WORLD FEDERATION FOR MEDICAL EDUCATION

CONTINUING PROFESSIONAL DEVELOPMENT

WFME GLOBAL STANDARDS FOR QUALITY IMPROVEMENT OF MEDICAL EDUCATION

Principles-based guidance document

The 2024 Revision

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FOREWORD

The World Federation for Medical Education (WFME) Standards for Continuing Professional Development (CPD) relate to the whole system. They are not just for education providers, but are for anyone who is involved in design, management, implementation, and involvement in CPD.

Definition of CPD

Continuing professional development is also known as 'continuing medical education', 'continuous professional development', and 'lifelong learning'. Although there are debates about the meaning of these terms, we regard them as essentially referring to the same activity. We therefore use 'continuing professional development'. We will also refer to this as 'CPD'.

Although the WFME standards are written for medical doctors, we believe that they are relevant to all professionals within the medical field.

For WFME, CPD is an ethical component of the professionalism of the doctor[1], defined as:

> The ongoing building of knowledge and skills that occurs during independent practice, after completion of specialist postgraduate medical education, or immediately after graduation from medical school if postgraduate medical education is optional.[2]

This definition includes clinicians, public health doctors, and laboratory-based doctors such as pathologists.

Planned (formal) and unplanned (informal) CPD

CPD represents a stage of self-directed learning, where doctors decide for themselves what and how they will learn. Some learning will be structured and planned in advance (*planned learning*), while some may occur *ad hoc,* as needed during practice. This *ad hoc* learning will be referred to as *unplanned* because it is not scheduled in advance and does not involve formal provision. Others might refer to this type of learning as *informal*. Factors such as changing circumstances in healthcare services, employment conditions, professional requirements and registration, advancements in knowledge, the evolving health landscape, serving as an educator of others, and the experience of daily patient care may drive a doctor's decision to learn more or learn again, whether *planned* or *unplanned*.

[1] This document is aimed at the CPD of *medical* doctors. Wherever we refer to doctors, this means medical doctors only.
[2] In some countries, graduates are allowed to enter independent practice straight from medical school. In this case, they will go directly into the phase of CPD.

CPD can therefore be categorised into two types:

> *Planned CPD:* Formal learning that is planned in advance and involves processes such as courses and events, or the provision of learning materials and resources that are designed specifically for CPD.
>
> *Unplanned CPD*: Informal learning that occurs in response to opportunities arising during everyday professional processes (such as findings from audits), events (such as reading available journals) and patient care (such as an unusual presentation or new medication, or bedside teaching and learning through discussion of a case at the point of care).

We cannot recommend any particular ratio of planned to unplanned learning, since there is no research to support that, and the opportunities for each will vary from context to context. But we do recognise that these are equally valuable, and both contribute to the lifelong learning that occurs. The WFME standards encompass both.

Setting standards for CPD around the world

The WFME standards have been written to be useable by anyone at any stage of development of CPD practice. They are intended to support the analysis and development of CPD systems. We therefore do not recommend any particular models, approaches or practices. We simply set out a framework of issues about different CPD systems that might be addressed.

Approaches to CPD vary considerably around the globe. Some countries have systems which are well-developed, while others have no system at all. In some countries, CPD is mandatory while in others it is voluntary. Some CPD systems only recognise observable participation in *planned* educational and training events or provided educational processes, such as online learning, formal courses and meetings. Others also recognise entirely individual, *unplanned* or opportunistic and self-directed learning, such as learning from colleagues, being an examiner or reviewer, reading journals and articles, and learning from practice. Some systems recognise both types of learning.

Some countries have ways of recording engagement in CPD and offering a particular type of credit[3] for that; some do not. In some countries, CPD is controlled by the professions, in others it is controlled by regulators, or by government. In some countries, participation in CPD is considered evidence of professionalism, and is expected by a licensing authority or other regulator, while in others it is simply regarded as a personal professional responsibility. We intend these standards to be useful in all these circumstances.

[3] The system of gathering credits for CPD is commonly used. This involves a responsible professional or regulatory body in specifying the types of learning activity that they will recognise, and then offering credits for that, usually on the basis of time spent on those activities. The doctor is required to accrue a specified number of CPD credits over a stated period of time. Different bodies recognise different forms of learning and might allow different amounts of each and give different credit weightings to each. These system design decisions are made on the basis of judgement about what is appropriate to the context. There is no evidence to date that any one system has a better effect than any other. These standards do not recommend any particular way of recognising CPD undertaken.

Given these differences, we intend the WFME standards to support both the review of existing systems, and the development of new systems. We do not suggest a single model for CPD but offer standards that will guide the purpose and process of CPD in ways appropriate to different contexts and stages of development. Similarly, we cannot specify any particular activities, or ways of keeping up to date. For both planned and unplanned learning, there are many different effective ways of learning.

To cope with all these variations, the WFME standards are based on a generic model of CPD that addresses the following four stages:

- **Identify** what will be learned.
- **Decide** how it will be learned.
- **Learn**.
- **Record** and **reinforce** the learning and apply it to practice.

These stages reflect a generic approach to *planned* (formal) and *unplanned* (informal) learning that has been widely applied to CPD[4]. The standards address all key aspects of these stages.

Alignment with other documents

At every level of medical education, there are local, national, and international documents that set out standards for content and process. These might be for accreditation, regulation, or practical guidance. We have not aligned the WFME standards with any specific view. Instead, we have written principles-based standards that will enable users to develop their own approach for their own purposes, given their stage of development and local approach to CPD.

Using the 2024 edition

The first edition of the standards for CPD was published in 2003, with a revision in 2015, followed by this current 2024 edition which presents a principles-based approach.

The WFME standards are not written as a framework for accreditation. They are written to help in the work of designing, implementing, developing, and evaluating CPD processes. That work may be conducted by a wide variety of interested people and organisations. It is for accreditation bodies each to set out their own requirements to reflect the systems that operate in their jurisdiction.

WFME emphasises that the standards are a guide to the development and evaluation of medical education at all stages and in all settings. They are not mandatory, as regulatory standards would be, or prescriptive, and not a rulebook. They are intended to be used as a framework to be modified and customised for the local context in the most beneficial way.

[4] To support this model, we will quote from Grant, J. (2011) *The Good CPD Guide: A Practical Guide to Managed Continuing Professional Development in Medicine*. Second ed. Oxford, Radcliffe Publishing. This provides the only listing of methods adopted at each stage of this generic model.

The standards set out a framework encompassing every aspect of CPD that might be considered.

Each section comprises:

- principles-based **standards**,
- **guidance** on how to think about each standard in relation to the specific context of the user,
- **key questions** that might be used when designing, implementing or evaluating the CPD system locally.

Because CPD is so highly varied in its organisation, the WFME standards may be used by individuals, professional bodies, education and training providers, planners, regulators, governments, researchers, non-governmental agencies, and others. When referring to those individuals or organisations, we have chosen to use the term '*doctor*' or '*organisation*', or '*responsible body*', as appropriate.

CPD beyond medicine

Although these WFME standards are written for doctors, they are generally applicable to all healthcare professions. However, applying them in practice may differ between contexts and professions. If asked, WFME is happy to discuss operationalising the standards.

BACKGROUND

Reasons for the revised standards: A contextual approach

CPD is much more variable and driven by contextual conditions than either basic or postgraduate medical education. WFME has reviewed its standards to ensure that they can be applied in all contexts and circumstances[5].

Other differences are in organisation and responsibility, in educational approaches, and assessment systems. Although some systems have inbuilt assessment, most commonly, there is no formal assessment of doctors in practice or in relation to CPD, although there may be systems for reviewing practice (for example, through audit or peer review).

We also recognised that while medicine strives to base itself on evidence-based science and practice, medical education, as a social science, tends to follow socially constructed values and ideas[6], rather than being a primarily evidence-based discipline. Appropriate educational practice, therefore, varies between social and geographical contexts, and is influenced by culture, epidemiology, the healthcare system, and material and human resources. What is right for one part of the globe, might not be right for another.

WFME therefore decided to modify its standards, away from prescriptive, process-based requirements towards a principles-based approach[7] which encourages anyone or any organisation using them to make their own version that is adapted to their context.

In setting these standards, WFME believes that the process of CPD must enable the physician to practise their profession with conscience and dignity to promote the health and well-being of their patients. We have also recognised that sponsors must not improperly influence the content or delivery of CPD, and that financial interests or conflicts should be clearly and transparently laid out. In doing so, we have drawn on the principles laid out in the World Medical Association Declaration of Geneva, the World Medical Association International Code of Medical Ethics, and the WMA Statement concerning the Relationship between Physicians and Commercial Enterprises[8,9,10].

The new standards invite institutions or organisations to modify and develop the standards for their own culture, context, systems, resources, aspirations, and values, while still addressing the specified components of the system. We encourage a variety of locally relevant standards to be derived which ensure appropriate and effective CPD within the broad framework that is set out in this publication.

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[5] Karle, H., Christensen, L., Gordon, D. and Nystrup, J. (2008) Neo-colonialism versus sound globalisation policy in medical education. *Medical Education*, 42, 956–958.
[6] Grant, J. and Grant, L. (2023) Quality and constructed knowledge: Truth, paradigms, and the state of the science. *Medical Education,* 57, 1, 4-6.
[7] Black, J., Hopper, M. and Band, C. (2007) Making a success of principles-based regulation. *Law and Financial Markets Review,* May, 191-206.
[8] To be found at https://www.wma.net/policies-post/wma-declaration-of-geneva/
[9] To be found at https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/
[10] To be found at https://www.wma.net/policies-post/wma-statement-concerning-the-relationship-between-physicians-and-commercial-enterprises/

Organisation of the revised standards

As in other versions of these standards, we have set out a framework of areas to consider when reviewing, developing, or planning any stage of education. The importance of the standards in each area is highlighted, along with guidance and key questions to consider when applying these to any given context. The guidance suggests issues to be considered when adapting each standard for the local context. The key questions can be used to inform evaluation of the quality of provision. The guidance and key questions are always very similar.

The standards are presented in eight areas which address all elements of CPD to facilitate doctors' ongoing learning and achievement:

1. Purposes
2. The process and content of continuing professional development
3. Assessment
4. The individual doctor
5. The recognition of continuing professional development activity
6. Educational resources
7. Quality improvement
8. Governance and administration

What are principles-based standards?

Principles-based standards provide a broad level of generality for CPD without prescribing specific designs or approaches to implementation. The flexibility of these standards allows stakeholders to make contextual decisions. The approach accommodates the diverse needs of the profession, regulatory bodies and CPD designers, providers, and managers. It supports independent practitioners everywhere, whatever their resources, contexts, purposes, and stages of development.

Using principles-based standards

This principles-based approach outlines key areas for consideration and provides guidance, allowing individuals, professional bodies, agencies, institutions, national authorities, and other responsible entities to establish their own standards for effective CPD according to their specific needs and contexts. These standards can be applied to new or established systems in any medical specialty and to new or established regulatory systems.

The revised standards offer flexibility for local decision-making, ensuring that requirements are culturally and contextually appropriate. The standards are intended to be streamlined and straightforward. They require thought and discussion so that they deter a shallow or instrumental compliance response. It is hoped that they might trigger a deep analysis of the CPD process.

These standards can be applied directly or adapted to develop more specific set of local requirements. Each standard offers associated guidance and key questions to facilitate discussions and define the appropriate level of detail, whether for local institutional needs or national regulation.

WFME recognises that some organisations may need additional guidance to develop their own standards. Therefore, WFME welcomes requests for further support and encourages consultation with WFME Regional Associations or local qualified medical educationists. The standards may also be a topic for discussions in regional meetings.

We hope that the revised standards will stimulate productive analysis, thought, conversations, and decisions, whether they are applied as presented here, or are versioned and supplemented with more specific requirements.

THE STANDARDS

AREA 1: PURPOSES

Importance of this area

This area concerns the purposes of CPD activities and systems, and their role in practice. These provide a frame of reference against which all aspects of CPD can be judged. The purpose statement reflects the distinct qualities of CPD and their relationship to the work of the doctor, relevant organisations, and the healthcare system.

1.1 THE PURPOSES OF CONTINUING PROFESSIONAL DEVELOPMENT
There is a public statement that outlines the purposes of CPD tailored to their own context, culture, healthcare system, and practice.
1.1 Guidance:
It may be helpful to: • Identify the body or organisation that has responsibility to make a statement of purpose. • Consider how the purposes stated might enable doctors to provide the best possible care in their context. • Consider the context, culture, healthcare system, ethical responsibilities, and medical practice underpinning the stated purposes of CPD. • Consider the role, users, and uses of the statement of purpose. • Include both general and specific practice-related, planned and unplanned activities in the underlying definition of CPD. • Briefly describe the purposes of CPD in terms of its values and goals, in relation to the doctor, the healthcare service, governmental, societal, professional, individual and community needs and interests, the promotion of health, support of people with disabilities, and prevention and treatment of illness. • Indicate the extent to which the statement has been developed in consultation with a wide range of stakeholders including patients, healthcare service staff, doctors, CPD providers, regulators, and the healthcare service. Consider if other groups might be involved. • Consider the alignment of CPD activities and systems with the values and performance of the healthcare system. • Describe how CPD positively enhances population and patient outcomes. • Describe how the statement is made public. • Describe how the purposes of CPD are periodically reviewed and updated.

1.1 Key questions:	
1. What body or organisation has responsibility to make a statement of purpose? 2. How might the purposes stated enable doctors to provide the best possible care in their context? 3. What cultural, contextual, ethical, and professional values underpin the stated purposes of CPD? How do these shape the vision of professional development? 4. How does CPD align with ethical standards and professional norms? 5. How are the stated purposes linked to current CPD activities and systems? 6. To what extent are the stated purposes current or aspirational, reflecting a vision of how CPD might be conducted? 7. Which interested individuals and groups were involved in defining and agreeing purposes, and why? What others might usefully be involved? 8. In what ways does the statement of purposes address the relationship between CPD, the individual doctor, the healthcare service, and the community?	9. How does the statement of purposes reflect the roles, needs, and interests of doctors, patients, and society? 10. How will the statement of purposes guide the development of specific goals for planning, quality assurance, and management of CPD? 11. How does the statement of purposes encompass the values and performance of the healthcare system? 12. How does the statement of purpose align with the regulatory standards of the relevant accrediting bodies and with relevant professional and governmental requirements, if any? 13. What methods are used to publicise and share the statement with all stakeholders, key interest groups, and users? 14. What is the process for periodic review and amendment of the statement of purposes?

1.2 PERSONAL AND PROFESSIONAL DEVELOPMENT	
The doctor, organisation, or responsible body ensures that the CPD process enhances the professional and personal development of doctors and their ability to act in the best interests of their patients and society.	
1.2 Guidance	
It may be helpful to: • Consider the ways in which the CPD process enhances the personal and professional development of the doctor. • Consider how CPD enables doctors to work in the best interest of patients and society.	
1.2 Key questions:	
1. How does the CPD process enhance the personal and professional development of the doctor? 2. How does CPD enable doctors to work in the best interest of patients and society?	

AREA 2: THE PROCESS AND CONTENT OF CONTINUING PROFESSIONAL DEVELOPMENT

Importance of this area

CPD is usually based on the needs of each individual doctor, deriving from their own practice. Individuals have different CPD needs and therefore identifying the relevant learning opportunities is individualised rather than having a standardised curriculum for an overall programme of CPD within or across the range of specialties[11]. From time to time, governments or the profession may issue guidelines, directives, or information which may be classified as CPD, depending upon local definitions. Given this, the self-directed content and process of CPD for each doctor, and how that is derived, will be the main focus of this section.

We recognise that CPD often occurs within multiprofessional teams and other interprofessional groups. Although the WFME standards refer only to medical doctors, they will be equally useful in relation to multiprofessional and interprofessional learning.

[11] Of course, formal courses of study within CPD, such as a higher degree, will have its own curriculum.

2.1 CONTINUING PROFESSIONAL DEVELOPMENT AND LICENSURE[12]

The responsible body[13] has defined the relationship between the CPD system and continued licensure and professional advancement.

2.1 Guidance:

The relationship between licensure and the CPD system will depend on the policies of the medical registration body. Responsible bodies might therefore wish to consider:

- how current CPD arrangements meet the requirements for continued licensure and professional advancement, if any,
- whether evidence of CPD undertaken is part of relicensure, and how that process is defined,
- whether evidence of CPD undertaken is part of professional advancement, and how that process is defined,
- how the profession and relevant organisations have been consulted about the relationship between CPD and licensure,
- whether the relationship is the same for all specialties,
- what bodies, with what powers, have responsibility for ensuring the relationship between CPD and licensure in practice,
- what bodies are responsible for licensure and what relationship they have with the bodies and individuals responsible for CPD activities and processes.

2.1 Key questions:

1. How does the CPD system map on to ongoing licensure to practise?
2. What bodies are responsible for licensure and what relationship do they have with the bodies and individuals responsible for CPD activities and processes?
3. If evidence of CPD activity is required for continued licensure, how is that evidence collected and submitted?
4. If evidence of CPD activity is required for professional advancement, how is that evidence collected and submitted?
5. What bodies, with what powers, have responsibility for ensuring the relationship between CPD and licensure in practice?
6. How are the profession and relevant bodies consulted about the relationship between CPD and licensure?
7. Are the CPD requirements for continued licensure the same for all specialties? If not, how are the requirements different and how is each set applied?

[12] 'Licensure' here refers to the listed qualification for practice as a qualified specialist. In some countries, this might be called 'registration' or 'certification'.
[13] The responsible body may be the regulator, a professional body, or government, depending upon how licensure is organised.

2.2 THE PROCESS OF CONTINUING PROFESSIONAL DEVELOPMENT

Actions identified are associated with the generic stages of CPD design and implementation, as follows:

- **identify what will be learned (See also Standard 2.3),**
- **decide how it will be learned (See also Standard 2.4),**
- **learn,**
- **record and reinforce the learning and apply it to practice[14].**

2.2 Guidance:

- The four stages set out address the activities of both *planned* and *unplanned* CPD. How each of these stages is undertaken will vary, depending on context.
- *Defining what will be learned* for CPD can be a planned process involving a formal needs assessment, or an unplanned personal reflection on practice, knowledge, or skills, that occurs as part of professional life[15].
- *Defining how it will be learned* might involve a planned course of study, or a learning event, or it might result in ad hoc, unplanned learning, such as consultation with a colleague, or reference to the literature or guidelines.
- *How learning actually occurs* can be influenced by factors such as access to resources, funding, and the availability of time or permission to engage in learning activities.
- It is not always possible to predict when new learning will be applied in practice. Practical constraints such as time and resources may delay application. If new skills are learned, or new knowledge is acquired, opportunities to apply them may not arise immediately in practice. However, knowledge and skills benefit from rehearsal. If immediate application is not possible, then they can be reinforced by sharing with the team or with colleagues, writing guidelines or patient information leaflets, or teaching new knowledge and skills to medical students or postgraduate doctors. In these ways, learning can be used to *reinforce or apply it to practice.*
- The record of learning might be for personal or regulatory purposes.

2.2 Key questions:

1. What planned and unplanned ways of identifying what will be learned are an acknowledged part of the CPD process?	4. What ways are defined to encourage the doctor to use and reinforce their learning by sharing or applying it in practice?

[14] The assessment of learning in CPD is not part of the system in most countries, so this is addressed separately in Area 3.
[15] *The Good CPD Guide* identified 47 such planned and unplanned ways in which doctors identify what they need or want to learn.

2. What range of planned and unplanned ways of learning should be available to the doctor? 3. What might enable or inhibit the doctor's learning in terms of access to provision, resources, funding, and time?	5. What barriers exist to applying new learning in practice? How can they be overcome? 6. What record of learning is made for personal or regulatory purposes?

2.3 DECIDING WHAT TO LEARN

In relation to choices about what to learn:

- **The content and conduct of CPD activities are primarily the responsibility of the doctor but may be mandated or guided by the regulator or professional body or required by the employer.**
- ***The individual doctor is* aware of the range of ways in which they identify what to learn and how to find pertinent learning resources.**
- **The responsible body recognises the range of ways in which doctors choose what to learn, including reflection on clinical and non-clinical activities, interactions with team members, appraisal, quality management, and planned systems of needs assessment.**
- **Organisations that provide CPD learning resources are aware of what doctors need and want to learn, and how they might do that, to support their current and future practice.**

2.3 Guidance:

- *The CPD process* should:
  - primarily be determined by doctors, taking into account the public interest and patient safety, and the requirements of the regulator, professional body, and employer,
  - encourage doctors to be aware of their reasons for choosing what to learn in relation to their current and future practice. Such awareness may encourage a range and balance of personal, professional, and service-related learning.

- *The responsible body* can influence the content of learning by recognising the full range of ways in which doctors choose what to learn, including reflection on clinical and non-clinical activities, interactions with team members, appraisal, quality management, and planned systems of needs assessment. Where responsible bodies fail to recognise how doctors actually identify what they want and need to learn, those doctors may comply with requirements while continuing to pursue their own learning. The responsible body will therefore have an incomplete picture of doctors' learning.

- *Organisations that provide CPD learning resources* should be aware of what doctors need and want to learn to support their current and future practice, as well as how they prefer to learn. They should be able to explain how they decide on their provision, and how that supports doctors and the healthcare service.

2.3 Key questions:

1. How does the medical profession control their own CPD system and process, taking the public interest and patient safety into account?
2. How are the requirements of the regulator, professional body, and employer taken into account?
3. *How does the CPD system* encourage doctors to be aware of their reasons for choosing what to learn in relation to their current and future practice?
4. How does the system encourage a range and balance of learning suitable to the resources and context of the doctor?
5. How does *the responsible body* recognise, support, or influence the content of learning?
6. What range of ways in which doctors learn is recognised? These might include, for example, reflection on clinical and non-clinical activities, interactions with team members, appraisal, quality management, and formal systems of needs assessment.
7. How does *the responsible body* know that it has a complete picture of doctors' learning?
8. How do *organisations that provide CPD learning resources* show that they are aware of what doctors need, want and like to learn, to support their current and future practice?
9. What methods do they use to decide on their provision?
10. How does that provision support doctors and the healthcare service?

2.4 ACCESSIBILITY OF LEARNING

The CPD system ensures access to a range of unbiased, accurate, or quality assured sites and methods of learning that provide the resources that doctors require.

2.4 Guidance:

- Doctors may require access to a range of resources and experiences to ensure their achievement of intended outcomes.
- All stakeholders should be encouraged to question and verify the accuracy of information offered, to identify sources of potential bias, and to consider the relevance of the information accessed.
- Information should be provided to all doctors about available CPD opportunities.

2.4 Key questions:

1. How does the CPD system ensure that doctors have access to a range of unbiased, accurate, and quality-assured learning resources and methods?
2. How is equity in access to learning resources and opportunities ensured for doctors across different locations and specialisations?
3. What criteria are used to identify appropriate access to unbiased, accurate, or quality assured learning resources and experiences?
4. How is adequate provision of resources to support CPD ensured?
5. How is information about available opportunities for CPD communicated to all doctors?
6. How are accessibility issues identified and addressed within different healthcare settings?
7. How are stakeholders encouraged to question and verify the accuracy of information offered, to identify sources of potential bias, and to consider the relevance of the information accessed? Who takes responsibility for this process?
8. What mechanisms are in place for doctors to provide feedback on the quality and effectiveness of learning resources and experiences?
9. How is the continuous improvement of learning resources and their accessibility monitored and implemented?

2.5 CONTRIBUTION OF CONTINUING PROFESSIONAL DEVELOPMENT TO PRACTICE

The individual doctor can state the role of CPD activities in the actual or potential development of their practice.

2.5 Guidance:

- The effects and outcomes of learning for CPD might be specific, purposeful, and tied to practice (as when a doctor decides to learn more about a specific patient they have in their care). Or they might be for general professional and specialty updating (such as arises from attendance at specialty conferences and local meetings, or incidental learning from colleagues, journals, podcasts, or magazines). It is therefore not always appropriate to ask for specific learning outcomes for every learning activity.
- Likewise, not all learning will result in change in practice, either because the reality of practice does not permit such change or because the new learning suggests that practice is already acceptable, or because the opportunity to put the new learning into practice has not arisen, or because other factors also affect patient outcomes. Measuring change in practice or patient outcomes is therefore not always a reasonable approach to studying the outcomes of learning.
- Specific or general outcomes and effects on practice can be stated in any manner that clearly describes what is intended or achieved in terms of knowledge, skills, behaviour, or change, as appropriate. An increase in general professional knowledge, even without immediate instrumental purpose, would be an acceptable stated outcome.
- Encouraging doctors to reflect on how CPD enhances their practice could lead to deeper insights.
- If relevant professional, regulatory, government, or employer bodies have CPD requirements related to the clinician's practice, these should be considered when describing outcomes and effects.

2.5 Key questions:

Remembering that it is not always possible to state specific outcomes:

1. How are the specific or generic outcomes stated?
2. Do they clearly describe what is intended or achieved in terms of knowledge, skills, behaviour, or change in practice, as appropriate?
3. Do they enable outcomes not immediately or instrumentally linked to practice?
4. Are doctors encouraged to reflect on how their learning might enhance their practice?
5. Do the identified outcomes map on to relevant professional, regulatory, government, and employer requirements, if any?

AREA 3: ASSESSMENT

Importance of this area

Assessment is not commonly a part of CPD systems. Where learning is primarily unplanned and driven by the individual doctor, assessment cannot be built into the process. It is more feasible, therefore, that a doctor's performance, rather than learning, is subject to review by processes such as audit or peer review.

These standards for assessment[16] mainly refer, therefore, to planned learning and formal provision. In most cases, assessment is part of that, so appropriate standards for assessment can be applied where CPD is formal.

Different models of CPD are seen around the world. In most countries, CPD is an informal, largely self-directed and unplanned process, during which individual doctors respond to issues that derive from their practice. In this case, doctors tend to undertake learning in the form of reading, talking with colleagues, and using a wide range of online and other available resources. It is an individual experience, often reported and recorded as part of ongoing licensure. In contrast, a minority of countries take a different approach, whereby doctors receive recognition for attending or undertaking courses offered by accredited CPD providers, which may be accompanied by various forms of largely formative assessment.

Regardless of whether the process is planned or unplanned, there are two decisions to be made, each informed by assessment and together constituting a 'system'. First, what should be learned? In both planned and unplanned CPD, this is generally left up to the participants and their answers are typically based on a self-assessment, which may be a simple process of reflecting, for example, on things that are done well, and things that could be done better. However, in some of the more planned models, participants are aided in their choices by a well-developed formative assessment process designed to identify areas for improvement.

The second decision to be made is whether an acceptable level of knowledge, skill, or performance has been gained and demonstrated. Again, in the unplanned models of CPD, this decision is left up to the participants who engage in their own form of self-assessment, perhaps based on personal identification of things that they need or would like to learn more about. In contrast, planned models sometimes incorporate summative assessment as part of the process.

Given the limitations of self-assessment[17], it is desirable for CPD to incorporate external sources of formative and summative assessment. However, in many settings that is not current practice, nor are there the resources to accommodate it.

In this section, the standards are set out to address those circumstances where it is possible to enhance the quality of assessment for CPD in planned systems.

[16] This section does not address prior learning needs assessment, but the assessment of learning that has occurred.
[17] Andrade, H. L. (2019). A critical review of research on student self-assessment. *Frontiers in Education*, *4*. https://doi.org/10.3389/feduc.2019.00087

3.1 THE ASSESSMENT SYSTEM

The responsible body requires a system of assessment that is consistent with the programme's scope as well as its formative and summative[18] purposes. It ensures that all assessments are aligned with the learning needs of the participants and the expected outcomes of the programme.

3.1 Guidance:

- An assessment system should aim to offer reliable and valid information. It typically entails the use of multiple formative and/or summative methods that will contribute to acquisition of knowledge and skills. The system when used for CPD should be responsive to:
  - the purpose and organisation of the course or programme,
  - the mission of the responsible body,
  - any specified outcomes,
  - the resources available,
  - the context.
- In a planned CPD system, the responsible body should be clear about:
  - whether and why formative assessments are required or advised,
  - whether and why summative assessments are required or advised,
  - the balance of formative and summative components, where relevant, and the reasons for that,
  - how the assessment system is expected to be consistent with requirements and the scope of learning.

3.1 Key questions:

1. What processes ensure the reliability and validity of the results of assessment?
2. How does the assessment system support the purpose of the course or programme?
3. How does the assessment system support the organisation of the course or programme?
4. How does the assessment system support the mission of the responsible body?
5. How does the assessment system address specified course or programme outcomes?
6. How does the assessment system take available resources into account?
7. In what ways is the assessment system appropriate to the context?

[18] Formative assessments provide feedback to the learner about their progress and may indicate future learning needs, whereas summative assessments define whether or not intended outcomes have been achieved by the learner.

3.2 ASSESSMENT IN SUPPORT OF LEARNING (FORMATIVE ASSESSMENT)

The system of assessment identifies the doctor's strengths and need for further learning and guides them to appropriate educational activities. Throughout the educational process, it provides them with actionable feedback which directs them to educational resources and experiences intended to support and create their learning.

3.2 Guidance:

- Feedback is one of the most powerful drivers of educational achievement[19]. Participants should benefit from being assessed throughout the educational process for the purpose of providing feedback. Identification of areas of strength and areas that require further learning must then be coupled with access to educational resources to address underperformance.
- Formative feedback should aim to:
  - be timely and specific,
  - highlight what the doctor has done well, as well as areas for future development,
  - enable the doctor to compare their performance with the intended performance,
  - offer advice about how to bridge any gap between current and intended performance,
  - enable the doctor to make accurate future judgements about their own performance and develop their own strategy for learning.

3.2 Key questions:

1. In what way is the provision of formative assessment and feedback part of the planned CPD process?
2. Are the purpose and design of feedback clarified?
3. How are areas of strength and areas requiring further learning identified?
4. How can the doctor compare their performance with any intended performance?
5. What methods for bridging the gap between current and intended performance are available to doctors?
6. How is access to appropriate remedial educational resources organised?
7. How does feedback deriving from formative or summative assessment equip the doctor to judge their own future performance?

[19] Hattie J, Timperley H. (2007) The power of feedback. *Review of Educational Research*, 77, 1, 81–112.

3.3 ASSESSMENT IN SUPPORT OF DECISION-MAKING (SUMMATIVE ASSESSMENT)

The system of assessment informs decisions regarding learning achievement when appropriate to the purpose of the course or programme. The summative assessments used as part of the system are well designed, producing reliable and valid results, appropriate to measuring educational outcomes, and ideally associated with performance in practice.

3.3 Guidance:

- Where assessment is used in the CPD process for the purpose of decision-making, it should be clear about:
  - the role of assessment and the consequences of reaching or not reaching a required passing standard,
  - in what ways the assessment system ensures the protection of patients and communities,
  - how fairness of the assessment system to participants is ensured,
  - who designs the assessments, and how appropriate that is,
  - how decisions are made about the learning achievements to be assessed, and their relevance to the purposes of CPD.

3.3 Key questions:

1. Is summative assessment part of the planned CPD process?

Where assessment in the CPD process is used for the purpose of decision-making:

2. Are the role of assessment and the consequences of reaching or not reaching a required passing standard clarified to all stakeholders?

3. In the event of unsatisfactory assessment results, what remediation systems are in place?

4. In what ways does the assessment system ensure the protection of patients and communities?

5. How is the fairness of the assessment system to participants ensured?

6. How are the assessments designed and by whom, and what is the appropriateness of that?

7. How are decisions made about the learning achievements to be assessed, and their relevance to the purposes of CPD?

3.4 QUALITY ASSURANCE OF THE ASSESSMENT SYSTEM

There are mechanisms in place to assure the quality of assessments across all locations and with different assessors. Assessment data contribute to the improvement of the course or programme and those involved with it. Measures focus on improvements in learner performance (where applicable) and changes in patient health status (where practical)[20].

3.4 Guidance:

- The responsible body has a duty to undertake a regular quality review of its individual assessments, as well as the whole assessment system.
- The purpose of quality assurance of the assessment system should be clearly defined, and the methods used for conducting this quality assurance should be described.
- The responsible body should clearly state the purpose of quality assurance of the assessment system and describe how this is conducted.
- The review should be based on quality assurance data from the assessments, feedback from stakeholders, and, where feasible, practice performance data to support the continuous quality improvement of each assessment, the system as a whole, and its implementation.
- The results of assessment should be communicated to individuals and bodies for service or system improvement.

3.4 Key questions:

1. Does the responsible body clearly state the purpose of quality assuring the assessment system, and describe how it is done?
2. How often does the responsible body undertake a quality review of its individual assessments as well as the whole assessment system? Is this sufficient to ensure appropriate and consistent quality?
3. How is the quality review undertaken for each assessment and for the assessment system as a whole?
4. How is implementation of the system reviewed?
5. What quality assurance data are taken from the assessments?
6. What feedback is taken from stakeholders?
7. With whom are the results of assessment communicated? How does this affect service or system improvement?

[20] Changes in patient health status might only be seen when the doctor has learned and can apply, for example, new operative skills, or new treatments which have immediate effect.

AREA 4: THE INDIVIDUAL DOCTOR

Importance of this area

CPD is the most self-directed stage of learning in medicine, meaning that the doctor decides what, why, how, and when to study. The choice to study may sometimes derive from professional, employment, or licensing conditions: the doctor's professional body or the body with which the doctor is registered or licensed to practise may require a certain amount of ongoing CPD, or the employer might require evidence that the doctor keeps up to date. But for most doctors, continuing to learn is simply a function of their professional practice.

People like to learn in different ways for different purposes at different times. *The Good CPD Guide*[4] lists at least forty-seven ways in which doctors identify things that they wish to learn more about. Some ways are planned and some unplanned. Of those, thirteen derived from the clinician's own experiences in direct patient care. Seven derived from interactions with the team and department. Nine derived from non-clinical activities. Six derived from formal processes of quality management and risk assessment, and only twelve derived from specific needs assessment activities and peer review. Therefore, CPD is largely the domain of the individual doctor.

The key issue is of equity: how can each individual doctor be supported to undertake the CPD they want and need?

4.1 RESPONSIBILITY FOR CONTINUING PROFESSIONAL DEVELOPMENT

The responsibility of individual doctors for their own CPD is recognised and supported by responsible bodies, organisations, employers, and the profession.

4.1 Guidance:

- Although the individual doctor has personal and professional responsibility for their own CPD, that responsibility is more likely to be discharged if supported by responsible bodies, relevant organisations, employers, and the profession itself. This can be demonstrated by:
    - policy statements issued by bodies relevant to CPD, such as educational providers and regulators, recognising the primary role of the individual doctor in determining their own CPD,
    - employer commitment to supporting the doctor's CPD by means of contract time or financial support,
    - commitment of the profession to CPD, through policy statements from professional bodies.

4.1 Key questions:

1. What policy statements are available from relevant bodies, addressing their relationship with the individual doctor, and the ways in which they can support each individual doctor's CPD ?
2. In what ways are employers committed to and supportive of the CPD of their doctor employees, in terms of contracts, time, resources and financial support?
3. What policies do medical professional bodies have that support the CPD of their members?
4. How do different organisations or bodies provide practical support for individual doctors' CPD?
5. What mechanisms are in place to monitor and evaluate the effectiveness of the support provided by organisations, employers, and the profession in fulfilling doctors' CPD responsibilities?

4.2 DOCUMENTATION FOR THE INDIVIDUAL DOCTOR

Documentation and recording systems are provided to help the individual doctor in planning and recording their CPD activities.

4.2 Guidance:

- Every doctor should understand relevant policies and processes that set out the CPD system and the individual doctor's responsibilities in relation to that.
- Documentation should be provided to assist the doctor in preparing a record of their CPD activities, and to help them plan those activities.
- Documentation should be simple, allowing a record of every type of learning experienced, and not time-consuming to complete.
- Documentation should be in an accessible format and designed in consultation with the intended users.

4.2 Key questions:

1. How have doctors been informed of policies and processes that set out the CPD system?
2. What are the doctor's responsibilities in relation to CPD policies and processes?
3. What documentation has been provided to assist the doctor in preparing a record of their CPD activities, and to help them plan those activities?
4. What has been done to ensure that documentation is simple, allowing a record of every type of learning experienced, and not time-consuming to complete?
5. How were users involved in designing documentation?
6. In what ways is documentation in accessible formats and designed in consultation with the intended users?

4.3 THE INDIVIDUAL DOCTOR'S WORKING CONDITIONS AND CONTINUING PROFESSIONAL DEVELOPMENT

The doctor's employment contract or working conditions should provide time and ensure funding for CPD.

4.3 Guidance:

- Every doctor should have time built into their working schedule for CPD activities.
- Employers should ensure that every doctor has access to funding to support their CPD.
- There might be different sources of funding to support the individual doctor's CPD.
- Principles for distribution of funding should be set out.

4.3 Key questions:

1. How is time for CPD activities built into the doctor's working schedule?
2. How have institutions successfully integrated CPD time and funding into doctors' contracts and working conditions?
3. How is access to funding to support CPD ensured for every doctor?
4. What sources of funding are available for individual doctors' CPD, with what results?
5. What principles are employed in relation to distribution of funding?

AREA 5: RECOGNITION OF CONTINUING PROFESSIONAL DEVELOPMENT ACTIVITY

Importance of this area

CPD requirements may be set by an authority that regulates the individual practitioner, such as a licensing agency, or by another responsible body, such as a professional organisation. Where there are specific educational providers in a system (such as a hospital, professional association, university department, or publishing company) these may be subject to the rules of the regulatory body. Responsible bodies may have methods for recording and recognising CPD undertaken and reported by the doctor. One or more of these entities may track the amount of CPD undertaken so that a record can be made available to the doctor and the responsible body on request, or the doctor may do that for themselves and report it when required.

Because CPD is often a completely self-directed activity, individual doctors will find their own learning resources and methods which might be planned or unplanned. Doctors have many ways of learning: *The Good CPD Guide*[4] identifies at least forty-seven, ranging through academic activities, meetings, learning from colleagues, learning from practice, reflection on clinical cases and incidents, using technology and media, management and quality processes, and other specially arranged activities. Responsible bodies may choose to recognise all these ways of learning. If they do not, then justification for choosing to omit some ways of learning should be given.

Doctors live in a rich learning environment where there is no ‘best’ or ‘right’ way to learn. It is a matter of personal choice. However, the quality and relevance of these methods may vary. The importance of thinking about the quality of CPD provision and activity, whether planned or unplanned, is a key issue.

Although the accumulation of ‘credits’ for CPD activity is the most common mechanism for recognition of CPD activity, these standards do not endorse this particular system as the only or preferred method. Instead, the standards in this section set out the elements that might be of interest to a regulatory body and ask how that recognition or record might be compiled. The resulting process might be based on a wide range of recording methods that focus, for example, on quality, relevance and outcome, rather than quantity or participation or time spent.

5.1 THE RECOGNITION OF ALL LEARNING

Doctors **are aware of the range of ways in which they continue to learn.**

The responsible body **recognises individual, self-directed, and unplanned learning, as well as completion of specific planned courses of study, and attendance at local, national, or international meetings.**

5.1 Guidance:

- This standard refers to the types of actual learning that occur and are recognised by the responsible body. There are many options and variants. *The Good CPD Guide*[4] identifies forty-seven common methods of learning, ranging through academic activities, meetings, learning from colleagues, learning from practice, reflection on clinical cases and incidents, using technology and media, management and quality processes, and other specially arranged planned activities. Responsible bodies may choose to recognise or not recognise all these ways of learning, with or without a justification for the selection.
- A justification for the selection of which learning activities are accepted for CPD is a key document that should be provided.

5.1 Key questions:

1. Are doctors aware of the range of planned and unplanned or incidental ways in which they continue to learn?
2. Does the responsible body recognise individual, self-directed, and unplanned learning, as well as completion of specific courses of planned study, and attendance at local, national, or international meetings?
3. In what way has the responsible body provided clear information about accepted learning activities and those that it does not recognise, if any?
4. What criteria are used to evaluate and recognise various types of learning activity?

5.2 RECOGNITION POLICY FOR PROVIDED LEARNING

The profession or responsible bodies **have a system for quality assurance and recognition of CPD offered by for-profit and not-for-profit providers of educational resources.**

Organisations providing **CPD resources can explain the rationale for their choice of content and learning methods.**

5.2 Guidance:

- Organisations providing courses and resources have an obligation to ensure that their provision of CPD content and activities meets relevant local, national, or adopted international educational quality requirements in planning, design, implementation, and quality assurance, to ensure appropriateness, effectiveness, and accessibility for the intended audiences. This will include costing and pricing.
- Organisations providing CPD resources have choices in terms of learning methods, and how those relate to the doctor's experience, appropriateness to context and culture, cost, and accessibility. Each organisation should be able to explain how those choices are made.
- Policies to manage and mitigate potential conflicts of interest should be available.
- Organisations should state how they developed, designed, piloted, costed, priced, and quality assured their provision.
- Organisations may sometimes have commercial links associated with their provision. If so, users of the service should be made aware of this.
- Organisations should declare no conflict of interest in the provision they offer.

5.2 Key questions:

1. How do organisations providing courses and resources ensure that their provision of CPD activities meets stated educational quality requirements in:
   - planning,
   - design,
   - implementation, and
   - quality assurance?
2. What relevant local, national, or international educational quality requirements are adopted and how are they implemented?
3. How did organisations develop, design, pilot, cost, price, and quality assure their provision?
4. How do organisations providing CPD resources or activities ensure appropriateness, effectiveness, and accessibility for the intended audiences, including costing and pricing?
5. What policies are required and available to manage and mitigate potential conflicts of interest?
6. Have organisations declared any commercial links associated with their provision?
7. Have organisations declared no conflict of interest in the provision they offer?

5.3 RECOGNITION POLICY FOR SELF-DIRECTED LEARNING	
There is a system for recognising self-directed and personal ways of learning for CPD.	
5.3 Guidance:	
• The CPD system should allow doctors to report their own self-directed and personal unplanned learning which should be recorded and recognised. • If quality assurance is required, a system for reviewing self-directed learning with the doctor should be used.	
5.3 Key questions:	
1. How does the CPD system allow doctors to report their own self-directed and personal unplanned learning? 2. How is the doctor's self-directed and unplanned learning recorded and recognised?	3. Where quality assurance is required, what system of reviewing self-directed learning with the doctor has been developed? How is that system implemented?

AREA 6: EDUCATIONAL RESOURCES

Importance of this area

The range of educational resources and methods for CPD is broad. Some (such as courses) are deliberately designed for the process. Others (such as books and journals) are simply resources that doctors might choose to consult when they recognise that they need to learn. Others are individually identified and organised (such as conversations with peers, local journal clubs and meetings, and visits to other practitioners to observe them work or to share in their work to learn a new skill). Other resources might include qualified trainers, supporting staff, physical facilities, library access, and technology.

At least forty-seven ways of learning are listed in *The Good CPD Guide*[4]. These standards recommend that all those ways are recognised, which must be done if we accept the importance of the independent, self-directed learning which medical schools try to inculcate in their students.

This represents a challenge for standard setters in relation to CPD because common approaches to quality control cannot easily be applied to self-directed learning. This section of standards therefore refers to educational resources very broadly.

6.1 RESOURCES FOR LEARNING

The doctor has access to adequate learning resources as needed, including literature, web-based and electronic resources[21], courses, skills training equipment, and a safe environment for learning.

Information is provided by the responsible body about how to judge the trustworthiness[22] of sources of educational materials.

6.1 Guidance:

- Not all doctors will need all types of facility for learning. However, when the doctor does need a library, or skills training, or a place to study, then that should be made available by the employer, or professional body, or other responsible bodies.
- Learning facilities might include virtual resources and simulations, courses, and information technology services including web-based and electronic resources.

  Physical facilities might include:
  - items needed for training in practical techniques,
  - information technology and record systems,
  - virtual and artificial intelligence resources,
  - electronic or distance learning resources,
  - physical spaces for study,
- Responsible bodies might consider providing information to doctors about the validity of content, and the objectivity and trustworthiness (accuracy and lack of bias) of sources.
- Mechanisms for access to resources and learning facilities should be communicated to doctors.

6.1 Key questions:

1. How are facilities for learning made available to all doctors? These might include:
- a library,
- items needed for training in practical techniques,
- virtual resources and simulations,
- planned courses,
- web-based and electronic resources,
- information technology services,
- electronic or distance learning resources,
- physical spaces for study.

2. What information is available to doctors about the validity of content, and the objectivity and trustworthiness of sources?
3. How are mechanisms for access to resources and learning facilities communicated to doctors?

[21] Artificial intelligence and large language models are included under the heading of web-based and electronic resources.
[22] Trustworthiness implies accuracy and lack of bias.

6.2 INTERACTIONS WITH COLLEAGUES

The doctor has the opportunity to collaborate with colleagues and professionals in other disciplines and areas in CPD activities.

6.2 Guidance:

- It may be useful to consider the range and availability of collaborative learning with and from colleagues. These may include, at a minimum[23]:
  - clinical and departmental meetings,
  - conferences,
  - case review meetings,
  - collaborative learning,
  - consulting with other professionals about cases,
  - peer review,
  - professional conversations,
  - visits to other departments and parts of the healthcare system,
  - conversations with professionals in other areas of healthcare,
  - conversations with professionals in other areas such as technology and information science.

6.2 Key questions:

1. What range and availability of collaborative learning with and from colleagues is made available to each doctor? 2. How is learning with and from colleagues encouraged by the CPD system?	

[23] *The Good CPD Guide* lists about 15 such types of learning.

AREA 7: QUALITY IMPROVEMENT

Importance of this area

Because doctors often engage in self-directed CPD, improving the quality of their learning experience presents challenges [24]. When courses are attended, CPD providers can be held accountable for implementing effective quality improvement systems. However, for self-directed learning, formal quality improvement of the materials and resources used is not feasible.

CPD requires its own approach to quality improvement. That might be designed, for example, as a system of peer review or peer support for CPD. We should recognise that an experienced doctor has often been trained to be a sophisticated consumer of education. Even when providers can show the quality of their learning resources, these are only effective for CPD if they occur within a process that ensures that the doctor has selected the right resources, and then can use the resultant learning in practice. It cannot be assumed, however, that all learning can immediately be applied to practice. Such application will be limited by the nature of the healthcare service and by available resources and opportunity for implementation and change.

Likewise, the quality and effectiveness of learning cannot be judged, in most cases, by patient outcomes: those too are limited by resources, and affected by other factors and by the patient's own circumstances and context. There are usually too many jeopardising variables between the doctor's learning and any particular patient outcomes to make this link meaningfully.

Given these limiting factors, quality improvement systems must be reasonable in their aims and process[25].

Quality improvement[26] can be seen as the implementation of a variety of processes and methods designed at local level, to ensure that the CPD that each doctor experiences is continually being reviewed and improved. The process therefore serves individual needs and is locally run. Regular review of CPD activities, and the management of CPD systems will help to ensure their appropriateness and will provide a means of early intervention if problems arise.

[24] There are many models of quality improvement, and a wide variety of data collection and feedback methods. Each quality improvement system must be designed for its own purposes and context.
[25] Although there are publications about the effect of CPD on staff, systems, costs, satisfaction, and patient outcomes, there is no universal and comprehensive model or set of metrics. Studies of effect for quality improvement must be designed according to local purposes and resources.
[26] We have moved away from quality assurance, which is the judgement made about a programme against external standards, at one point in time, to focus on quality improvement which involves regular review, and implementation of interventions to solve problems and enhance education and training, which will later be reviewed again as part of the quality improvement cycle.

7.1 THE QUALITY IMPROVEMENT SYSTEM

There is a locally implemented quality improvement system that regularly addresses the process and availability of CPD resources and opportunities for all doctors, along with methods for making improvements.

7.1 Guidance:

It should be useful to:

- State which stakeholders are involved in developing the quality improvement system. These might include doctors, especially those with expertise in the field of learning, providing organisations, responsible bodies, professional bodies, and healthcare service representatives.
- Consider the purposes, role, design, management, and appropriateness of the quality improvement system, including what is regarded as appropriate quality in its planning and implementation practices.
- Consider how to gather regular data about the experience and provision of opportunities for CPD in practice.
- Consider how to collect information from all stakeholders.
- Design and apply a decision-making and change management structure and process, as part of quality improvement.
- Prepare and disseminate a written document that sets out the quality improvement system.

7.1 Key questions:

1. How have all stakeholders been involved in designing and implementing a quality improvement system?
2. How are the purposes and methods of quality improvement, including data collection, and subsequent actions taken, defined and described, and made publicly available?
3. Are there appropriately knowledgeable and skilled individuals to design and implement the quality improvement system?
4. How is responsibility for design and implementation of the quality improvement system allocated?
5. How are resources allocated to quality improvement?
6. How is the quality improvement system used to update CPD in practice for all doctors?
7. How is the quality improvement system communicated to all stakeholders?

7.2 QUALITY IMPROVEMENT SYSTEMS FOR PROVIDED RESOURCES AND ACTIVITIES

There is a quality improvement system that ensures the appropriateness, availability, and suitable costs of CPD activities offered by provider organisations[27].

7.2 Guidance:

It may be helpful to:

- State which stakeholders are involved in developing the quality improvement system for formally provided CPD resources and activities. These might include doctors, especially those with expertise in the field of learning, provider organisation, the responsible body, professional bodies, and healthcare service representatives.
- Consider how to gather data about the purposes, role, design, management, appropriateness, and costs of the provided activities and resources, including what is regarded as appropriate quality in planning and implementation practices.
- Consider how to offer feedback to provider organisations for quality improvement of their provision.
- Prepare and disseminate a written document that sets out the quality improvement system for provided resources and activities.
- Prepare and disseminate a written document that sets out the quality improvement system.

7.2 Key questions:

1. Which stakeholders are involved in developing the quality improvement system for formally provided CPD resources and activities: do these include doctors, especially those with expertise in the field of learning, provider organisations, the responsible body, professional bodies, and healthcare service representatives?
2. How are data gathered about the purposes, role, design, management, appropriateness, and costs of the provided activities and resources, including what is regarded as appropriate quality in its planning and implementation practices?
3. How is feedback given to provider organisations for quality improvement of their provision?
4. How is a written document prepared and disseminated to that sets out the quality improvement system for provided resources and activities?

[27] These will mainly be face-to-face and online courses and meetings developed by CPD provider organisations. Local meetings such as journal clubs or clinical case reviews would not come into this category.

7.3 PATIENT SAFETY	
The CPD quality improvement system addresses doctor error, patient safety, and the safety of clinical and public health interventions within health care systems.	
7.3 Guidance:	
It may be helpful to consider: • Establish how responsibility for doctor error, patient safety, and the safety of clinical and public health interventions within health care systems is taken at both management level and in relation to CPD. • Show how risks are mitigated by CPD.	
7.3 Key questions:	
1. How are doctor error, patient safety, and the safety of clinical and public health interventions within health care systems addressed by the CPD system? 2. How are risks addressed and mitigated by the CPD system?	

AREA 8: GOVERNANCE AND ADMINISTRATION

Importance of this area

Effective implementation and quality improvement of the CPD system requires management, administration, budget allocation, and accountability involving all interested parties.

Whether CPD processes or resources are provided by an organisation or organised by the individual doctor for their self-directed learning, this should be supported by appropriate governance and administration. These terms have many meanings, but in relation to CPD:

Governance is defined as:

> The system by which CPD activities, whether individual or corporate, are planned, controlled, and held to account.

Administration is defined as:

> The processes by which information about CPD process, provision, and uptake is prepared, organised, recorded, stored, and used.

Responsibility for governance and administration may differ from place to place.

Commercial interests

CPD is different from medical school and early postgraduate training since it is learning undertaken by practising doctors who have the power and responsibility to prescribe medications and health technologies for both clinical and public health interventions. Manufacturers of these might therefore see CPD as a marketing opportunity; and they often have budgets to fund CPD activities. The potential power of such commercial funding to influence the content of CPD, to add commercial presence and so to bias future clinical decisions, has been a concern expressed by parts of the medical profession for many years[28]. Although industry funding may be welcome in some contexts, a key responsibility for all jurisdictions is to protect doctors from this conflict of interest.

Funding

The funding of CPD varies widely. In some contexts, physicians routinely receive a discretionary budget as part of their employment contract and can freely choose their preferred CPD activities. In other contexts, funding may be provided by the employer to an internal team responsible for delivering learning experiences to doctors and others on site, customised to meet the quality standards and goals of the institution. In other contexts, there may be no funding at all. Practice varies widely.

[28] Cervero RM, Gaines JK. Is there a Relationship between Commercial Support and Bias in Continuing Medical Education Activities? [Internet]. Chicago; 2014. Available from: www.accme.org.

8.1 GOVERNANCE

There is a defined governance structure for CPD systems which is transparent and accessible to all stakeholders, and aligns with the purposes of CPD.

8.1 Guidance:

It may be helpful to:

- Check that specific governance structures (e.g., committees, boards) are in place, and identify how they function.
- Consider including doctors, professional bodies, responsible bodies, providers, and the healthcare service in decisions about CPD governance structures.
- Identify whether there are pharmaceutical companies' interests impinging on doctors' CPD. If so, define in what way are they regulated.
- Describe the leadership and decision-making model for governance of CPD.
- Check to whom those responsible for governance are accountable.
- Ensure that there is appropriate medical leadership and engagement at every level.
- Ensure that each stakeholder group is adequately represented in governance committees or bodies, outlining who makes decisions, who provides oversight, and how leadership is organised, accountability maintained, and performance monitored.
- Check if the responsible body has a risk identification and management procedure.
- Ensure that there are accessible records that set out the governance system and record governance activities.

8.1 Key questions:

1. What is the specific governance structure for CPD?
2. How and by which committees, organisations, or groups are decisions made about the functioning of the responsible body?
3. By what processes and committee structures is CPD governed?
4. What governance arrangements are there to review the performance of the responsible body?
5. Do the pharmaceutical companies' interests play any role in doctor's CPD? If so, in what way are they regulated?
6. What records are available that set out the governance system and record governance activities?

8.2 SHARED GOVERNANCE

Where responsibility for CPD is shared between more than one body, there is a clear statement of roles, responsibilities, and relationships.

8.2 Guidance:

The statement might:

- Identify the bodies involved in the definition, delivery, management, and governance of CPD.
- Consider including patients, communities, service users, and the healthcare service in the governance process.
- Identify what steps are taken to ensure consistency and standardisation of CPD activities managed by different bodies.
- Define the roles and responsibilities of each body and the relationships between them, including communication, distribution and management of resources, accountability, reporting, resolution of disagreements, and involvement in quality improvement processes.

8.2 Key questions:

1. What bodies are involved in the definition, delivery, management, or governance of CPD? 2. What steps are taken to ensure consistency and standardisation of CPD activities managed by different bodies?	3. What are their roles and responsibilities and the relationships between them, including communication, distribution and management of resources, accountability, reporting, resolution of disagreements, and involvement in quality improvement processes?

8.3 RESPONSIBILITY FOR ACCREDITATION OF PROVIDER ORGANISATIONS

Where CPD is associated with accreditation of provider organisations, the requirements and processes are clarified for providers and doctors.

8.3 Guidance:

It may help the clarification to

- Define whether and how accreditation is applied to CPD providers.
- Define which body or bodies have responsibility for accreditation of providers, and the standards that must be upheld.
- Identify:
    - the roles and responsibilities of the accrediting body or bodies,

- the process for CPD providers to obtain accreditation,
- how often CPD providers are reviewed for accreditation purposes,
- how the requirements and processes for accreditation are communicated to providers and doctors,
- how transparency is maintained in the accreditation process applied to providers,
- what mechanisms are in place for providers to receive feedback on their accreditation status,
- the process for providers to appeal against accreditation decisions,
- how accreditation affects the CPD activities offered by providers,
- what support is available to providers to help them meet accreditation standards,
- how is the accreditation process reviewed and improved over time,
- how stakeholder inputs are incorporated into the accreditation process.

8.3 Key questions:

1. How is accreditation applied to CPD providers?
2. Which body or bodies have responsibility for accreditations of providers?
3. What are the roles and responsibilities of the accrediting body or bodies?
4. What is the process for CPD providers to obtain accreditation?
5. How often are CPD providers reviewed for accreditation purposes?
6. How are the requirements and processes for accreditation communicated to providers and doctors?
7. How is transparency maintained in the accreditation process applied to providers?
8. What mechanisms are in place for providers to receive feedback on their accreditation status?
9. What is the process for providers to appeal against accreditation decisions?
10. How does accreditation affect the CPD activities offered by providers?
11. What support is available to providers to help them meet accreditation standards?
12. How is the accreditation process reviewed and improved over time?
13. How are stakeholder inputs incorporated into the accreditation process?

8.4 RESPONSIBILITY FOR RECOGNISING CPD UNDERTAKEN[29]

Where a system for recognising CPD undertaken is implemented, the requirements and processes are clarified for providers and doctors. Such requirements and processes address the balance between autonomy and accountability of doctors for their CPD activities.

8.4 Guidance:

It might be helpful to:

- Define which body has responsibility for recognising the CPD undertaken.
- Define whether and how the individual doctor's planned and unplanned CPD is recognised by interested bodies.
- Define and justify the system for awarding such recognition[30].
- Define and justify penalties applied, if any, for failure to undertake sufficient recognised CPD.
- Decide how the autonomy of doctors in choosing and undertaking CPD activities, is balanced with accountability for those choices and their effects.

8.4 Key questions:

1. Which body or bodies have responsibility for recognising CPD undertaken?
2. How is the individual doctor's planned and unplanned CPD recognised?
3. What is the system for recognising CPD undertaken, and what is its justification, including an analysis of strengths and weaknesses and likely effects on CPD behaviour?
4. If penalties are applied for failure to undertake sufficient recognised CPD, what are they, how were they decided and what analysis has been undertaken of the positive and negative effects on the doctor's learning?
5. How is the autonomy of doctors in choosing and undertaking CPD activities balanced with accountability for those choices and their effects?

[29] This standard does not assume that CPD credits are the only way of recording the CPD that an individual doctor has undertaken. There are many other options that can be explored, developed, and implemented. This standard applies to any existing or future system of recording and recognising CPD undertaken.

[30] Such a system might recognise different types of learning or be defined in terms of time spent in study. However, recognition might also be given, for example, for undertaking the full cycle of defining what is to be learned, planning the learning, learning and reinforcing that learning by using it or putting it into practice. How learning is recognised, is a matter of local choice and design.

8.5 FINANCIAL MANAGEMENT

Sources of funding related to CPD are clarified and their likely effects on learning considered, including:

- **who pays the doctor's costs for CPD activities,**
- **who funds the development and use of resources for CPD,**
- **whether commercial resources are developed for-profit or not-for-profit.**

8.5 Guidance:

- The doctor's costs might be met by self-funding, or by the employer, or by another source such as a commercial organisation. These should be identified and their acceptability to the profession and likely effects on learning evaluated.
- Resources might be general, as in a university library, or specific to CPD. Who funds these and how this might affect the doctor using them, in terms of accessibility and influence on practice, should be considered.
- The implications of not-for-profit and for-profit models of provision should be considered in relation to cost to the doctor, likely effects on learning, and accessibility.

8.5 Key questions:

1. Are the doctor's costs met by self-funding, by the employer, or by another source such as a commercial organisation? Is this acceptable to the profession? What are the likely effects on the doctor's learning?
2. Who funds the development and provision of learning resources and how might this affect the doctor using them, in terms of accessibility and influence on practice?
3. What are the implications of not-for-profit and for-profit models of provision in relation to cost to the doctor, likely effects on learning, and accessibility? Specifically:

- How does the source of funding for CPD activities influence the selection and quality of these activities?
- Are there any conflicts of interest associated with the funding sources for CPD activities and resources? How are these managed?
- How does funding from commercial organisations affect the content and delivery of CPD activities?
- What measures are in place to ensure equitable access to CPD resources for all doctors, regardless of their funding sources?
- How does the cost of CPD activities affect participation rates among doctors?
- Are there differences in the effectiveness of CPD activities based on whether they are funded by for-profit or not-for-profit organisations?
- How transparent are the funding arrangements for CPD activities and resources? Are doctors fully informed about the sources of funding and potential biases?
- What strategies can be implemented to mitigate any negative effects of commercial funding on CPD learning outcomes?

8.6 TRANSPARENCY AND INDEPENDENCE[31]

Codes of conduct requiring transparency and independence are available that address:

- **the involvement of private and commercial sectors,**
- **disclosure of conflicts of interest, relationship with commercial companies, and financial interests,**
- **the legal or professional status of CPD,**
- **ways of recording a doctor's CPD activities,**
- **implications of compliance or non-compliance for doctors and providers,**
- **incentives to participate in CPD,**
- **barriers to CPD participation,**
- **the suitability of allowing commercial entities to pay or reimburse the physician for their travel to conferences or other educational events,**
- **whether and how sponsorship of educational activities, and any associated exhibits, is to be handled.**

8.6 Guidance:

Codes of conduct requiring transparency and independence may be drawn up by anybody or agency but should be acceptable to all stakeholders. Such codes might set out:

- the involvement of private and commercial sectors, their reasons for that involvement, and the effects of that involvement,
- disclosure of conflicts of interest, relationship with commercial companies, and financial interests, over specified periods,
- what disclosures preclude the participation of teachers or educational providers, and what mitigation strategies are to be used for teachers or educational providers who declare commercial relationships,
- how disclosure of conflicts of interest is managed,
- the legal or professional status of CPD, including the legal framework for licensure,
- ways of recording a doctor's CPD activities,
- implications of compliance or non-compliance for doctors and providers, including penalties, if any,
- incentives to participate in CPD including the source of those incentives and their likely effect on participation and quality of learning,
- the suitability of allowing commercial entities to pay or reimburse the doctor for their travel to conferences and other educational events,

[31] Transparency in financial matters is addressed in Standard 8.5 above.

- whether and how sponsorship of educational activities and any associated exhibits is to be handled,
- barriers to CPD participation, that might be personal, financial, contextual, or organisational, including employment contracts.

8.6 Key questions:

1. How are codes of conduct published and made available to all interested parties?
2. Who draws up codes of conduct for CPD?
3. Do those codes require transparency and independence?
4. Do the codes set out:

- the involvement of private and commercial sectors, the reasons for that involvement, and the effects of that involvement,
- the legal and professional status of CPD, including the legal framework for licensure,
- the need for disclosure of conflicts of interest, relationship with commercial companies, and financial interests,
- ways of recording a doctor's CPD activities,
- implications of compliance or non-compliance for doctors and providers, including penalties, if any,
- incentives to participate in CPD including the source of those incentives and their likely effect on participation and quality of learning,
- barriers to CPD participation, that might be personal, financial, contextual, or organisational, including employment contracts?

8.7 ADMINISTRATION

The responsible body has appropriate and sufficient administrative processes and support to achieve its goals in the governance of CPD.

8.7 Guidance:

It may be helpful to:

- Develop a policy and review process to ensure adequate and efficient administrative procedures, staff, and budgetary support for all activities and operations of the responsible body.
- Ensure that these procedures are efficient and facilitate the smooth running of CPD activities.
- Ensure that the responsible body has adequate staffing levels and budgetary provisions to handle administrative tasks efficiently.

8.7 Key questions:

1. How do the administrative procedures, structure and resources support the functioning of the responsible body?

2. What policies are in place to ensure the efficiency and effectiveness of administrative processes within the responsible body? Specifically:

- How are administrative staff trained and supported to handle CPD-related tasks?
- What mechanisms are in place for regular review and improvement of administrative procedures?
- How is budgetary support allocated and managed to ensure the responsible body meets its CPD governance goals?
- How does the responsible body ensure transparency and accountability in its administrative operations?
- What systems are in place to track and manage CPD activities and compliance?
- How does the responsible body communicate administrative decisions and processes to stakeholders?
- How are feedback and concerns from doctors and other stakeholders regarding administrative processes addressed?
- What contingency plans are in place to handle disruptions in administrative support?
- How does the administrative structure of the responsible body align with its strategic goals for CPD governance?

3. How does the decision-making process support the functioning of the responsible body?

4. What is the reporting structure for administration in relation to CPD in practice?