chamber Landesärztekammer Hessen confirms this, stating that 150 CME credits must be gained in topics specific to the doctors' specialty, with the other 100 CME credits from topics of their choice. GPs and specialists working in ambulatory care do not have any restrictions placed on the CME topics they can cover. Radiologists who interpret mammograms have to take part in a specific recertification procedure.

The following table outlines the types of CME activity recognised, as well as the credits available.

Category A	Lecture and discussion	<b>1 pt. for 45 min</b> max. 8 pts. per day
Category B	Congress	<b>1 pt. for 45 min</b> max. 6 pts. per day
Category C	Active Participation (workshops)	<b>1 pt. for 45 min</b> max. 8 pts. per day
Category D	Interactive education (print and online)	<b>1 pt. per unit</b> 1-2 pts. for CME test
Category E	Self study of scientific literature	max. 10 pts. per year
Category F	Author / Referent	1 pt. per article / lecture
Category G	Hospitation / practical training	8 pts. per day

The amount of points a Regional State award to similar event can across Germany, as the system of credit accreditation is not standardised. For example, a lecture that is held twice, once in Munich and then Berlin, may be accredited with more CME points in one state than the other.

#### *Quality Assurance of CME Providers*

The system of quality assurance as set out in the German Medical Association's regulatory framework is rather vague. CME providers should apply to Regional Chambers for recognition of their CME event and must set out details of the participants as well as methods for 'checking the learning success'. Their CME events must 'give consideration to the nationally applicable, standard recommendations of

the Medical Chambers on quality assurance in continuing medical education.' On application to the Regional Chamber, a CME provider can be given a 'promise' that all CME events staged by it will be recognised without being 'reviewed individually.'<sup>41</sup> According to one article, however, the 'bar [set by the Regional Chambers] for offering a course, seminar, or conference that qualifies for credit points is not very high.'<sup>42</sup> This is because any request to offer a CME activity only needs to be signed by any physician with a licence in order to certify the academic rigour of the academic programme.

### **Quality Assurance of Doctors Attendance at Events and Sanctions**

Almost every Regional Chamber has introduced an online CME system to help doctors record their CME activity.<sup>43</sup> Each doctor is given their own 15-digit "uniform CME number" (einheitliche Fortbildungsnummer, EFN), an identification card and a set of personal barcode stickers. When doctors apply for a place on a CME activity, they place one of their barcode stickers on the application. This is then scanned when the doctor attends the event and shows their ID card. The CME points are immediately added to the physician's online account, meaning they do not need to fill in any paper work themselves. This system has been in place since October 2005, and according to one study 'is working out quite well.'<sup>44</sup> CME credits given by EACCME are, in essence, accepted by the Regional Chambers, if they meet the requirements of the Medical Association Regulation.

According to one source, if doctors are non-compliant with the CME requirements, doctors face 'strict financial sanctions (fees reductions) and withdrawal of [their] licence after two years.'<sup>45</sup>

A recent article by Schlette and Klemperer (2009) suggests that there are various problems with CME in Germany. Apparently, 'CME and quality management systems were introduced by the government against the will of the professional bodies; yet implementation and oversight fall under the latter's remit. Moreover, CME and quality management requirements are not aimed at identifying poor or harmful practitioners.'<sup>46</sup> Furthermore, 'more modern, internationally recognized models of CPD still have not entered the medical community's language beyond lip-service'.<sup>47</sup>

## Austria

- Since 2001, doctors in Austria have been required to engage in CPD. However, there is no obligation for doctors to undertake CPD in any formal or demonstrable way and it is not linked to recertification.
- The Österreichische Ärztekammer (Austrian Medical Chamber), the national regulatory body, runs an official CPD programme. It delegates responsibility for organizing CPD to its educative arm, the Österreichische Akademie der Ärzte (Austrian Academy of Medicine).
- The Austrian Medical Chamber offers an official diploma to doctors who participate in its nationally standardised CPD programme. Participation in this programme remains essentially voluntary.
- The AMC CPD programme requires doctors to gain 150 CME points within a three year period. Should doctors achieve this, they can apply for a diploma, which is valid for three years. Doctors are encouraged to maintain a diploma throughout their career, by gaining 150 CME points every three years.
- The AMC, through its educative academy, accredits CPD programmes and providers in Austria. CPD activities officially accredited by the AMC can be used towards a CPD diploma.

## Legislative and regulatory background

The Austrian Medical Chamber (AMC) is the statutory professional organization which regulates all doctors practising in Austria. Its responsibilities are delegated from the Austrian Minister of Health. The AMC is the umbrella organisation of the nine provincial Medical Chambers and has approximately 37,000 doctors on its register.<sup>48</sup> All doctors who practise medicine, including those in training, need a license from the AMC, but there is no system of license re-accreditation. The responsibilities of the AMC include promoting medical training, continuing medical education and professional development, quality assurance in continuing medical education and medical practice.<sup>49</sup>

Under section 49 of the Physician Act 1998/Amendment 2001, Austrian doctors are under the obligation to participate in continuing professional education. The Act states that doctors must undertake CPD 'under recognized training programmes of medical associations in the provinces or the Austrian Medical Chamber, or under recognized foreign training programs.'<sup>50</sup> The Act specifies the number of hours of continuing education that are required for 'work physicians' and emergency medicine specialists, but for all other doctors, no set amount or type of CPD is specified.

The stipulation for participation in 'recognized training programmes' is somewhat ambiguous: whilst legislation compels the AMC to run a CPD diploma scheme and to accredit CPD providers (both activities delegated to the Academy), it remains unclear whether doctors are legally obligated to take part in AMC-accredited CPD programmes. In any case, adherence to the regulations is 'in practice not checked' by the AMC.<sup>51</sup>

As stipulated by the legislation, the Austrian Medical Chamber runs an official CPD programme, though it has delegated the 'actual implementation of its CPD programme' to the Austrian Academy of Physicians, which is the educational forum of the AMC.<sup>52</sup> The Academy is made up of the National Medical Association and the Regional Association of Physicians, as well as other organisations. The AMC's Academy has its own National Committee for CME, which sets the guidelines on CME. These guidelines are published by the AMC, not the Academy.

## DFP Programme and Diploma

In 1995, the AMC attempted to standardise CPD across Austria by running a voluntary CPD programme for doctors called Diplom-Fortbildungs-Programme (DFP).

The DFP programme is now in its sixteenth year and remains essentially voluntary. Importantly, it allows a doctor to gain a DFP diploma, which acts as confirmation that he or she has met what the AMC considers to be their CPD obligations. The Doctors' Law Act (2001) made it a statutory mandate for the AMC to run the DFP as well as to accredit CPD providers and certify CPD courses. CPD which is sanctioned by the AMC or AMC-accredited can be used as credit toward a DFP diploma. The AMC has issued detailed guidance on the accreditation of CPD providers, which are generally the medical universities, specialist societies, and departments of hospitals.

Accredited providers can certify their own events as being DFP-approved, but an organisation that is not an accredited provider which wishes to gain DFP approval for a CPD event has to apply directly to the AMC. The AMC will 'scrutinise the event as to its compliance with the Regulations and criteria for creditable CPD.'<sup>53</sup> These Regulations and criteria can be found [here](#). The AMC allows many different organisations to provide CPD and certifies various CPD events in this manner. There are approximately 4,000 DFP-approved events per year and more than 1,000 approved DFP providers of DFP-certified training. DFP is also used as a trademark: a logo that states this is an officially accredited course/CPD activity.

Doctors are able to apply for a DFP diploma every three years, should they take part in an accredited DFP programme. A DFP diploma lasts three years and doctors are encouraged to maintain a diploma throughout their career, by gaining 150 CME points every three years. The AMC has issued CPD regulations on the DFP regularly, with the latest, an eighteen page document, published on 30 June 2010.

Doctors have to provide evidence of at least 150 CME points within a 'collection period' of three years in order to apply for a DFP diploma. A minimum of 120 points have to be acquired through certified clinical CPD. Up to 30 points can be acquired through non-clinical CPD. A minimum of 50 points have to be acquired through direct participation in CPD events; the remaining points can be gained through any CPD activity which is sanctioned by DFP programme. What constitutes direct participation is not made clear.

Clinical CPD is defined as being that which is certified and directly based on patient oriented clinical practice. Doctors are not compelled to undertake clinical CPD which focuses on their own particular specialty, although this type of CPD is obviously likely to be related to their own field of practice. Non-clinical CPD, whilst still certified under the DFP, does not have to be purely patient oriented (it can include such activities as attending a lecture on medical law).

Doctors can choose the types of CPD activities they undertake, and the AMC certifies a wide range of activities. Points can be gained by attending certified lectures, courses, workshops or seminars. Doctors can also take part in 'quality circles' or working in structured groups to consider a specific medical problem with the purpose to improve patient care. Supervisions are creditable as non-clinical CPD. Publishing articles, professional (directed) reading and e-learning are also accepted as CPD credit towards a DFP diploma.

CPD ACTIVITY	DFP CME CREDITS
CPD activity of 45 minutes: Supervision Lecture Traineeship Quality Circle	1 (maximum 10 per day)
Author of clinical article in peer-reviewed journal	5 for main contributor 2 for co-author
Contributor to non-peer reviewed book/article	3 for main contributor 1 for co-author
E-Learning/Professional Reading	1 – 2

In response to the *Green Paper On the European Workforce for Health*, the Austrian Medical Chamber issued the following response:

*The Austrian Medical Chamber welcomes that focus should be put on continuous professional development of health professionals. However, it must be ensured that for one there is sufficient time for CME/CPD of physicians and for the other that sufficient funds are provided for the financing of CME/CPD by the health care system, especially when it comes to those CME/CPD requirements which are implemented by legislative acts.<sup>54</sup>*

## Netherlands

- CPD is compulsory for GPs and specialists, but is not for non-specialist doctors. It is directly linked to a system of re-certification, which has been referred to as revalidation.<sup>55</sup>
- Doctors must take part in 40 hours of CME per year, and GPs must take part in at least two hours' peer review per year.
- There is little information available on the peer review of CPD. However, it has recently been made compulsory for a trained specialist GP to attend peer review meetings. The framework for accreditation has also been standardised on a national level.

## Background

The formal CPD authority in the Netherlands is the KNMG (Royal Dutch Medical Association). In 2002, over thirty professional specialist societies, the three Registration Committees (for medical specialists, social medicine doctors, and the GPs and nursing home doctors) came together to create the KNMG. This was 'to develop a harmonised system of accreditation of continuing medical education and awarding of credits.'<sup>56</sup>

Accreditation of CME remains the responsibility of the separate professional societies and, according to the KNMG, 'establishment of a central national continuing education authority is not contemplated.'<sup>57</sup> However, since November 2004, a uniform application form and a uniform assessment framework have been used by all the professional societies, in order to standardise accreditation of CME events. English versions of these forms can be found [here](#) (framework for accreditation of CME meetings) and [here](#) (application form).

## CPD requirements

In 1996, it became a requirement for GP and specialist doctors to re-register every five years. In that year, the requirements for re-registration were a minimum of eight hours a week of medical work, participation in 40 hours accredited CME per year and participation in one peer review every five years. An online system called GAIA has been developed for doctors to record their CPD activities. The requirements have changed over the past fifteen years. Currently, in order for GPs to re-register it is compulsory that they do the following:

- 1) Demonstrate that they have undertaken 16 hours per week of general practice work in each year, over the previous five years. Since 2009, GPs have also had to demonstrate that they have undertaken 50 hours of evening, night or weekend work per year.
- 2) They must have undertaken at least 40 hours of accredited CPD each year for five years.
- 3) From January 2009, this had to include at least two hours per year of *visitatie* or peer review. As of January 1, 2010, peer review was only recognised if the peer review was accompanied by a specialist consultant GP with approved training supervision qualification, granted by the College of Specialist GPs.<sup>58</sup>

For specialists to reregister it is compulsory that they complete the following:

- 1) For medical Geriatric, psychiatric specialist and GPs specialists: demonstrate that they have worked for at least 16 hours per week in their speciality.
- 2) Otherwise, doctors must have achieved at least 200 hours of accredited CPD in the previous five years.

It would appear from the guidance that participation in peer review is not required for specialist doctors ('Deelnemen aan het *visitatie*programma van de wetenschappelijke vereniging is nog geen operationele herregistratie-eis voor specialisten...' – participation in the peer review scheme is not yet a requirement for the re-registration of specialists).<sup>59</sup>

Should doctors fail to comply with CPD, there is the possibility to re-register doctors for a shorter period (for example, one year). During this time, the doctors should make up the CPD hours they were missing.<sup>60</sup> Doctors must then attempt to re-register at the end of this period.

### Peer review

The system of *visitatie* was established in the Netherlands in the 1990s 'as a way of ensuring the quality of patient services and to reconfirm the trust of the public, financiers, and government in the self-regulating mechanism of the profession....The 27 medical specialty societies in The Netherlands developed and executed the *visitatie* system: a doctor-led and doctor-owned peer review system aimed at assessing the quality of medical practice of hospital-based specialist groups.'<sup>61</sup> As stated above, it is currently only compulsory for GPs.

## France

- It seems that a system of compulsory CME in France is currently on hold.
- Laws were passed in 2009 which prepared the way for a new, presumably mandatory system of CPD, but they have yet to be implemented. There are few details available regarding this new system of CPD at the present time.
- France has never participated in the UEMS European Accreditation Council for Continuing Medical Education system.

The implementation of new, compulsory revalidation and CME in France is still underway. As a critic recently pointed out, relations between doctors and the government have, at times, been hostile, which has meant that participation in CME activities has often been limited. There have been many changes to the French CME system over the past fifteen years, which have come with regular changes in the law and various decrees. According to an unpublished review of CME in Europe, such frequent changes have been damaging, and 'in practice excessive government bureaucracy has ensured that [CME] has not worked'.<sup>62</sup>

It would appear that at the present time, a system of CME/CPD is not actually in existence in France. On 24 June 2009 a law was passed that paved the way for a simplified system of CPD. However, the implementation of the law has been delayed for over two years. According to the National Council of Physicians in France, the law has not come into place because 'decrees which will organize the implementation of the CPD, together with decrees which will manage professional incompetence' are still pending.<sup>63</sup> There is no indication when these decrees will be established. The bodies which had previously overseen and accredited CME in France have, as of 15 September 2010, ceased operation.

It is worthwhile, however, briefly recollecting the history of CME in France. In 1996, a significant reform of the health care system was introduced, which, amongst other things, made CME a legal requirement for all doctors. Another change in legislation arrived with the Act on Patient Rights and Quality of Care (2002) made CME compulsory for all medical health professionals. Then in 2003, CME became regulated in France at both regional and national levels. Centralised bodies were set up to oversee CME. Conseils Nationaux de Formation Médicale Continue (CNFMC) were established which had responsibility for producing guidelines on CME and for

accrediting CME activities. The Regional Conseils Regionaux de Formation Médicale Continue (CRFMC) came into being, with the purpose of checking that CME activities followed national guidelines. The CRFMC were also responsible for making sure that doctors fulfilled their requirements and for providing recommendations for those who have not reached them. Significantly, no sanctions were defined in the legislation for failure to fulfil CME requirements.

Physicians were able to choose from a diverse range of CME activities, which were arranged in four categories: Educational events (such as conferences); Individual Education Activities (which included the subscription to medical journals and e-learning); Personal Practice Activities (such as teaching) and finally, a CME activity entitled Evaluation des Pratiques Professionnelles (EPP) EPP involved the evaluation of a doctor's work by trained physicians and accredited providers. EPP was managed by the Haute Autorité de Santé (HAS), 'the highest medical authority in France'. In 2008, 28.9% of EPP submissions were rejected. The French system allowed for CME activities to be funded by pharmaceutical companies, except for EPP.

With ongoing developments in this area, it will be interesting to observe what new system is implemented when the decrees which are currently pending are brought into force. Furthermore, 'it is still not known whether the new arrangements will build on what already has been achieved or if this reform will start from scratch, changing CME processes, organizational structures and compliance requirements.'<sup>64</sup>

## Slovakia

- CME is compulsory in Slovakia. It has its legislative grounding in a 2004 law that covers continuing education of health professionals. CME is regulated by the Slovak Medical Chamber, the regulatory body for doctors.
- Doctors must gain 250 CME credits over a five year period. 150 of these credits must be gained by participating in officially accredited medical education events. The remaining 100 credits can be accrued through personal study.
- The Slovak Medical Chamber officially delegates the delivery of CME to the Slovak Medical Association (SMA). The Slovak Accreditation Council for CME accredits CME providers and activities in Slovakia. The Council was formed in 2004. It consists of representatives from the Slovak Medical University, Association of Medical Schools, Slovak Medical Association, Slovak Medical Chamber, and Association of Private Physicians. The SMA collects doctors' CME data and passes this to the Medical Chamber every five years.
- In 2006, a formal agreement was signed in Brussels between the Union of European Medical Specialists (UEMS) and the European Accreditation Council for CME (EACCME). In line with this, 1 hour of CME is equivalent to 1 CME credit in Slovakia.
- Apparently, insurance companies check CME records annually, but there no is no information about sanctions for non-compliance. It appears that a system of five year CME recertification has been introduced.<sup>65</sup>
- CME can include:
  - Non supervised personal learning activities in the area of the specialization - discipline;
  - Performance of a practice within the discipline;
  - Attendance at courses, eventually individual training activities organized by training
  - Institutions, which is at minimum one time during one cycle obligatory;
  - Scientific meetings organized in co-operation with educational institutions;
  - Study stays;
  - Professionally oriented meetings of local, regional and international character;

- Lecturing including pedagogical activities;
  - Publications;
  - Scientific research.
- 
- According to an article on CME in Slovakia, 'from 2004-2009, the number of accredited events (educational meetings, conferences and congresses) increased from 133 to 938 including the autodidactic tests in medical journals.'<sup>66</sup>

## Greece

- In 1983 the Ministry of Health passed a law making CME mandatory for doctors in the National Health Service System.<sup>67</sup> There is no re-licensing system in Greece.
- The law states that all NHS doctors must accumulate 100 hours of CME every 5 years. In effect, the Minister of Health has the right to revoke the licence to practice medicine of any doctor in the NHS system who does not present certification of 100 hrs of CME-CPD credits.
- Despite the legal framework, a mandatory system of CME is not, in reality, implemented in Greece, meaning that, according to an article published in 2010, 'CME in Greece happens on a voluntary basis, without fixed rules, without real evaluation, and without legally backed accreditation of the participants.'<sup>68</sup>
- The Panhellenic Medical Association oversees CME and accredits CME providers. According to a 2007 presentation, the PAM CME office 'is staffed with 2 Doctors, 2 Administrative Assistants and 1 Secretary.'<sup>69</sup>
- Major CME providers are Scientific Societies, Medical Schools, hospitals and private medical associations. CME providers must be endorsed by a Medical Society or a Medical School.

## Croatia

- A six-year re-certification cycle was introduced in 1995, for which the only requirement is the accumulation of 120 CPD points (or 20 CPD points per year). CPD is therefore mandatory in Croatia. The Croatian Medical Chamber (CMC) regulates and registers all doctors and oversees CPD in the country. Currently around 13,000 doctors are registered with the CMC.
- Doctors can gain CPD points by attending national or regional conferences (which are listed on the CMC website), seminars and CPD courses, obtaining postgraduate degrees, publishing articles, or presenting conference papers (amongst others). Doctors can also complete tests given in the country's official MEDIX medical journal and send the answers to the journal. MEDIX will then publish a list of those doctors who correctly answered 60% of the questions, which will allow the doctors to gain 7 points.<sup>70</sup> The CMC is in the process of offering online CPD courses, for which it will award 5 points. However, only half of CPD points can be gained from one form of CPD activity.
- It would appear that only a few doctors failed to accumulate the required number of CPD points for re-certification in 2001 and subsequently had their licence to practise removed. In order to re-certify after failing CPD, doctors must sit a formal examination. The major providers of CPD in Croatia are the specialist associations, medical training universities and the Academy of Sciences of Croatia.

## Poland

- CPD has been compulsory in Poland since 2004, when the Minister of Health issued specific regulations for CPD for physicians and dentists. The central body overseeing CPD is the Chamber of Physicians and Dentists, which registers all doctors in Poland. Regional Chambers then directly accredit CPD activities in their own regions.
- Physicians must accumulate 200 CPD points every five years, which must include 140 CME points and 60 CPD points. Accredited activities can belong to six categories, (such as attending conferences, academic training, and writing publications). Generally, one hour is equivalent to 1 CME point. Poland participates in the UEMS EACCME system.

## Norway

- Since 2001, CME has been compulsory in Norway for specialist GPs, but not for other doctors. There is no requirement for a doctor to be a specialist GP to work in general practice, but, through CME, specialist GPs are able to charge higher fees than other non-specialist GPs. The Norwegian Medical Association oversees CME in Norway. It is compulsory for doctors to be registered with the Norwegian Medical Association, and approximately 97% of doctors (22,000) in Norway are members of the NMA.<sup>71</sup>
- Specialist GPs must undergo re-certification every five years and CME requirements form part of the re-certification process.<sup>72</sup> GPs are expected to gain 40 CME points every year and if they meet their CME targets, they can claim 20% higher fees.<sup>73</sup> Essentially, the sanction for not gaining the required number of CME points is largely financial: the GPs will lose their specialist status and access to higher fees.
- According to a 2006 study, the financial incentive meant 90% of specialist GPs complied.<sup>74</sup> Although CME is voluntary for other specialists, the NMA has designed an online system called LIEF which aids all doctors in CPD.<sup>75</sup> Activities such as attending conferences, self-evaluation of practice, e-learning, and publishing articles constitute CPD.
- The provision of CPD is dominated by the Norwegian medical faculties, but universities and medical associations can provide CPD. Private companies which operate for profit are not able to present CPD activities. The NMA assesses training bodies every year. Pharmaceutical companies are not allowed to hold, sponsor or indirectly fund CPD events in Norway: commercial ties with CPD are forbidden. According to its website (admittedly from 2001), 'the Council of the Nordic Medical Associations fully supports the European Accreditation Council for CME (EACCME) established by the European Union of Medical Specialists (UEMS).'<sup>76</sup>
- One interesting piece of research that was recently published on CPD in Norway found that over the last decade, 'Norwegian doctors spend less time on attending courses/congresses and more time on medical reading... The consistent finding of a correlation between reading and attending courses, subjective coping and job satisfaction gives good reasons for recommending a high level of CME-activities among doctors.'<sup>77</sup>

## Hungary

- CME is compulsory in Hungary and has been since 1999 (the system was updated 2003).<sup>78</sup>
- The Hungarian Medical Society (MOTESZ) oversees CME in Hungary. It is responsible for accrediting CME activities.
- Doctors are required to collect 250 CME points over 5 years. One CME point is awarded for one hour of activity. Failure to accumulate 250 CME points can result in a doctor losing his or her specialist status and lead to the doctor having to retake specialty examinations.
- MOTESZ does participate in the UEMS EACCME system.

## Slovenia

- CPD has been mandatory in Slovenia since 1992. A seven-year re-certification cycle is managed by the Medical Chamber of Slovenia (MCS) and in order to re-certify their licence to practise, doctors must accumulate 75 CPD points in the seven year period. The MCS manages the CPD programme and oversees the accreditation of CME activities. The MCS is supported by the Slovene Medical Society in the accreditation of CPD activities.
- CPD points can be accumulated by participating in lectures or passive involvement seminars, publication in a medical/peer reviewed journal or book, MCQs in a journal, participation in peer review, and e-learning courses.
- The MCS audits approximately 2.5% of CPD declarations. The MCS participates in the UEMS EACCME system.

## Italy

- There are over 300,000 doctors registered in Italy and CME has been compulsory for all doctors (and all health professionals) since 2002. Doctors must gain 150 CME credits every three years. It not known what sanctions are in place for doctors who fail to accrue the required number of credits.
- The regulatory authority for CME is the National Commission for CME and there are twenty-one Regional CME Committees beneath the National Committee. However, there has not been successful central coordination of the CME system, which has meant that implementation and auditing of a national scheme has been slow to develop. A number of changes are occurring within the system which may transform the Italian CME system.<sup>79</sup>
- The system of accrediting individual events in Italy is changing to one where providers are given a licence to hold numerous CME events throughout the year – as opposed to the Commission accrediting every individual CME event. Between 2002 – 2008, some 12,000 providers had been accredited which, according to the Health Ministry website, had held over 400,000 events. It is likely that a cap of 2,000 institutions will be allowed to provide CME in the future. Providers will be made up of universities, hospitals, medical societies and will be authorized to award credits and organize CME activities for doctors. They will be accredited by the National Commission for CME every 2 – 4 years. No pharmaceutical company will be able to be a provider.
- CME providers will have to follow a set of rules and regulations determined by the National Commission for CME. The Ministry of Health sends inspectors to audit the provider after one year, and then, if successful, after five years.
- CME can be gained by: self-study at home, interactive home-based education, research activities, self-learning with a tutor (including distance learning), or teaching activity.

## Sweden

- CME is not compulsory in Sweden, but a voluntary scheme is run by the Institute for Professional Development of Physicians in Sweden (IPULS), which encourages doctors to spend ten days per year participating in CPD activities. IPULS was established in 2002 and is overseen by the Swedish Medical Association, the Swedish Society of Medicine and the Swedish Federation of County Councils.<sup>80</sup>
- IPULS participates in the UEMS EACCME scheme and recommends that doctors spend approximately ten days per year taking part in CME activities.

## Spain

- CME is not compulsory in Spain. There are no requirements to collect a defined number of credits, although doctors may be able to earn more money by taking part in CME programmes. In 2002, the Ministry of Health and the professional medical associations signed an agreement which gave the medical associations the ability to administer CME programmes.
- The central body for responsible for CME in Spain is the National Commission of Continuing Health Education. There are also 17 Regional Commissions for continuing education which are linked to the 17 regional governments. The National Commission of CE accredits national CME events, while the Regional Commissions accredits regional events.

# AUSTRALASIA

## New Zealand

- Since 2003, all doctors in New Zealand have had to participate in CPD. The Medical Council of New Zealand has defined CPD as being involvement in clinical audit, peer review and CME. The Medical Council has issued detailed guidance for doctors on their CPD duties.
- In order to recertify each year, doctors must confirm that they have taken part in the required CPD.
- There are two main systems of CPD in New Zealand. One is for non-specialist doctors, who have to form a collegial relationship in order to carry out CPD. The other is for specialist doctors, who are able to participate in the CPD Programmes run by their specialist colleges or societies.
- The MCNZ audits 10% of all recertification applications, in order to ensure doctors are taking part in CPD. Specialist colleges may also audit a percentage of participants in their CPD programmes.
- There does not appear to be a requirement for CME activities to be accredited.

## Legislative and regulatory background

Any doctor wishing to practise medicine in New Zealand must be registered with the Medical Council of New Zealand (MCNZ), an independent organisation which is accountable to parliament. Under the Health Practitioners Competence Assurance Act 2003 (HPCAA), all doctors must also hold a practising certificate issued by the MCNZ, which has to be renewed yearly.<sup>81</sup> The requirement for the yearly renewal of a practising certificate was introduced to ensure that doctors maintained competency and fitness to practise.

An annual practising certificate (APC) will only be issued by the MCNZ if a doctor can demonstrate that they are taking part in CPD. The participation in CPD is therefore mandatory and explicitly linked to recertification. It is the core mechanism used to ensure that doctors are competent and safe to practise in their particular scope. The HPCAA allows a responsible authority (e.g. the MCNZ) to decide the requirements for recertification from a set of various options. These options include requiring a practitioner to pass examinations, complete practical training, or undergo an inspection, although neither CPD nor CME are directly referenced in the Act.<sup>82</sup> The law therefore gives regulators the flexibility to alter their recertification programmes as and when they see fit, without the necessity for further legislation.

Should a doctor not satisfy the requirements for recertification, the HPCAA gives the MCNZ the right to alter the doctor's scope of practice, change any health services that the doctor is permitted to perform, or include any condition or conditions that the MCNZ considers appropriate, including suspending the doctor's registration.

## Medical Council of New Zealand requirements for CPD

The MCNZ stipulates that CPD must cover five main domains of practice:

- Medical Care - providing good clinical care, keeping records, cultural competence
- Communication - establishing and maintaining trust, confidentiality.
- Collaboration and management - working with colleagues.
- Scholarship - teaching, researching and improving performance.
- Professionalism - raising concerns about patient safety, conflicts of interest.

As a general rule, the MCNZ requires doctors to participate in 50 hours of CPD each year, including CME, clinical audit and peer review.

The MCNZ states that CME can include:

- Attendance at relevant educational conferences, courses and workshops
- Self-directed learning programmes and learning diaries
- Assessments designed to identify learning needs in areas such as procedural skills, diagnostic skills or knowledge; journal reading
- Examining candidates for College examinations; supervising or mentoring others; teaching; publication in medical journals and texts; research
- Committee meetings with an educational content, such as guideline development; giving expert advice on clinical matters; presentations to scientific meetings working as an assessor or reviewer for the Council.<sup>83</sup>

The MCNZ does not stipulate that CME has to be accredited by any body or organisation.

Examples of peer review that the MCNZ gives are:

- joint review of cases; review of charts
- practice visits to review a doctor's performance; 360° appraisals and feedback
- critique of a video review of consultations; discussion groups
- inter-departmental meetings, which may review cases and interpretations of findings; mortality and morbidity meetings.<sup>84</sup>

Examples of clinical audit include:

- comparing the processes, or outcomes of health or patient care, with best practice in that domain
- analysis of patient outcomes; audit of departmental outcomes including information on where you fit within the team; audit of your performance in an area of practice against that of your peers
- taking an aspect of practice such as transfusion rates and comparing your performance to national standards
- formal double reading of scans or slides and assessment of your results against those of the group; patient satisfaction survey
- check that cervical smear, diabetes, asthma, heart failure, lipid control and other procedures are done to pre-approved standard formats, including reflection on the outcome
- plans for change and follow-up audit to check for health gains for that patient or for that group of patients.<sup>85</sup>

The MCNZ has two main systems of CPD recertification for doctors in New Zealand, depending on their registration status. The first is 'vocational scope recertification', which is for doctors who are registered specialists (known as vocational scope doctors). Vocational scope doctors include GPs. Recertification programmes for specialists are run by their specialist colleges or societies of which they will be members or Fellows. The general term for specialist colleges and societies in New Zealand is Branch Advisory Boards (BABs).

The second provides 'general scope recertification', which is for non-specialist doctors who are not in formal specialist training (who are known as general scope doctors). The 'general scope' scheme is also applicable to new registrants, such as IMGs, regardless of seniority, who must work under supervision for at least their first 12 months in New Zealand to become familiar with the culture. If a doctor is enrolled as a registrar and actively participating in formal vocational training, there is no need for that doctor to undertake CPD: their vocational training is considered to constitute maintenance of competency. Certain general scope doctors may carry out some of their CPD requirements by participating in a BAB scheme, but for other general scope doctors, CPD requirements must be fulfilled via a collegial relationship.

### **General Scope Recertification**

For non-specialists, general scope doctors, there are two methods by which general scope recertification can be gained:

- a. General scope doctors can develop their own CPD plan, in line with MCNZ regulations and guidance, by maintaining a collegial relationship with a specialist doctor. The specialist doctor must work in the same or closely related field as the general scope doctor, and will assist the general scope doctor in meeting his or her CPD requirements.
- b. Medical Officers are able to recertify if they a BAB allows them to participate in one of their recertification schemes. Medical Officers must also undergo formal organisation performance appraisal, as well as credentialing in order to fulfil their CPD requirements.

A collegial relationship is ideally with a specialist who works in the same place as the general scope doctor. If this is not possible, a distance collegial relationship can be maintained, but only if both doctor and specialist meet face to face for one hour six times a year for the first year and to use email and internet technology to augment these meetings. Once the relationship is established, formal contact must be made

at least four times a year, with a minimum of eight interactive hours a year. The main role of the specialist is to assist the general scope doctor in developing a CPD plan each year. They are also able to audit a number of the doctor's clinical records and observe a number of consultations each year and give feedback on improvement, or help the doctor in their CPD progress in any other mutually agreed way.

Significantly, the MCNZ requires that both parties sign a Collegial Relationship Agreement, which forms a contract between the two and stands as evidence of the relationship for the MCNZ, which holds copies of all Agreements:



## Continuing professional development and recertification

CPD1 – May 06  
Registration  
No:

### Collegial relationship agreement

The purpose of this agreement is to set out the terms of reference for the collegial relationship and clarify the objectives and responsibilities of each colleague.

#### The objective of the relationship is to:

- maintain safe clinical practice
- facilitate continuing professional development (CPD) by way of continuing medical education, peer review and clinical audit.

#### Responsibilities of the doctor registered within a general scope:

- organise meetings as necessary—face-to-face meetings lasting one hour, initially six times a year, then at least four times a year
- provide materials for assessment as needed (eg, case notes, videos)
- record all details of CPD activities.

#### Responsibilities of the colleague:

- be available for meetings
- ensure adequate records of meetings are kept
- ensure the doctor is not professionally isolated
- work with the doctor in developing appropriate CPD
- assess progress and review needs
- take appropriate action if concerns arise about the doctor's fitness to practise.

#### Liability

If you are working in a collegial relationship, your colleague is neither responsible nor liable for your clinical decisions unless he or she has been directly involved in the care of your patients. In this case any investigation would include an investigation of your colleague's level of involvement.

#### Doctor registered within a general scope (please fully complete this section)

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Period agreed on: From: \_\_\_\_\_ To: \_\_\_\_\_

Employment level (e.g. HO) \_\_\_\_\_ Branch of medicine: \_\_\_\_\_

Workplace: \_\_\_\_\_

#### Colleague registered within the same or related vocational scope (providing collegial relationship)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ MCNZ Registration no: \_\_\_\_\_

Please take a copy for your record and post or fax this form to the Council office:  
P O Box 11649, Wellington 6142  
Fax: 04 385 8902

The general scope doctor must maintain a CPD development plan and document all their CPD activities. All collegial relationship meetings must be recorded on a form which requires doctors to list the educational and quality assurance activities carried

out since the last meeting, along with commendations or recommendations. This form must be counter-signed by the specialist doctor. A practice clinical audit form must also be completed each year, which asks doctors what they learnt from the process and how their practice changed as a result. Once again, this form must be signed off by the collegial colleague. All CME activities totalling at least twenty hours per year must be recorded and signed off by the collegial colleague. Evidence of attendance must be kept. Finally, a form documenting at least ten hours of peer review must be kept, which again must be signed by the specialist doctor.

### **Quality assurance of general scope doctors**

When general scope doctors apply for their Annual Practising Certificate, the MCNZ asks doctors to declare that they are actively taking part in CPD and have completed all the annual requirements. This declaration must be countersigned by their collegial colleague. The MCNZ audits 10% of all recertification applications each year, including general scope doctors. This is done to ensure that doctors' declarations are correct. If a general scope doctor in a collegial relationship is audited, they have to send all the documentation described above to the MCNZ.

In the event of non-compliance, the MCNZ is able to suspend a doctor's registration. However, a doctor is given the opportunity to attend a meeting with the MCNZ before it makes a final decision in order to explain the reason for non-compliance.

### **Vocational scope recertification and BAB schemes**

For specialist doctors, including GPs, doctors must engage in a recertification programme run by an accredited BAB. Specialist doctors are not required to establish a collegial relationship. The MCNZ sets out which BAB a specialist must register with.

### **BAB CPD programmes**

There are 22 accredited BABs for the 36 specialties recognised in New Zealand. These include the Royal New Zealand College of GPs, the Royal Australasian College of Physicians (RACP), Royal Australian and New Zealand College of Ophthalmologists. To become accredited, all BABs have to demonstrate that they 'provide an existing recertification programme that assists doctors working in the vocational scope to maintain their competence throughout their working lives.' Despite this, evidence of CPD programmes is not identifiable on a number of BAB websites (such as New Zealand Association of Musculoskeletal Medicine and the [New Zealand Society of Otolaryngology Head and Neck Surgery](#)). It may be that these

BABs compel their members to take part in a CPD programme provided by one of the larger Colleges, such as the RACP.

Many accredited BABs serve both Australia and New Zealand but only have one CPD scheme. CPD requirements are different in Australia and New Zealand. For example, participating in peer review is not mandatory in Australia and is therefore a voluntary component of many of the joint BABs' CPD schemes. In these cases, it is up to the New Zealand doctor to ensure all the MCNZ's mandatory requirements (clinical audit and peer review) are met, regardless of whether they are only voluntary on the CPD scheme. The MCNZ has issued specific frameworks for CPD schemes so doctors are aware what they must do in order to fulfil requirements.

### ANZCA CPD Programme

The Australian and New Zealand College of Anaesthetists (ANZCA) runs a CPD programme that operates on a three year cycle. Doctors must submit information annually in order to receive a Statement of Participation, which doctors must submit to the MCNZ if selected for audit.

Doctors either print out or can fill in online a CPD Portfolio. This must include their CPD Plan for the triennium, a record of all activities undertaken, reflective notes and an evaluation of the programme. The ANZCA provides advice to doctors in the form of toolkits which cover all the main areas of required CPD, such as practice assessment. There are four categories which doctors can claim credits for which are: (1) Group Learning; (2) Self-Learning; (3) Practice Assessment; and (4) Education and Development. Each category has two levels, one for passive activities and another for interactive activities. Doctors are awarded fewer credits for taking part in passive activities than interactive activities.

A robust system of quality assurance of the activities doctors can participate in does not exist. The ANZCA attempts to accredit specialty-specific CME activities, but it would not appear that only accredited events are recognised for inclusion on the programme. The ANCA guidance simply states that 'activities for which CPD points can be earned have to meet the ANZCA's standards for the programme' and that 'private organisations are encouraged to apply for accreditation'.<sup>86</sup> There are few details relating to the ANZCA's accreditation process. Following accreditation, the event is added to the ANZCA's official calendar.

The MCNZ has issued a framework for New Zealand doctors taking part in the ANZCA. Doctors must obtain 40 credits per year (or 120 credits over the triennium) in any combination of activities, but must include at least 10 credits each from Categories (1), (2), and (3). A cap (of 10 credits) only applies to passive self-learning. A shortfall of credits (less than 40) in a year can be made up with surplus credits in the following year, or the preceding year of the triennium.

The ANZCA audits up to 5% of CPD participants who complete their triennial programme.<sup>87</sup> Those randomly chosen for audit need to provide evidence of participation in activities as well as providing their CPD portfolio and plan. This documentation will be examined by a panel of auditors who are Fellows appointed by the College. They will look at the CPD Plan, the implementation of CPD Plan, the accuracy of annual returns, validation and relevance of activities for the credits claimed and compliance with the CPD Program requirements.<sup>88</sup>

Those who successfully pass the audit are excluded from the random selection for the next six years (two CPD cycles).<sup>89</sup> Those who do not will have to undertake further CPD activities until they meet requirements.

Unlike the CPD programme of the Australian and New Zealand College of Anaesthetists other Colleges are far more strict on the accreditation of CME events. For example, the Royal Australasian College of Surgeons publishes a specific list of approved CME activities for each year.<sup>90</sup>

The RACS will audit 3.5% of CPD programme participants, in order to verify their CPD data. Each audit will only focus on verifying one component of the CPD Programme, rather than fully auditing the entire annual return. Participants selected for audit will have to provide supporting documentation to match the information that they have supplied on their online CPD account.<sup>91</sup>

Vocational scope doctors are audited as part of the MCNZ's overall 10% audit of recertification applications. If a vocational scope doctor is audited, they either have to send their BAB CPD certificate or participating certificate to the MCNZ, or the MCNZ will check directly with the BAB to verify if the doctor is participating in their CPD scheme. In the event of non-compliance, the MCNZ is able to suspend a doctor's registration. As with general scope doctors, a specialist doctor is given the opportunity to attend a meeting with the MCNZ before it makes a final decision in order to explain the reason for non-compliance

An article published in 2008 suggested that take up rates for CPD may not be as high as the MCNZ has hoped, despite the legal requirement. According to Barry Taylor, 'although the Medical Council in New Zealand requires all doctors to provide proof of satisfactory engagement in CPD each year as a condition of practice CPD compliance rates are only 70 percent.'<sup>92</sup>

## Australia

- From July 2010, it became a legal requirement for all doctors to take part in CPD in order to re-register each year.
- The Medical Board of Australia requires all doctors to enrol in one of the specialist medical colleges' CPD programmes in order to fulfil their CPD obligations. All medical practitioners are asked to declare annually on renewal of registration that they have met the CPD standard set by the Medical Board.
- The Australian Medical Council is, by law, responsible for the accreditation of education providers, as well as colleges which provide CPD programmes. The AMC has accredited 27 specialist medical colleges which each run CPD schemes. The accreditation process is appears to be one of the most robust in the world.

Sweeping changes to the regulatory framework of doctors in Australia have occurred recently. Up until July 2010, more than 85 health profession boards in eight States and Territories were governed by 66 Acts of Parliament. Doctors were regulated on a state/territory-specific basis, and no uniform, national system of regulation or CPD was in place. The registration and regulation of medical practitioners, including specialists, 'was governed by the relevant state and territory Acts which established medical boards in each of the individual jurisdictions.'<sup>93</sup>

In 2008, the Council of Australian Governments 'agreed to establish both a single national registration board and a single national accreditation board for the registration, education and training of health professionals.'<sup>94</sup> The Medical Board of Australia was established under the Health Practitioner Regulation Act 2008 to be the national regulator of doctors. The Medical Board of Australia is a sub-organisation of the Australian Health Practitioner Regulation Agency (AHPRA). The AHPRA oversees the regulation of all health professionals in Australia (Dental, Medical, Nursing and Midwifery, Optometry, Osteopathy, Pharmacy, Physiotherapy, Podiatry and Psychology).

From 1 July 2010, the National Law (the *Health Practitioner Regulation National Law Act 2009*) came into effect, meaning that every doctor practising medicine in Australia had to be registered with the Medical Board of Australia, and has to renew their registration every year. It is also now a legal requirement for doctors to take part in CPD in order to re-register each year.

The Medical Board of Australia (MBA) has not issued as prescriptive advice on CPD requirement as the MCNZ has. Instead, the MBA has issued the following guidance: 'CPD must include a range of activities to meet individual learning needs including practice-based reflective elements, such as clinical audit, peer-review or performance appraisal, as well as participation in activities to enhance knowledge such as courses, conferences and online learning. CPD programs of medical colleges accredited by the Australian Medical Council (AMC) meet these requirements.'<sup>95</sup> All practising doctors who are not in training are advised to enrol on a college CPD scheme.

All medical practitioners are asked to declare annually on renewal of registration that they have met the CPD standard set by the MBA:

**Mandatory Disclosure Questions**

5. From 1 July 2010, all registrants are required to meet the Board's Recency of practice standard. Do you meet the Board's recency of practice requirements? \*  Yes  No

6. I understand that I am required to meet pro rata requirements of the Board's continuing Professional Development Standard during the period of registration that I am now applying for. \*  Yes  No

7. Have you practised the profession since July 1 only while covered by professional indemnity insurance that meets the Board's standard? \*  Yes  No  N/A

8. If your registration is renewed, do you commit to only practise the profession while covered by professional indemnity insurance arrangements? \*  Yes  No

This declaration will be subject to audit, which will require a doctor to submit all their CPD to the MBA. The percentage of doctors to be audited has not yet been publicised. Doctors must ensure that their CPD activities are recorded, either by keeping records themselves or by using college systems, such as online CPD accounts.

According to the MBA guidance, 'a failure to comply with this CPD standard is a breach of the legal requirements for registration and may constitute behaviour for which health, conduct or performance action may be taken.'<sup>96</sup>

### Australian Medical Council accreditation

Under the Health Practitioner Act, the Australian Medical Council is responsible for the accreditation of education providers, as well as colleges which provide CPD programmes. The AMC has accredited 27 specialist medical colleges which each run CPD schemes. The AMC takes a very active accreditation role. For example, in 2011, the AMC is reaccrediting, amongst others, the College of Intensive Care Medicine of Australia and New Zealand, the Australasian College of Sports Physicians, the Royal Australasian College of Surgeons and the Royal Australian and New Zealand College of Ophthalmologists.

The AMC accreditation process includes both formal accreditation (validating that standards are met) and also peer review of CPD programme providers. During a peer review process, AMC expert assessment teams examine CPD programmes against standards set by the Council. The standards define the knowledge, skills and professional attributes expected at the end of CPD training. Training organisations that meet AMC standards are granted accreditation.

Under the Councils' standards, the CPD programmes must be based on self-directed learning and the provider must assist participants to maintain and develop knowledge, skills and attitudes essential for meeting the changing needs of patients and the health care delivery system. The CPD programme provider must determine the formal structure of the CPD program in consultation with stakeholders, and must take into account the requirements of authorities such as the MBA and the MCCNZ. The CPD programme providers should have processes and criteria in place for assessing and recognising external CME providers and/or the individual CME activities.

CME should be based on educational quality, the use of appropriate educational methods and resources, and take into consideration feedback from participants. The CPD programme provider must document the recognised CPD activities of participants in a systematic and transparent way, and must monitor participation. Finally, the CPD programme provider must ensure there are mechanisms to allow doctors who are not its fellows to access relevant continuing professional development and other educational opportunities.<sup>97</sup>

# NORTH AMERICA

## United States of America

- CME is compulsory in the majority of American States. Each State Medical Board is responsible for setting guidelines on CME and as such, CME requirements differ between States.
- State Medical Boards audit CME activity and can, for example, fine or publicly reprimand doctors for non-compliance. It is not clear whether Medical Boards remove the state licences from doctors who do not comply.
- All compulsory CME activities that a doctor attends must be accredited by a legitimate organisation. There are two main organisations which accredit CME in the USA: Accreditation Council for Continuing Medical Education and the American Medical Association.
- Both these accreditation organisations have strict quality assurance processes for accrediting providers of CME. The American Medical Association has developed a 'gold standard' credit system.
- The American Board of Specialties has been running a CPD recertification scheme entitled Maintenance of Certification for over ten years. It is a voluntary scheme for doctors but has a high take up of doctors. CPD on this scheme can be quality assured because doctors must undertake online evaluations and gain peer references.
- There may be sweeping changes in terms of CPD within the USA if, firstly, Maintenance of Licensure is adopted by State Medical Boards and, secondly, the American Medical Association is able to push through its policy of distancing commercial sponsorship from CME activities.

## **CME: regulatory background**

All doctors wishing to practise medicine in a State must apply for a State Medical License from a State Medical Board (SMB). A State Medical License is the minimum requirement a doctor needs in order to undertake clinical work in that State. CME in the USA is a mandatory requirement for re-licensure with 62 of the 68 SMBs in America.<sup>98</sup>

Most SMBs require doctors to participate in between 20 – 50 hours of CME per year, although the CME system is officially based on credits (for most activities one CME credit equates to one hour of CME). Re-licensure cycles are on average two years, but can be between one to four years depending on the SMB. A number of SMBs also require specific topics to be covered by certain doctors. For example, over a four year period, doctors in California who regularly encounter elderly patients must participate in at least twenty hours of CME in geriatric medicine. In Ohio, doctors must undertake a minimum of two hours CME every ten years in HIV/AIDS courses approved by the Cabinet for Health and Family Services.

All SMBs require that the CME activities that doctors participate in be accredited (although self-learning CME does not need to be accredited). However, SMBs do not undertake accreditation themselves. A number of SMBs only require CME to be accredited by state medical societies, but many, such as the Arizona SMB, require that all CME is officially accredited by the Accreditation Council for Continuing Medical Education (ACCME). The ACCME is the main organisation responsible for accrediting the institutions and organisations that offer CME in the USA. The ACCME accredits organizations, and does not accredit individual activities.<sup>99</sup> Almost all SMBs also require that a percentage of CME must be 'gold-standard' accredited by the American Medical Association, or equivalent. Many SMBs also consider that a doctor's Maintenance of Certification with his or her specialty board fulfils CME requirements. Accredited providers held 95,062 events in the USA in 2009.

### **Quality assurance of CME: ACCME accreditation**

To be accredited by the ACCME – and therefore provide CME which doctors can use toward compulsory requirements – a CME provider must undergo an extensive process of form-filling, interview and examination. This rigorous process is to ensure that the provider meets the following Essential standards set by the organisation:

- The provider must have a written statement of its CME mission, which is approved by the provider's governing body. The mission must include the CME

purpose, target audience, type of activities the provider will provide, and the expected results from the programme.

- The CME Provider must employ a planning process which connects identified educational needs with desired outcomes. Assessment data must be used to plan CME activities and the objectives of the activity must be made clear to the learner before the activity begins.
- The Provider must adhere to the ACCME policies for commercial support.
- The Provider must evaluate the effectiveness of its CME activities in meeting the identified educational needs. It must also evaluate its overall CME programme.

The ACCME asks all new CME provider applicants to complete a Pre-application questionnaire. This provides providers with an opportunity to explain their eligibility for ACCME accreditation, as well as to demonstrate that your organization has mechanisms in place to fulfil the ACCME's Essential standards. If the application is deemed eligible, potential providers must submit an Initial Self Study Report for ACCME accreditation. Once this has been received, the ACCME schedules an accreditation interview, which includes a CME activity being reviewed by an ACCME surveyor. These requirements are also part of a Provider's subsequent reaccreditation review process.

During the interview, ACCME surveyors discuss the objectives of the proposed CME programme with the applicant. The surveyors clarify any questions regarding the CME programme. Following the interview, the surveyors will document the results and send the findings to the ACCME. Once the findings are received, the ACCME's decision making process begins.

The decision making process includes review by two ACCME committees - first, the Accreditation Review Committee, and second, the Decision Committee. Both Committees look in detail at the documents from the CME provider and the interview, and decide whether to provide accreditation. Provisional Accreditation is given for first-time applicants and has a two year term. For those providers who are successfully reaccredited, a four year term is given.

## AMA PRA credit

The American Medical Association owns an official 'gold-standard' accreditation system, through which it allows the CME organisations it accredits the ability to award nationally recognised AMA PRA Credits. PRA stands for Physician Recognition

Award, which was, before CME became mandatory, what doctors accumulated their CME credits for. Now CME is mandatory for most doctors, AMA PRA Credits are more commonly seen as an indication of the participation in approved CME.<sup>100</sup>

That said, doctors can still receive a PRA certificate by taking part in at least 50 hours of CME per year, of which 20 hours must be AMA PRA accredited activities per year. A number of states accept the AMA PRA certificate as proof that doctors have met the CME requirements for licensure. Organisations may certify an educational activity for AMA PRA Credit only if the activity complies with all AMA PRA requirements, and the organization is already accredited by either the ACCME or by a state medical society recognized by the ACCME.

There are two categories of AMA PRA credit: AMA PRA Category 1 Credit™ and AMA PRA Category 2 Credit™. The AMA *directly* awards Category 1 Credit to doctors who teach at an AMA PRA accredited event, publish articles in peer-reviewed journals, undertake medical-related degrees or gaining Maintenance of Certification (see below). Category 1 Credit can also be awarded *indirectly* by CME accredited providers for events such as conferences and seminars, or activities like e-learning modules, which will result in the provider awarding the doctor credit.

There are approximately 2,500 recognised AMA PRA Category 1 Credit providers in the USA. Accredited providers of Category 1 Credit must retain documentation setting out the credit awarded for each certified activity, for a minimum of six years after the completion date of the activity. A certificate for attending the event must also be given to the doctor and should include the doctor's name, the name of accredited CME provider, the title of activity, the learning format, the location of activity (if applicable), the date(s) of live activity or date that physician completed the activity and the number of AMA PRA Category 1 Credits™ awarded.

Category 2 Credit includes more self-directed CME, such as teaching medical students, unstructured online searching and learning, reading authoritative medical literature, small group discussions and peer review and quality assurance participation. Doctors are able to self-claim credit for appropriate activities, but must document the activity title or description, subject or content area, date(s) of participation and number of credits claimed.

Many SBAs request that a percentage of CME credits that doctors gain are (or equivalent to) AMA Category 1 Credits. An increasing number of SMBs will not accept Category 2 (or equivalent) CME credits, and therefore require doctors to take

part in certifiable CME. This is, no doubt, in order to improve the quality of CME that doctors participate in.

### **SMB Quality Assurance of CME**

Because other bodies undertake the accreditation of CME, SMBs are not directly involved with the quality assurance of CME, beyond the issuance of regulations. All SMBs monitor the CME activities of doctors in their state, though this varies from state to state.

- In Arizona, doctors must fill out and return a form to the Board detailing their CME activities and points every two years. The doctor must sign, under penalty of perjury, that they have fulfilled their CME requirements. The Board may randomly audit physicians to verify compliance with the continuing medical education requirements under subsection, although there are no details of whether they do, or what form the audit takes.<sup>101</sup>
- In New Hampshire, a complete audit of all CME credits is undertaken annually by the New Hampshire Medical Society. Every doctor has to submit a CME report which includes copies of CME course certificates earned by the licensee, as well as and other documents which establish that CME course requirements have been met. The complete audit includes the collection, review, verification, and preservation of the CME documentation of each licensed physician, together with a report which records the credits awarded to each doctor.<sup>102</sup> There is no indication of any sanctions imposed.
- In Texas, a small percentage of the doctors returning an annual CME renewal form will be required to produce proof of completion of the CME points they reported each year. The Board does not require original documents; copies of certificates and forms are sufficient. If the doctor does not comply with the request for documentation within 60 days, the doctor will be investigated by the Board. If the investigation shows that the requirement was not met, the doctor may be disciplined. The penalty for non-compliance with the annual CME requirement is no less than a Public Reprimand and a \$500 Administrative Penalty.<sup>103</sup>

### **Maintenance of Certification: CPD**

As stated above, many SMBs now accept Maintenance of Certification as proof that CME requirements have been fulfilled. The Maintenance of Certification (MOC)

scheme is run by a group of Specialist Boards in the USA and was implemented in 2000. It requires the doctor to successfully complete various CME activities every few years, such as attending lectures or completing online activities. However, doctors must also take part in performance assessment in order to maintain their specialty certificate. According to the Specialty Boards, this makes MOC far more focused on continuous professional development than continuing medical education.

Although a State Medical License is the minimum requirement a doctor needs in order to undertake clinical work in that State, close to 90% of physicians in the USA voluntarily apply for specialist board certification and take part in the MOC scheme.<sup>104</sup> Participation in MOC is a requirement for specialist certification. According to a survey undertaken in 2006, the majority of doctors sought certification and recertification because they desired to uphold and maintain a 'professional image'.<sup>105</sup>

The American Board of Medical Specialties (ABMS) is the 'pre-eminent entity' which supervises the maintenance of certification of its member boards.<sup>106</sup> It is made up of 24 medical speciality Member Boards, who joined the organisation over a period of years. Through ABMS, the specialist boards collaborate in order to establish common, consistent standards for physicians to achieve and maintain board certification.

The intent of both the initial certification of physicians and the maintenance of certification is to provide assurance to the public that a physician specialist certified by a Member Board of the ABMS 'has successfully completed an approved educational program and evaluation process...The ABMS serves to coordinate the activities of its Member Boards and to provide information to the public, the government, the profession and its Members concerning issues involving certification of physicians.'<sup>107</sup>

Maintenance of Certification schemes vary from specialty board to specialty board, but all consist of four components:

- Evidence of professional standing: A doctor must maintain his or her State License
- Evidence of lifelong learning and self-assessment: This component relates to CME. Doctors must participate in the educational and self-assessment programs that meet specialty-specific standards that are set by their member board

- Evidence of cognitive expertise: Doctors must demonstrate, through formalized examination, that they have the fundamental, practice-related and practice environment-related knowledge to provide quality care in their specialty.<sup>108</sup>
- Evidence of performance in practice: Doctors must be evaluated in their clinical practice according to specialty-specific standards for patient care. Doctors are asked to demonstrate that they can assess the quality of care they provide compared to peers and national benchmarks and then apply the best evidence or consensus recommendations to improve that care using follow-up assessments.<sup>109</sup>

As all 24 MOC schemes are slightly different and change over time, to reflect ABMS standards. It is worthwhile focusing on one scheme to illustrate how MOC works:

#### **American Board of Anesthesiology (ABA) MOC Scheme**

Each MOC-Anesthesiology cycle is a 10 year period during which doctors should seek to improve their skills in six core competencies: Medical Knowledge; Patient Care; Practice-based Learning and Improvement; Professionalism; Interpersonal and Communication Skills; and Systems-Based Practice.

**Part 1:** ABA members must hold an active and unrestricted license to practise medicine. They must update and review their medical license information online, via the ABA's MOC website

**Part 2:** To 'continually seek to improve the quality of their clinical practice and patient care through self-directed professional development', ABA members must complete 350 CME credits during a 10 year cycle. Of that total, at least 250 credits must be Category 1 credits — that is ACCME/AMA PRA approved. A maximum of 70 credits per calendar year can be applied toward the requirement. Ninety of the 250 Category 1 credits must be evaluative CME. Doctors must complete therefore complete 90 CME credits through the American Society of Anesthesiologist's (ASA) Anesthesiology Continuing Education Program (ACE) and/or the ASA's Self Education and Evaluation Program (SEE). Finally, 20 CME credits of patient safety education must be included in the doctor's CME portfolio. Both the ASA and the ABMS offer Patient Safety Modules that meet this requirement. Doctors must submit CME activities to the ABA online, via their portal accounts at [www.theABA.org](http://www.theABA.org). Self-reported CME activities are subject to audit and verification by the ABA within three years of submission. CME activities reported to the ABA by qualified CME providers, such as the ASA, are not subject to audit.

**Part 3:** Doctors must demonstrate their cognitive expertise once every ten years by passing an ABA examination. The examination may be completed only in years 7 through 10 of the MOCA cycle. Doctors are allowed to take the examination up to twice a year. If the examination is not passed before the end of the 10-year cycle, then the doctor's certification will expire.

**Part 4:** Doctors must complete three activities over the 10-year cycle to demonstrate that they are participating in evaluations of their clinical practice and are engaging in practice improvement activities. They must complete one four-step case evaluation process to assess their practice and implement changes that improve patient outcomes. They must also complete one simulation course at an ASA-endorsed simulation centre. One of these activities must be completed during the first five years of the cycle and the other activity must be completed during the last five years. Doctors only receive credit for one simulation course per 10-year cycle. Doctors must also complete one attestation in year 9 of the MOCA cycle to verify their clinical activity. Doctors must solicit references to verify their clinical activity, and evidence of participation in practice improvement activities.

Through self-assessment testing, examinations and practice performance assessments, the Specialty Boards are able to verify that doctors are actively taking part in CPD, as opposed to just receiving evidence that a doctor has attended an event. To this end, the ABMS has started to wonder whether CME in its current form – such as attending seminars – can be of sufficient quality to help its members improve practice and maintain certification.<sup>110</sup>

### All Change?

There are several important developments occurring at the present time which may have a big impact on the way CME and CPD is regulated and delivered in the US. The first of these is the possible arrival of Maintenance of Licensure:

### Maintenance of Licensure Plans

The Federation of State Medical Boards released a new framework for maintenance of licensure rules in April 2012. The Federation has previously stated that 'as currently mandated by state medical boards, CME is not sufficient to verify or ensure continued competence'.<sup>111</sup> Under FSMB's proposed system, which is known as Maintenance of Licensure (MOL), the current SMB requirements detailed above would be expanded. 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.<sup>112</sup> The FSMB's framework appears very similar to the MOC system. Under proposals, doctors would have to participate in:

- Reflective self-assessment: 'This could involve the use of an assessment tool such as an accredited continuing medical education (CME) pre-test, as one example, to identify needs or opportunities for improvement, followed by a tailored improvement activity based on those outcomes.'<sup>113</sup>
- Assessment of Knowledge and Skills: This could be fulfilled by completion of a MOC programme. For those doctors who are not specialty board certified, SMBs would have to consider other options '(e.g., computer-based clinical case simulations, hospital procedural privileging, etc.)'.<sup>114</sup>
- Performance in Practice: This is similar to Part 4 of MOC, and could be fulfilled by doctors' participation in the MOC scheme.

The FSMB is 'now assisting the nation's medical boards as they consider implementation of state MOL policies.'<sup>115</sup> The press have reported that many doctors fear 'that the new maintenance-of-licensure rules will force them to duplicate CME and other requirements they already carry out for maintenance of certification.'<sup>116</sup>

#### *Problems with Commercial Sponsorship of CME*

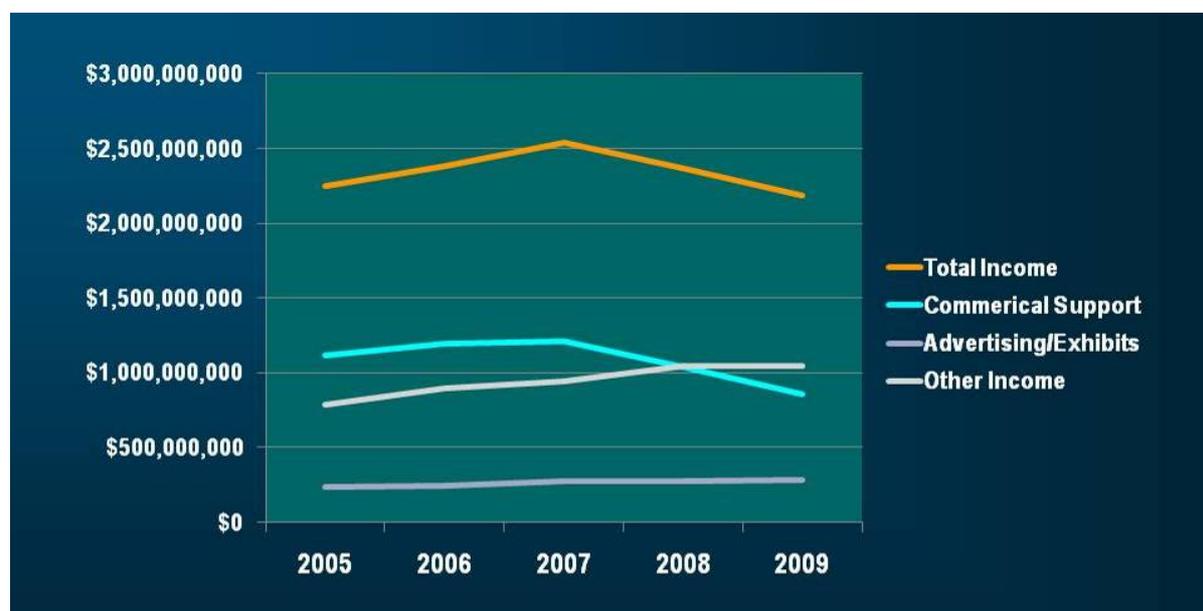


Figure: Total income by source and year of CME activities in the US.<sup>117</sup>

As the above diagram shows, CME in the USA is a \$2.5bn industry, with some \$1bn coming from commercial (predominantly pharmaceutical companies). For a number of years, the American Medical Association has been increasingly vocal in its questioning of whether such huge commercial support is, ultimately, beneficial for patient health or public trust. The AMA's Council on Judicial and Ethical Affairs (CEJA) issued a report early in 2011 entitled *Financial Relationships with Industry in Continuing Medical Education*.

It was 'CEJA's fifth attempt to ask individual physicians and institutions of medicine to reject industry funding to support professional educational activities.'<sup>118</sup> The report focused on the AMA's 'growing concern' of the 'potential for bias' that commercial funding of CME brings. The report stated that 'where patients' health and public trust are concerned, the perception of bias, even if mistaken, can be as potentially damaging as the existence of actual bias.'<sup>119</sup> In late June 2011, delegates to the AMA annual meeting voted to discourage industry sponsorship of CME.

On 20 June 2011, the AMA released the following ethical guidance to CME providers:

*Financial or in-kind support from pharmaceutical, biotechnology or medical device companies that have a direct interest in physicians' recommendations creates conditions in which external interests could influence the availability and/or content of continuing medical education (CME). Financial relationships between such sources and individual physicians who organize CME, teach in CME, or have other roles in continuing professional education can carry similar potential to influence CME in undesired ways.*

*CME that is independent of funding or in-kind support from sources that have financial interests in physicians' recommendations promotes confidence in the independence and integrity of professional education, as does CME in which organizers, teachers, and others involved in educating physicians do not have financial relationships with industry that could influence their participation. When possible, CME should be provided without such support or the participation of individuals who have financial interests in the educational subject matter.<sup>120</sup>*

Obviously, such a response has received a fairly hostile reaction from the pharmaceutical industry.

## Canada

- Mandatory CPD schemes are currently being rolled out in the Canadian provinces and territories. These may include the implementation of revalidation schemes which are linked to the participation in CPD.
- Regulatory Authorities in several of the provinces and territories have had to pass new laws in order to make CPD compulsory.
- Regulatory Authorities will probably directly QA a CPD scheme by auditing a certain number of CPD portfolios.
- The transition to mandatory CPD is made easier because two CPD programmes are already up and running in Canada. These are run by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians in Canada. There is a system of auditing a small percentage of responses and reviewing documentation in order to QA the process.
- Specialty Societies and Universities accredit the CME activities for both CPD schemes.

The system of state medical licensing in Canada is similar to that of the USA. Upon successful completion of the Medical Council of Canada's MCCQE Part I and Part II examinations, doctors receive the Licentiate of the Medical Council of Canada (LMCC), and are then included in the Canadian Medical Register. The LMCC is a prerequisite that provincial and territorial medical regulatory authorities require for a licence to practise medicine in their jurisdiction.<sup>121</sup> Doctors must gain a licence to practise in a particular province or territory.

Canada is now entering a new era of mandatory CPD (and moving away from an old system of CME). In 2007, Quebec became the first regulatory authority in Canada to introduce mandatory CPD requirements for doctors. Saskatchewan followed in 2008. Soon all regulatory authorities across Canada will introduce mandatory continuing CPD requirements for doctors, which may be linked to revalidation of licences.<sup>122</sup> The Federation of Medical Regulatory Authorities of Canada (FMRAC) believes 'that all licensed physicians in Canada must demonstrate, through participation in a recognized revalidation process, their commitment to continued competence in performance. The purpose of revalidation is "[to] reaffirm, in a framework of professional accountability, that physicians' competence and performance are maintained in accordance with professional standards."<sup>123</sup>

The move towards a system of CPD has meant various provinces have had to, or are having to, pass new legislative Acts. In Newfoundland and Labrador, for example, the Medical Act 2011 – Respecting the Practice of Medicine in the Province was passed on 31 May 2011.<sup>124</sup> Under the Medical Act 2011, the College is now responsible for the promotion of continuing competence and quality improvement through continuing medical education as well as the administration of a quality assurance program. Revalidation and the QA committee will both come into force on December 31, 2011.

Many of the regulatory authorities have published information on how they intend to quality assure the schemes. In Quebec, doctors have to inform the regulator of which CPD plan they are participating in when they renew their annual CPD assessment. Physicians who could not do so are asked to complete the CPD plan enrolment form and to return it to the regulator. The regulator will ask approximately 3% of its members to provide proof of enrolment in a CPD program each year. If a doctor is unable to produce documents, such as certificates of attendance or learning logs, or if the documentation is not satisfactory, the regulator will propose 'a mentorship process with a colleague who will assist the physician in drawing up his or her own CPD plan.'<sup>125</sup>

## MainPro/MOC

The regulatory authorities that have now implemented a compulsory system of CPD have all taken the view that compliance with two already established CPD schemes will be sufficient for revalidation. In effect, the Maintenance of Certification programme run by the Royal College of Physicians and Surgeons of Canada, and the similar but differently named Maintenance of Proficiency (MAINPRO®) programme run by the College of Family Physicians of Canada, have now become mandatory in Canada. It has also meant that the MOC and MAINPRO® programmes, which used to only be available to members, are open to all doctors in Canada.

In January 2001, the Royal College of Physicians and Surgeons of Canada (RCPSC), which represents all specialties in Canada aside from family physicians, established the first 5-year cycle of the Maintenance of Certification program. As well as now being mandatory for many doctors, MOC certification is also required for admission to the RCPSC and to renew Fellowship privileges.

In the RCPSC's scheme, doctors must earn 400 credits in each five-year cycle, and must ensure that they do not accrue less than 40 credits in any year. MOC CPD Activities are separated into six sections; accredited group learning activities, other learning activities, accredited self-assessment programmes, structured learning projects, personal practice review, and personal education development.

Doctors must self-report completed learning activities on the RCPSC's online MOC tool MAINPORT. Documentation of activities is central to the MOC scheme and documentation of the learning process (how learning was planned) and the outcomes or improvements identified during the process is required. Each year, three per cent of participants in the MOC program are selected for an audit, although no other information on this audit, or possible sanctions, are available.<sup>126</sup>

A new MAINPORT system was launched in May 2011, and is now 'an integrated learning space that provides physicians with strategies to manage their learning and access a wide variety of web resources and assessment programs...One new feature of MAINPORT is a new continuing professional development (CPD) planning tool. Physicians input the learning goals they intend to pursue, create comprehensive plans to achieve each learning goal and track their progress during the year.'

Accredited CME activities are still a fundamental part of the MOC programme. The RCPSC's Accredited CPD Providers are the national specialty societies and university

CME offices which have met the RCPSC's accreditation standards. Accredited CPD Providers are able to approve activities that satisfy the standards for accredited group learning activities and accredited self-assessment activities in the Framework of CPD Activities within the MOC Programme. As well as automatically having all their own educational events approved, Accredited CPD Providers can also approve programmes created by physician organisations or co-develop events with physician or non-physician organizations.

Physician organisations can seek approval from an accredited provider for an event and can co-develop an event with an accredited provider. A physician organisation can also co-develop an event with a non-physician organisation. Non-physician organisations are able to co-develop events but cannot develop an event on their own. The RCPSC publishes detailed guidance for each scenario.

The CFPC's MAINPRO® system is also run on a five-year cycle, although doctors must complete and report a minimum of 250 MAINPRO® credits in order to complete the cycle. As opposed to six sections, MAINPRO® consists of three categories of credit, which are shown below:

[Mainpro C](#) Mainpro-C credits are earned when you participate in CFPC accredited programs that include a demonstrated self-reflective component. Eligible activities will include opportunities to reflect on what you have learned and how you might best incorporate newly acquired knowledge and/or skills into your practice.

[Mainpro-M1](#) Mainpro-M1 credits are earned when you participate in structured learning programs, events or activities that focus on enhancing knowledge and skills relevant to the practice of family medicine.

A variety of activities are eligible for Mainpro-M1 credits, including CFPC-accredited conferences and workshops, faculty development activities, contributions to the medical community and more.

[Mainpro-M2](#) Mainpro-M2 credits are earned when you participate in self-directed and/or non CFPC-accredited learning activities. Mainpro-M2 eligible activities include teaching, journal reading and more.

Doctors must submit proof of participation (for example a copy of certificate of completion/participation.) for all Mainpro-C activities to the CFPC for verification purposes. Doctors have to retain a personal copy of proof of participation for a minimum period of 6 years in case they are selected to participate in CPD credit validation or auditing. There is no further information available on the CFPC auditing processes. The CFPC has a similar system of CPD activity accreditation as the RCSCP.

## Jamaica

- The Medical Council of Jamaica (MCJ) regulates all doctors. According to the Medical Act of Jamaica (1976), mandated in 2004, it must register all doctors and 'ensure the maintenance of proper standards of professional conduct by registered medical practitioners'<sup>127</sup>. Following an amendment of the Medical Act in 2004, a requirement for compulsory CME for doctors was introduced. The MCJ set up a National Committee of CME and introduced a compulsory CME system in 2004. Doctors must complete 10 hours of CME per year in order to maintain their licence to practise and stay on the register.
- CME providers must apply to the National Committee for CME in order to have their event accredited. The form they must complete can be found [here](#). The Medical Association of Jamaica holds monthly accredited CME meetings.
- In February 2006, the MCJ requested that all doctors submit documentation confirming that they had taken part in CME activities, or risk losing their licence to practise. Unfortunately in May 2006, 1,600 (around a third of doctors in Jamaica) failed to provide evidence of CME.<sup>128</sup> Whilst the MCJ removed their licences, it appears that many doctors continued to practise.

# AFRICA

## South Africa

- As of 1 January 2007, all doctors in South Africa have been required to take part in CPD.
- The Medical and Dental Board, which registers all doctors, oversees the system of compulsory CPD and issues guidance on it. It also issues guidance on the accreditation of CME activities, but delegates the provision of CME to universities and specialist medical societies.
- The HSPCA – the central statutory body which governs the Medical Board – encourages practitioners to accumulate thirty hours of CME per year after two years, which must include ten hours of ethical CME.
- The HSPCA randomly selects individual doctors for compliance checks every two months. Serious cases are referred to the Medical Board, which can suspend a doctor for any period they see fit or can, if necessary, remove a the doctor from the medical register.

## Regulatory and legislative background

The Health Professions Council of South Africa (HPCSA) is a centralised, statutory body, which regulates all the health professions in the Republic of South Africa. It regulates and offers guidance on registration, education and training, professional conduct, ethical behaviour and continuing professional development. The HPCSA has twelve Professional Boards, each of which serves the various health professions. As of 1 January 2007, the members of all Professional Boards have been required to participate in CPD. The overall structure of CPD in South Africa is the same for all health professionals and was developed by the HPCSA CPD Committee. It is the responsibility of the practitioner to take part in CPD.

Although the HPCSA has now made participation in CPD mandatory, the legislation (the Health Professions Act 1974) merely endorses CPD as a 'means for maintaining and updating professional competence, to ensure that the public interest will always be promoted and protected.' The Act states that CPD should address the emerging health needs and health priorities of the country.<sup>129</sup> However, the Act allows for the HPCSA to issue rules relating to continuing education and training, the nature of continuing education and training, and the criteria for recognition of continuing education and training courses by the HPCSA.

The Medical and Dental Professional Board is the section of the HPCSA which registers physicians and regulates physician education and training. It also oversees the CPD system for physicians. The Medical Board has delegated responsibility for delivering CPD to (currently) sixteen Accreditors – most are specialist societies and universities – which can, in turn, accredit other organisations that want to deliver CPD activities.

Every doctor must accumulate thirty Continuing Education Units (CEUs) each year. Five of the units must be on ethics, human rights and medical law. Each CEU is valid for two years from the date on which the activity took place (or ended, in the event of post-graduate studies). The HSPCA encourages practitioners to accumulate sixty CEUs after two years, and, by topping up thirty credits per year, maintain a balance of sixty CEUs (including ten ethical CUEs each year).

## CPD System Structure

Accreditors are the groups or institutions that the Medical Board appoints in order to review and approve individual applications for the provision of CPD events. They can be departments of universities involved in medical education, the education committees of the Medical Board or professional medical associations. Commercial

organisations cannot become Accreditors. Accreditors are tasked with monitoring CPD activities. They are also, with permission for the Medical Board, able to grant annual licences to CPD providers so that they can provide CPD activities throughout the year without having to gain accreditation for each specific event. Accreditors must provide the HPCSA CPD Committee with an annual report listing all the activities that were provided during the year, all ethical activities, the relevance of the activities to the field of practice, and any problems experienced.<sup>130</sup> Currently most of the South African medical universities, as well as the Colleges of Medicine of South Africa, the South African Medical Association and the South African Academy of Family Practice are approved Accreditors.

There are two types of providers of CPD in South Africa: service providers and accredited service providers. Accredited service providers are those institutions or associations which are able to present CPD activities throughout the year without gaining specific permission for each activity. Accredited service providers must apply annually for accreditation to do this. Plain service providers must submit an application to the Accreditors each time they wish to present a CPD event. Successful applicants will be allocated a specific activity number, which has to appear on all event documentation.

Providers of CPD must keep a record of all course attendants for three years after the activity, in case these are required for HPCSA audit. Providers must also present a doctor who attends their event with a certificate detailing the event and the accreditation activity number. Doctors have to make sure that they are issued with a certificate of attendance for every activity that they attend. They are required to keep these for at least two years so that certificates can be submitted to the Medical Board if required for audit. Doctors should also maintain an Excel spreadsheet record of their Individual CPD Activity Record (Form CPD 1 IAR).

Pharmaceutical companies, together with 'commercial enterprises or companies that support health care professionals through products or services' are able to present CPD events, providing that their main intention is not to market or promote their products.<sup>131</sup> System providers only have to provide limited information for the CPD activity, but they must specify the 'intended mechanism for monitoring attendance (per hour or per session) for the duration of the activity' as well as the 'intended method of evaluation'.<sup>132</sup>

## Learning Activities Structure

There are three levels of CPD activity that doctors can undertake. A doctor is free to accumulate CUEs from any level they desire.

LEVEL	TYPE	EXAMPLE ACTIVITIES	CEUs
1	No clear outcome, single events	Breakfast meetings; Inter-departmental meetings; Case study discussions; conferences; symposia; interest group meetings.	<b>1 per hour, max. 8 per day</b>
2	Clear outcome, single events	Author of peer reviewed publication	<b>15</b>
		Co-author of reviewed publication	<b>5</b>
		Principal presenter of paper at conference	<b>10</b>
		Co-presenter at conference	<b>5</b>
		Examiner of medical students	<b>2 per student</b>
		Pass 70% MCQs of learning material	<b>3 per activity</b>
3	Clear outcome, formal CPD programme	Postgraduate degree	<b>30</b>
		25 hour minimum short course	<b>30</b>
		Practice Audit	<b>30</b>

Doctors are required to accumulate 60 (CEUs) every two years, of which at least 10 CEUs should be on ethics, human rights or medical law. Each CEU is valid for 24 months from the date that the activity took place (or ended, in the event of post-graduate studies) after which it lapses. The HSPCA recommends that doctors aim to accumulate a balance of 60 CEUs by the end of their second year of practice, and 'thereafter top-up the balance through additional CPD as each consecutive 24-month validity period expires.'<sup>133</sup>

Doctors must record their CPD activities in a CPD Activity Record, 'which will constitute his/her CPD Portfolio, supported by documentary evidence, e.g. certificates of attendance of CPD activities during the previous 24 months'.<sup>134</sup>

## Quality assurance of CPD

The HPCSA CPD System is monitored by the CPD Section of the Council. The CPD Section of the CPD randomly selects individual doctors for compliance checks every two months, although the sample size is not set. An individual only has to submit his or her CPD Portfolio to the HPSCA if they happen to be audited. Doctors must submit the required documents within 21 working days on receipt of notification of being selected.

## Non compliance

On the first instance, doctors who are non-compliant or who do not submit their CPD portfolio are automatically given a further six months to comply with the CPD requirements. They will be included in another audit after six months. If doctors remain non-compliant after the second audit, their names will be submitted to the Medical Board, who will then decide on the relevant action to be taken. CPD Guidelines set out clearly the sanctions that can be taken.

Doctors can be re-registered in a category that will provide for supervision, or a remedial programme of continuing education and training can be implemented. The Medical Board can also make the doctor take an examination. In serious cases, the Board can suspend a doctor for any period they see fit, or are able to use other sanctions at their disposal, including removing the doctor from the register.

If a doctor is removed from the register the doctor has to apply for restoration healthcare professional will only be granted restoration onto the register once they have submitted proof that they have accrued the required number of CEUs.<sup>135</sup>

## Kenya

- As of January 2007, it became a requirement for all practitioners registered with the Medical Practitioners and Dentists Board to complete board-organized or accredited CPD activities.
- The Board issues doctors with a CPD Diary, which must be kept as a record of every learning event attended or completed. When doctors apply for their annual licence to practise, they must submit their CPD Diary, together with attendance certificates for CPD events and copies of CPD qualifications which have been obtained during the previous year.
- In the event of non-compliance, a doctor must write a letter to the Board explaining the reasons for non-compliance. The guidance then simply stipulates that the Board will then look into the matter. It is unknown what sanctions can be given for non-compliance
- Each doctor must gain at least 5 CPD units per year. There are three levels of activities and a doctor cannot obtain all CPD units from only one level:

Level	Type	Units
1	Group Meetings	
	Small group: case study discussions, journal clubs, educative ward rounds, small lectures.	1 – 2
	Large groups: Conferences, short courses, workshops, seminars	1 – 2
2	Research and Education	
	Author/co-author of article, chapter or book, presenter of conference paper or short course.	2 – 4
	Interactive skills workshop, MCQs in journals, examiner of medical students practice audit	2 - 3
3	Structured Learning	
	Postgraduate degrees and diplomas	3 – 4

# ASIA

## Singapore

- CME has been compulsory in Singapore since 2003. Doctors must undertake CME in order to be issued with their annual practising certificate.
- The Singapore Medical Council manages the CME system in Singapore and also issues practising certificates.
- The basic requirement for doctors is the accumulation of a minimum total of 25 CME points per year, of which 20% or 5 points shall be core points which are specific to their specialty. 1 CME point is generally equivalent to 1 hour of CME activity.
- In terms of quality assurance, it would appear that the SMC has, in the past, with withheld doctors' practising certificates in the event of non-compliance and not re-issued certificates until CME requirements have been met.
- The SMC is now planning to implement a more comprehensive CME-CPD program and is moving toward a system of Maintenance of Competency for doctors.

Singapore is one of the few countries in Asia with compulsory CME. It was introduced on 1 January 2003. CME is overseen by the Singapore Medical Council (SMC), which is a statutory board under the Ministry of Health. The SMC also maintains the Register of Medical Practitioners and regulates the professional conduct and ethics of registered medical practitioners.<sup>136</sup>

The SMC introduced its system of CME over a number of years. A CME programme was first launched in 1989, which was entirely voluntary. In 1993 a more formal but still voluntary system of CME was established. Then, in 2003, a formal system of CME was made mandatory. CME is directly linked to recertification. Every doctor in Singapore must have a practising certificate (PC) in order to practise medicine. The PC must be renewed either annually or biannually. The SMC decided to link the renewal of PCs with CME, by making it a requirement that doctors must fulfil their CME obligations before a PC will be issued to them. In effect, if a doctor fails to meet the CME requirements, his or her licence to practise will be removed until the CME requirements are met.

The SMC-CME Coordinating Committee accredits CME programmes and activities and reviews CME policies and programmes. The Committee includes representatives from the Academy of Medicine Singapore, the College of Family Physicians Singapore, Singapore Medical Association, as well as doctors working in the restructured hospitals and private sector.<sup>137</sup> The Academy of Medicine Singapore, the College of Family Physicians, and the Singapore Medical Association are also the primary CME providers. An online system has been in place since 2003 which allows CME providers to apply for accreditation and doctors to submit their CME claims.

A CME provider that wishes to present an event must apply for accreditation from the Committee four weeks before the event is to be held, though details of the accreditation requirements are not obtainable. However, it is known that CME Providers must record doctors' attendance at the beginning of every session and submit these attendance records online within 20 days after the event to the Committee, on behalf of doctors. CME providers are required to keep these hard copies of registers for a minimum period of 2 years for audit purposes.<sup>138</sup>

According to the SMC website, events organised exclusively by pharmaceutical or commercial companies will not be accredited unless the activities are co-organised with CME providers, such as the Academy of Medicine Singapore, College of Family Physicians Singapore or the Singapore Medical Association. Accreditation applications and attendance records can only be submitted electronically by the medical co-organiser (and not the pharmaceutical or commercial companies).<sup>139</sup>

The basic requirement for doctors is the accumulation of a minimum total of 25 CME points per year, of which 20% or 5 points shall be core points which are specific to their specialty. In 2011, the SMC made it a requirement for subspecialists practising in palliative medicine, intensive care medicine, sports medicine or neonatology to gain 20% core subspecialty points.<sup>140</sup>

There are a number of activities which doctors can participate in, in order to gain CME points. The system has been designed so that doctors are not able to claim the required number of points each year based only on self-study. This means that physicians have to at least attend accredited CME events in order to meet the CME requirements. The table below includes all the categories:

Category	Description	Maximum Points per year
1A	Pre-Approved Established Programmes	25
1B	Local Events (e.g. scientific meetings, conferences, workshops, etc.)	
1C	Overseas Events (e.g. scientific meetings, conferences, workshops, etc.)	
2	Publication / Editorial Work / Presentation of Original Paper or Poster	20
3A	Self-study (e.g. reading of refereed journals listed in PubMed or MOH Clinical Practice Guidelines)	5
3B	Accredited distance-learning programmes with verifiable self-assessment (e.g. Medscape)	18
All	CME activities related to aesthetic practice	5 points per year This cap does not apply to dermatologists and plastic surgeons

Attendance records for Categories 1A and 1B CME activities are submitted by the CME providers. Doctors are responsible for submitting their own claims for participating in Categories 1C, 2, and 3A activities and (for specialists) Category 3B.

According to one article, by 2008, 'two cycles of CME had been completed and the majority of doctors - more than 95 percent - had fulfilled their requirements.' Significantly, the article states that 'those who had not achieved their points had their practicing certificates withheld until they completed their CME requirements.'<sup>141</sup>

This suggests that the SMC has indeed sanctioned physicians for failing to participate in CME.

It is worth noting that a member of the SMC has stated that 'the SMC is now planning to implement a more comprehensive CME-CPD program [and] move toward Maintenance of Competency for doctors. A committee has been set up to look into issues of revalidation and recertification. We are working on a process for revalidation based on acquisition of core skills and competencies as well as the introduction of components that will contribute to practice improvements.'<sup>142</sup>

## Japan

- In 2008, there were over 270,000 physicians in Japan. The Ministry of Health, Labour and Welfare registers all physicians and regulates the profession. However, it does not provide any system of CPD. Until 2004 even postgraduate training was voluntary in Japan. However, since 1987, the Japan Medical Association (JMA) has been independently providing voluntary CME programmes for physicians, which is now overseen by the JMA's Council for Academic Affairs. The JMA, established in 1916, is a private organisation with a membership of 165,000 (meaning around 60% of doctors in Japan are registered with the JMA). The JMA administers over 40 prefectural (regional) medical associations. There are approximately 900 independent, municipal medical associations which are affiliated with the JMA.
- Physicians who accumulate ten credit units or more per year can apply for a JMA CME Certificate. If a physician accumulates ten credits or more per year in three successive years, they will receive a Certificate of Recognition for Completion of CME.
- In terms of self or group learning, the JMA has developed various curricula for physicians to follow. These include 106 basic healthcare courses which are broad, non-specialty specific courses, covering, for example, medical ethics or social security. There is also a curriculum for medical topics, which has two sections, one on important medical practice procedures, and the other on important diseases. Physicians can study these curricula together at workshops planned by the regional medical associations or can study them privately. Unsurprisingly, the JMA Journal is also considered one of the main learning media. Each group or self-learning event amounts to 1 credit unit.
- If a physician attends a CME lecture, he or she will receive a certificate, and can then claim three or five credit units. Taking part in hospital clinics or peer review leads to 5 credit units. Publishing a paper in an academic journal can provide up to 10 credit units.
- Despite CME being voluntary, the prefectural medical associations do appear to offer many opportunities for CME. According to one article on CME in the Kumamoto prefecture of Japan (which has a population of 1.7 million), the Kumamoto Medical Association (KuMA) held over 800 medical lectures throughout 2009. Of these, 212 were sponsored by the KuMA and 420 were

jointly sponsored by the KuMA and municipal medical associations. The number of study sessions held independently by various specialist societies including ophthalmologists, obstetricians/gynecologists, pediatricians, and orthopedic surgeons was 105.<sup>143</sup>

- The 'acquisition of credit units is based on self-declaration principle' and it would appear that there is little quality assurance of the CME programmes in Japan. Physicians receive a report form each year, which comes as a supplement to the JMA Journal. Physicians then fill in the form and can attach certificates of any courses or seminars attended. These forms are then sent to their local medical association who proceed to send the forms to the JMA. The forms are then added to a database and certificates are sent to physicians.

## Malaysia

- The Malaysian Medical Council is in the process of rolling out a compulsory system of CPD linked to recertification for all doctors. According to the MMC:

*Despite the CME system having been in operation for more than 10 years, as administered by the MMA, the participation by registered medical practitioners has been poor. It therefore becomes necessary, to achieve the objectives of the Ministry of Health Malaysia and the Malaysian Medical Council, to make CPD compulsory. Within the next few years, and after successful completion of the pilot projects, the acquisition of minimum credit points in the CPD Grading System will be made compulsory for the issuance of the Annual Practising Certificate.<sup>144</sup>*

- An online system for doctors to record CPD points is being developed.

## Pakistan

- CPD is not mandatory in Pakistan. In fact, there is no 'structured or systematic CPD programme for medical doctors...in Pakistan...CPD activities are generally unscheduled, infrequent, unstructured and inadequate for the large number of professionals...Once qualified and registered, a doctor is licensed to practice for life.'<sup>145</sup>
- There are over fifty professional organizations which provide CPD, but their activities are not regulated and are not coordinated. There are over 100,000 doctors in Pakistan registered with the Pakistan Medical and Dental Council, serving a population of almost 170 million people.<sup>146</sup>
- In August 2009 the Pakistan Medical and Dental Council (PMDC) held a National Consultation on CPD to attempt to rectify the difficulties CPD in Pakistan was facing. The Consultation drew together individuals from all the professional medical associations in Pakistan (which was a task in itself, as a complete list of the medical associations in Pakistan had to first be drawn up). The WHO also collaborated with the Ministry of Health in order to arrange the National Consultation. The Consultation reached a number of recommendations:
  - A well organized CPD programme is needed in Pakistan
  - The key stake holders in CPD are to be the Ministries and Departments and Health, the Pakistan Medical Association, the PMDC, and other specialty societies and institutions.
  - The government should, initially, provide funding to establish the infrastructure of the CPD programme.
  - Universities should establish Medical Education Departments and a CPD Department should be established at either the Ministry of Health or the PMDC, or both, in order to regulate CPD activities.
  - Documents for CME should be developed jointly by all key stake holders.
  - CPD must be accessible by district level doctors.
  - CPD should be piloted in one district before it is rolled out nationally.
  - CPD at district level should be linked with the medical requirements of the area.

- It remains to be seen if CPD will be implemented in Pakistan.

CPD is also voluntary in **Bangladesh**.

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<sup>1</sup> Gary Culliton, 'Medical Practitioners Act Update', *Irish Medical Times*, 14 May 2009, <http://www.imt.ie/opinion/guests/2009/05/medical-practitioners-act-update.html> [accessed 17 June 2011]

<sup>2</sup> Medical Practitioners Act 2007, Pt. 11, S.91.

<sup>3</sup> Professional Competence Guidelines, p.6.

<sup>4</sup> If a doctor practises across more than one specialty, the doctor is able to choose which training body's scheme he or she enrolls in. The MCI suggests that doctors whose work crosses specialties may want to exceed the minimum requirement of 50 CPD hours and one clinical audit. However, there are no formal guidelines on this.

<sup>5</sup> Professional Competence Guidelines, p.12.

<sup>6</sup> Professional Competence Guidelines, p.15.

<sup>7</sup> These are the College of Anaesthetists Ireland, College of Psychiatry Ireland, Faculty of Occupational Medicine (RCPI), Faculty of Paediatrics (RCPI), Faculty of Pathology (RCPI), Faculty of Public Health (RCPI), Faculty of Radiologist (RCPI), Faculty of Sports and Exercise Medicine (joint collaboration between RCPI and RCSI), Institute of Obstetricians and Gynaecologists (RCPI), Irish College of General Practitioners, Irish College of Ophthalmologists, Irish Committee on Higher Medical Training (RCPI), Royal College of Surgeons (RCSI).

<sup>8</sup> <http://www.medicalcouncil.ie/Professional-Development/Professional-Competence/Info-on-Schemes/Arrangement-doc.pdf> [accessed 17 June 2011]

<sup>9</sup> [http://www.irishpsychiatry.ie/Libraries/PCS\\_Documents/PCS\\_Handbook.sflb.ashx](http://www.irishpsychiatry.ie/Libraries/PCS_Documents/PCS_Handbook.sflb.ashx), p.9. [accessed 17 June 2011]

<sup>10</sup> [http://www.irishpsychiatry.ie/Libraries/PCS\\_Documents/Peer\\_Review\\_Group\\_Guidelines\\_V7\\_-\\_May\\_11.sflb.ashx](http://www.irishpsychiatry.ie/Libraries/PCS_Documents/Peer_Review_Group_Guidelines_V7_-_May_11.sflb.ashx) [accessed 18 June 2011]

<sup>11</sup> <http://www.rcpi.ie/PC/Documents/ICHMT%20Professional%20Competence%20Scheme%20-%20General%20Division.pdf>, p.17. [accessed 20 June 2011]

<sup>12</sup> See, for example,

[http://www.rcpi.ie/PC/Documents/FOM%20Professional%20Competence%20Scheme\\_%20Specialist%20Division.pdf](http://www.rcpi.ie/PC/Documents/FOM%20Professional%20Competence%20Scheme_%20Specialist%20Division.pdf), p.19. [accessed 20 June 2011]

<sup>13</sup> [http://www.irishpsychiatry.ie/Libraries/PCS\\_Documents/Guidelines\\_for\\_CPD\\_Accreditation\\_of\\_Events.sflb.ashx](http://www.irishpsychiatry.ie/Libraries/PCS_Documents/Guidelines_for_CPD_Accreditation_of_Events.sflb.ashx) [accessed 17 June 2011]

<sup>14</sup> [http://www.irishpsychiatry.ie/Libraries/PCS\\_Documents/PCS\\_Handbook.sflb.ashx](http://www.irishpsychiatry.ie/Libraries/PCS_Documents/PCS_Handbook.sflb.ashx), p.8.

<sup>15</sup> <http://www.medicalcouncil.ie/FAQ/Professional-Competence/Monitoring-and-Audit.html> [accessed 20 June 2011]

<sup>16</sup> Professional Competence Guidelines, p.6.

<sup>17</sup> Merkur, 2008.

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- <sup>18</sup> Merkur, 2008. The UEMS puts the figure slightly higher, at 4.5%: see <http://admin.uems.net/uploadedfiles/117.pdf> [accessed 24 June 2011]
- <sup>19</sup> <http://admin.uems.net/uploadedfiles/117.pdf> [accessed 24 June 2011]
- <sup>20</sup> <http://www.inami.fgov.be/care/fr/doctors/accreditation/legislation/ar-20010713.htm> [accessed 25 June 2011]
- <sup>21</sup> Livio Garattini, 'Continuing Medical Education in six European countries: A comparative analysis', *Health Policy*, 94 (2010) 246 – 254 (p.248).
- <sup>22</sup> <http://www.inami.fgov.be/care/fr/doctors/accreditation/formation/agreement-pharmaceutical-industry.htm> [accessed 25 June 2011]
- <sup>23</sup> For a full list, see <http://www.inami.fgov.be/care/fr/doctors/accreditation/formation/attribution.htm> [accessed 25 June 2011]
- <sup>24</sup> Continuing Medical Education (CME) in Europe A survey of the situation in the 27 EU Member States, p.3.
- <sup>25</sup> <http://www.inami.fgov.be/care/fr/doctors/accreditation/formation/attribution.htm> [accessed 25 June 2011]
- <sup>26</sup> Livio Garattini, 'Continuing Medical Education in six European countries: A comparative analysis', *Health Policy*, 94 (2010) 246 – 254 (p.248).
- <sup>27</sup> <http://admin.uems.net/uploadedfiles/117.pdf> [accessed 17 June 2011]
- <sup>28</sup> <http://www.inami.fgov.be/care/fr/doctors/accreditation/peer-review/multidisciplinaire/> [accessed 18 June 2011]
- <sup>29</sup> <http://www.inami.fgov.be/care/fr/doctors/accreditation/peer-review/multidisciplinaire/> [accessed 18 June 2011]
- <sup>30</sup> <http://www.inami.fgov.be/care/fr/doctors/accreditation/peer-review/reglement.htm> [accessed 18 June 2011]
- <sup>31</sup> <http://www.inami.fgov.be/care/fr/doctors/accreditation/news/news02.htm> [accessed 18 June 2011]
- <sup>32</sup> <http://www.inami.fgov.be/care/fr/doctors/accreditation/news/pdf/accrediting.pdf> [accessed 18 June 2011]
- <sup>33</sup> <http://www.inami.fgov.be/care/fr/doctors/accreditation/news/pdf/accrediting.pdf>, slide 7. [accessed 18 June 2011]
- <sup>34</sup> <http://www.inami.fgov.be/care/fr/doctors/accreditation/individual-accreditation/pdf/individualpresenceaccreditation.pdf> [accessed 18 June 2011]
- <sup>35</sup> [http://www.rand.org/content/dam/rand/pubs/technical\\_reports/2011/RAND\\_TR946.pdf](http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR946.pdf), p.1. [accessed 22 June 2011]
- <sup>36</sup> Figures correct as of 2008.
- <sup>37</sup> [http://www.g-ba.de/downloads/17-98-2804/2010-01-01-Faltblatt-GBA\\_engl.pdf](http://www.g-ba.de/downloads/17-98-2804/2010-01-01-Faltblatt-GBA_engl.pdf) [accessed 14 June 2011]

- <sup>38</sup> [http://www.g-ba.de/downloads/17-98-2804/2010-01-01-Faltblatt-GBA\\_engl.pdf](http://www.g-ba.de/downloads/17-98-2804/2010-01-01-Faltblatt-GBA_engl.pdf) [accessed 14 June 2011]
- <sup>39</sup> [http://www.rand.org/content/dam/rand/pubs/technical\\_reports/2011/RAND\\_TR946.pdf](http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR946.pdf), p.1. [accessed 22 June 2011]
- <sup>40</sup> Merkur, 2008.
- <sup>41</sup> <http://www.bundesaerztekammer.de/downloads/ADFBSatzungEn.pdf> [accessed 22 June 2011]
- <sup>42</sup> Schlette
- <sup>43</sup> Merkur writes that Baden Wurttemberg AK was the only regional chamber that had not introduced an electronic registration system for CME.
- <sup>44</sup> EC Survey
- <sup>45</sup> <http://www.acoe.be/binarydata.aspx?type=doc/SurveyresultsSeptember09.pdf>, p.13. [accessed 28 June 2011]
- <sup>46</sup> Sophia Schlette and David Klemperer, 'Revalidation of the Medical Profession in Germany', Euro Observer, 11 (2009) 5 – 7 (p.5).
- <sup>47</sup> Sophia Schlette and David Klemperer, 'Revalidation of the Medical Profession in Germany', Euro Observer, 11 (2009) 5 – 7 (p.7).
- <sup>48</sup> For more information see <http://www.uemo.eu/organisations/27-austria.html> [accessed 18 June 2011]
- <sup>49</sup> [http://ec.europa.eu/enterprise/newsroom/cf/getdocument.cfm?doc\\_id=4884](http://ec.europa.eu/enterprise/newsroom/cf/getdocument.cfm?doc_id=4884) [accessed 18 June 2011]
- <sup>50</sup> W Routil, Medical Education in Austria: Structures, Guidelines and Quality Assurance', p.2.
- <sup>51</sup> LSE Project 'Quality in Health Care systems with an emphasis on policy options for Austria: Chapter 2'.
- <sup>52</sup> <http://admin.uems.net/uploadedfiles/117.pdf> [accessed 17 June 2011]
- <sup>53</sup> [http://www.arztakademie.at/fileadmin/template/main/dfpPdfs/20101001\\_DFP\\_Verordnung\\_englisch\\_eFassung.pdf](http://www.arztakademie.at/fileadmin/template/main/dfpPdfs/20101001_DFP_Verordnung_englisch_eFassung.pdf) [accessed 14 June 2011]
- <sup>54</sup> [http://ec.europa.eu/health/archive/ph\\_systems/docs/amc\\_en.pdf](http://ec.europa.eu/health/archive/ph_systems/docs/amc_en.pdf) [accessed 14 June 2011]
- <sup>55</sup> See, for example, [www.nwpgmd.nhs.uk/sites/default/files/A%20Revalidation%20Primer.pdf](http://www.nwpgmd.nhs.uk/sites/default/files/A%20Revalidation%20Primer.pdf); [www2.lse.ac.uk/LSEHealthAndSocialCare/.../pdf/Clin%20Med\\_Merkur.pdf](http://www2.lse.ac.uk/LSEHealthAndSocialCare/.../pdf/Clin%20Med_Merkur.pdf); and [www.napce.net/pdf/March%202010.pdf](http://www.napce.net/pdf/March%202010.pdf) [all accessed 15 June 2011]
- <sup>56</sup> <http://www.ipcaa.org/assets/Netherlands42818.pdf> [accessed 17 June 2011]
- <sup>57</sup> <http://knmg.artsennet.nl/web/file?uuid=6c8ddae9-fbc8-4cf2-8e50-d6d0b1b8debe&owner=a8a9ce0e-f42b-47a5-960e-be08025b7b04&contentid=80150> [accessed 17 June 2011]
- <sup>58</sup> [http://translate.googleusercontent.com/translate\\_c?hl=en&prev=/search%3Fq%3DCHBB-geregistreerd%26hl%3Den%26safe%3Doff%26biw%3D1280%26bih%3D630%26prmd%3Divns&rurl=translate.google.co.uk&sl=nl&u=http://chbb.artsennet.nl/Home.htm&usg=ALkJrhj8GZvBHmW0FisMPk2umchnmfYsQ](http://translate.googleusercontent.com/translate_c?hl=en&prev=/search%3Fq%3DCHBB-geregistreerd%26hl%3Den%26safe%3Doff%26biw%3D1280%26bih%3D630%26prmd%3Divns&rurl=translate.google.co.uk&sl=nl&u=http://chbb.artsennet.nl/Home.htm&usg=ALkJrhj8GZvBHmW0FisMPk2umchnmfYsQ) [accessed 17 June 2011]

- <sup>59</sup> <http://knmg.artsennet.nl/&ei=0MwVTs23AoXDhAf98tRi&sa=X&oi=translate&ct=result&resnum=1&ved=0CCcQ7gEwAA&prev=/search%3Fq%3Dknmg%26hl%3Den%26safe%3Doff%26prmd%3Divns>  
[accessed 17 June 2011]
- <sup>60</sup> <http://knmg.artsennet.nl/&ei=0MwVTs23AoXDhAf98tRi&sa=X&oi=translate&ct=result&resnum=1&ved=0CCcQ7gEwAA&prev=/search%3Fq%3Dknmg%26hl%3Den%26safe%3Doff%26prmd%3Divns>  
[accessed 18 June 2011]
- <sup>61</sup> <http://intqhc.oxfordjournals.org/content/15/2/119.full> [accessed 18 June 2011]
- <sup>62</sup> [http://www.ipcaa.org/document\\_archive/CME - A Global Perspective \(as of July 06\).pdf](http://www.ipcaa.org/document_archive/CME_-_A_Global_Perspective_(as_of_July_06).pdf)  
[accessed 18 June 2011]
- <sup>63</sup> <http://www.conseil-national.medecin.fr/article/fin-des-cnfm-c-naissance-attendue-du-dpc-1028>  
[accessed 20 June 2011]
- <sup>64</sup> Karine Chevreul, 'Revalidation of Doctors in France'
- <sup>65</sup> <http://www.rcplondon.ac.uk/sites/default/files/rcp-scoping-visit-to-slovakia-summary-report.pdf>  
[accessed 22 June 2011]
- <sup>66</sup> Kristúfek P, and Gajdosik J. 'Twelve years of continuing medical education in Slovakia', *Vnitr Lek.* 56 (2010) 686-689 (p.687).
- <sup>67</sup> <http://www.ipcaa.org/assets/Greece77669.pdf> [accessed 23 June 2011]
- <sup>68</sup> [http://www.helleniccardiol.com/archive/full\\_text/2010/2/2010\\_2\\_189.pdf](http://www.helleniccardiol.com/archive/full_text/2010/2/2010_2_189.pdf), p.189. [accessed 15 June 2011]
- <sup>69</sup> <http://admin.uems.net/uploadedfiles/912.ppt> [accessed 15 June 2011]
- <sup>70</sup> <http://www.hlk.hr/190> [accessed 14 June 2011]
- <sup>71</sup> <http://www.legeforeningen.no/id/81039> [accessed 16 June 2011]
- <sup>72</sup> According to the NMA website, it would appear that recertification and CME are interchangeable: 'etterutdanning (resertifisering).' – see <http://www.legeforeningen.no/leif/about.action#evaluating>
- <sup>73</sup> <http://www.legeforeningen.no/id/508.0> [accessed 17 June 2011]
- <sup>74</sup> Development and Structure of National CPD.
- <sup>75</sup> <http://www.legeforeningen.no/leif/about.action#evaluating> [accessed 18 June 2011]
- <sup>76</sup> <http://www.legeforeningen.no/id/507.0> [accessed 18 June 2011]
- <sup>77</sup> Doctors' learning habits: CME activities among Norwegian physicians over the last decade
- <sup>78</sup> For more information see <http://www.motesz.hu/>.
- <sup>79</sup> Continuing Medical Education (CME) in Europe, p.18.
- <sup>80</sup> <http://www.aemh.org/pdf/lpuls.pdf> [accessed 20 June 2011]
- <sup>81</sup> The HPCAA is a legislative framework that applies to many health professionals in New Zealand. It allows for consistent procedures and terminology across the professions which are regulated by the Act.
- <sup>82</sup> Part 3,s 41.

- <sup>83</sup> <http://www.rnzcgp.org.nz/assets/documents/Training-and-Beyond/MCNZ-CPD-Recertification.pdf>  
[accessed 22 June 2011]
- <sup>84</sup> <http://www.rnzcgp.org.nz/assets/documents/Training-and-Beyond/MCNZ-CPD-Recertification.pdf>  
[accessed 22 June 2011]
- <sup>85</sup> <http://www.rnzcgp.org.nz/assets/documents/Training-and-Beyond/MCNZ-CPD-Recertification.pdf>  
[accessed 22 June 2011]
- <sup>86</sup> <http://www.anzca.edu.au/fellows/cpd/cpd-program-book.html> [accessed 14 June 2011]
- <sup>87</sup> <http://www.anzca.edu.au/fellows/cpd/Toolkit%20%20-%20Preparing%20for%20CPD%20Audit.pdf> [accessed 14 June 2011]
- <sup>88</sup> <http://www.anzca.edu.au/fellows/cpd/Toolkit%20%20-%20Preparing%20for%20CPD%20Audit.pdf> [accessed 14 June 2011]
- <sup>89</sup> <http://www.anzca.edu.au/fellows/cpd/cpd-program-book.html> [accessed 14 June 2011]
- <sup>90</sup> [http://www.surgeons.org/media/66897/1st2011\\_cme\\_activities\\_2011.pdf](http://www.surgeons.org/media/66897/1st2011_cme_activities_2011.pdf) [accessed 16 June 2011]
- <sup>91</sup> [http://www.surgeons.org/media/6982/CPD\\_Info\\_Manual\\_2010-2012.pdf](http://www.surgeons.org/media/6982/CPD_Info_Manual_2010-2012.pdf) [accessed 16 June 2011]
- <sup>92</sup> Barry Taylor, 'Global challenges for CME/CPD in Australasia', *Journal of Continuing Education in the Health Professions*, 28 (2008) 27 – 28 (p.28)
- <sup>93</sup> Forrester, Forrester and Griffiths, *Essentials of Law for Medical Practitioners*, p.252
- <sup>94</sup> Forrester, Forrester and Griffiths, *Essentials of Law for Medical Practitioners*, p.252
- <sup>95</sup> <http://www.medicalboard.gov.au/documents/default.aspx?record=WD10%2f101&dbid=AP&chksum=Nx18OyXfwajDAfAm%2fQQNNO%3d%3d>
- <sup>96</sup> <http://www.medicalboard.gov.au/documents/default.aspx?record=WD10%2f101&dbid=AP&chksum=Nx18OyXfwajDAfAm%2fQQNNO%3d%3d> [accessed 15 June 2011]
- <sup>97</sup> <http://www.medicalboard.gov.au/documents/default.aspx?record=WD10%2f2851%5bv3%5d&dbid=AP&chksum=J8tKkt1xq7NTC8aFufcRJO%3d%3d> [accessed 15 June 2011]
- <sup>98</sup> Only boards in Colorado, Indiana, Montana, New York, South Dakota and Vermont do not stipulate CME. See <http://www.ama-assn.org/resources/doc/med-ed-products/table16.pdf>. [accessed 18 June 2011]
- <sup>99</sup> The ACCME was founded in 1981 and seven member organisations are involved in its running: the American Medical Association, American Board of Medical Specialties, American Hospital Association, Association for Hospital Medical Education, Association of American Medical Colleges, Council of Medical Specialty Societies and Federation of State Medical Boards
- <sup>100</sup> PRA certificates can still be gained by doctors, which they can disp
- <sup>101</sup> [http://www.azsos.gov/public\\_services/title\\_04/4-16.htm](http://www.azsos.gov/public_services/title_04/4-16.htm) [accessed 20 June 2011]
- <sup>102</sup> <http://www.gencourt.state.nh.us/rsa/html/XXX/329/329-16-g.htm> [accessed 27 June 2011]
- <sup>103</sup> <http://www.tmb.state.tx.us/news/Spring97/spring97.doc>
- <sup>104</sup> Cassel, C & Holmboe, E., 'Professionalism and Accountability: The Role of Specialty Board Certification', *Trans Am Clin Climatol Assoc.* 2008; 119: 295–304 (p.297).

- <sup>105</sup> Lipner RS, Bylsma WH, Arnold GK, Fortna GS, Tooker J, Cassel CK. Who is maintaining certification in internal medicine — and why? A national survey 10 years after initial certification. *Ann Intern Med* 2006;144: 29-36.
- <sup>106</sup> [http://www.abms.org/About\\_ABMS/who\\_we\\_are.aspx](http://www.abms.org/About_ABMS/who_we_are.aspx) [accessed 16 May 2011]
- <sup>107</sup> [http://www.abms.org/About\\_ABMS/who\\_we\\_are.aspx](http://www.abms.org/About_ABMS/who_we_are.aspx) [accessed 16 May 2011]
- <sup>108</sup> [http://www.abms.org/Maintenance\\_of\\_Certification/MOC\\_competencies.aspx](http://www.abms.org/Maintenance_of_Certification/MOC_competencies.aspx) [accessed 19 May 2011]
- <sup>109</sup> [http://www.abms.org/Maintenance\\_of\\_Certification/MOC\\_competencies.aspx](http://www.abms.org/Maintenance_of_Certification/MOC_competencies.aspx) [accessed 19 May 2011]
- <sup>110</sup> <http://www.mmm-online.com/is-abms-proposal-a-threat-to-the-cme-system/article/196554/> [accessed 19 May 2011]
- <sup>111</sup> <http://www.fsmb.org/pdf/mol-board-report-1003.pdf>, p.15. [accessed 19 May 2011]
- <sup>112</sup> <http://www.fsmb.org/mol.html> [accessed 17 May 2011]
- <sup>113</sup> <http://www.fsmb.org/pdf/mol-bg.pdf>, p.5. [accessed 17 May 2011]
- <sup>114</sup> <http://www.fsmb.org/mol.html> [accessed 17 May 2011]
- <sup>115</sup> <http://www.fsmb.org/mol.html> [accessed 17 May 2011]
- <sup>116</sup> <http://programsmedicine.com/new-ama-policies-target-certification-and-licensure/> [accessed 17 May 2011]
- <sup>117</sup> Picture source: <http://www.policymed.com/2010/07/accme-releases-2009-annual-report-data-the-cme-economy-sees-7-reduction-in-total-income.html> [accessed 17 May 2011]
- <sup>118</sup> [http://www.hopkinscme.edu/uploads/staticfiles/ACRE\\_Resp\\_CEJA\\_2011Final.pdf](http://www.hopkinscme.edu/uploads/staticfiles/ACRE_Resp_CEJA_2011Final.pdf) [accessed 17 May 2011]
- <sup>119</sup> <http://www.ama-assn.org/assets/meeting/2011a/ceja-r1.pdf> [accessed 17 May 2011]
- <sup>120</sup> <http://policymed.typepad.com/files/ceja-recommendation-6-20-11.pdf>, p.1. [accessed 19 May 2011]
- <sup>121</sup> [http://www.mcc.ca/en/faq/about\\_mcc.shtml](http://www.mcc.ca/en/faq/about_mcc.shtml) [accessed 21 May 2011]
- <sup>122</sup> The College of Physicians and Surgeons of Nova Scotia is one of the regulatory bodies which has yet to implement CPD requirements.
- <sup>123</sup> <http://www.cfpc.ca/Nonmembers/> [accessed 21 May 2011]
- <sup>124</sup> <http://www.cpsnl.ca/default.asp?com=Pages&id=79&m=261>
- <sup>125</sup> <http://www.cmq.org/en/MedecinsMembres/Dpc.aspx>
- <sup>126</sup> <http://www.cpa-apc.org/browse/documents/96> [accessed 19 May 2011]
- <sup>127</sup> The Medical Act. The Jamaica Gazette: November 1, 1976.
- <sup>128</sup> [http://caribbean.scielo.org/scielo.php?script=sci\\_arttext&pid=S0043-31442007000300003&lng=en&nrm=](http://caribbean.scielo.org/scielo.php?script=sci_arttext&pid=S0043-31442007000300003&lng=en&nrm=) [accessed 18 June 2011]
- <sup>129</sup> CPD Guidelines, February 2010, p.4.

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- <sup>130</sup> [http://www.hpcsa.co.za/downloads/cpd/accreditors/criteria\\_and\\_guidelines\\_for\\_accreditors\\_2010.pdf](http://www.hpcsa.co.za/downloads/cpd/accreditors/criteria_and_guidelines_for_accreditors_2010.pdf) [accessed 18 June 2011]
- <sup>131</sup> [http://www.hpcsa.co.za/downloads/cpd/service\\_providers/criteria\\_and\\_guidelines\\_for\\_service\\_providers\\_2010.pdf](http://www.hpcsa.co.za/downloads/cpd/service_providers/criteria_and_guidelines_for_service_providers_2010.pdf), p.3 & Guide to CPD, p.14. [accessed 18 June 2011]
- <sup>132</sup> [http://www.hpcsa.co.za/downloads/cpd/service\\_providers/criteria\\_and\\_guidelines\\_for\\_service\\_providers\\_2010.pdf](http://www.hpcsa.co.za/downloads/cpd/service_providers/criteria_and_guidelines_for_service_providers_2010.pdf), p.13. [accessed 18 June 2011]
- <sup>133</sup> <http://www.hpcsa.co.za/downloads/newsletters/cpd.pdf> [accessed 17 June 2011]
- <sup>134</sup> <http://www.hpcsa.co.za/downloads/newsletters/cpd.pdf> [accessed 17 June 2011]
- <sup>135</sup> <http://www.hpcsa.co.za/downloads/newsletters/cpd.pdf> [accessed 17 June 2011]
- <sup>136</sup> [http://www.smc.gov.sg/html/SMC\\_Home.html](http://www.smc.gov.sg/html/SMC_Home.html) [accessed 18 June 2011]
- <sup>137</sup> <http://www.smc.gov.sg/html/1140055893077.html> [accessed 18 June 2011]
- <sup>138</sup> <http://www.smc.gov.sg/html/1153709442850.html> [accessed 18 June 2011]
- <sup>139</sup> <http://www.smc.gov.sg/html/1153709442850.html> [accessed 18 June 2011]
- <sup>140</sup> Certain doctors do not have to gain as many CME points each year, such as those who are overseas for prolonged periods or those who are semi-retired.
- <sup>141</sup> Eng Hin Lee, Global Challenges in CME/CPD: The Singapore Perspective, Foundations of Continuing Education.
- <sup>142</sup> Eng Hin Lee, Global Challenges in CME/CPD: The Singapore Perspective, Foundations of Continuing Education.
- <sup>143</sup> Yuki Tashiro, 'Continuing Medical Education Activities of the Kumamoto Medical Association', *JMAJ*, 53 (2010) 51 – 53 (p.51)
- <sup>144</sup> [http://mmc.gov.my/v1/index.php?option=com\\_content&task=view&id=10&Itemid=96](http://mmc.gov.my/v1/index.php?option=com_content&task=view&id=10&Itemid=96) [accessed 22 June 2011]
- <sup>145</sup> National Consultation, p.8.
- <sup>146</sup> Zarrin Seema Siddiqui, Continuous Professional Development of Medical Doctors in Pakistan, p.3.