



**EAHC/2013/Health/07**

**Study concerning the review and mapping of continuous professional development and lifelong learning for health professionals in the EU**

Contract no. 2013 62 02

**[ D.4 FINAL REPORT ]**

**ANNEX IIIA - A REVIEW OF THE EXISTING LITERATURE**



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## ABBREVIATIONS

CE	Continuing Education
CME	Continuing Medical Education
CPD	Continuing Professional Development
CHAFEA	Consumers Health and Food Executive Agency
EU	European Union
HCPs	Health Care Professionals
IE	Interprofessional Education
LLL	Lifelong Learning
PD	Professional Development
UK	United Kingdom
UNESCO	United Nations Education, Scientific and Cultural Organisation

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## INTRODUCTION

The term continuous professional development (CPD) emerged in the 1960s. In the health sector, it was first elaborated in a veterinary publication in 1984 (Dumur, 2012) before it entered the mainstream of employment policy in the 1990s and then developed more rigorously in the 2000s. It embodies a range of concepts relating to learning undertaken after an individual has qualified within their given profession. For many years, healthcare professionals (HCPs) were not subject to any systematic evaluation of their knowledge and competence after qualification (Costa et al 2010). However, as the pace of scientific and technological change has quickened, the need for HCPs to stay up-to-date with the latest evidence based research and innovations has increased. Furthermore, such change often leads to new clinical approaches and is therefore closely linked with patient safety and provision of high quality care (European Commission, 2010; Council of the EU 2009). This is becoming ever more important given the changing face of the broader public health environment marked by an ageing European population and the concomitant increases in chronic diseases, as well as the mounting prevalence of non-communicable diseases, linked to unhealthy lifestyles. CPD and the various concepts that have developed alongside it are designed to meet these challenges by facilitating a process of ongoing learning for HCPs. Another driver is the economic / fiscal state of the Union which is redefining HCPs' roles.

The assumption that high standard, regulated and comparable CPD systems across the European Union (EU) Member States contribute to protecting patients moving from country to country to receive healthcare, supporting the free movement of professionals with recognised competency, and mitigating the negative effects associated with an open market in HCPs, has motivated increased interest in CPD at EU level. As such, the European Commission (EC; hereafter Commission) launched in 2012 an Action Plan for the EU health workforce, highlighting the importance of avoiding future skills shortages and mismatches, and the 'brain drain' and HCP emigration that accompanies this, by ensuring that all European HCPs are equipped with the appropriate competences throughout their careers (EC 2012). The role of CPD is further addressed in the Directive on the recognition of professional qualifications<sup>1</sup>, the Directive on patients' rights in cross border healthcare<sup>2</sup> and the Council Recommendations on patient safety<sup>3</sup>.

This literature review is part of the Consumers, Health and Food Executive Agency (CHAFEA) service contract study concerning the review and mapping of CPD and lifelong learning (LLL) for health professionals in the EU-28 Member States and EEA/EFTA countries. It will focus on the five regulated health professions as defined in Directive 2013/55/EU, namely physicians, nurses, midwives, pharmacists, and dentists.

The project seeks to map the existing and potential future models of CPD and, on the basis of this mapping exercise, to facilitate a discussion with policy-makers and regulatory and professional bodies about the value of European cooperation in this area. The objective of the literature review is to establish the context for the review and mapping of CPD and lifelong learning (LLL) for health professionals in the EU, by identifying and clarifying the key terms and definitions used in the discussion on this issue, and creating a reference framework for subsequent analysis.

Though the CPD systems which exist in Europe exhibit great differences in relation to accreditation, funding, providers, credit utilisation and revalidation, relatively few pan-European studies exist and almost none take account of the differing definitions used (Desbois et al 2010). The terms CPD and LLL are brought into play in many different contexts and in reference to many different sectors, including health. They are also supplemented by terms such as 'continuing education' (CE),

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<sup>1</sup> Directive 2013/55/EU OJ L354/132 of 28 December 2013

<sup>2</sup> Directive 2011/24/EU OJ L 88/45 4.4.2011.

<sup>3</sup> Council Recommendation OJ C 151/1 3.7.2009.

'continuing medical education' (CME), 'fitness to practise' and 'professional development'. The definitions of these terms vary amongst the existing literature and embody a wide range of concepts. As Grant (Swedish Medical Association / Swedish Society of Medicine, 2012:9) notes, the terms employed are not objective but depend on whether they are used by regulators, professional bodies, educational agencies, governments or other stakeholders. Notwithstanding such bias, what they have in common is that they describe a process of career-long development, improvement of practice and safety in the workplace, which should bring value for health professionals and patients alike. The most frequently used terms are CPD and CME (as a medically specific variant of CE), but each of these can also be divided into a number of sub-categories, according to particular features. For example, types of CPD could be categorised according to the *form* of learning undertaken – classroom lectures, problem-based learning, internet-based resources, interactive peer review etc. – or the *type* of development pursued – personal, clinical, administrative, managerial etc.

A handful of studies (e.g., Murgatroyd, 2011; EFN, 2012) have been conducted which look at the systems of CPD currently in place in Europe in their respective health professions, focusing on their place within the revalidation and fitness-to-practise frameworks, effective methods of learning and teaching, and contribution to patient outcomes. Further research examines the financing and accreditation of CPD in European countries and how this affects the delivery and sustainability of such activities. However, these studies use differing concepts and definitions of CPD and its related terms, sometimes interchangeably, making comparison and evaluation difficult. Given the abundance of competing and complementary definitions as a result of Europe's different health systems coupled with differing professional / educational cultures and codes of practice, this literature review seeks to clarify the terms used and work towards a set of descriptions of common value.

As outlined in the Inception Report, this review is guided by a number of research questions:

1. How can CPD be described?
2. What sub-types of CPD can be described?
3. What are the differences between CPD, CE, LLL, informal CPD, regulatory CPD etc.?
4. What studies exist on CPD systems for healthcare professionals in Europe?

It proceeds by reviewing the term CPD and examining the different elements of the concept, as defined in existing legislation and policy documents, the academic literature, grey literature, and by the professions themselves. It then looks at the terms which have developed alongside CPD, including LLL and CE, as well as the profession-specific variants of the latter (i.e. continuing medical/nursing/midwifery/dental/pharmacy education) and similar concepts used in non-English speaking countries. Next it explores the relationships between these terms and affiliated notions such as 'fitness to practice' and 'revalidation'. It goes on to examine the existing studies and research in CPD, looking particularly at research on financing and accreditation. Finally, some conclusions are offered, highlighting potential common definitions and signposting further research and next steps that might be taken. Resulting from this inventory, a jointly agreed glossary of key terms offering descriptions of their use for the purposes of this study is also being provided.

## METHODOLOGY

The literature review was conducted primarily online with a non-systematic approach, targeting academic publications, project reports, policy documents, existing legislation, non-academic research and studies from within the professions. The PubMed and MEDLine databases were used, as well as

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the research database of Lancaster University Library, based in the United Kingdom (UK). The EAHC projects database was searched for projects between the years 2003 and 2013 and the Community Research and Development Information Service (CORDIS EU) research portal was reviewed for all projects within the fifth, sixth and seventh EU research frameworks, as well as other relevant programmes. The specific legislation and policy initiatives mentioned in the tender specifications and inception report were reviewed and a search of EU websites was conducted for other relevant documents and resources. A search of the EUR-Lex database proved ineffective, as it was not possible to sufficiently narrow the search terms, but relevant results were captured by searches of the individual institutions. Furthermore, searches of Google and Google Scholar were conducted, taking in each case the first five pages of results. Finally, time was dedicated to following up leads discovered during the initial searches.

The search strategy identified a number of key terms, as outlined in the Inception Report. These included: 'continuous professional development', 'continuing professional development', 'continuous education', 'continuing education', 'professional development', 'lifelong learning', 'revalidation', 'fitness to practise' and 'professional development tools'. Where appropriate, these terms were accompanied by the words 'health' or 'Europe', to filter the search results. The above search terms were then used in combination with words to filter results relevant specifically to the five professions investigated in this study, i.e. 'doctor/physician/medical', 'nurse/nursing', 'midwife/midwifery', 'dentist/dental' and 'pharmacist/pharmacy', as outlined in the Inception Report.

In the course of the research it became apparent that certain terms were ineffective for soliciting results from specific search targets and so were excluded. For example, a number of professional journals have long included a page in each edition dedicated to offering a set of questions or challenges that readers can use to obtain CME points. These pages are usually entitled 'Continuing Medical Education', thereby flooding searches of such journals using that key term with irrelevant material. To balance this, the search looked at the content and (where available) outcomes of discussions that took place at conference or educational events. Finally, searches were conducted in EU languages other than English<sup>4</sup>, using translations of the key terms and language or region specific functions of the target databases and websites.

## **INCLUSION AND EXCLUSION CRITERIA**

To focus the literature review in accordance with its research questions, a number of inclusion and exclusion criteria were identified. The literature review excluded all resources published before 1990, giving preference to the most recent data available. European studies were prioritised, though some international research is included where it offers instructive insights and national sources, including the websites and materials of national regulators, were reviewed where applicable. Resources offering accounts of specific aspects of CPD, such as financing or teaching methods, but not containing stated definitions or exposition of the terms used were also included but not given primacy, since the aim of the review is to scope the latter rather than to analyse the content of the existing literature. Documents referring to CPD, LLL and related terms outside of the healthcare and education context were, for the most part, omitted – CPD is not a health-specific term but in the interests of scope and time management, not all sectoral definitions could be examined.

Broadly speaking, the inclusion criteria were based upon the stated role of the literature review in supporting and framing the rest of the project. Priority was given to resources which offered an insight into the different concepts, definitions and meanings employed and contributed to answering the specific research questions listed above.

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<sup>4</sup> This research focused at the beginning on sources in French, German, Spanish, Italian, Dutch, Romanian, Portuguese and Slovenian. It was then extended to the remaining EU/EEA languages; however, for some of the less widely spoken EU languages, little or no appropriate CPD information could be identified.

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## LIMITATIONS

In the course of the research, several limitations became apparent, which are acknowledged in the following. CPD and LLL are dynamic by nature as academic and professional discourses continuously evolve the ideas and concepts of what professional development should contain and strive for. Hence the most up-to-date information regarding a country's CPD system is usually available on the websites of regulatory bodies, professional associations and chambers, in addition to governments. However, there is a disconnect between the academic literature – where CPD tends to be an almost globally accepted term – and professional and government documents, which do not automatically employ the same terminology even if in essence they describe the same idea. Given the still developing nature of CPD, many of the insightful articles and professional documents available online are unfortunately also quickly obsolete.

Only few European countries provide extensive information on CPD. Given its origins in the United States and subsequent conceptual elaboration in other English-speaking countries such as Canada, Australia and New Zealand, where extensive CPD systems are in place, it is no surprise that it has predominantly been taken up and discussed in the Anglophone countries (i.e., the UK and Ireland), where CPD systems exist for many different professions and contexts. The literature therefore showed a bias towards English language sources.

Another limitation stems from the fact that there is more literature on CPD for doctors than for the other four health professions. While great care was taken to select appropriately 'neutral' sources in order to draw conclusions for all professions, it must be recognised that each source is written from a particular professional perspective and hence cannot be representative of other professions.

Other European countries such as the Netherlands also have a substantive body of research on CPD and implementation modes, however in spite of functioning CPD systems in many other countries, the volume of literature differs according to the size of a country, as well as its national approach to CPD. Hence the real 'status quo' of CPD/LLL is not always evident from the literature as academic and professional, national and international debates are overlapping.

Moreover, for many of the smaller EU/EEA countries there is very little if any official information on CPD, and hence relevant information pertaining to these countries (e.g. Luxembourg, Baltic States, some central and Eastern European countries) will be collected with help of the Reference Network and the experts in order to produce a comprehensive matrix by profession and country.

## DEFINING CONTINUOUS PROFESSIONAL DEVELOPMENT

Approximately 20 of the 200 sources reviewed<sup>5</sup> gave clear, comprehensive, specific definitions of CPD. Among these definitions a set of core ‘components’ can be identified – not every component is present in each definition, and the individual components themselves can vary in meaning. However, the literature generally defines CPD by reference to what kind of process it is, what it does, what it targets and what it is for.

### CONSTRUCTING A DESCRIPTION OF CPD

Firstly, CPD is understood as an ‘educational’ or ‘educative’ process (CPME 2006; Union Européenne des Médecins Spécialistes - UEMS 2001), based upon ‘learning outcomes’ and comprising ‘learning activities’ (RCN et al 2007). Yfantis et al (2010) make explicit reference to CPD being a ‘systematic’ process – a notion implicit in much of the debate about formal and informal practices, discussed below. Within the parameters of educational activity, CPD is inherently understood as a ‘personal programme’ based on self-development and, following Schön (1983), ‘reflective practice’ (Carbon 2005; Brigley et al 1997). As compared to other forms of education, it is considered to be ‘aspirational’ and ‘owned by the individual’ (Schostak et al 2010). It is also understood to be a process which is undertaken after, beyond, outside of or further to undergraduate and postgraduate study and training, extending throughout the professional’s career (General Medical Council - GMC 2012; Peeke 2000; ACT Health 2005). There is also a ‘setting’ characteristic to CPD – it is generally considered to be something which takes place ‘at work’ or ‘in the context of...working lives’ (Peeke 2000; ER-WCPT 2006).

Looking at what CPD ‘does’, there are a number of keywords which feature in the literature. Definitions generally refer to maintaining, improving, updating, acquiring, enhancing, reinforcing, developing, gaining, broadening, integrating and expanding various target areas and HCP characteristics including skills and competences. These learning processes are the goals of CPD activities and embody the notion of going beyond and sustaining previous undergraduate and postgraduate training, or indeed all previous professional knowledge.

Similarly, a number of keywords can be identified which describe the ‘targets’ of CPD activity. These include knowledge, expertise, competence, practice, skills, performance, standards and attitudes. Most crucially, the target areas of CPD activities are understood to have changed quite dramatically in recent years. This shift reflects the acknowledgement that healthcare is now provided by many workers, who are not necessarily qualified as health professionals – CPD has over time broadened to include these other health workers (Simkiss 2011). The term CPD now accommodates ‘not only the wide ranging competences needed to practise high quality care delivery but also the multi-disciplinary context of patient care’ (EFN et al 2006). It refers to development of ‘personal qualities necessary for execution of professional and technical duties’ and covers all areas of professional practice, as well as the personal, social and political aspects of health (Yfantis et al 2010; GMC 2012; Brigley et al 1997). Murgatroyd (2011) stipulates the inclusion of health, managerial, ethical, social and personal skills within effective CPD, which reveals the growing need for HCPs to be aware of wider health system shifts coupled with increasing demands for ensuring high professional standards, and displaying accountability and transparency to the public, to regulatory authorities and to professional bodies. However, CPME (2006), in defining CPD for physicians, also specify improvement in ‘medical competence and clinical performance’.

Finally, CPD is frequently defined by reference to its objectives. Most commonly, the primary objective is ‘improving patient care, ‘meeting the patient needs’ or improving the ‘quality and security of healthcare’ (Schostak et al 2010; EFN et al 2006; Maillet and Maisonneuve 2011). However,

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<sup>5</sup> This includes the sources listed in the bibliography, as well as additional material and websites that were deemed to be either irrelevant or not pertinent enough for inclusion in this study.



references are also made to 'recruiting, motivating and retaining high quality staff' – thus linking CPD to human resources management tools such as appraisals, as is the case in the UK - and even 'taking into account the priorities of public health and the management of medical health expenditures' (Brown et al 2002; Maillet and Maisonneuve 2011). Perhaps the broadest scope is ascribed in Italy, where the CPD programme is linked to 29 national health system objectives (Ministero della Salute, 2013).

While definitions can result in a number of different conclusions as to the various purposes of CPD, following Grant (Swedish Medical Association / Swedish Society of Medicine, 2011:8) these might be summarised as follows: to ensure the standards of professional practice, to demonstrate to the public and to employers that HCPs are up-to-date with modern practice and knowledge, thereby ensuring patient safety, and to be accountable to regulatory bodies and to the profession. To this might be added the desire to develop professional knowledge and skills, and using CPD as a tool for career development (EFN, 2012).

It is important to note that at present there are no clear indicators that allow measuring the impact of CPD on the competences or the performance of HCPs, and even less on health outcomes (Unaformec, 2010).

## **PROFESSIONS' DEFINITIONS OF CPD**

There are many different definitions of CPD in the health sector, including amongst the five regulated professions covered by this study. To illustrate, examples are provided for the organisations represented by this consortium, which represent the European umbrella organisations of national professional associations.

The definition used by the Standing Committee of European Doctors is 'the educational means by which doctors ensure that they maintain and improve their medical competence and clinical performance' (CPME, 2006).

The Pharmaceutical Group in the European Union (PGEU) describes CPD as a 'self-directed, ongoing, systematic and outcomes-focused approach to learning and professional development' (Svarcaite, 2009). However, in the community pharmacy sector it has also been noted that there is confusion between the terms CPD and CE in particular, (Atewell and Black, 2005) but also with LLL as all three terms are 'inherently practitioner motivated' (Svarcaite, 2009).

The Council of European Dentists (CED), meanwhile, defines CPD in its Resolution as a 'continued structured learning process of dental practitioners, aimed to maintain, update or enhance knowledge, technical skills or professional clinical or behavioural standards, all of which can improve the provision of oral healthcare to the public' (CED, 2013).

In addition to the CPD description contained in a Civil Society Resolution and which has been adapted for the purposes of this review (see below) the European Federation of Nurses Associations (EFN) has also situated CPD as a part of life-long learning, thereby describing it as 'a continuous process of personal growth, to improve the capability and realise the full potential of professional people at work. This can be achieved by obtaining and developing a wide range of knowledge, skills and experience, which are not normally acquired during initial training or routine work, and which together develop and maintain competence to practise' (EFN, 2012).

The European Midwives Association follows the terminology of the International Confederation of Midwives (ICM) which, in their glossary, refers to CPD as 'a range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their scope of practice' (ICM, 2011).

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## LEGAL DEFINITIONS OF CPD

While it is beyond the scope of this literature review to examine in depth the different legal bases and terminologies deployed across the EU/EEA countries covered by this study, some examples will suffice to show how CPD is 'different yet common' both at European and at national level.

CPD and LLL as concepts are not regulated or well defined at the European level. However, they feature in or are affected by a number of legislative instruments. Perhaps the most specific mention of CPD in the EU context is contained in the text of Directive 2013/55/EU<sup>6</sup>, which is particularly important for this review as it aims to encourage CPD for the sectoral professions. Article 15 states that CPD 'contributes to the safe and effective practice of professionals who benefit from the automatic recognition of their professional qualifications. (...) The measures taken by Member States to promote continuous professional development for those professions should be communicated to the Commission, and Member States should exchange best practice in that area. Continuous professional development should cover technical, scientific, regulatory and ethical developments and motivate professionals to participate in lifelong learning relevant to their profession.'

The Council Conclusions on investing in Europe's health workforce (Council of the EU 2010) specifically address CPD and led to the development of the Health Workforce Action Plan, though they recognise the competence of member states in the administration and regulation of CPD systems and related health workforce policies. The Directive on patients' rights in cross border healthcare (Directive 2011/24/EU) took a first step towards European level coordination in CPD activities, however. It requires that patients can receive relevant information on the safety and quality standards enforced in any EU member state they wish to seek treatment in, including which healthcare providers are subject to these standards. In addition to forcing the centralised collection of CPD data at national level, the Directive may go some way to encouraging the uptake of similar standards between countries.

Finally, the Council Recommendation on patient safety (Council of the EU 2009) defines this concept as freedom, for the patient, from unnecessary harm or potential harm associated with healthcare. It suggests embedding patient safety education in the CPD activities of healthcare professionals and collaboration with those organisations providing professional education in healthcare to ensure patient safety is a core part of training at all levels. However, the definition of patient safety can also be read to relate to harm caused by healthcare professionals as a result of failure to maintain their professional knowledge and skills. This implies that CPD is a tool in the direct protection of patient safety. It is not clear, however, how such an understanding of patient safety would fit with a broader definition of CPD. For example, if CPD is defined as the maintenance of all skills required to practice, including social skills related to bedside manner and patient-doctor relations, it is not clear at what point poor practice would constitute harm and a threat to patient safety. It should also be noted that a report by the European Commission found that member states have been poor in implementing the Council Recommendations (European Commission 2010).

At national level, legal provisions tend to emphasise prescribed aspects of CPD, often leaving 'informal' aspects open to interpretation. In France, *développement professionnel continu* (DPC) has long been promoted by medical associations and it now falls under Article 59 of the legislation introduced to reform hospitals, patient care, health and territories (the so-called *loi HPST*, 2009). The goal of *DPC* is defined as 'evaluation of professional practices, the improvement of knowledge, the improvement of the quality and safety of care as well as taking into account public health priorities and the management of healthcare expenditures'. This description does not include some of the non-clinical aspects cited elsewhere (e.g., ethical and behavioural obligations of the individual); however it establishes an explicit link with economic governance, and it is applicable to all health professions (Maillet and Maisonneuve, 2011).

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<sup>6</sup> See <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2013:354:0132:0170:en:PDF>

## MOVING TOWARDS A COMMON UNDERSTANDING

Explicating a common definition of CPD across all European countries is beyond the scope of this Review but the above identification of components facilitates the construction of a framework description, which shall apply for the purposes of this study.

Bringing together the elements highlighted above, the following description-in-progress, which has been adapted from the Civil Society Resolution on CPD (EFN et al, 2006), is suggested for the health context:

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*‘Continuing Professional Development (CPD) is the continuous and systematic maintenance, improvement, acquisition and reinforcement of the lifelong knowledge, skills and competencies of health professionals. It is pivotal to meeting patient, health service delivery and individual professional learning needs. Furthermore, it acknowledges not only the wide ranging competences needed to practise high quality care delivery but also the multi-disciplinary context of patient care.’*

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## CATEGORISING CONTINUOUS PROFESSIONAL DEVELOPMENT

This section further explores the characteristics identified above as components of CPD definitions. In particular, it examines what is meant by references to formal CPD, regulatory CPD, modes of delivery and types of skill development. This examination is important since how and what we learn and from whom has an impact on professional skills, behaviours and self-perception.

### FORMAL VS. INFORMAL CPD

Many accounts of CPD refer to informal and formal variants of learning activities. The best explanation of these terms is given by Arnold (2001: 260) – whilst it is given in reference to CME activities, it is illustrative in highlighting the difference between the two forms and in offering a framework upon which to build a common understanding of formal v informal CPD (regardless of the semantic term used – see EUCIS-LLL for a CPD-based definition) across health professions. For the purposes of this study, CME has been replaced with CPD in the text below.

*Formal [CPD], for which credit can be received, is generally offered in more traditional formats. Formal lectures, such as grand rounds, short or long courses on selected topics, and board review courses compose the majority of formal offerings. Informal [CPD] activities include reading journals and textbooks, consulting with colleagues and specialists, on-line searching of the literature pertaining to specific patient-related problems, and participation in (...) on-line discussion groups. Although these activities comprise the majority of (...) ongoing self-directed learning, they are generally not eligible for [CPD] credit.*

Davis et al (1999: 868) emphasise the breadth of activities which constitute formal CPD, ranging from 'passive, didactic, large-group presentations to highly interactive learning methods, such as workshops, small groups and individualised training sessions'. The World Federation for Medical Education (WFME) views it as teacher-conducted activities, 'generally provided and supported by institutions such as medical schools/universities or postgraduate institutes, professional organisations, national or international scientific organisations, local or national health authorities or the pharmaceutical/medico-technical industry' (WFME, 2003:7).

Meanwhile Coles (1993: 60) identifies three forms of informal CPD: on-the-job training; feedback; and counselling. Generally speaking, informal CPD is contrasted to the traditional, lecture and reading-based formats of formal CPD, often utilising new modes of delivery facilitated by the internet (e.g., e-learning, professional discussions in specialised online fora) and the growing flexibility of studying location (e.g., distance learning). Many professional associations and regulatory bodies advocate a balance between formal, structured learning on the one hand, and informal activities and learning in the workplace, on the other (EFN 2012; GMC 2012, WFME, 2003; see also Poredoš, 2011). Hence, although 'informal' by title and method, this type of learning is an integral part of CPD that can be either planned or spontaneous, and that can also 'count' in order to meet mandatory requirements. It is thus important to underline that the literature does not generally view informal CPD as being *in opposition to* regulatory CPD (as is being suggested in the tender specifications) but it principally refers to the *mode of delivery*. It is this perspective that has informed the jointly agreed glossary definitions outlined in Annex 2.

Finally, there is a debate about which of these methods of learning is more effective. A recent independent review in the UK concluded that 'Doctors must be fit for purpose throughout their careers, which requires a structured CPD approach', whilst other reviews question the effectiveness of formal

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activities (Greenaway, 2013). Some underline the particular importance of informal CPD given that it provides applied knowledge via learning opportunities such as professional conversations, multidisciplinary team meetings, self-learning, etc., which entirely relate to real life situations and hence might be more 'memorable' and thought-provoking than structured learning, although it has also been cautioned that opportunities for informal CPD differ between professional roles and interactions, countries and regions. Geographic location in particular often determines the size, composition and diversity of health institutions' staff and their available CPD training, equipment and technology (Giri et al. 2012).

While there are ongoing debates over the provision of formal CPD and its potential bias given the opportunities for commercial and ideological interests to influence the learning agenda (Mladovsky et al, 2009) - a problem that has been tackled through legal or ethical requirements in many countries (e.g. the German Medical Chamber's detailed guidance for doctors stipulates that 'continuing education content must remain independent from commercial interests' and that 'sponsoring must be transparent', 2007) - there are other access barriers such as age, gender, availability of CPD offerings, cost, location and freedom of choice. Generally speaking, the trend in some EU countries for CPD to encompass a broader range of skills including communication and management, as well as reflective awareness of demographic shifts and the wider health system context favours CPD systems flexible enough to take advantage of learning opportunities that can accommodate both learners' individual needs - which can be constrained by family obligations, managerial attitudes, etc. - and those of the needs of service (Gould et al, 2007).

Formal CPD often goes hand in hand with keeping and maintaining a Personal Development Plan (GMC, 2012a) or 'portfolio' (EFN, 2012) as official proof for obtaining CPD credits, which can also be linked to appraisal processes as is the case in the UK. However, it may be less straightforward to provide evidence of certain informal CPD activities which occur in a more ad hoc manner, e.g. learning from own or colleagues' experiences and mistakes/errors, spontaneous interactions with colleagues, social media activity or patient feedback received during challenging situations. In nursing, specific reference is made to formal, informal and *incidental* learning, thereby allowing the entire spectrum of learning experiences to count as CPD. In dentistry, the UK General Dental Council (GDC) differentiates between 'verifiable' and 'non-verifiable' (also called 'general') requirements, the latter describing activity that 'reasonably advances your development as a dental professional and is relevant to your practice or intended practice' and which can be counted as non-verifiable CPD (GDC, 2013). The GDC's requirements apply across the multi-professional workforce that they regulate, namely dentists and six groups of dental care professionals (DCPs) (including, dental nurses; dental hygienists; dental therapists; dental technicians; orthodontic therapists; clinical dental technicians). They thus encourage multi-professional CPD education and training of the entire 'dental team'.

Broadly speaking, CPD can thus be said to take the form of mass, group, individual or self-education (Kersnik, 1995). No matter what type of CPD is undertaken, workplace support - freeing up time and resources, and offering a professional culture that promotes learning throughout one's professional career - is cited as crucial for CPD to succeed (EFN et al, 2006; GMC, 2012a). Moreover, the more health professionals are themselves able to shape the CPD activities at their disposal, the more they are accepting of CPD in general.

## **MANDATORY VS. VOLUNTARY CPD**

European countries differ in their approaches to CPD. In some cases, fulfilment of a CPD programme or completion of a set amount of CPD activity is a mandatory part of a HCP's employment and/or licence to practise and is regulated by an internal or external body (Wise et al 2010). In others, CPD is undertaken voluntarily, with activities tending to be more closely linked to on-the-job learning (see next paragraph).

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The 2011 survey undertaken by the General Medical Council (GMC) (Murgatroyd, 2011) found that for physicians, CPD was compulsory in 12 countries (UK, IRL, DE, GR, HU, IT, NL, NO, PL, SK, SL) and voluntary in 4 of the countries surveyed (AU, BE, ES, SW). Similarly, the recent country report for nurses (EFN, 2012) found that CPD was compulsory in 14 EU Member States (UK, BE, CY, CZ, EST, FR, IT, LV, LIT, RO, SK), with different exigencies regarding the number of study days or credits to be gained in a set time period, the minimum number of study days per year to continue to practise as a nurse, and requirements for providing evidence of CPD activity. Most of the regulatory bodies have also developed standards and guidelines on the use of CPD, which can be rather broad or very specific. The findings of the DentCPD project, based on an extensive literature inventory as well as data gathered from dental educators on European CPD systems, requirements, provision and accreditation, resulted in guidelines expressed in seven recommendations. They do not wish to impose any specific structure for CPD activities but underline that, for dentists, “CPD should be organised in a way which facilitates learning, endorses good practice or, if needed, is reflected and reflects a change in the prevailing practice” (Suomalainen et al, 2013:33). In particular, they highlight the benefits of an outcome-centered framework for CPD including assessment and feedback.

Moreover, where CPD is mandatory, it is sometimes also linked to financial and status benefits for the individual HCP, e.g. being able to charge higher fees in Norway, which has been combined with one-off payments in Belgium (Murgatroyd, 2011). However, legal sanctions do not always apply even in countries where CPD is mandatory, either because there is no agreed system of certifying CPD participants as in Greece, or because extra time is granted to non-compliant doctors in order to catch up and meet the requirements as is the case in the Netherlands (KNMG, 2013). In Germany however, financial sanctions do apply to some practitioners (Hjelmqvist; see Swedish Medical Association / Swedish Society of Medicine, 2012:19), while in the case of non-compliance licences may also be revoked, as in Croatia and in Hungary (Murgatroyd, 2011).

Bailey et al (2013) and Bullock et al (2013) note that a shift is underway across Europe, in the field of dentistry, towards compulsory, mandatory CPD. CPD is described as a professional obligation by the Council of European Dentists (2013). Meanwhile, for many physicians and other HCPs in Europe, CPD is not a mandatory requirement.

Two recent articles have argued that the German system, which makes CPD mandatory for physicians (except for purely private practitioners) yet leaves them a degree of freedom to self-select appropriate activities, arguably provides higher quality training than the American model where CPD is part of recertification systems that can become ‘box-ticking’ exercises in the worst case (Böthin 2013; Scholze and Finkeißen 2012). That said, Loch and Rieck (1999) advocate a credit system for CPD, arguing that this would increase awareness of quality and competition between professionals, whilst Mazmanian and Davis (2002) contest that mandatory CPD with credit hours is not conducive to efficient and beneficial learning. Similarly, Holm (1998) questions the role of traditional mandatory activities, encouraging their linkage to workplace learning and group-based activities. From the community pharmacist perspective, it has been noted that mandatory CPD systems could prevent learners’ move from dependency to self-directedness (Švarcaitė, 2009). But the necessity to steer HCPs towards appropriate and relevant activities to avoid that they only choose topics they are interested in - but that may not benefit daily practice - has also been pointed out in Germany and elsewhere (Adler et al., 2008).

Whilst consensus that CPD is an ethical responsibility of health professionals is relatively universal, opinion as to whether or not this should and needs to involve a regulated system of mandatory requirements remains divided (UEMS 2001). In spite of globalisation, professional roles are to a great extent shaped by the specific histories of each profession in their countries, hence titles do not necessarily correspond to the same self-understanding or professional ethos. For example, it has been argued that in France, the philosophy of *DPC* has been imposed ‘from above’, which has led to a

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proliferation of new administrative bodies that do not cooperate well with doctors and determine the content of training, hence acceptance of the new mechanism is low (Dumur, 2012). Although the inclusion of evaluation is viewed as a positive step, continuing (medical) education used to be more self-directed and appealed to doctors' sense of independence. Similar comments have been made in Germany, where for physicians, CME was introduced against the will of the professional bodies (Schlette & Kemperer, 2009) and provider control has also been critically viewed as a potential threat to professional independence, especially given the ideological exploitation of the health sector by the Nazis and ongoing influence by the pharmaceutical industry (Böthin, 2013). The importance of objectivity in medical education has also been pointed out by other commentators (European Society of Cardiology Board, 2011).

Seeking to strike a balance, the UK's GMC states that its role is 'not to prescribe what CPD doctors must do or how they must do it, but to provide a framework of principles around which doctors should plan, undertake and evaluate their CPD activity' (GMC, 2011). It is however important to the GMC that mandatory CPD, whether formal, informal or a combination of both, equips HCPs with relevant and meaningful skills and information that will translate into better quality of care and higher patient safety.

### **TEACHING METHODS AND MODES OF DELIVERY**

Much of the literature divides CPD into sub-types according to the mode of delivery or teaching method (see Swedish Medical Association / Swedish Society of Medicine, 2012:10). These tend to include lectures, skills training, multimedia platforms, video conferencing, meetings, classes, workshops, audiotapes, courses, journal reading, distance learning, audit and computer learning, among others (Torpy et al 2002; Buck and Newton 2002; Barnes et al 2013). Furthermore, a small but growing subgroup of literature identifies, discusses and evaluates specific modes of CPD delivery. These range from assessments of new phenomena such as 'blended learning', e-CME and other formats, including learning in local languages, linked to the proliferation of ICT-based learning (Glogowska et al 2011; Maisonneuve and Chabot 2009; Gross and Pelz 2009), to reviews of the effectiveness of more traditional methods, such as self-assessment, peer review and multiple-choice question testing (Best and Messer 2003; Chop 2012; Rotthoff et al 2008). Olson (2013) examines the use of grey literature, defined as that not published commercially or indexed by major databases, in light of the increasing range of such resources and the potential they offer.

There is also a school of CPD devoted to 'interprofessional education' (IE). The WHO issued a report (2010) on interprofessional education and collaborative practice in 2010, highlighting the systems and practices in place across the world for learning between health professions. IE is understood to involve students from two or more professions learning about, from and with each other in order to form a collaborative practice team (Gilbert, Yan and Hoffman, 2010).

### **TYPE OF DEVELOPMENT PURSUED**

A less common but equally valid categorisation of CPD classifies activities according to the type of skill or competence they attempt to develop. As mentioned in the first section, CPD is increasingly acknowledged to involve medical, managerial, ethical, social and personal skills and different activities are thus necessary to maintain and develop these distinct types of competence (Murgatroyd 2011). Some literature advocates inclusion of particular specialist skills in CPD – for example, Barker (1998) argues that more attention should be given to the skills involved in the patient-doctor relationship and corresponding psychosocial issues, whilst Delphin and Rowe (2008) call for a specific 'cultural competence' element in CPD, particularly for mental health professionals. The WFME (2003) notes that physicians require formal, factual, procedural and intuitive knowledge in order to offer high quality care, whilst a study of CPD for German surgeons recognises the importance of research, teaching and administration, as well as clinical skills, and advocates tailored CPD activities to match the professional needs of each doctor (Ansorg and Betzler 2006).

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By incorporating such broad skills, CPD expresses not only that learning is experienced differently by each and every person, but also that it can take place at different levels including individual, team, departmental and organisational realms. Different types of development make it clear that CPD is personal and professional, and that it involves both private/team responsibilities (e.g., to gain skills, improve performance or meet revalidation requirements) but it is also an employer responsibility in the sense that clinical governance demands CPD systems that support it (Cartabellotta, 2011). This 'professional' function of CPD appears to be particularly strong in UK midwifery, where the Royal College of Midwives (RCM), a professional organisation and union have approached CPD in practical terms, e.g. by creating the role of Learning Representative (LR) for members in their work environment. LRs are depicted as '(...) enthusiasts and advocates of learning and development who actively promote a learning environment', thereby going beyond what employers themselves can offer in terms of identifying and fulfilling midwives' lifelong learning and development needs (RCM, 2013). This role broadens the approach provided by dedicated practice development midwives, who provide the mandatory training and education defined by an employer and the Supervisor of Midwives' annual review assessing individual CPD requirements on behalf of the regulator. Moreover, the RCM's Framework for CPD and LLL (COIN) describes how CPD is an applied educational tool for *consolidation* of knowledge and skills and move towards professional *ownership* and *independence*, ultimately steering midwives towards '*new ways of working*' (RCM, 2003).

Perhaps the most comprehensive definition of how specific *types of skill* can be the target of CPD is that offered by Barnes et al (2013: 11). This notes differing CPD activities for dentists in the areas of:

theory, clinical demonstration, practical work and the laboratory work...practice management, hands-on training, computer use, restorative techniques, preventative treatment and oral surgery...risk assessment in medically compromised patients, communication with attending physicians, medical emergencies and formal courses on topics such as otolaryngology, pharmacology, haemostasis and antibiotics...oral implantology, cosmetic dentistry and root canal therapy.

This is a much more detailed categorisation, according to specific clinical and non-clinical dentistry skills, but could apply to any of the regulated health professions covered by this review.

Moreover, CPD is also connected to other regulatory changes, especially in countries with an Anglo-centric tradition, including the concepts of competence/competency and their insertion into wider competency frameworks that may also seek to describe leadership development (see Svarcaite, 2009 and Royal Pharmaceutical Society, 2011 for examples in the pharmacy sector). Competence/competency are task focused and describe something that must be demonstrated – and hence can be assessed and quality assured (EQAVET, 2011) – in order to enable a regulator or health service provider to meet pre-set performance standards and reassure the public. On the other hand, competency frameworks involve 'a collection of competencies that are thought to be central to effective performance' (Svarcaite, 2009:29) often also tied to a qualifications framework.

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## CORRESPONDING TERMS

A number of other terms have emerged around, alongside and complementary to CPD, and they are not infrequently used synonymously in the literature. Some of their definitions vary from that of CPD whilst others are very similar, and many of the concepts form part of one another. This section first examines the definitions of these supplementary terms, before mapping the relationships and interactions between them.

### LIFELONG LEARNING (LLL)

The term Lifelong Learning was brought into mainstream use in 1972 with the publication of the Faure Report by the United Nations Education, Scientific and Cultural Organisation (UNESCO). This stated that

*Lifelong education can produce the kind of complete man the need for whom is increasing with the continually more stringent constraints tearing the individual asunder. We should no longer assiduously acquire knowledge once and for all, but learn how to build up a continually evolving body of knowledge all through life—'learn to be' (1972: vi)*

The holistic, life-course notion embodied in this definition forms the centre of modern-day understandings of LLL. The European University Association, in its Charter on lifelong learning (EUA, 2008), points at the evolving nature of LLL, which 'embraces many concepts – including initial education for disadvantaged groups, continuing education and training for well-qualified graduates, and post-retirement opportunities for cultural enrichment', while Polyzois (2010: 84) concludes that 'Lifelong learning today is perceived as a dynamic process, inseparable from everyday clinical practice'. LLL is widely recognised as intrinsic to a person's development and an important part of their professional, as well as personal, advancement. Horsley et al (2010: 4) define LLL as 'a continuously supportive process that stimulates and empowers individuals (physicians and other health professionals) to acquire all the knowledge, values, skills and understanding they will require throughout their lifetimes'. The ongoing nature of LLL is also highlighted by Bennetts et al (2012: 542), who argue that there has been a conceptual move to LLL in recent years and consider LLL to involve 'multifaceted dimensions of everyday learning for individuals, including workplace learning and professional development...best viewed as a process, not a discrete educational event'.

To some degree this opening up is reflected in the definition of LLL used by the Commission in its Lifelong Learning Programme 2007-2013 Glossary, which describes it as "all general education, vocational education and training, non-formal education and informal learning undertaken throughout life, resulting in an improvement in knowledge, skills and competences, within a personal, civic, social and/or employment-related perspective.'. Interestingly though, the new Article (I) contained in the text of Directive 2013/55/EU uses almost the same definition in a professional context, dropping however the 'personal, civic and social' aspect and instead stating that '(...) resulting in an improvement in knowledge, skills and competences, which may include professional ethics'.

Importantly, while CPD and CE/CME might not be voluntary, especially if tied to revalidation procedures, LLL describes a purely self-motivated process for acquiring knowledge, 'from cradle to grave'.

### CONTINUING EDUCATION (CE)

Continuing Education embodies a similar set of notions as LLL. The World Health Organisation (WHO 2003) defines CE as 'education that builds upon initial professional or vocational education', whilst the Royal Pharmaceutical Society of Great Britain (RPSGB 2009) describes 'the traditional methods of

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learning such as attending workshops, following diploma or distance learning courses, or structured reading'. Horsley et al. (2010) refer to the 'historic notion of continuing education', where learning is understood to be 'part of a structured delivery system and is an adjunct to daily practice'. Rouse (2004), speaking from the pharmacy perspective, goes as far as to state that CE should be synonymous with LLL, highlighting the recurrent themes of ongoing learning, but missing the distinct emphasis, made in definitions of the former, on more formal structures of education. As such, CE can be understood as an early, non-sector specific term used to formalise the structures around Lifelong Learning, and that continues to be used by the health professions (Horsley et al., 2010).

The methods of training delivery in particular of CE (and, by extension, CME) tend to be less applied and more 'passive' and didactic than in CPD, giving precedence to activities such as lectures and courses. Since the latter are also a component of 'formal' CPD, continuing education has thus been called an integral part of CPD (Svarcaite, 2009).

### **CONTINUING MEDICAL EDUCATION (CME)**

Generally speaking, CME describes the most ubiquitous and widely researched variant of CE and hence it is explored in more detail in this study. However, equivalent concepts also exist for the other professions, e.g. 'continuing nursing/dental/pharmacy/midwifery education'.

Since the 1980s, the Dublin Declaration has recognised that 'CME is an ethical and professional duty and individual responsibility of every practising doctor throughout his professional life'.<sup>7</sup> In some cases, the definition of CME is even almost identical to that of CPD, and at least in the medical sector, the terms are often used synonymously, something that the Rome CME-CPD Group has also recognised in its harmonisation efforts (Rome CME-CPD Group, 2013). For instance, Chakhava and Kandelaki (2013: 20) 'self-education, as well as participation in formalised education...programmes and also other activities promoting the enhancement and improvement of a physician's professional knowledge and skills'. Similarly, Bockel et al (2004: 535) consider CME to consist of 'educational activities that serve to maintain, develop, or increase the knowledge, skills and/or professional performance of a physician'. There is also an equivalent body of literature which discusses individual components, such as new and innovative learning forms, different modes of delivery and the link between CME and practices such as relicensure and recertification (Maisonneuve and Chabot 2009; Davis et al 1999; Davis 1998).

The primary distinction between CPD and CME lies in the skill areas targeted. Bloom (2005: 380) defines CME as designed to help physicians keep current with the latest advances, help them accept or reject new practices, and 'convince them to discontinue use of existing care of lesser effectiveness'. As such, CME focuses on medical or clinical knowledge whereas CPD is unambiguously 'practice-based, learner-centred and multidisciplinary', with reflection at the heart of its cycle (Brigley et al., 1997). Though the term CME is considered to have broadened in meaning since the early 1990s, taking into account a greater range of activities, the target of these formal and informal activities is still understood to be narrower than that of CPD (Mazmanian and Davis 2002).

### **OTHER TERMS AND CONCEPTS USED TO DESCRIBE CPD**

A number of other, less commonly used terms are also identified in the literature. Olson (2012) refers to 'continuing education of health professionals' (CEHP), whilst Bockel et al (2004) use the term 'continuing physician professional development' (CPPD). The Nursing and Midwifery Council (NMC, 2012) also uses a profession-specific term, linking CPD to the post-registration education and practice (PREP) requirements that exist in the UK by reference to the 'PREP CPD' standard which should be met in addition to the 'PREP practice' standard. Meanwhile, the term 'professional development' (PD) is not commonly used, appearing only in relation to specific sectors, most often teaching in the EU and

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<sup>7</sup> For the full text of the Dublin Declaration, see [http://cpme.dyndns.org:591/adopted/cp%201993\\_26.pdf](http://cpme.dyndns.org:591/adopted/cp%201993_26.pdf)

academic contexts. However, Plymouth University (2014) define PD as ‘a means of supporting people in the workplace to understand more about the environment in which they work, the job they do and how to do it better. It is an ongoing process throughout our working lives’.

Davis et al. (2003) have also proposed the term ‘knowledge translation’ as being even more relevant to daily practice than CPD, since the former recognises ‘barriers of change’ to improving public health and thus contains a political element that can stimulate not only HCPs but also patients, consumers and policy makers into action.

Unsurprisingly, a number of culturally and linguistically specific terms exist across Europe. In Spain, for example, CPD is often compared to the term ‘Professional Career’, which is defined as ‘the right a professional has to progress, on an individual basis, as acknowledgement of their professional development in matters concerning knowledge, experience and satisfaction of the objectives of the organisation he or she works for’ (Pardell Alenta 2008: 54). Other authors highlight the need to distinguish this term from CPD and address the discrepancies that have been institutionalized by the 2003 Spanish Law on Health Professionals (Zurro 2008; Ramirez-Puerta et al 2006).

In France, the *loi HPST* effectively reunited and subsumed the concepts of continuing education and the uniquely French notion of *évaluation des pratiques professionnelles (EPP)*, which became dissociated from continuing education by focusing firmly on the analysis and evolution of professional practice (Dumur, 2012; Unaformec, 2010).

In Germany, CPD is not the term of preference and instead the generic *Fortbildung* is used, which translates more closely as continuing education. For doctors, CME has become mandatory under article 4 of the *Berufsordnung* and since 2004 there is also a legal obligation to show proof of their activities under the *GKV-Modernisierungsgesetz*.

In Italy, ECM stands for *Educazione continua in medicina*, however its exceptionally broad scope, of which ‘updating’ is only one small element, is much more in line with the descriptions and goals of CPD than with those of (conventional) CME. Since 2002, continuing education is an obligation of all health professionals in Italy regardless of whether they are medical or non-medical, independent or employed, public or private sector (Cartabellotta, 2011). Besides, unlike in many other countries, in Italy accreditation of ECM involves both events and providers (Ministero della Salute, 2013).

## RELATIONSHIPS AND INTERACTIONS

Almost all of the literature surveyed explains one of the terms above by reference to one or more of the others. The relationships and interactions between them are understood differently in different sources but a common hierarchy can be seen to emerge from the definitions given – this is best illustrated in a chronological description.

LLL can be considered as the founding concept. It encapsulates the broadest range of activity, skills and development, understanding an individual’s learning as something not confined to ‘childhood, schools or what was previously seen as the “educational” sector’ (UNESCO 2008). It embodies learning across all platforms – formal, informal and non-formal – and in all areas of life – personal, professional, social, spiritual, psychological and all other spheres (EUCIS-LLL 2013).

Elements of LLL can be seen to be formalised in continuing education. Rouse (2004) considers the two terms to be synonymous, a view based upon their similarities with regards to emphasising on-going, life-course education and development, whilst Austin (2013) describes CE as old-fashioned learning, highlighting the ‘age’ of the term and its development alongside LLL. In sum, CE can be seen as a concept developed to formalise some of the notions embodied in LLL, generally understood in the context of the working or educational environment.

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In the early 1990s, the concept of CPD entered into debates. The initial understanding was relatively narrow, referring specifically to education and training within the professional environment, designed to target a fairly narrow range of professional skills needed to perform a particular job efficiently. Though adopted as a common term by most sectors, CPD was still not a profession-specific concept, but was understood as 'part of a personal programme of lifelong learning' (Carbon 2005). CPD is therefore hierarchically under the umbrella of LLL, incorporating 'the principles of adult learning' (UEMS, 2001), but is also a development and expansion of the overarching term, taking account of contemporary learning structures and individual needs (EFN 2012), hence providing a quality improvement of current CE systems (Rouse, 2004).

In its broadest sense, CME can be understood as a physician-specific variant of CPD, targeting the development of clinical and medical skills. As such, CPD can be understood to 'contain' CME (Zilling 2005; WFME 2003; Matos-Ferreira, 2007). CME is one part of CPD, focusing on the training of physicians in areas of clinical practice, medical knowledge, updated protocols and new treatments (Ratsimbazafy 2009; Dumur 2012). Mladovsky et al (2009: 1) explain that '[t]he broader concept of CPD includes CME, along with the development of personal, social and managerial skills'. Similarly, UEMS (2011) recommends in its Basel Declaration that 'CPD incorporates and goes beyond CME; it should therefore be the preferred concept'. Using these categories only, CME can therefore be understood as continuing education in medical or clinical practices. When completed alongside activities to develop personal, social and managerial skills, CME is a component of CPD for health professionals.

More recently, an expansion of the terms outlined above has occurred. Looking firstly at CPD, a 'conceptual move' and greater emphasis on LLL has served to broaden the definition of the former concept (Bennetts et al 2012). LLL has moved back into the mainstream, as the interconnection between personal, professional and social development has become more widely recognised. This in turn has prompted CPD systems to acknowledge the need to develop professional skills, meaning clinical practice and medical knowledge, alongside and in the context of personal, social and other broader skills, reflecting more of the life-course approach advocated in LLL. As such, CPD has begun to 'reconsider' its activities in light of the LLL agenda (Sermeus and Bruyneel 2010).

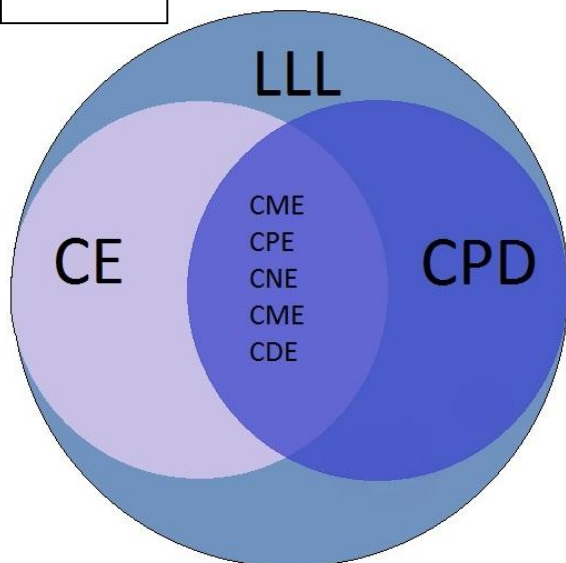
Finally, a similar expansion is occurring in the use of the term CME. The broadening of CPD has had a knock-on effect on the understanding of CME – CME has been forced to 'embrace' the new, wider concept of CPD, in some cases absorbing managerial, social and personal skills, 'topics beyond the traditional clinical medical subjects', within its remit (Ansorg and Betzler 2006; Peck 2000). Varetto and Costa (2012) surmise that CPD 'reflects where CME is heading'. This shift is occurring across Europe, with 'many countries...now moving from a knowledge and skills based CME systems towards a system that seeks to promote the wide-ranging competencies...that CPD entails' (Murgatroyd 2011). The broadening of CME can be seen as a trickle-down result of the revival of LLL – the latter prompted an expansion of the topics covered by CPD, which has itself resulted in an extension of the subjects understood to constitute CME activities (Lowe 2009).

Bringing the above explanations together, a clear historical evolution of the terms and hierarchical relationship can be illustrated (see figure 1). LLL is the over-arching term, present for the longest time and embracing the widest understanding of an individual's development and learning. CE emerged as part of the attempt to formalise the notion of LLL and encourage the creation structures within which it could be pursued. It brings the notion of LLL into the professional sphere, relating to an individual's development within the workplace. CPD represents a chronological leap, coming into use in the early 1990s to describe formal activities of CE offered or required by employers and regulators. The topics and type of development it includes has expanded over the years to embrace more elements of LLL. Finally CME is a medical-specific type of CPD activity, covering mostly clinical practice and some other, non-clinical, skills necessary for efficient practice as a health professional. Both CPD and CME

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can be further categorised according to their voluntary or mandatory nature, their formal or informal mode of delivery and the content of the activities offered, as outlined in the first section. As Silva et al (2012: 223) conclude: 'continuing medical education and its broader term continuing professional development are indispensable as part of lifelong learning'.

Figure 1



### CPD AND FITNESS TO PRACTISE

'Fitness to practise' is a term which has long been used in the UK within nursing and midwifery and that has gained in prominence following high profile cases of health professionals putting patient safety at risk. According to the UK Council for Healthcare Regulatory Excellence (2012:1), 'in order to be fit to practise, a professional must practise in accordance with the regulator's standards, including requirements relating to the maintenance of professional skills and knowledge, however, compliance with input-based continuing professional development requirements is not of itself a demonstration of continuing fitness to practise'. In other words, the power of CPD in ensuring professionalism is limited in the sense that, by combining 'input-based learning' with more output-based activities, it still cannot encompass the full reality of conducts and behaviours that determine whether an individual is fit to practise; it becomes merely a method to show that one is up-to-date.

Gallagher's explanation (2010: 71) offers some insight into what this broader concept might embody, noting that 'aside from criminal matters, there are various other behaviours, competency issues and attitudes that can render a healthcare professional unfit to practice. These may include...mental illness, racist or sadist attitudes, bankruptcy, abuse of drugs or alcohol, inappropriate sexual behaviour, malice, and technical incompetence.' As such, it can be discerned that revalidation is concerned purely with the maintenance of medical or technical ability, whilst fitness to practice is to do with the individual's broader personal and professional ability. Schostak et al (2010) make a similar distinction, between being 'fit to practice', embodying those ideas described above by Gallagher (2010), and being 'safe to practice', as embodied by the concepts of revalidation and CPD.

Moreover, fitness to practise is closely linked to (re)registration and (re)licensing schemes as an assurance mechanism subject to public scrutiny, and to professional standards (thereby again entering the realm of CPD).

### CPD AND REVALIDATION

Revalidation is becoming a widely discussed topic in Europe as the experiences of transatlantic and European pioneering countries are being followed. Its rise is described as a response to loss of trust by the public and the media and the resulting increasing demand for professional accountability (Pringle 1999; Villaneuva 2010). As such, it seeks to identify underperforming health professionals and

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is subject to discussions in the UK, where it was introduced for the medical profession in 2012 (Wilkins 2010).

At the most basic level, revalidation entails participating in CPD activities whereas 'more demanding methods incorporate peer review, external evaluation and practice inspection' (Merkur et al, 2008:371). In most countries, professional bodies (e.g national or regional chambers, councils in collaboration with colleges, etc.) are in charge of revalidation, either independently or in collaboration with government ministries, while in other countries insurers are involved, e.g. when doctors are contracted with them. In their study of seven countries Merkur et al (Ibid.:373) observe that 'self-regulation is more willingly accepted' and that the preferred process should be transparent but not involve sanctions, e.g. Belgium promotes it but does not oblige physicians to take part.

Some of the literature also deals with the link between revalidation and the terms related to CPD and LLL. Davis (1998) explains and defines CME by its relation to relicensure, recertification and mandatory CME, demonstrating the role of CME as a component in revalidation systems. Austin (2013) gives perhaps the most detailed description of the link between CPD and revalidation – the notion of 'ability', he says, is what connects the two ideas. Revalidation relates to fitness to practice and maintenance of competence, Austin states, whilst CPD refers to the mechanisms which health healthcare professionals achieve these goals. Finally, Greenhalgh and Wong (2011: 168) express their concern that CPD might not be compatible with revalidation, since 'professional development is a formative and supportive process, while dealing with unacceptably poor practice must surely be summative and judgemental'.

Countries such as the Netherlands, Germany, Norway and Croatia have made CPD a formal condition for recertification of doctors, i.e. they must prove that they have taken part in x-hours of CPD per year combined with peer review. These requirements are part of a recertification cycle that can be five or six years long (Murgatroyd, 2011). In the Netherlands, this involves a visitation system whereby teams of doctors assess other doctors' competence (KPNG, 2013). Other countries are tying CPD to re-registration, which might involve annual declarations that health professionals comply with given CPD requirements.

In the UK, revalidation was introduced for doctors in December 2012, although it has been criticised as being potentially damaging and burdensome (Cawston et al, 2012:32). The GMC calls it 'the process through which doctors show periodically that they are up-to-date and fit to practise. You can use revalidation to show your CPD is appropriate for the work that you do and to discuss your developmental needs' (GMC 2011:16). It involves recommendations by so-called Responsible Officers – who are senior doctors – on whether individuals should retain their license to practise. In addition, in order to revalidate, doctors need to participate in annual appraisals according to a *good medical practice framework* (GMC, 2012c) during which CPD portfolios are also examined. Patient feedback will also play a vital part in this (GMC, 2012b). This mirrors the well-established annual supervisory review in midwifery by the Supervisor of Midwives. Every registered midwife has a named Supervisor of Midwives who conducts an annual review or interview; facilitating discussion, reflection and assessment of personal needs to maintain and update professional skills and competencies. As with doctors and nurses, midwives develop personal portfolios which comprise various types of CPD activities with personal reflection.<sup>8</sup>

Some have argued that in countries like Germany, where public concerns over quality are less pronounced, the term is largely used as a synonym for (re)certification, i.e. it is subject to relatively undemanding CME requirements that neither measure nor improve quality (Schlette and Kemperer, 2009). Certification and recertification schemes have also been reported to be developed in Spain,

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<sup>8</sup> More information is available on the Nursing and Midwifery Council website, <http://www.nmc-uk.org/Nurses-and-midwives/Revalidation/>

where the regions – like in Germany – are largely responsible for healthcare education (Merkur et al, 2008).

Audit schemes are another feature that is being introduced in some countries, with Ireland's Medical Council allegedly auditing about 15% of doctors undergoing re-licensure (Murgatroyd, 2011).

## THE CPD CYCLE

Given CPD's growing role in fitness to practise and revalidation models, it is thus becoming ever more structured. As part of a managed CPD cycle, there might be different steps including, at a minimum, self-appraisal, planning, learning, and follow-up (Grant, 2011). An initial tailored individual needs assessment is crucial to define the type(s) of CPD activities that are most suitable to each HCP based on their pre-existing knowledge base, professional role and activities, and individual career path.

The CPD cycle helps distinguish it from CME and LLL: whereas CPD includes the demonstration of implementation into practice or practice change, the former concepts assume that learning will translate into change. They thus focus primarily on content rather than on how knowledge and skills are acquired. Since CPD includes, inter alia, preparing HCPs to deal with situations of uncertainty and change arising in clinical practice, it must offer opportunities to impart 'practical wisdom' that cannot be studied (WFME, 2003).

This is why the concept of *reflection*, which has been defined as 'the systematic enquiry into one's practice and deepen one's understanding of it' (Svarcaite, 2009) occupies such a central place in the CPD cycle, alongside evaluation of activities. It is crucial for attaining a high standard of CPD and by extension, professional competency. In the UK, the GMC guidance stipulates that '[y]ou must reflect on all aspects of your professional work(...) you must also reflect on what you have learnt from your CPD activities and record whether your CPD has had any impact (...). Reflection must be integrated into your PDP and appraisal and job planning discussions' (GMC, 2011:11) It is thus a practice that involves not only in-depth thinking over one's professional activities but that also requires recording and documentation to illustrate the journey.

It has been suggested that many practitioners lack the skill, motivation or time to reflect properly, hence reflective practice is increasingly seen as something that needs to be developed as part of health professionals' education at all levels (Mann et al., 2009).

## EXISTING STUDIES

The main results of the key CPD-CE studies undertaken across Europe in the sectoral professions have been presented in previous chapters. One major limitation is that these studies have looked at only one profession, e.g. doctors (Murgatroyd, 2011) and nurses (EFN, 2012) while there are virtually no studies on CPD and related concepts that have been conducted across professional boundaries. Moreover, even the studies mentioned throughout this literature review do not cover all the countries (EU-28 + EEA/EFTA) investigated under the current study, a notable exception being the DentCPD survey which included 30 European countries. To provide an example of how CPD systems can be grouped, the DentCPD survey concluded that dental CPD systems can be described by four categories:

Official, regulated CPD system, compulsory for all (14 countries);

Official, regulated optional CPD system (8 countries);

No official, regulated system but recommended hours (3 countries); and

No official system (5 countries)

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However, CPD is subject to a lot of current discussion and change across Europe, which means that in order to produce a comprehensive matrix covering all the dimensions of CPD in all five professions and across 32 countries, it is imperative that the results of this literature review are compared to and complemented by up-to-date information by national CPD experts.

As shown above, the discussion of the role of CPD is also topical in the context of EU legislation and policy.

In addition to the studies mentioned thus far, there are others that inform the future development of CPD. To provide one example, the links between improved working environments and increased patient satisfaction are being explored by the 'Nurse forecasting in Europe' (RN4CAST) project, which aims to simulate scenarios that indicate what would happen both to quality of care and nursing outcomes when features of the work environment and of education (e.g. skill mix, qualifications) are altered (Sermeus et al, 2011). It is discussed if CPD could potentially play a role in improving hospital healthcare work environments, which has been found to be a 'relatively low cost strategy to improve safety and quality (...) and to increase patient satisfaction' (Aiken et al, 2012). According to the Commission's report to the Council on the implementation of the 2009 patient safety Recommendation, specific patient safety modules only feature in 15 EU countries in one or more types of education, hence there is great scope for CPD in particular to deepen knowledge and skills in this area beyond the limited offerings that exist already, primarily for doctors and nurses (EC, 2012). That said, there are national strategies in place in some Member States (e.g. Slovenia, see Kiauta et al, 2010) which partially address CPD.

The Commission's Patient Safety and Quality of Care Working Group brings together representatives from EU-28/EFTA countries, international organisations, and EU bodies. It assists in developing the EU patient safety and quality agenda, including the role of training and education.<sup>9</sup>

Two specific topics – financing and accreditation – are covered in a number of studies and examined in more detail below.

## **FINANCING OF CPD**

Much of the literature of CPD, LLL and their related terms discusses the financing structures used to fund systems of ongoing professional education. In an overview of five EU countries, Maisonneuve et al (2009) found that CME was primarily funded by medical societies, medical associations and employers. However, much concern has been raised about the increasing amount of CPD which is funded and/or delivered by industry (Silva et al 2012). The insufficient funding of CPD activities by national governments, particularly in light of the economic crisis and the pressure on healthcare budgets, are combining with commercial interests to threaten the objectivity of CPD activities (Van Harrison 2003; ESC Board 2012). However, some note that commercial activity and industry roles should not be exclusively targeted, since academic institutions also have intellectual property and other commercial concerns, but that commercial interests should not be a part of CPD funding or administration (ESC Board 2012).

Moving away from financing of systems to costs for participants, it is possible that, where CPD activities are delivered externally and health professionals are required to pay something towards their attendance, this could present a barrier (Donyai et al., 2011; Barnes et al., 2013). Data on this issue is scarce and further research, beyond the scope of the current Review, would need to be conducted in order to assess the impact of such barriers on professional competence and development.

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<sup>9</sup> For more information on the meetings of the Commission Patient Safety Working Group and its documents, see [http://ec.europa.eu/health/patient\\_safety/events/ev\\_20131104\\_en.htm](http://ec.europa.eu/health/patient_safety/events/ev_20131104_en.htm)

A further issue raised is that of the cost-effectiveness of CPD – Brown et al (2002) state that not enough studies exist in this area and that very few interventions are followed by a cost-effectiveness analysis, making their value difficult to measure.

### **ACCREDITATION OF CPD**

Another common topic in the CPD and LLL literature is accreditation systems. Accreditation usually entails endorsement of CPD activities or providers of activities by a specific regulatory body, subject to explicit policies relating to quality standards and conflicts of interest (Arnold 2001). The regulators vary from country to country – sometimes they are government bodies, in other cases they are academic or professional bodies, such as the Instituto de Formación Médica in Spain or the Royal Colleges in the UK (Braido et al 2005). Accreditation bodies are also established for individual professions or specialities – for example, CME for those practicing dermatology in the EU is administered by the European Academy of Dermatology and Venereology (Frentz 1995).

It should be noted that accreditation can apply to providers of CPD, the activities themselves, or the individual educators or trainers used to deliver the course. Different systems apply in different countries and regulation is the responsibility of different bodies, depending on the system chosen. Furthermore, there is a distinction to be made between accreditation of CPD and approval/recognition or verification of CPD. In the latter case, certificates are issued by certain bodies, usually in accordance with specific guidelines, whereas accreditation is generally understood to involve high level endorsement by an appropriate regulatory body, subject to a quality assurance framework.

Accreditation systems are relatively new, having been developed primarily in the US and the EU 'in an attempt to self-regulate and advance practice standards, as well as to respond to environmental pressures for advancement of healthcare quality and insulation of any commercial influence on education' (Barnes, Bellande & Miller, 2011:254). Here, the link between accreditation and financing is revealed – accreditation systems go some way to address the concerns about industry influence on CPD via financing, though the standards and policies set by the individual accreditation bodies have to explicitly restrict the role of industry in order for this to have the desired effect. The Rome Group – an international group of CPD accreditation experts established in 2003 whose aim is harmonisation of CPD/CME in the medical sector – has developed documents that include basic common values of CPD systems and responsibilities of CPD accrediting bodies, providers and learners (Horsley et al., 2010).

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## CONCLUSIONS

### FURTHER RESEARCH AND FUTURE CHALLENGES

As set out in the introduction, this literature review sought to find answers to four guiding research questions:

1. How can CPD be described?
2. What sub-types of CPD can be described?
3. What are the differences between CPD, CE, LLL, informal CPD, mandatory CPD, etc.?; and
4. What studies exist on CPD systems for healthcare professionals in Europe?

Regarding the first two questions, as the discussion has shown, there is an extensive body of knowledge, emanating both from English-speaking Europe and non-English speaking EU/EEA countries, which seeks to describe various aspects of CPD systems and its sub-types, and yet has also resulted in considerable terminological overlaps.

Furthermore, and also addressing the third question, although the main differences between, and limitations of, the various concepts and terms examined in this review are illustrated both in the academic literature and in the studies conducted by health professionals themselves, the boundaries between CPD, CE, LLL and other terms are not always clearly defined, the demarcation between delivery modes, e.g. mandatory and informal CPD, being an exception.

From this it can be derived that there is a danger that different terms are being used synonymously (e.g., CPD and CME in some countries), which may not necessarily be intentional. Part of the difficulty in reviewing the terms and their current usage is the different purposes to which they may be put and the interest or perspective of the stakeholders. Most available studies mix the perspectives of health professionals with those of health providers and regulatory bodies.

Moreover, the available literature suggests that, although CPD is now a commonly understood concept across Europe, when it comes to CPD terminology there are still considerable variations between countries and professions regarding its precise meaning, methods and its overall reception. As long as the term CPD remains rather Anglocentric and is used predominantly by international researchers, i.e. without common currency amongst professional bodies and regulators in non-English speaking Europe, it will remain malleable, i.e. simultaneously full of meaning in some areas yet 'blurry' in others.

Cited throughout the literature review, a handful of European level studies could be identified that were broad enough in scope to provide indicative information on the status quo of CPD systems for the healthcare professions included in this study, the most comprehensive information having been gathered for medical profession. However, since these studies differ in their research design, methodology, comprehensiveness and objective, in addition to having been conducted in different time periods, the production of an up-to-date and comprehensive matrix depends on coherent and aligned research questions for all five professions.

The sources consulted in this examination suggest that the notion of 'managed CPD' appears to be more contested on the Continent (e.g. France, Germany, Spain) given the existence of other terms used in the national context of these countries, but also due to different professional self-understandings of HCPs' roles and responsibilities and the additional layer of bureaucracy that CPD has created in these countries. Consequently it could be concluded that it will become more important to establish an evidence base in order to determine whether or not it is advantageous for CPD in Europe to remain as diverse as it is now between different professions and countries, or whether it should become more harmonised – and thus also formalised - in the sense that content, activities, delivery modes and purposes could be aligned.

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Given the broadening of the conceptual framework describing CPD, the literature also points at the growing necessity to obtain more information on how CPD is linked not only with the real life experiences of health professionals – which, in any case, must inform future CPD activities – but also with those of public health at large. The handful of studies conducted so far on CPD systems in Europe does not provide information on this, and there is much scope to conduct further profession- and country-specific research on CPD outcomes and effects on clinical practice. Moreover, researchers might wish to further explore the links between assessing learning/practice outcomes and existing qualifications and/or competency frameworks in the health professions.

More mobility within Europe of both patients and health professionals resulting from the transposition of Directives 2011/24/EU and 2013/55/EU might also stimulate an increase of more targeted CPD activities for specific categories of learners, e.g. migrating HCPs who need to be able to quickly grasp not only their role within healthcare institutions but also the wider socio-economic environment they are situated in, as well as the particular issues and inequalities experienced by their new patient communities.

In this context, the summary report of the three Policy Dialogues held under the Belgian Presidency in 2010, which emphasised the impact of CPD and LLL, is directional in the sense that it acknowledged that CPD 'is still in a transitional phase' (Horsley, Grimshaw and Campbell, 2010). It proposed a number of questions for further exploration, including:

- How to prevent CPD/LLL from becoming provider-driven?
- What is the minimum required achievement in CPD/LLL?
- How to transfer CPD/LLL achievements, through an appropriate recognition process, between Member States?
- Training of migrant health professionals and re-training health professionals returning to practise
- Ensuring that the outcomes of CPD are appropriate for improving patient care; and
- Learning from the patient perspective

Establishing a stronger link between CPD and clinical and professional practice, without becoming overly prescriptive in terms of requirements, but strengthening quality assurance of CPD, could be one way to achieve greater awareness and discursive acceptance of CPD, which should then lead to a stronger implementation effort. The link between the application of CPD learning outcomes to practice and high quality patient care needs to be explicit (Royal College of Nursing, 2007; Horsley, Grimshaw and Campbell, 2010).

## **NEXT STEPS**

As mentioned above, rather than seeking to 'fix' a commonly accepted definition of CPD, LLL and related terms, this literature review indicates that, in spite of the various approaches to CPD, there are still many common understandings and approaches which allow, for the purposes of this study, to arrive at commonly applicable descriptions of key terms. The review also illustrates the existing discussion as to the potential of sharing areas of 'best practice' in the delivery of CPD across the different HPCs, and to promote more inter- and intra-professional CPD - learning as a team of healthcare workers both within a profession and across professional boundaries - collaborating together for the benefit of patient health and well-being

The descriptions are directional in the sense that they emphasise some of the most common aspects of CPD, thereby indicating that each profession is responsible for ensuring that CPD can develop according to new realities that translate into professional needs, skills and eventually standards. It is broad enough to take into account 'social, cultural, financial, and contextual' spheres of CPD (Horsley, Grimshaw and Campbell, 2010:19) and hence it reflects the reality of healthcare challenges in the 21<sup>st</sup>

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century, which also includes the move towards integrated care, multidisciplinary learning and diversity (Grant, 2011).

Focusing on learning that is outcome based and that will 'make a change', CPD thus becomes an approach to LLL that covers 'the continuum of lifelong (...) education' (Varetto and Costa, 2012). The agreed description of CPD will be used, together with the more comprehensive glossary of terms (see Annex 2), as descriptive guidance for the tasks that follow under this study, including drawing up a comprehensive map of CPD systems across Europe.

## ANNEX 1: GLOSSARY

The literature review is to support the development of the survey for member state representatives of the regulated professions. Whilst it does not seek to establish one final 'definition' for each concept, descriptions of the core terms are offered below, to ensure a level of common understanding and reference for completion of the survey questions.

<b>Lifelong Learning</b>	All general education, vocational education and training, non-formal education and informal learning undertaken throughout life, resulting in an improvement in knowledge, skills and competences, which may include professional ethics. [Such learning might occur within a personal, civic, social and/or employment-related perspective.]
<b>Continuous Education</b>	The structured educational activities undertaken in pursuit or/as part of a LLL approach.
<b>Continuous Professional Development</b>	The systematic maintenance, improvement and continuous acquisition and/or reinforcement of the lifelong knowledge, skills and competences of health professionals. It is pivotal to meeting patient, health service delivery and individual professional learning needs. The term acknowledges not only the wide ranging competences needed to practise high quality care delivery but also the multi-disciplinary context of patient care. [For example, this might include technical, scientific, regulatory and ethical developments, as well as research, management, administration and patient-relationship skills. Activities can be categorised as formal/informal and mandatory/voluntary.]
<b>Continuous Medical Education</b>	An element of CPD involving the development of specific clinical and technical skills within the field of medicine, primarily relating to physicians. Activities can be categorised as formal/informal and mandatory/voluntary.
<b>Continuous Nursing Education</b>	An element of CPD involving the development of specific clinical and technical skills within the field of health, relating to nurses. Activities can be categorised as formal/informal and mandatory/voluntary.
<b>Continuous Midwifery Education</b>	An element of CPD involving the development of specific clinical and technical skills within the field of health, relating to midwives. Activities can be categorised as formal/informal and mandatory/voluntary.
<b>Continuous Dental Education</b>	An element of CPD involving the development of specific clinical and technical skills within the field of health, relating to dentists. Activities can be categorised as formal/informal and mandatory/voluntary.
<b>Continuous Pharmacy Education</b>	An element of CPD involving the development of specific clinical and technical skills within the field of health, relating to pharmacists. Activities can be categorised as formal/informal and mandatory/voluntary.
<b>Formal CPD</b>	Activities undertaken intentionally with the objective of improving knowledge, skill and competences, which are planned and can be recorded, verified and certified. This may include learning activities such as attending courses, seminars, conferences, and workshops, teaching and preparing lectures, higher education programmes, blended learning, peer review, as well as other directed professional activities, including online courses / distance learning, and reading professional journals involving knowledge assessments, study visits, etc.
<b>Informal CPD</b>	Activities undertaken intentionally and contributing to the improvement of knowledge, skill and competences, which may or may not be recordable and verifiable. This may include incidental learning opportunities such as spontaneous interactions and conversations with colleagues and other health professionals, learning from mistakes and from feedback, but also planned learning activities such as attending in-service education programmes, self-

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	directed professional reading of books and other types publications, participation in social media discussions, etc.
<b>Mandatory CPD</b>	CPD that is <b>mandatory</b> for a professional, on the grounds of predefined requirements set by a competent authority (e.g. regulator or professional body), sometimes related to relicensure, re-registration or revalidation Mandatory CPD may require activities to fulfil, e.g., minimum requirements pertaining to the number of study days or credits to be gained in a set time period, the number of study days needed in a set time period, requirements for providing evidence of the CPD activity or other requirements. It may encompass both formal and informal CPD activities.
<b>Voluntary CPD</b>	CPD that is <b>not mandatory</b> for a professional on the grounds of predefined requirements set by a competent authority (e.g., regulator or professional body) and is in particular not related to relicensure, re-registration or revalidation, regardless of whether or not there are professional guidelines in place for the profession in question. It may encompass both formal and informal CPD activities.
<b>Revalidation</b>	The process through which registered health professionals demonstrate periodically that their knowledge is up-to-date and their continuing fitness-to-practise. It can be a tool for showing that CPD activities undertaken are appropriate for supporting and enhancing professional practice. It may be a prerequisite for relicensure and re-registration, and can be tied to professional appraisals.
<b>Relicensure</b>	The renewal of a professional license or certificate within a specified period of time, generally linked to assessment of a health professional's continuing fitness to practise.
<b>Re-registration</b>	Keeping one's name on an official public record of qualified/licensed/certified health professionals, as identified by the relevant regulatory authority in a given jurisdiction, generally linked to assessment of a health professional's continuing fitness to practise.
<b>Fitness to Practise</b>	Fitness to practise implies that health professionals continue to practise in accordance with regulators' standards, including requirements relating to the maintenance of professional skills and knowledge. It encompasses an assessment of both conduct and competence.

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