

# Global perspective on continuing professional development

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## Abstract

Healthcare professionals worldwide participate in continuing professional development (CPD) to remain competent in practice, and to ensure they provide high-quality care to patients. Globally, CPD systems have evolved at different rates resulting in significant variation in structure, requirements, and oversight. In some countries, CPD has moved from single profession educational designs and formal didactic methods of delivery to educational models that are innovative, dynamic, and learner-centric. In other countries, CPD is a neglected part of the healthcare education continuum. This article provides a global perspective on the evolution of CPD over the past 20 years, and identifies opportunities for the future.

## Practice Highlights

- CPD is a vital part of the medical education continuum.
- CPD systems vary worldwide.
- It is essential that healthcare professionals participate in CPD.
- CPD is moving from single profession education to interprofessional continuing education models.
- High-quality CPD is innovative, dynamic, and learner-driven.

## I. INTRODUCTION

In the United States, the role of continuing professional development (CPD) as a strategy to ensure healthcare professionals are engaged in lifelong learning and maintaining clinical competence has evolved significantly over the past 20 years. Historically, CPD consisted primarily of didactic lectures delivered away from the work place setting, classroom style, and teacher-focused with little learner engagement. CPD was experts telling you how to practice. CPD was delivered in silos and in single profession models (as compared to interprofessional), with physicians lecturing to physicians, nurses to nurses, and similar.

A body of evidence linking CPD to improving clinical practice and patient outcomes has changed the field significantly, and for the better (Cervero & Gaines,

2014). CPD is now dynamic, flexible, and outcome-focused. Today's CPD blends multiple educational methodologies to meet the needs of learners including but not limited to live (face-to-face) meetings, digital delivery, flipped classrooms, and simulation. CPD is embedded in the work place where experiential learning takes place, guided by expert faculty who provide opportunity for activities such as small group, problem-based learning built around real world problems. CPD is also embedding more opportunity for interprofessional continuing education (IPCE), as health care is delivered by teams of professionals in collaboration with patients and care givers, and research has demonstrated the positive impact of IPCE on team performance and patient outcomes (Reeves et al., 2016; Joint Accreditation, 2016).

## II. CURRENT STATE OF GLOBAL CPD

Throughout the world, healthcare professional education starts with the undergraduate curriculum and continues through postgraduate training and specialization. CPD is the longest part of the continuum, often encompassing 40 or more years of a healthcare professional's career, yet in many countries it is the least structured or regulated component of the continuum. Because new evidence in medicine and health care is published at an increasingly rapid rate, CPD is a vital component to ensuring healthcare professionals remain competent in practice and are able to deliver high-quality, evidence-based care. Unfortunately, there are still systems worldwide in which CPD is not considered a contiguous part of the healthcare education continuum, which poses a significant threat to maintaining healthcare providers' competence and improving the quality of patient care. Globally, challenges in CPD include significant variability in how it is defined and structured, and the differing requirements and levels of oversight by country or region.

### A. Definition of CPD

The definition of CPD varies greatly around the world. Most often, CPD is a catch-all term referring to the combination of formal continuing medical education (CME) and other types of activities designed to help healthcare professionals acquire knowledge and skills necessary for professional growth. Alternatively, others use the terms CPD and CME interchangeably, referring to only the educational components of learners' ongoing development.

In the absence of a formal definition of CPD worldwide, the approaches to healthcare professional education for practicing clinicians vary widely. Countries that have more formal CPD systems are often those where participation in CPD is required for re-licensure, revalidation, or for financial/salary benefits. In countries where there is little or no need for documented, relevant CPD, there are fewer opportunities for physicians and other healthcare professionals to participate in high-quality CPD activities that have been designed to improve practice and outcomes.

### B. Structured System for CPD

Another area of inconsistency globally is the structure of CPD systems. In North America, Australia and Europe, there are structured systems of CPD in which organizations that have met pre-established standards set forth by accrediting bodies ("accredited providers") or organizations that develop certified educational activities using accreditation standards award continuing education (CE) credit to learners. While accredited

providers vary in type, structure, and affiliation, they follow common practices when developing education. In systems that use accreditation standards, accredited provider types include but are not limited to academic medical centres, hospitals or healthcare systems, associations, specialty societies, government agencies, and medical education companies. In areas of the world that have not implemented accreditation standards, organizations that include commercial interests are able to develop education for healthcare professionals.

### C. Activity Design, Evaluation and Credit

Healthcare professionals seek out and participate in CPD with the intent of improving their own knowledge and practice, and with a desire to provide the best care possible to the patients they serve. The design of educational activities including how they are evaluated, and the type of CE credit awarded (if any) reflect regional differences.

In countries using accreditation standards, accredited providers or organizations submitting activities for approval design educational activities to address professional practice gaps, or identified practice-based needs. Assessment of gaps, content development, implementation, and evaluation are the responsibility of the provider or organization. In some countries, however, CPD topics are selected by stakeholders such as governmental health authorities, and not determined by those who are responsible for designing and developing the education. This poses significant constraints for providers/organizations to conduct their own needs assessments and identify appropriate topics for CPD activities for their learners. In some areas of the world, commercial interest organizations are permitted to develop or participate in developing CPD that awards CE credit, while in others areas there is strict separation of commercial interest organizations from the educational activity design process.

Commercial interest organizations are defined by the Accreditation Council for Continuing Medical Education (ACCME) and other accrediting bodies as: produces, markets, sells or distributes health care goods or services consumed by or used on patients; is owned or operated, in whole or in part, by an organization that produces, markets, sells or distributes health care goods or services consumed by or used on patients; or advocates for use of the products or services of commercial interest organizations (Accreditation Council for Continuing Medical Education, 2004).

The vast majority of CPD developed globally is focused on single-profession education. While this "educational

isolation” is common, it is not representative of the environment in which healthcare providers practice. The evolution of interprofessional continuing education (IPCE), in addition to single-specialty multidisciplinary education, has begun to emerge within North America, Europe, Australia, the Middle East, and Asia.

When evaluating CPD activities, the seven-level approach of Moore and colleagues (Figure 1) has been

adopted in many areas worldwide (Moore, Green, & Gallis, 2009). Outside the US where accredited providers are required to measure at the level of competence or higher, the lower level outcome measures, participation and satisfaction, are assessed most frequently. Changes in knowledge are also measured, but the higher levels of measurement including changes in competence, performance, and patient or population health are measured far less often.



Figure 1. Moore's CME Outcome Model

Finally, awarding of CE credit is inconsistent globally. In some countries, participation in CPD with associated CE credit is required for healthcare professionals to maintain a license to practice or for maintaining board certification. Some countries impose mandatory participation in CPD as a requirement for remuneration. In other areas, credit is not meaningful or relevant. This poses significant challenges for the global healthcare education community. There are no global standards for CPD, although accrediting bodies in some areas of the world have collaborated to use congruent standards and develop systems of mutual recognition, such as ACCME's substantial equivalency evaluation process. In other areas of the world, standards have not been adopted. This is one of the major challenges to harmonize credit systems around the world.

### III. THE EVOLUTION OF CPD IN THE UNITED STATES

#### A. Early 2000s

In the early 2000s, the CPD system in the United States was largely based on the concept of “formal” education delivered in live, face-to-face meetings. Commercial support, or funding from commercial interest organizations, was a significant driver of revenue for many continuing medical education (CME) companies. Educational activities were developed in a single profession model, with little opportunity for interaction or engagement between members of different health care

professions. There was a lack of formal faculty training opportunities, and evaluation of educational activities was often based solely on satisfaction rather than higher level outcomes that reflected learning, practice change, and impact. The US accreditation system was strong, having implemented standards for commercial support and independence that required CME providers to prohibit commercial interest organizations from influencing the process of planning and presenting educational activities. The US accreditation system was also beginning to use its evidence-based criteria as a lever for change.

In 2006, the Accreditation Council for Continuing Medical Education (ACCME) began to require its providers design educational activities to change competence (ability to apply), performance, or patient outcomes. ACCME also required its providers to assess whether change in competence, performance, or patient outcomes occurred. Concurrently, the ACCME was also collaborating with the major accreditors in nursing and pharmacy to develop a joint accreditation system that recognized and promoted team-based learning. The foundation of the US accreditation system was based on provider accreditation rather than individual activity approval. A provider-based accreditation system allows for the review and approval a greater number of activities than an activity-based system, and facilitates an

environment of self-regulation and educational innovation.

### B. Present Day

CPD has evolved to encompass a wide range of educational experiences that reflect the needs of today's healthcare professionals working within multiple and diverse health care settings. CPD includes activities such as conferences and formal meetings, but also incorporates less structured, informal learning that occurs in the workplace. CPD may include Grand Rounds, Tumor Boards, and organizational or unit-based quality improvement initiatives. CPD is incorporated within journals, and within poster presentations. CPD is flexible and adaptable, with better alignment across the education continuum - from undergraduate, to postgraduate, to the practice setting.

CPD is learner-focused and faculty-supported, in contrast to faculty-driven. Education is designed to meet the professional practice gaps of individual health care practitioners and of health care teams. CPD providers incorporate adult learning principles, active learning strategies, and longitudinal design interventions. CPD providers evaluate the impact of education using higher level outcomes that reflect competence (or intent to change practice), performance, and/or patient outcomes.

In the US, CPD is also moving from single profession to team-based models that incorporate multiple healthcare professionals into planning and designing educational activities. Accreditors across the major health care professions of medicine, nursing, and pharmacy have aligned expectations for continuing education providers, improving congruence and expectations. Three accreditors have also collaborated to create a joint accreditation program to promote IPCE in CPD. Providers that are jointly accredited have opportunity to award IPCE credit for team-based education, as well as retain the ability to award credit for single profession CE as appropriate (Joint Accreditation, 2016).

Although commercial support remains a source of funding for CME, there has been an overall reduction in the amount of support provided by commercial interest organizations. Data from the 2006 ACCME annual report indicated that 50% of the \$2.4 billion spent on continuing medical education came from commercial support; this dropped to 28% of the \$2.5 billion spent on CME as reported in the ACCME annual report in 2015, and only 11% of all CME activities in 2015 received commercial support (Accreditation Council for Continuing Medical Education, 2015).

Finally, CPD is being engaged as a strategy to address major public health issues in the US. Providers, accreditors, and the Food and Drug Administration (FDA) have combined forces to address opioid-related deaths through the Extended Release/Long Acting (ER/LA) Opioid Risk Evaluation and Mitigation Strategies (REMS) program. Funded by pharmaceutical manufacturers of ER/LA opioids, providers independently develop education designed for prescribers of these medications, while oversight of compliance is managed by the accreditors.

## IV. CONCLUSION

CPD continues to evolve worldwide as it is increasingly recognized as an important part of the healthcare education continuum. Alignment is occurring among the healthcare accreditors in academia, post-graduate training, and practice. Changes and progress made in North America, Australia, and Europe are influencing and affecting change in countries throughout the rest of the world. This has led to the emergence of CPD professionals who have built the necessary skill set required to develop CPD activities worldwide. These changes are leading to the recognition of CPD as a critical element of the health care system, addressing health care gaps for individual practitioners, teams, patients, and the system.

### Notes on Contributors

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### Declaration of Interest

The authors of this paper have no conflicts of interest to declare.

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