



CONTINUING PROFESSIONAL DEVELOPMENT OF MEDICAL DOCTORS

WFME GLOBAL STANDARDS

FOR

QUALITY IMPROVEMENT

The 2015 Revision

WFME Office
University of Copenhagen
Denmark

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Explanatory note to guide the use of the Standards

These standards are based on our current understanding of fundamental principles and best practices in designing, maintaining, and enhancing medical education programmes.

Standards are intended to guide medical education programme development and evaluation, facilitate diagnosis of strengths and weaknesses relating to the medical education programme, and to stimulate quality improvement.

Each institution or regulator should review the relevant standards and develop a version of them that is appropriate to the local context. It would be helpful if those local, contextual standards are mapped on to the original WFME standards.

Not all standards may have application in every setting.

A medical school may well receive a satisfactory overall evaluation and maintain accreditation (where appropriate) without necessarily meeting every standard and sub-standard.

Note: In 2017 the document design was updated. The content remains unchanged.

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Preface

Starting in 1998, the World Federation for Medical Education (WFME) developed the WFME Trilogy: *Global Standards for Quality Improvement of Medical Education*, covering all three phases of medical education: *Basic (Undergraduate) Medical Education (BME)*; *Postgraduate Medical Education (PME)*; and *Continuing Professional Development (CPD) of Medical Doctors*. Preliminary results were presented in 2000 and the Trilogy was published in 2003.

The global standards for medical education have been implemented and used extensively all over the world. They offer medical education programmes at various stages of development, and with different educational, socio-economic and cultural conditions and different disease patterns, a template for defining institutional, national and regional standards, and a lever for reform programmes.

As a result, valuable experience was gained and fruitful advice and recommendations compiled from the use of the standards in institutional and national medical education reforms, evaluation and accreditation procedures.

From the outset it was decided that the global standards should not be changed too frequently with the risk of creating unnecessary inconvenience among user institutions. However, ten years after publication of the global standards for medical education, the Executive Council of WFME realised the need for a revision taking into account the commentaries received from medical educators, institutions and organisations and the accumulated relevant literature in the field. Therefore, in 2012 the Federation initiated a revision of the Trilogy.

During the revision process, which involved a small working party and a broad international panel of experts, extensive comments and proposals were received, showing a need for a thorough overhaul. However, it should be emphasised that this revised version of the WFME standards for continuing professional development (CPD) of medical doctors respects the original overall principles and structure. The revised version presents much the same standards at two levels of attainment, basic and developmental, as the original 2003 standards document.

WFME is profoundly indebted to all who have contributed to the process of reviewing the global standards. The enthusiasm and readiness to assist encountered in all regions have been overwhelming, thereby signalling that the standards are both desirable and feasible.

The WFME Executive Council trusts that the revised standards document will be useful for everybody involved in continuing professional development of medical doctors. The document will be of interest for health authorities, medical associations, medical schools and national and international institutions/organisations dealing with continuing professional development of medical doctors in all countries. WFME would advise that trustworthy authorities are established country-wise to oversee the application of the global CPD standards.

Introduction

HISTORY

The improved health of all peoples is the main goal of medical education. This is also the overall mission of the World Federation for Medical Education (WFME), the international body representing all medical teaching institutions, medical teachers and students and medical doctors in all aspects of their education. In keeping with its constitution, WFME undertakes to promote the highest scientific and ethical standards in medical education, and to encourage development of learning methods, new instructional tools, and innovative management of medical education.

Since 1984, WFME has conducted an "International Collaborative Programme for the Reorientation of Medical Education". Cornerstones in this process were the Edinburgh Declaration, 1988, which was adopted by the World Health Assembly, WHA Resolution 42.38, 1989, and the Recommendations of the World Summit on Medical Education, 1993, reflected in WHA Resolution 48.8, Reorientation of Medical Education and Medical Practice for Health for All, 1995.

In compliance with its mandate, WFME launched the programme on global standards in medical education in a position paper of 1998. The purpose was to provide a tool for quality improvement of medical education, in a global context, to be applied by institutions responsible for medical education, and in programmes throughout the continuum of medical education.

The WFME programme on global standards in medical education, approved by the World Health Organization (WHO) and the World Medical Association (WMA), had from the very outset three main intentions:

- to stimulate authorities, organisations and institutions having responsibility for medical education to formulate their own plans for change and for quality improvement in accordance with international recommendations;
- to establish a system of national and/or international evaluation, accreditation and recognition of medical educational institutions and programmes to assure minimum quality standards for the programmes; and
- to safeguard practice in medicine and medical manpower utilisation, in the context of increasing internationalisation, by well-defined international standards in medical education.

The WFME global standards embrace all phases of medical education, i.e. basic (undergraduate) medical education, postgraduate medical education and continuing professional development of medical doctors. The trilogy of global standards intends to facilitate the relationship between the stages of medical education.

In developing the Trilogy, WFME appointed three International Task Forces, each comprising a Working Party meeting on a retreat basis, and a broader Panel of Experts that communicated mainly electronically. Members of the Task Forces were selected on basis of their expertise and with geographical coverage an important consideration. The drafts of the standards documents were discussed frequently and in numerous settings around the world. The many commentaries received were collated and taken into account.

Implementation around the world of the standards programme started immediately after the first presentation in 2000 and the conduct of pilot studies in all 6 WFME Regions. The process of implementation was accelerated after broad international endorsement of the standards at the WFME World Conference *Global Standards in Medical Education for Better Health Care* in Copenhagen 2003.

The global standards, translated into several languages, have been used and have influenced national planning of medical education in many countries.

In the early stages of developing the global standards for medical education, it became clear that specifying global standards in any restricted sense would exert insufficient impact and would have the potential to lower the quality of medical education. The criticism, whether justified or not, has become commonplace that medical education has adjusted slowly and inadequately both to changing conditions in the health care delivery systems, and to the needs and expectations of societies. Thus, a lever for change and reform was incorporated into the standards. This led the WFME standards to being framed to specify attainment at two different levels: (a) basic standards or minimum requirements; and (b) standards for quality development.

That the WFME standards would have the status of an accreditation instrument was considered from the inception. After deliberation, WFME has taken the position that only nationally appointed agencies can be directly responsible for accreditation procedures. However, WFME can have a role in assisting in accreditation processes and globally adopted standards can function as a template for the agencies designated to implement evaluation and accreditation. WFME, in collaboration with WHO, developed guidelines and procedures for accreditation as an activity of the WHO/WFME Partnership of 2004 to improve medical education.

The medical workforce is globally mobile and the WFME standards have a part to play in safeguarding adequate educational grounding of migrating doctors. However, incentives for retaining locally trained doctors in their own countries and regions are equally essential. The WFME standards should not be viewed as encouraging increasing medical mobility and spurring brain drain of doctors from developing countries. The world is characterised by increasing internationalisation, from which the medical workforce is not immune, and compliance with the standards should serve as necessary quality-assuring credentials of medical doctors wherever they are based.

To ensure that the competencies of medical doctors are globally applicable and transferable, readily accessible and transparent documentation of the levels of quality of educational institutions and their programmes is essential. The *Avicenna Directory of Medical Schools*, developed by WFME from 2007 to replace the *WHO World Directory of Medical Schools*, aimed to constitute a roster of medical educational institutions, indicating specifically whether institutions included have attained globally approved standards for medical education programmes. The *New World Directory of Medical Schools*, established in 2012 as a merger of the *Avicenna Directory* and the *International Medical Education Directory (IMED)* of the *Foundation for the Advancement of International Medical Education and Research (FAIMER)* has continued this line. However, a similar model for creation of a register of Programmes for CPD is unrealistic, given the wide range of formal and individual CPD activities, organisational models and regulatory contexts. Instead, the international community must rely on adequate national information about CPD systems and activities.

FUNDAMENTALS OF CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

The concept of CPD

Continuing professional development (CPD) designates the period of education and training of doctors commencing after completion of both basic and postgraduate medical education, thereafter extending throughout each doctor's professional life. However, CPD can also be seen as a life-long continuing process, starting when the student is admitted to medical school and continuing as long as the doctor is engaged in professional activities.

CPD stands as a professional imperative for every doctor, and is also a prerequisite for enhancing the quality of health care. CPD differs in principle from the preceding two formal phases of medical education: basic medical education and postgraduate medical education. Whereas the latter two are conducted according to specified rules and regulations, CPD mainly implies self-directed and practice-based learning activities in addition to supervised education, and rarely involves supervised training for any extended period of time. As well as promoting personal professional development, CPD aims to maintain and develop the relevant knowledge, clinical and communication skills and attitudes of the individual doctor, vital for meeting the changing needs of patients and the health care delivery system, responding to new challenges arising from the scientific development in medicine, and meeting the evolving requirements of licensing bodies and society. This implies that in the future it will be necessary to make use of feedback and supervision in order to increase efficiency of CPD activities.

Doctors must be autonomous and independent, i.e. they must be able to act in the best interest of the patient without undue external influence. However, the majority of medical doctors work in some form of a regulated system. Engaging in CPD is a professional obligation but also a prerequisite for enhancing the quality of health care. The strongest motivating factor for continuing professional learning is the will and desire to maintain professional quality.

The term continuing medical education (CME), dealing with knowledge and skills of medical practice, which is still preferred in some countries, has in this document been replaced by continuing professional development (CPD). This term reflects both the wider context in which this phase of medical education takes place, and it signifies that the responsibility to conduct CPD rests with the profession and the individual doctor. Law and formal rules rarely regulate CPD, although participation in CPD activities is mandatory in some countries. Where regulations do exist, they are not rigid, even in countries which demand re-licensure or re-registration of doctors in practice.

Educational rationale

In order to practise appropriately throughout their professional life, doctors must remain up-to-date, which entails engaging in some form of continuing learning and education. The role of CPD in quality assurance and quality development of the health care delivery systems is increasingly significant.

Motivation for CPD, from the perspective of the individual doctor, derives mainly from three main sources:

- The professional drive to provide optimal care for the individual patient;
- An obligation to honour the demands from employers, colleagues, professional organisations and society;
- The need to preserve job satisfaction and prevent “burn out”.
- In principle, motivation for life-long learning should be nurtured through all phases of medical education and by the working conditions of clinical practice.

The best available evidence suggests that effective CPD is characterised by the presence of (a) a clear need or reason for the particular CPD activities to be undertaken; (b) learning based on such an identified need or reason; and (c) follow-up CPD activities to reinforce the learning accomplished. Needs assessment based on dialogues with patients and colleagues and information about the priorities of the health care system is therefore, in most cases, an integral component of a successful CPD.

Generally doctors develop and change their practice through professional conversational exchanges and dialogue with colleagues rather than as a result of formal educational processes. Thus, the learning process necessary for effective clinical practice is one of continuous development rather than targeted, intermittent input. Doctors must learn about and from their practice through reflection and deliberation about their own and others’ practice. Also, it is through such an on-going process that they identify and clarify their learning needs.

Much of this continuous development is informal and often not even consciously identified as CPD. CPD is thus to some extent an integral part of the practice of doctors worldwide, even in the remotest location without access to information technology or planned CPD activities.

Emphasising the importance of non-formal CPD in no way disregards how systematic formalised elements, such as courses, conferences, etc. are essential in effective CPD. A multi-faceted CPD system best fulfils all needs of doctors, taking into account differences in professional roles, requirements and learning priorities.

Organisation and methods

The organisation of CPD varies hugely from country to country. A basic assumption is that the profession bears a major responsibility for CPD, with medical associations, medical societies and other professional organisations functioning as major initiators, promoters and providers of CPD in many countries.

CPD providers include primarily the professional associations and organisations, national, regional and global medical scientific societies, medical schools/universities, postgraduate institutes, employers in the health care system and others such as health authorities, the pharmaceutical and the medical device industry, companies in information technology and consumer associations. There is a growing awareness that involvement of pharmaceutical and medical device industry in CPD provision must be transparent and conflict of interests avoided.

In some countries major institutes for CPD exist. Some are privately hosted on a commercial basis, illustrating the growing tendency that education is marketed as a purchasable commodity. Other institutes are government-run, and in addition often provide systematic specialist (postgraduate) training in addition to CPD courses. National medical councils or academies are yet another model

for provision and development of CPD. In some countries, elements of the labour market legislation are used to secure access to CPD for large numbers of doctors.

Formalised institutional involvement of medical schools varies greatly. In some countries medical schools are a major regulator and provider, in other they are an occasional contributor, by providing specific medical scientific capacity. It is the opinion of the WFME that medical schools have an important role in all phases of medical education, including CPD. There are many reasons for this:

- Medical schools represent expertise in education, research and clinical activities.
 - expertise in medical education could be used in design, methodology and evaluation of CPD.
 - expertise in research could be used in CPD to teach research methodology and critical appraisal of medical literature.
 - medical schools and university hospitals are leaders in new and innovative diagnostic and therapeutic methods to be introduced into the doctors' professional life.
- Medical schools have a key role in the interactions between the three phases of medical education.
 - involvement of medical schools in CPD could give feedback to basic medical education curriculum committees regarding competencies of graduates.
 - former graduates and CPD providers could contribute to design and revision of basic medical education curricula.
 - CPD providers could help curriculum committees in providing clinical instructional facilities in real life situations, which better prepare students to deal with family and community problems.

Opportunities to benefit regularly from CPD depend largely on the working conditions and environment. Informal learning is commonplace and an important component of professional development, equally as effective as more formal versions. Extreme contrasts are present. Work in a thriving clinical research environment, affording stimulating contacts with colleagues, with ample resources to participate in international workshops, conferences etc. differs vastly from working in a rural area, in a single-handed or small practice in the community. While use of information technology can remedy some handicaps of isolation, still the stimulus from close personal relations and communication with colleagues can effectively enhance engagement in CPD.

Information technology and distance learning concepts are increasingly influencing the provision of CPD by using e-learning, blended learning, etc., according to relevant IT - innovations.

The organisational variation worldwide is also reflected in enormous differences in methods of funding CPD. However, the financial resources necessary for CPD should be perceived as part of the operational costs of the health-care sector.

Generally, systems for CPD are presently neither well structured nor transparent. Therefore, there is a great need for research within the field, especially regarding the outcomes of CPD in relation to the quality of clinical practice.

Assessment and documentation

The educational outcomes of CPD are rarely tangible, let alone measurable. CPD does not always directly relate to current practice, but also extends the capacity of doctors to make wiser judgements in the situations of uncertainty they will certainly encounter. A CPD event or activity alone cannot reasonably be expected to show robust improvement of patient treatment – there are too many intervening variables. However, CPD is one of the necessary conditions for improved patient care.

Differentiated systems have been developed which specify the level of acceptable CPD engagement, in which individual doctors obtain CPD points or credits. There is always the danger that the accumulation of points, especially if measured in hours, becomes the main aim of the activity and acts as a perverse incentive which detracts from the integration of CPD with practice and health-care development.

The increasing concern that CPD of medical doctors should be adequate has led to demands for systematic re-certification in some countries, entailing the development of systems for examination or other types of reassessment.

A recent development in CPD focuses on monitoring individual daily learning activities. By use of personal portfolios or log-books for registration of CPD activities, and by comparison with similar results of colleagues, a tool is increasingly provided for planning individual self-directed learning or for managing individual development. Doctors being accountable to society must thus find means – such as realistic monitoring and documentation of CPD activities - to demonstrate that they are capable of continued effective practice.

VALUE OF GLOBAL STANDARDS

A central part of the WFME strategy is to develop global standards and guidelines for medical education, that are supportive of the institutions concerned, their educational programmes, the medical profession, and the individual student and doctor. The global standards constitute a framework, serving as a yardstick against which those responsible for CPD can evaluate their own activities and organisations. Moreover, globally accepted standards could be used as a basis for national and regional approval and accreditation of educational programmes. At the individual level, approved global standards could guide and help medical doctors in planning their own CPD training programmes.

Equally relevant for global standards is the process of medical education. Desirable practices in educating the basic doctor, incorporating well-recognised and accepted principles of learning, together with the institutional conditions for educational activities, must form the basis for global standards.

Moreover, quality assurance of medical education must emphasise the need for improvement and provide guidance for achieving it. This will avoid interpretation of standards as a levelling at a lower level of quality among institutions.

Standards are not an »either/or« matter, but a matter of specific conduct and intentional planning. Furthermore, some doctors might develop so unique a quality as to go beyond standards achieved by most colleagues. Such qualities might, in the long run, serve as examples for new goal-settings.

Standards must be clearly defined, and be meaningful, appropriate, relevant, measurable, achievable and accepted by the users. They must have implications for practice, acknowledge diversity and foster adequate development.

Evaluation based on generally accepted standards is an important incentive for improvement and for raising the quality of medical education, both when reorientation and reform are pursued, and also when continuous development is strived for.

WFME considers that the operation of standards can promote discussion and stimulate development of consensus about objectives, and will help to formulate essentials of educational programmes and to define the fundamentals of medical education. Standards will broaden opportunities for educational research and development and foster discussion and cooperation across subject areas and other boundaries.

The existence of standards will empower providers in their effort to bring about change, and will serve to guide doctors in their choices.

For CPD planners, acceptance of standards will save time and resources. Adoption of standards for evaluation will provide valuable information for providers of funds, politicians and society.

Placing medical education on a basis of shared global standards will facilitate exchange of medical students, and ease the acceptance of medical doctors in countries other than those in which they trained. In consequence, it will diminish the burden of judging the competencies of doctors who have been educated in medical schools in different countries.

Finally, low quality CPD activities can be improved by use of a system of evaluation and accreditation based on internationally accepted standards. This is likely to enhance the quality of health care, both nationally and internationally.

PREMISES FOR STANDARDS IN CONTINUING PROFESSIONAL DEVELOPMENT

The Executive Council of WFME is evidently of the view that global standards for medical education, which have general applicability, can be defined. These definitions take account of the variations in the content, structure, process and outcomes of medical education among countries, due to differences in teaching traditions, culture, socio-economic conditions, the health and disease spectrum, and the different forms of health care delivery systems. Similar differences can also occur within individual countries. Nevertheless, the scientific basis of medicine and the necessity to base clinical practice on evidence is universal; the task of medical education everywhere, throughout its phases, is the provision of high quality health care. Notwithstanding great diversity, there is an increasing degree of convergence of structure, process and product of medical education worldwide.

Global standards for CPD, as for other phases of medical education, must be specified, modified or supplemented in accordance with regional, national and institutional needs and priorities. WFME stress that there can be no benefit in fostering uniformity of educational programmes and learning activities and hereby jeopardising social accountability. Moreover, quality assurance of medical training programmes must give emphasis to improvement, and provide guidance for advancement, instead of simply advocating “fulfilment of standards” as the ultimate goal. It is the prerogative of any national accrediting body to determine the level that will be examined for evaluation/accreditation.

In drafting standards for CPD, the WFME applied the principles used in developing the global standards for basic medical education and for postgraduate medical education. Attention was given to the application of general guidelines in quality development of medical education. Therefore, for global standards in CPD to be generally accepted, the following premises were adopted:

- Only general aspects of CPD should be included.
- Standards should be concerned with broad categories of process, structure, content, outcomes/competencies, assessment and learning environment.
- Standards should function as a lever for change and reform.
- Standards are intended not only to set minimum global requirements but also to encourage quality development beyond the levels specified.
- Standards should be formulated in such a way as to acknowledge regional and national differences in educational programmes, and allow for different local, national and regional profiles and developments.
- Compliance with standards must be a matter for each community, country or region.
- Use of a common set of global standards does not imply or require equivalence of programme content and outcomes of CPD, but deviations should be clearly described and motivated.
- Standards should acknowledge the dynamic nature of programme development.
- Standards should be formulated as a tool that the individual doctor, the medical profession and authorities, organisations and institutions responsible for CPD can use as a model for their own programme development.
- Standards should not be used to rank CPD activities or programmes.
- Standards should be further developed through broad international discussion and consensus.
- The value of the standards must be tested in evaluation studies in each region.
- Standards must be clearly defined, and be meaningful, appropriate, relevant, measurable, achievable and accepted by the users. They must have implications for practice, recognise diversity and foster adequate development.
- Standards must be formulated in collaboration with stakeholders.

USE OF STANDARDS

It should be emphasised that, in working with the standards for planning or evaluation of CPD, the principles underlying each standard are the essential points. Over-attention to details should not obscure the need to apply the *basic standards*, and the desirability of working towards the *standards for quality development*. WFME wants to stress that that all details in the standards document should not necessarily be fulfilled in organising individual CPD activities.

WFME holds that the set of standards, offering as it does a developmental perspective from attainment of basic to quality development levels, can be used globally as a tool for quality assurance and development of CPD in the following ways:

- **Participants in CPD**

The standards provide a framework against which individual doctors and the medical profession can judge themselves in a voluntary self-evaluation and self improvement process. This should be supplemented by feedback from peers and assessment of outcomes when relevant.

- **Providers of CPD**

The standards should form the basis for CPD providers in designing CPD activities.

- **Monitors of CPD**

Depending on local needs and traditions, the standards should also be used by national or regional agencies engaged in supervision, monitoring, approval and accreditation of CPD.

Process and Principles of Revision

It was decided that the WFME Standards should remain to be formulated as a combination of process, structure, content, outcomes/competencies, assessment and learning environment standards.

The plan used for the 2015 revision of the CPD Standards document comprised:

Phase I:

Production of a draft by a small working party of persons associated with the WFME office.

Phase II:

Gathering of comments and proposals for amendments and additions from a broad international panel of experts representing all six WFME Regions.

Phase III:

Presentation of the amended document for further comments from the main partners of WFME, including the members of the WFME Executive Council.

In this work the original premises for setting standards for CPD were followed, but it was realised that a system should be introduced to allow clearer presentation of standards. Annotations should provide clarification and exemplification based on accumulated experiences in using the standards. Formulations should be harmonised between the three sets of WFME global standards.

General principles underpinning the standards were not changed during the revision, e.g. using two levels of attainment, i.e. basic standards and standards for quality development, and not only minimum requirements. The dividing line between basic standards and standards for quality development was considered and changed in some cases in accordance with the international developments in requirements to medical education. The number of areas and subareas is basically the same, but composite standards have been split to increase the overview of standards content. The sequence of standards is in some cases changed. A numbering system has been introduced, thereby facilitating references to and communication about the standards.

As with the standards for basic medical education and postgraduate medical education it was regarded as desirable to clearly place and define the responsibility for fulfilment of the standards. As responsibility for CPD may be shared by different agents, we have chosen the **medical profession** as the overall responsible actor. Explicit responsibility for action to achieve all standards is now placed with the profession through its authoritative bodies as well as the individual doctor.

The classification of standards has been kept close to the original, but minor reformulation of some areas and standards was needed to clarify the content. Repetition and overlap have been reduced. Several standards specify that implementation rather than just the simple formulation of the policy is required.

The revised set of WFME standards appears to be somewhat more detailed than the former version. However, this is more a result of editorial revision.

To aid better understanding, the number of annotations were expanded. The intention is to clarify the meaning of the standards, primarily by explanation and exemplification of activities and conditions, taking into account social and cultural differences. This should also facilitate the

planning of data collection for self-evaluation studies and external evaluations and provide a more secure basis for translations.

THE WFME GLOBAL STANDARDS FOR QUALITY IMPROVEMENT OF CPD

DEFINITIONS

CPD, a broader concept than CME, refers to the continuing development of the multi-faceted nature of medical practice, covering - in addition to knowledge and skills of medical practice - the wider domains of professionalism (e.g. medical, managerial, social and personal subjects) needed for high quality professional performance. It includes all activities that doctors undertake, formally and informally to maintain, update, develop and enhance their knowledge, skills, and attitudes in response to the needs of their patients.

In the standards document the term **medical profession** refers to

- the **profession as a group**, generally acting through their professional associations, medical scientific societies, medical colleges, medical schools/universities, medical academies and national regulatory authorities overseeing the CPD system.
- the **individual members of the profession**, the individual doctors taking care of their own CPD, e.g. by reading of medical journals, studying the internet or participating in CPD courses.

WFME recommends the following set of global standards in CPD. The set of standards are divided into **9 areas** and **32 sub-areas**, being aware of the complex interaction and links between them.

AREAS are defined as broad components in the, process, structure, content, outcomes/competencies, assessment and learning environment of CPD covering:

1. Mission and outcomes
2. Educational programme
3. Assessment and documentation
4. The individual doctor
5. CPD provision
6. Educational resources
7. Evaluation of CPD activities
8. Organisation
9. Continuous renewal

SUB-AREAS are defined as specific aspects of an area, corresponding to performance indicators.

STANDARDS are specified for each sub-area using two levels of attainment:

Basic standard.

This means that the standard must be met and fulfilment demonstrated during evaluation of CPD.

Basic standards are expressed by a “must”.

Standard for quality development.

The implication is that the standard is in accordance with international consensus about best practice in CPD. Fulfilment of - or initiatives to fulfil - some or all of such standards should be documented. Fulfilment of these standards will vary with the stage and development of CPD activities, available resources, the educational policy and other local conditions influencing learning priorities and possibilities. Even the most advanced programmes might not comply with all standards.

Standards for quality development are expressed by a “should”.

ANNOTATIONS are used to clarify, amplify or exemplify formulations of the standards. No new requirements are introduced in the annotations.

The listing of examples in annotations is in some cases exhaustive, in others not. It should also be noted, that a CPD activity will rarely use and possess all the characteristics mentioned in examples.

THE STANDARDS

The 2015 revision of the WFME global standards for quality improvement of continuing professional development of medical doctors, comprising altogether 76 basic standards, 62 quality development standards and 80 annotations, are presented in the following section.

1. Mission and Outcomes

1.1. MISSION

Basic standards:

The medical profession **must**

- state the mission of the CPD providers and CPD activities. (B.1.1.1)
- make the mission publicly known to the health sector it serves. (B 1.1.2)
- base the mission on
 - needs assessment. (B 1.1.3)
 - the professional's general need to explore, develop and consider new areas of competence. (B 1.1.4)
 - reflection and deliberation with peers about own and other's practice. (B 1.1.5)
- balance the mission between general and specific activities. (B 1.1.6)
- include in the mission
 - requirements determined by the roles and expected competencies in terms of clinical skills, theoretical knowledge, attitudes and communication skills, in relation to the organisation of clinical work, teaching, research or administration. (B 1.1.7)
 - aspects of medical ethics/bioethics. (B 1.1.8)
 - follow-up of learning undertaken. (B 1.1.9)
 - training of the ability to make judgements in complex and unpredictable situations. (B 1.1.10)
 - considerations of the health needs of the community, the needs of the health care delivery system and other aspects of social accountability. (B 1.1.11)

Quality development standards:

The medical profession **should** ensure that the mission

- encourages and supports doctors to improve their practice performance. (Q 1.1.1)
- addresses the obligation to improve the conditions for effective CPD. (Q 1.1.2)

Annotations:

- *Mission* provides the overarching frame to which all other aspects of the programme must be related. The mission statement would include general and specific issues relevant to institutional, national, regional and, if relevant, global health needs. Mission in this document includes visions about CPD.
- *Medical profession*, cf. p.18.
- *CPD providers* can be independent or part of an organisation, e.g. the ministry of health, a professional body or a medical college.
- *CPD activities* would include all individual or formalised elements of CPD. Individual elements would include reading, reflection, discussions with peers and visits to institutions such as medical schools, hospitals and laboratories. If relevant, it would also include visits to skills laboratories. Regarding formalised elements, cf. 6.5 annotation.

- *Needs assessment* may be based on formal assessments, whether part of re-licensing procedures or not. This implies using tests of knowledge, skills and attitudes, peer review, systematic review of practice such as audit or significant event analysis. Informal assessment would be the more common and equally effective ways that are part of everyday clinical practice: reflecting on practice, thinking about mistakes or receiving complaints and feedback and interaction with the team. Professional learning would also equip doctors to deal with unpredictable future clinical demands and thus draw on a broad base of knowledge and experiences, besides making up for deficiencies from past practice.
- *Reflection and deliberation* can take place with a colleague or mentor and would identify and clarify the educational needs.
- *Organisation of clinical work* would include basic management skills, team building and leadership.
- *Follow-up of learning undertaken* reinforces learning and offers opportunities for disseminating and sharing such learning with others, resulting in beneficial alterations in methods of practice. Also, evaluation can be made of the effectiveness of CPD undertaken in relation to the original need or reason for it.
- *Complex and unpredictable situations* would include situations where high levels of uncertainty occur and where paradox is common. The unstated contract between doctors and the people they serve calls for capacity to know what is “best” in any particular circumstance rather than what is “right” in some absolute sense. General over-sight, improvisations and professional judgements are central to medical practice.
- *Social accountability* would include willingness and ability to respond to the needs of society, of patients and the health and health related sectors and to contribute to the national and international development of medicine by fostering competencies in health care, medical education and medical research.
Social accountability is sometimes used synonymously with social responsibility and social responsiveness. In matters outside the control of the profession, it would still demonstrate social accountability through advocacy and by explaining relationships and drawing attention to consequences of the policy.
- *Practice performance* would refer to the function of the doctor in any of his/her roles, cf. 1.3 outcomes, annotation.

1.2. PROFESSIONALISM AND PROFESSIONAL AUTONOMY

Basic standards:

The medical profession **must**

- ensure that CPD activities serve the purpose of enhancing the professional and personal development of doctors. (B 1.2.1)

Quality development standards:

The medical profession **should** ensure

- that the process of CPD activities strengthens the potential of doctors to act autonomously in planning and choosing the CPD activities in the best interests of their patients and the society. (Q 1.2.1)
- academic freedom. (Q 1.2.2)

Annotations:

- *Professionalism* describes the knowledge, skills, attitudes, values and behaviours expected of individuals during their practice, and includes skills of life-long learning and maintenance of competence, information literacy, team work and communication skills, ethical behaviour, integrity, honesty, altruism, empathy, service to others, adherence to professional codes, justice, and respect for others, including ability to act as an advocate for the patient and consideration of patient safety. The perception of professionalism should reflect any ethical guidance produced from the national medical regulator.
- *Autonomy* in the patient-doctor relationship shall ensure that doctors at all times make informed decisions in the best interest of their patients and the society, based on the best available evidence. Autonomy related to doctors' learning implies that they have considerable influence on decisions about what to learn and how to plan and carry out learning activities. It also implies access to the knowledge and skills doctors need to keep abreast in meeting the needs of their patients and the society, and that the sources of knowledge are independent and unbiased. In acting autonomously, possible guidelines should be taken into consideration.
- *Personal development of doctors* in this context is limited to what is relevant to provide a more secure basis for medical practice and the profession.
- *Academic freedom* would include appropriate freedom of expression, freedom of inquiry and publication.

1.3. OUTCOMES OF CPD

Basic standards:

The medical profession **must**

- define intended outcomes of CPD that
 - are adequate to maintain and develop competencies necessary to meet the needs of the individual doctor, the medical profession, patients and society. (B 1.3.1)
 - ensure appropriate conduct of doctors with respect to colleagues and other health care personnel, patients and their relatives. (B 1.3.2)
 - cover requirements to life-long self-directed learning. (B 1.3.3)
 - are based on clinical data. (B 1.3.4)
- make the intended outcomes publicly known. (B 1.3.5)

Quality development standards:

The medical profession **should** – in consultation with professional organisations -

- ensure that learning from CPD activities is shared with peers. (Q 1.3.1)

Annotations:

- *Outcomes/competencies* refer to statements of knowledge, skills and attitudes that doctors demonstrate as a result of CPD activities. Outcomes might be either intended or acquired. Intended outcomes are often used for formulation of educational/learning objectives.

Knowledge would include conceptual and procedural knowledge; practical wisdom derives from a complicated amalgam of these. The link between doctors' knowledge and their practices is not straightforward. New knowledge is not always directed to practice.

The characteristics and achievements the doctor would display upon completion of the CPD activity might be categorised in terms of *the roles of the doctor* including (a) medical practitioner or medical expert, (b) communicator, (c) collaborator/team worker, (d) leader/manager or administrator, (e) health advocate, (f) health educator, (g) scholar and scientist, (h) teacher, supervisor and trainer to colleagues, medical and other health professions and (i) a professional. Similar frameworks could be defined.

Outcomes/competencies relevant for CPD would – dependent on local needs, interests and traditions and at a level determined by the chosen field of medicine - cover the following:

- patient care that is appropriate, effective and compassionate for dealing with health problems and health promotion, including patient safety.
- medical knowledge and understanding in (a) the basic biomedical sciences, (b) the behavioural and social sciences, (c) medical ethics, human rights and medical jurisprudence, relevant to the practice of medicine, and (d) the clinical sciences, including clinical skills with respect to diagnostic procedures, practical procedures, communication skills, treatment (including palliative care) and prevention of disease, health promotion and rehabilitation. It also includes clinical reasoning and problem solving as well as skills in doctor-patient relationship with emphasis on a compassionate attitude and humanity.
- appraisal and utilisation of new scientific knowledge to continuously update and improve clinical practice.
- interpersonal and communication skills.
- function as supervisor, trainer and teacher in relation to colleagues, medical students and other health professionals.
- scholarly and scientific capacity to contribute to development and research in the chosen field of medicine.
- professionalism, including interest and ability to act as an advocate for the patient and avoiding commercial exploitation of medical services.
- knowledge of public health and health policy issues.
- *Development of competencies* would include broadening and deepening of existing knowledge and skills besides activities undertaken to meet broader learning needs or purposes.
- *Appropriate conduct* would presuppose a written code of professional and personal conduct.
- *Life-long learning* is the professional responsibility to keep up to date in knowledge and skills through appraisal, audit, reflection or CPD activities.
- *Clinical data* would include results of diagnostic procedures and treatments, including operational results and frequency of side effects.

1.4. PARTICIPATION IN FORMULATION OF MISSION AND OUTCOMES

Basic standards:

The medical profession **must**

- state the mission and intended outcomes of CPD activities in collaboration with its principal stakeholders. (B 1.4.1)

Quality development standards:

The medical profession **should**

- base formulation of mission and intended outcomes of CPD activities on input from other stakeholders. (Q 1.4.1)

Annotations:

- *Principal stakeholders* would include individual doctors, professional associations or organisations, medical scientific societies, medical schools/universities, postgraduate organisations and institutions, employers, relevant CPD providers, health care providers and governmental authorities.
- *Other stakeholders* would include representatives of other health professions, patients, the community and public (e.g. users of the health care delivery systems, including patient organisations). Other stakeholders would also include other representatives of academic and administrative staff, medical schools, education and health care authorities, professional organisations and medical scientific societies.

2. Educational Programme

2.1. FRAMEWORK OF CPD ACTIVITIES

Basic standards:

The medical profession **must**

- tailor CPD activities to the needs and wishes of individual doctors, recognising the needs of the health care system. (B 2.1.1)
- ensure and support CPD activities. (B 2.1.2)
- encompass integrated practical and theoretical components. (B 2.1.3)
- ensure that CPD activities are conducted in accordance with the policies of representative professional organisations, including the recognition of activities. (B 2.1.4)
- include the commitment to ethical considerations. (B 2.1.5)

Quality development standards:

The medical profession **should**

- take advantage of a variety of instructional and learning methods for CPD. (Q 2.1.1)
- stimulate engagement with colleagues in learning networks, where appropriate, to share experiences and benefit from collaborative learning. (Q 2.1.2)
- encourage collaboration and mutual recognition through appropriate frameworks both nationally, regionally and globally. (Q 2.1.3)

Annotations:

- *Framework of CPD activities* in this document refers to the specification of the educational programme, including a statement of the intended educational outcomes (cf. 1.3), the content/syllabus, learning experiences and processes of the programme (cf. 2.2-2.3). Also, the framework would include a description of the planned instructional and learning methods (cf. 4.2), assessment methods (cf. 3.1) and guidance of learners (cf. 5.2).
- *Integration of practical and theoretical components* can take place in didactic learning sessions and supervised patient care experiences as well as through self-directed and active learning.
- *Instructional and learning methods* would include courses, lectures, seminars, problem- and case-based activities, hands-on-training, training in new diagnostic methods or interventional procedures, participation in conferences, use of computer-based simulation systems and individual reading (including use of the internet), self-assessment of knowledge base and practice performance, research projects as well as study visits and clinical experiences.
- *Networks* would include meetings with colleagues and net-based information exchange, discussions and counselling. They could also include other health care professionals and other relevant persons.

2.1. SCIENTIFIC METHOD

Basic standards:

The medical profession **must**

- firmly base the content of CPD activities on science, evidence-based medicine and experience, whenever possible. (B 2.2.1)

Quality development standards:

The medical profession **should**

- organise and use CPD activities to
 - facilitate access to updated evidence, scientific results and practice experience. (Q 2.2.1)
 - improve organisation and practice of the health care delivery system, drawing upon emerging evidence. (Q 2.2.2)
 - use knowledge of appropriate scientific methods to improve the critical appraisal skills of doctors. (Q 2.2.3)

Annotations:

- *Evidence-based medicine* means medicine founded on documentation, trials and accepted scientific results.

2.2. CONTENT OF CPD ACTIVITIES

Basic standards:

The medical profession **must**

- ensure diverse and individually appropriate content of CPD activities to enable doctors to develop their practice. (B 2.3.1)
- organise CPD activities with appropriate attention to patient safety and autonomy. (B 2.3.2)

Quality development standards:

The medical profession **should**

- select the content of CPD activities based upon the individual doctors' self-directed plans for learning consistent with their various professional roles. (Q 2.3.1)
- organise CPD activities, taking into account results of dialogues with employers. (Q 2.3.2)

Annotations:

- *Content* would encompass aspects of:
 - basic biomedical sciences (include -depending on local and individual needs- anatomy, biochemistry, biophysics, cell biology, genetics, immunology, microbiology (bacteriology, parasitology and virology), molecular biology, pathology, pharmacology, physiology).

- clinical sciences (include the chosen clinical or laboratory disciplines and other relevant clinical/laboratory disciplines).
- *behavioural and social sciences* (include – depending on local and individual needs - biostatistics, community medicine, epidemiology, global health, hygiene, medical anthropology, medical psychology, medical sociology, public health and social medicine and would provide the knowledge, concepts, methods, skills and attitudes necessary for understanding socio-economic, demographic and socio-cultural determinants of causes, distribution and consequences of health problems).
- the essential integration of the basic biomedical sciences, the behavioural and social sciences and the clinical sciences in CPD activities.
- *Diverse and individually appropriate content of CPD activities* refers to broader or narrower needs of doctors, depending on the nature of their practice, and also allows for personal interests and development and for consideration of national and regional priorities.
- *Various professional roles of doctors*, cf.1.3, annotation.

2.3. THE RELATION BETWEEN CPD AND SERVICE

Basic standards:

The medical profession **must**

- tailor CPD activities to fill gaps in knowledge, skills, attitudes and management ability, identified in appraisal of service or by individual reflection or review on practice and personal learning plan. (B 2.4.1)

Quality development standards:

The medical profession **should**

- ensure that CPD activities are regarded as an integral part of medical practice, reflected in budgets, resource allocations, working conditions and time planning, and taking into account that CPD activities may limit service provision. (Q 2.4.1)

Annotations:

- To ensure that *gaps in knowledge, skills, attitudes and management ability* are identified and adequate action taken, needs assessment by peers and/or self-assessment is recommended.

3. Assessment and Documentation

3.1. ASSESSMENT METHODS

Basic standards:

The medical profession **must**

- formulate and implement a policy on assessment of CPD activities. (B 3.1.1)
- develop and define appropriate assessment methods. (B 3.1.2)

Quality development standards:

The medical profession **should**

- promote appropriate development of assessment of CPD activities. (Q 3.1.1)

Annotations:

- *Appropriate assessment methods* would – besides traditional examination forms using normative- and criterion-referenced judgements - include consideration of various tools for self-assessment, the use of personal learning portfolios or log-books and special types of assessments, e.g. site visits by peers, an agreed protocol and comparison with similar results of colleagues. It would also include systems to detect and prevent plagiarism.

3.2. DOCUMENTATION OF CPD ACTIVITIES

Basic standards:

The medical profession **must**

- establish systems to monitor and document engagement in CPD activities systematically and transparently. (B 3.2.1)
- create, when relevant, personal learning portfolios that can be shared with peers. (B 3.2.2)
- use systematic documentation of CPD activities as a formative learning tool. (B 3.2.3)
- use feedback on relevance and quality of CPD activities for planning of CPD. (B 3.2.4)

Quality development standards:

The medical profession **should**

- ensure that documentation of CPD activities acknowledges actual learning and is based on enhancement of competencies, not mere participation in CPD activities. (Q 3.2.1)

Annotations:

- *Systems to monitor* would in some countries include mechanisms of control, often legally grounded, developed by medical professional organisations or licensing bodies. This would in some countries also include demands for systematic re-certification, entailing the development of systems for examination or other types of reassessment e.g. number of credits required for re-certification). Such systems would include specification of required CPD activities.

- *Formative learning tool* would include different types of self-assessment.
- *A system of documentation* would include the use of different types of certificates and diplomas.

4. The Individual Doctor

4.1. MOTIVATION

Basic standards:

The medical profession **must**

- ensure that delivering high quality care is the driving force for doctors' participation in CPD activities. (B 4.1.1)
- realise in its planning that the individual doctors have the main responsibility for their engagement in CPD activities. (B 4.1.2)
- stimulate the individual doctor to participate in CPD activities. (B 4.1.3)
- offer academic counselling when relevant. (B 4.1.4)
- stimulate doctors to judge the individual educational value of available CPD activities. (B 4.1.5)
- select appropriate activities which are relevant to the learning requirements of the individual doctor, e.g. based on clinical data. (B 4.1.6)

Quality development standards:

The medical profession **should** ensure

- that the CPD system enhances motivation to learn. (Q 4.1.1)
- that CPD activities are recognised as a meritorious professional activity. (Q 4.1.2)

Annotations:

- *High quality care* means health care delivery according to generally accepted principles, stated by e.g. medical scientific societies or national, regional and global health boards. It would also include compassionate care, i.e. awareness of patient and family aspects.
- *To stimulate the individual doctor* implies equal access to CPD activities.
- *Academic counselling* would include questions related to choice of CPD activities.
- *Motivation to learn* and skills for life-long learning can be stimulated during basic medical education and enhanced as part of postgraduate medical education.
- *Recognised as a meritorious professional activity* would include improved personal satisfaction, rewards, promotion and/or remuneration.
- *Clinical data*, cf. 1.3, annotation.

4.2. LEARNING STRATEGIES

Basic standards:

The medical profession **must** develop

- the ability of the individual doctor to systematically plan, execute and document practice-based learning in response to defined learning needs. (B 4.2.1)
- ways of helping doctors to identify their CPD requirements. (B 4.2.2)

Quality development standards:

The medical profession **should**

- require that CPD activities of doctors are based on learning strategies, which are tailored to the individual. (Q 4.2.1)
- encourage the use of distance-learning. (Q 4.2.2)

Annotations:

- *Practice-based learning* implies reflection on one's own practice to stimulate learning and improvement. This might occur by systematic analysis of patient and population data or by informal reflection on individual practice.

4.3. INFLUENCE OF INDIVIDUAL DOCTORS ON CPD

Basic standards:

The medical profession **must**

- give doctors, when relevant, the opportunity to discuss their learning needs with CPD providers. (B 4.3.1)

Quality development standards:

The medical profession **should**

- involve doctors in planning and implementing CPD activities. (Q 4.3.1)

Annotations:

- *CPD providers* would include primarily the professional associations and organisations, national, regional and global medical scientific societies, medical schools/universities, postgraduate institutes, employers in the health care system and others such as health authorities, the pharmaceutical and the medical device industry, companies in information technology, consumer associations.
- *Involvement in planning and implementing* would include participation in groups or committees responsible for programme planning at the local or national level. It would include questions related to mission, outcomes, framework, assessment, evaluation and management.

4.4. WORKING CONDITIONS

Basic standards:

The medical profession **must** ensure

- working and employment conditions for doctors in practice that provide protected time and other resources for CPD activities. (B 4.4.1)
- opportunities for the doctor to reflect on practice. (B 4.4.2)

Quality development standards:

The medical profession **should**

- establish systems of recognition of doctors or other kinds of stimulus that allow for their engagement in a broad range of CPD activities relevant to their needs. (Q 4.4.1)

Annotations:

- *Other kinds of stimulus* would include systems for remuneration of doctors.

5. CPD Provision

5.1. RECOGNITION POLICY

Basic standards:

The medical profession **must**

- ensure a system for evaluation and recognition of CPD provision and/or individual CPD activities. (B 5.1.1)
- establish a mechanism for authorisation of a formalised structure of CPD provision in consultation with relevant authorities based on agreed criteria. (B 5.1.2)

Quality development standards:

The medical profession **should**

- require that CPD providers are able to describe the educational basis of their activities including access to educational expertise. (Q 5.1.1)

Annotations:

- *CPD provision* would include all types of CPD engagement, not only formalised CPD activities.
- *Recognition of CPD provision* would include establishment of national accreditation institutions.
- *Educational expertise*, cf. 6.7, annotation.

5.2. PROVIDER OBLIGATIONS AND PROVIDER DEVELOPMENT

Basic standards:

The medical profession **must**

- ensure that the provision of CPD activities meet generally agreed educational quality requirements. (B 5.2.1)
- ensure that any conflicting interests of CPD provision are explicitly identified, declared and properly handled. (B 5.2.2)

Quality development standards:

The medical profession **should**

- establish acceptable norms for the provision of CPD activities. (Q 5.2.1)
- ensure that norms are adhered to by CPD providers. (Q 5.2.2)
- demand that the providers - in planning and conducting their activities - demonstrate use of effective and efficient educational methods and technology. (Q 5.2.3)

Annotations:

- *Conflicting interests* refers to undue influence on CPD provision, including inappropriate promotional activities.
- *Acceptable norms* would deal with areas like content, methods and evaluation.

5.3. ROLE OF MEDICAL SCHOOLS

Basic standards:

The medical profession **must**

- promote involvement of medical schools in improvement of the quality of CPD activities. (B 5.3.1)
- ensure that medical schools through the curriculum in basic medical education prepare the students for life-long learning, hereby stimulating motivation for and ability to engage in CPD activities. (B 5.3.2)

Quality development standards:

The medical profession **should**

- encourage medical schools to provide CPD activities when appropriate. (Q 5.3.1)
- stimulate medical schools to undertake research on CPD activities. (Q 5.3.2)

Annotations:

- *Medical schools* are the educational organisations providing a basic (undergraduate) programme in medicine and is synonymous with medical faculty, medical college, medical academy or medical university. The medical school can be part of or affiliated to a university or can be an independent institution of equal level. Medical schools would include academic teaching hospitals.

6. Educational Resources

6.1. PHYSICAL FACILITIES

Basic standards:

The medical profession **must**

- ensure access to adequate professional literature. (B 6.1.1)
- ensure access to skills training equipment. (B 6.1.2)
- offer a safe learning environment. (B 6.1.3)

Quality development standards:

The medical profession **should**

- ensure evaluation and regular updating of physical facilities and skills training equipment for the provision of adequate conditions for CPD activities. (Q 6.1.1)

Annotations:

- *Physical facilities* of the training location would include lecture halls, tutorial rooms, laboratories, libraries, information technology equipment, skill laboratories and recreational facilities where these are appropriate.

6.2. LEARNING SETTINGS

Basic standards:

The medical profession **must**

- ensure that CPD activities are provided in learning settings and circumstances conducive to effective learning. (B 6.2.1)

Quality development standards:

The medical profession **should**

- support formal and informal collaboration with stakeholders in order to obtain a broad spectrum of learning settings. (Q 6.2.1)

Annotations:

- *Learning settings* would include hospitals with adequate mix of primary, secondary and tertiary services and sufficient patient wards and diagnostic departments, laboratories, ambulatory services (including primary care), clinics, primary health care settings, health care centres, hospices and other community health care settings. Clinical training would also include use of skills laboratories.
- *Stakeholders* would include principal as well as other stakeholders, cf. 1.4, annotations.

6.3. INFORMATION TECHNOLOGY

Basic standards:

The medical profession **must**

- ensure access to web-based or other electronic media. (B 6.3.1)
- use information and communication technology in an effective and ethical way as an integrated part of CPD activities. (B 6.3.2)

Quality development standards:

The medical profession **should**

- stimulate doctors to be competent in the use of information and communication technology for
 - self-directed learning. (Q 6.3.1)
 - communication with colleagues. (Q 6.3.2)
 - accessing relevant patient data and health care information systems. (Q 6.3.3)
 - patient/practice management. (Q 6.3.4)

Annotations:

- *Effective use of information and communication technology* would include use of computers, cell/mobile telephones, internal and external networks and other means as well as coordination with library services.
- *Ethical use* refers to the challenges for both physician and patient privacy and confidentiality following the advancement of technology in medical education and health care. Appropriate safeguards would be included in relevant policy to promote the safety of physicians and patients while empowering them to use new tools.

6.4. INTERACTION WITH COLLEAGUES

Basic standards:

The medical profession **must**

- encourage collaboration with colleagues and other health professionals in CPD activities. (B 6.4.1)

Quality development standards:

The medical profession **should**

- engage doctors in development of the competencies of colleagues, including doctors in training, students and allied health personnel. (Q 6.4.1)

Annotations:

- *Collaboration with other health professionals* would foster multi-disciplinary learning.

6.5. FORMALISED CPD ACTIVITIES

Basic standards:

The medical profession **must**

- develop systems - in collaboration with stakeholders - that encourage and recognise participation in local, national, and international CPD activities, scientific meetings and other formalised activities. (B 6.5.1)
- ensure opportunities for doctors to attend formalised CPD activities. (B 6.5.2)

Quality development standards:

The medical profession **should**

- ensure opportunities for doctors to plan and execute special CPD activities such as in-depth studies to increase the level of their competencies. (Q 6.5.1)

Annotations:

- *Formalised CPD activities* would include attending courses or lectures, e-learning, institutional, national and international conferences, participation in research and organisational activities.
- *Stakeholders* would include principal as well as other stakeholders, cf. 1.4, annotations.

6.6. MEDICAL RESEARCH AND SCHOLARSHIP

Basic standards:

The medical profession **must**

- ensure possibilities for participation in quality development activities as part of CPD. (B 6.6.1)

Quality development standards:

The medical profession **should**

- allow for participation in research projects as part of CPD, if relevant. (Q 6.6.1)

Annotations:

- *Medical research and scholarship* encompasses scientific research in basic biomedical, clinical, behavioural and social sciences. Medical scholarship means the academic attainment of advanced medical knowledge and inquiry. The medical research basis of the CPD programme would be ensured by research activities within the training settings or affiliated institutions and/or by the scholarship and scientific competencies of teachers. Influence of medical research on current CPD activities would facilitate learning scientific methods and evidence-based medicine.

6.7. EDUCATIONAL EXPERTISE

Basic standards:

The medical profession **must**

- formulate and implement a policy on the use of educational expertise relevant to the planning, implementation and evaluation of CPD activities. (B 6.7.1)

Quality development standards:

The medical profession **should**

- ensure that individual doctors have access to and use educational expertise in CPD activities. (Q 6.7.1)

Annotations:

- *Formulate and implement a policy* would include consultation with principle and other stakeholders, cf. 1.4, annotation.
- *Educational expertise* would deal with problems, processes and practice of medical education and would include medical doctors, educationists, educational psychologists and sociologists with experience in medical education. It can be provided by an education unit at an educational institution or be acquired from another national or international institution.

6.8. LEARNING IN ALTERNATIVE SETTINGS

Basic standards:

The medical profession **must**

- facilitate doctors' freedom of movement to promote their ability to obtain experience by visiting other institutions or settings within or outside the country. (B 6.8.1)

Quality development standards:

The medical profession **should**

- facilitate - in collaboration with stakeholders - national and international study visits for doctors. (Q 6.8.1)
- ensure that relevant authorities establish relations with corresponding national, regional and global bodies to facilitate provision and mutual recognition of CPD activities. (Q 6.8.2)

Annotations:

- *Freedom of movement* indicates the non-mandatory character of learning in alternative settings, e.g. training rotations outside the doctors' own country.
- *Visiting other institutions* implies collaboration, sharing and exchange of experiences.
- *Stakeholders* would include principal as well as other stakeholders, cf. 1.4, annotation.
- To *facilitate provision and mutual recognition of CPD activities* would include establishment of cross-border CPD.

7. Evaluation of CPD Activities

7.1. MECHANISMS FOR PROGRAMME MONITORING AND EVALUATION

Basic standards:

The medical profession **must** establish and apply mechanisms to

- monitor the CPD activities. (B 7.1.1)
- evaluate processes and outcomes of CPD activities. (B 7.1.2)

Quality development standards:

The medical profession **should** – in monitoring and evaluation -

- address the mission, the intended outcomes, the educational programme, assessment, if any, documentation, the individual doctors' participation in CPD, the CPD provision and the educational resources. (Q 7.1.1)
- make use of data to monitor and evaluate the acquired outcomes, including the ability to deliver high quality patient care. (Q 7.1.2)
- consider involvement of expertise in health care delivery and in medical education for CPD evaluation. (Q 7.1.3)

Annotations:

- *Programme monitoring* would imply the routine collection of data about key aspects of the programme for the purpose of ensuring that the education is on track and for identifying any areas in need of intervention. The collection of data is often part of the administrative procedures in connection with admission of doctors, assessment and completion of the programme.
- *Programme evaluation* is the process of systematically gathering information to judge the effectiveness and adequacy of the education programme. It would imply the use of reliable and valid methods of data collection and analysis for the purpose of demonstrating the qualities of the programme in relation to the mission and the intended and acquired outcomes. Involvement of external reviewers from outside as well as experts in medical education and evaluation and regulatory bodies would further broaden the quality of CPD.
- *Consider involvement of expertise* would further broaden the base of evidence for quality. This would facilitate monitoring the resources available, the educational outcomes and the benefits derived by the individual doctor.

7.2. FEEDBACK TO PROVIDERS

Basic standards:

The medical profession **must** ensure that

- CPD providers on an on-going basis seek information from the targeted doctors on their professional performance and learning needs. (B 7.2.1)
- constructive feedback from participants in CPD activities is systematically sought, analysed and acted upon. (B 7.2.2)
- information of feedback results are made available to stakeholders. (B 7.2.3)

Quality development standards:

The medical profession **should**

- ensure development of systems for systematic feedback from participants in CPD activities to CPD providers and authorities responsible for CPD activities. (Q 7.2.1)
- analyse the benefit from doctors' engagement in CPD activities in relation to their learning needs. (Q 7.2.2)
- ensure that CPD participants are actively involved in evaluating the CPD activities and in using the results in planning CPD. (Q 7.2.3)

Annotations:

- *Feedback* would include planned communication between individual doctors and supervisors to ensure remedies necessary to enhance development of competencies.
- *Systems for systematic feedback* could be data on planning, execution and outcomes of CPD for a certain cohort of doctors.

7.3. INVOLVEMENT OF STAKEHOLDERS

Basic standards:

The medical profession **must** ensure that

- involve the principal stakeholders in its programme for monitoring and evaluation. (B 7.3.1)

Quality development standards:

The medical profession **should**

- for other stakeholders
 - allow access to results of course and programme evaluation. (Q 7.3.1)
 - seek their feedback on the performance of doctors. (Q 7.3.2)
 - seek their feedback on the programme. (Q 7.3.3)

Annotations:

- *Principal stakeholders* would include the individual doctors and CPD providers.
- *Other stakeholders*, cf.1.4, annotation.

8. Organisation

8.1. DOCUMENTATION AND NEEDS FOR PLANNING OF CPD

Basic standards:

The medical profession **must**

- plan CPD activities based on the statement of mission and the definition of outcomes. (B 8.1.1)

Quality development standards:

The medical profession **should**

- develop systems that provide documentation on practice quality, tracking outcomes and comparing peer groups for alerting doctors and principal stakeholders. (Q 8.1.1)

Annotations:

- *Statement of mission*, cf. 1.1.
- *Definition of outcomes*, cf. 1.3.
- *Principal stakeholders*, cf. 1.4, annotation.

8.2. ACADEMIC LEADERSHIP

Basic standards:

The medical profession **must**

- take responsibility for leadership and organisation of CPD activities. (B 8.2.1)

Quality development standards:

The medical profession **should**

- ensure that the professional leadership is evaluated regularly with respect to achievement of the mission and outcomes of CPD activities. (Q 8.2.1)

Annotations:

- The *leadership and organisation* would include medical associations, medical societies and other professional organisations. Numerous others would also provide CPD activities, not directly accountable to the medical profession, including the for-profit health-care companies, the pharmaceutical/medico-technical industry, consumers and consumer organisations and for-profit CPD providers. Formalised CPD activities, which traditionally are teacher-conducted, would be provided and supported by institutions such as medical schools/universities or postgraduate institutes, professional organisations, national and international scientific organisations, local or national health authorities as well as the pharmaceutical/medico-technical industry.

8.3. EDUCATIONAL BUDGET AND RESOURCE ALLOCATION

Basic standards:

The medical profession **must**

- establish budgetary systems to fund and sustain CPD activities in response to needs identified by the profession and the CPD providers. (B 8.3.1)
- ensure that funding of CPD activities in principle is included as part of the expenses of the health care system. (B 8.3.2)

Quality development standards:

The medical profession **should**

- organise funding systems for CPD activities, ensuring independence of doctors' choice of CPD activities. (Q 8.3.1)

Annotations:

- *Budgetary systems* would depend on the budgetary practice in the country.

8.4. ADMINISTRATION

Basic standards:

The medical profession **must**

- ensure that CPD activities are adequately managed. (B 8.4.1)

Quality development standards:

The medical profession **should**

- ensure that the administrative structures for formalised CPD activities facilitate quality assurance and improvement. (Q 8.4.1)

Annotations:

- *Adequately managed* would mean sufficient description, evaluation and documentation of CPD activities and their organisation and depend on efficient interaction between the individual doctor and the CPD provider.

9. Continuous Renewal

Basic standards:

The medical profession **must**

- initiate procedures for regular review and updating the process, structure, content, outcomes/competencies, assessment and learning environment of the programme. (B 9.0.1)
- rectify documented deficiencies in CPD activities. (B 9.0.2)
- allocate resources for continuous renewal of CPD activities. (B 9.0.3)

Quality development standards:

The medical profession **should**

- base the process of renewal on prospective studies and analyses and on results of local evaluation and the medical education literature. (Q 9.0.1)
- ensure that the process of renewal and restructuring leads to the revision of the policies and practices of CPD activities in accordance with past experiences, present activities and future perspectives. (Q 9.0.2)
- address the following issues in the process of renewal of CPD activities:
 - adaptation of the mission and outcomes to the scientific, socio-economic and cultural development of the society. (Q 9.0.3)
 - re-examination and definition of the competencies required to incorporate medical scientific progress and the changing needs of the society. (Q 9.0.4)
 - review of learning framework and educational methods to ensure that these are appropriate and relevant. (Q 9.0.5)
 - development of methods of self -assessment and practice- based learning to facilitate doctors' life-long learning. (Q 9.0.6)
 - development of the organisational and managerial structures to help doctors to deliver high quality care and to meet their patients' emerging needs. (Q 9.0.7)
 - reflection on and continual improvement of content and methods. (Q 9.0.8)

Annotations:

- *Prospective studies* would include research and studies to collect and generate data and evidence on country-specific experiences with best practice.

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