Medical Education

Continuing professional development of doctors

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ABSTRACT

After graduating from medical school, all doctors need to undertake some training activities lifelong to maintain, update or develop their knowledge, skills and attitudes towards their professional practice. Continuing professional development (CPD) refers to continuing development of medical and non-medical competencies including professionalism, and interpersonal, managerial and communication skills.

There is no single correct way of doing CPD. Most learning in CPD is self-directed and based on one's own learning needs. Effective CPD is characterized by the presence of three factors: a clear reason why a particular CPD needs to be undertaken, learning activities appropriate to identified needs and follow-up on learning. There are several models for CPD. However, the onus is on doctors to show that they continue to maintain appropriate professional standards after training. Here, regulation becomes essential for revalidation, monitoring and to provide the necessary impetus to make CPD mandatory.

In India, the credit point system is followed by some states, but the policy to link credit hours with renewal of registration thereafter is not uniform. While the present system is able to monitor time devoted to CPD, it encourages people to gather certificates of attendance at sessions without relevance to or real interest in the subject. The quality and relevance of CPD activities matter more than the quantity of hours.

Eventually, we need to move away from credit point counting towards a process of self-accreditation and reflection. Each individual will have to find appropriate methods, learn, document and present evidence that learning has happened, and show that it has been applied in practice. As a profession, we need to encourage a culture where doctors do not view CPD and recertification as a threat. Doctors will need to understand that they are accountable to their patients, and should prioritize and build CPD into their practice.

Natl Med J India 2017;30:89–92

INTRODUCTION

Medicine is a rapidly evolving subject. Most of what is taught in medical school is obsolete a decade after a student graduates. Hence, all doctors should take part in education and training activities throughout their careers to keep themselves abreast of the latest trends and to update their knowledge and skills. These are called 'continuing professional development' (CPD) activities, which play an important role in maintaining the quality of healthcare delivery systems.

DEFINITION

CPD is 'the period of education and training of doctors commencing after completion of basic medical education and postgraduate training, thereafter extending throughout each doctor's professional working life'.[1]

Continuing medical education (CME) is defined as 'any activity that serves to maintain, develop or increase the knowledge, skills and professional performance and relationships that a physician uses to provide services for patients, the public or the profession'.[2] The term CME has been largely replaced by CPD. While CME describes activities relating to medical knowledge and skills, CPD is a broader concept and has a wider context.[3] CPD extends throughout the continuum of medical education and refers to continuing development of a large number of medical and non-medical competencies including professionalism, and interpersonal, managerial, communication and social skills. Acquisition of all these competencies is essential to be a good professional. In other words, CPD includes all formal and informal activities that doctors undertake to maintain, update, develop or improve their knowledge, skills and attitudes towards their practice.[1]

Globally, there is no consensus on whether CPD should be mandatory; who should regulate CPD; how should it be implemented; how should it be quantified and monitored; whether CPD activities should be formally approved for quality; whether CPD should be linked to re-licensure; and the consequences of not complying with CPD guidelines.[4]

NEED FOR CPD

Doctors owe it to their patients to keep themselves abreast of the latest developments in their field of practice. This is in the best interest of their patients and a professional obligation. CPD promotes individual development, thereby enabling a doctor to respond to the challenges of evolution of scientific knowledge in medicine, and the changing requirements of patients, the healthcare delivery system and regulatory bodies. CPD also is an integral part of the process of improving the quality of healthcare that we deliver to society.

A majority of doctors grow in their practice by learning to respond to the changing needs of society and evolving trends in their field. Usually one's own desire to maintain professional quality is the strongest motivation to pursue lifelong learning. The motivation to engage in CPD is derived mainly from three sources: (i) the professional drive to provide optimal care to patients; (ii) the obligation to honour the demands from employers

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and society; and (iii) the need to preserve job satisfaction and prevent burnout.[1]

CONTENT OF CPD

CPD aims at enhancing competencies in the area of clinical skills and medical knowledge to deliver the best possible patient care. This includes broadening and deepening existing factual knowledge, procedural skills and intuitive knowledge. Medical practice has high levels of uncertainty and unpredictability, and doctors often have to make judgements in complex situations. Hence, they need to be aware of and responsive to societal trends that impact patient care. They must keep abreast of the latest developments in research, have the ability to critically appraise new scientific knowledge, and utilize it to continuously improve their clinical practice. Knowledge of behavioural and social sciences including sociology, biostatistics, public health, health economics and policies, and social and cultural determinants of health is also relevant to everyday practice.

Besides this, doctors must aim to acquire organizational skills such as administrative and managerial skills, team building abilities, leadership qualities, and communication and interpersonal skills, which will hold them in good stead in their daily activities. Knowledge and awareness of concepts of professional behaviour, judgement and ethics are crucial for providing best practice in medicine.

IMPLEMENTING CPD IN PRACTICE

CPD is different from the training one receives as an undergraduate or postgraduate student. While the latter is conducted according to the rules and recommendations of a regulatory body and under supervision; most learning that occurs in CPD is autonomous, self-directed and based on one's own learning needs. Training is seldom supervised for long durations. There is no single correct way of doing CPD. The content, context and processes chosen depend upon one's sphere of practice, learning style and personal preference.[5] Each person has preferences for learning and these must be taken into account rather than adopting a rigid approach to the best method for doctors to learn. Effective CPD is characterized by the presence of three factors:[4]

1. *Needs assessment*: A clear reason why a particular CPD needs to be undertaken;
2. *Appropriate learning activities*: Learning that is tailor-made to identified needs; and
3. *Follow-up on learning*: Some follow-up after the CPD, which provides reinforcement and dissemination of learning.

Needs assessment is an integral component of effective CPD. The most common way in which doctors identify their learning needs are by reflecting upon their everyday clinical practice—thinking about the errors they have made and recognizing areas that require improvement based on the feedback received from their patients or colleagues in the clinical team. New drugs, technology, equipment, procedures and techniques are always being introduced, and these need to be learnt. Further, changing clinical demands might require doctors to equip themselves to deal with unusual circumstances. For example, increasing cases of assault of doctors by patients' relatives might require doctors to introspect about the way they communicate with families of patients, and the need to learn the medico-legal implications of how to protect themselves and their premises from damages. More formal assessments such as tests of knowledge, skills and attitudes, audits of performance or clinicopathological meetings can also be used to identify lacunae that need to be addressed. Some organizations set out competence standards; these can be helpful as a starting point for gap analysis. Here a learning need is identified as the gap between current and ideal performance. The desired competencies are then defined and activities undertaken to acquire these needs.

Learning activities must be appropriate to the identified needs. Learning modalities and methods can vary depending on the learner requirements and availability. These modalities must take into account differing learning needs and priorities of individual learners. Didactic learning sessions may help in integrating theory with practice, but more collaborative learning should be encouraged. Self-directed learning, individual reading and self-assessment of knowledge are usually practised.

It must be emphasized that while formal academic sessions in conferences and seminars are useful, one cannot underscore enough the importance of informal conversations. Doctors tend to change their practice through professional exchanges or dialogues with their colleagues rather than as a consequence of attending formal educational sessions. Thus, these educational inputs need to be continuous and aimed at daily practice, rather than intermittent and targeted. The focus should be on encouraging reflection and deliberation on one's own and other's practice. Informal opportunities to discuss and share experiences such as peer-reviews, audit meetings and case discussions are equally useful. Networking opportunities and conversations with peers play an important part in transforming behaviour. An amalgamation of formal and informal activities has to be built in to make an effective CPD programme. Engaging in CPD reduces professional isolation and this is important for both doctors and their patients.

Equally important is to document one's learning. The documentation of the CPD cycle involves recording one's learning needs and then following the steps that were taken to fulfil those needs. This documentation is important both as a guide to the doctors as well as to the regulating bodies for purposes of accountability and demonstration of learning.

It is important to plan activities that will reinforce learning on a later occasion. This might include activities such as reporting back to colleagues, developing new services, demonstrating new skills or simply feeling more confident. This will offer opportunities to share learning with more people, alter methods of practice and also provide a chance to evaluate the effectiveness of the original CPD exercise.

MODELS OF CPD

CPD models vary from place to place. The three common models of CPD are: [4]

1. *Update models* where the aim is simply to communicate or disseminate information.
2. *Competence models,* which aim to ensure that minimum standards for knowledge, skills and attitudes are attained.
3. *Performance models,* which aim to help doctors overcome barriers to successful changes in practice and help them resolve clinical concerns.

The update models do not necessarily translate to better clinical practice, whereas the performance models are beginning to become more popular. Centralized recertification examinations to test competence are often perceived as a threat and are also difficult to tailor to the needs of individual practices.[2]

In most countries, the responsibility of organizing CPD activities is on professional organizations. Medical associations and

academies, professional bodies, government organizations or academic institutions usually initiate, conduct and promote CPD. In the UK, the Academies of the Royal Colleges take responsibility for providing a framework for CPD.[6] They set educational standards, monitor, facilitate and evaluate activities for their members. These schemes are flexible so that doctors can participate and be recognized for what they do in their professional practice contexts.

The Academy of Medical Royal Colleges in the UK has brought out a list of ten principles for CPD schemes.[7] These specify that CPD activities should be reflective of professional practice and performance. These should include development outside narrower specialty interests and use a balance of learning methods. These also allow credits for untimed activities such as writing, reading and e-learning if sufficiently justified by the participant. Participants are required to collect evidence of learning. Self-accreditation of relevant activities and documented reflective learning is allowed and encouraged.

In India, in 1996, the Amal Dutta Committee Report recommended amendments in the Indian Medical Council Act to make compulsory the renewal of registration every 5 years. The committee also put the onus of renewal on doctors by saying that 'the doctors should inform in writing the Medical Council that they want to renew their membership'. It recommended a minimum of 30 credit hours be made necessary to renew registration every 5 years.[8]

In May 1996, a national workshop on medical education conducted under the auspices of the Medical Council of India (MCI) made a recommendation for renewal of registration after every 5 years along with compulsory CME with at least 30 credit hours in each year. The general body of the MCI at its meeting on 27 February 1997 recommended the renewal of registration after every 5 years and said that for this purpose the Indian Medical Council Act should be amended as there is no provision in the Act for such renewal. The MCI also recommended that the renewal of registration should be linked with compulsory CME attendance with a minimum of 30 credit hours every year.[9] However, no efforts were made to link credit hours with renewal of registration thereafter.

Several state medical councils including those of Maharashtra,[10] Tamil Nadu[11] and Karnataka[12] have amended the Act and link mandatory CPD requirements for renewal of registration every 5 years. However, these requirements are not uniform. Most guidelines require all medical practitioners to gain 30 credit hours in 5 years (maximum 6 credit hours/year) by attending various conferences/CMEs/workshops till the age of 65 years and get their registration renewed once in 5 years. According to the Maharashtra Medical Council (MMC), for example, 6 credit points per year are mandatory and a minimum of 30 credit points are mandatory for renewal of registration. Accreditation/credit points are awarded to academic activities depending upon the duration of the activity, subject matter, status of the speaker and quality of papers presented in the CME/conference. Credit points are granted to CMEs having MMC accredited speakers. MMC appoints observers for each CME. For doctors residing in the state, up to 20% CME points for activities which are approved by the MMC in 5 years are considered. A maximum of 4 credit points are awarded for national conferences held by recognized specialty associations and a maximum of 2 points for any other conference or workshop. A maximum of 4 points are awarded for publishing textbooks, 3 points for other books in the subject specialty and 2 points for original research papers in indexed journals or presentations at state or national conferences. Credit points for international conferences or online courses are varied and a maximum of 3 points can be awarded based on the content and credibility of the conference/CME. All medical teachers and postgraduate students in MCI-recognized institutes get 2 credit points per 6 months term on production of a certificate to that effect from the head of the institution. Medical officers are granted credit points for all official training programmes conducted by the Directorate of Health Services. Doctors completing 70 years of age are exempted from credit points but renewal of registration is mandatory.[10]

Often pharmaceutical companies and other for-profit healthcare companies also support CPD. Some countries have privately run commercial purchasable CPD courses. When CPD becomes heavily dependent on support from drug and pharmaceutical companies, the ethical underpinnings of the medical profession may be compromised.[13] It has been shown that such support can distort the selection of topics, embellish the positive elements and play down the adverse effects of some interventions. To reduce this conflict of interest, it has been proposed that these sponsors should not have any influence over the choice of speakers and scientific content.[14] Some medical institutes have made it a policy to shun any kind of industry sponsorship for academic meetings.[15]

Distance learning and online courses have emerged as useful ways of providing flexibility to doctors for CPD. The use of portfolios and logbooks for documentation and monitoring individual CPD activities has been mooted in some institutions.[3,16] Portfolios are useful tools for recording learning and for external peer-review. These can provide documentary evidence of assessment of performance. These have the potential to evaluate a doctor's ability to reflect on practice and improve patient care. The advantage is that these are flexible and can be tailored to an individual's learning needs. However, with increasing clinical workloads, doctors often do not find enough time to use these tools and compliance is poor.

REGULATORY ISSUES

Once out of medical school, the onus is on doctors to show that they continue to maintain appropriate professional standards. The role of regulatory bodies is to support them in doing this and to monitor that it is done.[17] Some form of regulation becomes essential to provide the necessary impetus to make CPD mandatory and this role cannot be undermined. This is important for clinical governance,[18] revalidation[19] and monitoring poor performance. When subjected to external scrutiny, individual doctors should be able to justify their activities.[3]

In some countries, regulations exist and evidence of CPD is required either for re-licensure or re-registration of doctors. Some countries require recertification which involves assessment of knowledge and skills at periodic intervals. However, these regulations are largely flexible. The educational outcomes of CPD are rarely tangible[1] and measuring the capacity of doctors to make better clinical judgements in professional practice is rather difficult. Different systems use different criteria to specify the acceptable level of CPD engagement.

Generally, the number of hours spent in accredited courses is defined and credit points are allocated proportionately. The advantage of the credit point system is that the time devoted to CPD can be monitored and recorded. The disadvantage is that it encourages people to gather certificates of attendance at CPD sessions without relevance or real interest in the subject. This 'bums on seats' approach and pursuit of attendance certificates,

which is followed by both participants and organizers, provides a sense of false security about the actual outcomes of CPD endeavours.[3] The quality and relevance of CPD activities matters more than the number of hours and participants.[20] Further, organizers also need to be responsible enough to handle such issues professionally. It is not unusual to find certificates of registration enclosed in registration kits even before the participant has completed the session. This needs to be stopped and, perhaps, regulated.

A systematically managed CPD relates activities to personal, professional and health service needs, is based on documented evidence of effective learning and ensures that learning is used to improve practice. The process, content, time spent or outcomes can be awarded credits and innovative approaches are encouraged. CPD activities should be cost-effective. The regulation can be locally managed but nationally monitored.[4]

WHO recommends that: 'there should be a statutory body governing the CME/CPD system. The system should be efficient, fair, transparent, credible and accountable. The different characteristics of the system must be known and accessible to all stakeholders. The system would also ensure recognition, support, cooperation, collaboration, coordination and adherence to the guidelines. It should employ appropriate modalities based on comprehensive needs assessment in order to evaluate areas such as the physician perspective (training needs, career development needs, attitudes and perceptions on CME/CPD), patient perspective (expectations from a doctor), opinions of governing bodies, professional bodies and available logistics.'[2]

Law and regulation can rarely regulate CPD.[1] Bureaucratic tangles and lack of timely communication between regulatory bodies and professionals can hinder the purpose of CPD. It is important that audit and formal approval of CPD activities be achieved with minimum bureaucracy and with complete reciprocity between academic organizations for all approved events.[7] Attempts should be made to improve compliance by streamlining the submission process, making it less cumbersome and the forms simpler to fill.

Eventually, we need to move away from counting credit points, towards a process of self-accreditation and reflection. There is no single best way of performing CPD.[3] Each individual will have to find methods which are appropriate to their own personal preferences; learn, document and present evidence that learning has happened; and show that it has been applied in practice. Learning is likely to lead to better practice when it is relevant in the context of everyday clinical practice. Learning methods may include self-assessment, journal reading, discussion with colleagues, or visits to higher centres or academic institutions.[4] In addition, other forms of learning such as making presentations, writing for publication, reviewing journal articles, teaching and mentoring others, self-study, contributing to health consultations must make their way into recognized CPD formats. Much of actual CPD is not credit-bearing and is likely to remain so. Although this is difficult for professional bodies to recognize and reward, attempts should be made to further increase the recognition of such learning.[4]

In view of the importance of CPD in maintenance of quality assurance of healthcare, it becomes important to equip students with skills and strategies of self-directed learning throughout their education. As a profession, we need to encourage a culture where doctors do not view CPD, recertification and appraisal as a threat. A more positive and transparent approach towards CPD is required to determine if doctors are fit to practise and to ensure patient safety. Doctors will need to understand the need to be accountable towards their patients, prioritize their tasks and build CPD into their practice.

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