

## What is continuing professional development

The literature confirms that regulators are using multiple tools to recertify their practitioners. Regardless of the mechanism, at the heart of these approaches is the question of what regulators are requiring practitioners to do to continue to maintain their competence and fitness to practise.

One of these regulatory tools—CPD—is being used by health regulators to encourage, assess and determine whether a practitioner is maintaining the appropriate level of competence. While there are common elements in the way that CPD is applied by regulators, the starting point is to determine how CPD is being defined in New Zealand and overseas.

The Dental Council defines CPD as

... verifiable educational activities and interactive peer contact activities aimed at ensuring an oral health professional's continuing competence to practise. The activities must reflect the content of the scope in which the practitioner is registered.

Peer contact activities are defined as interactive contact with peers with the specific objective of professional development.<sup>71</sup>

The Medical Council of New Zealand describes CPD as

... involvement in audit of medical practice, peer review and continuing medical education, aimed at ensuring that a doctor is competent to practise medicine. CPD is also intended to foster a culture of peer support and lifelong learning.<sup>4</sup>

In the 4<sup>th</sup> edition of its *Recertification Guidelines*, the Physiotherapy Board of New Zealand states that

... as a physiotherapist you are expected to maintain your competence in physiotherapy. It is your responsibility to keep your knowledge up-to-date by undertaking relevant continuing professional development (CPD). The ultimate purpose of CPD is to ensure your practice develops throughout your career.<sup>91</sup>

The Optometrists and Dispensing Opticians Board states that CPD is a

... career long process, which has become increasingly important for practitioners as knowledge and new areas of expertise develop. The [Optometrists and Dispensing Opticians Board] requires practitioners' participation in CPD activities to assure the public and the Board that practitioners are up to date and have appropriately developed their knowledge and skills on an ongoing basis.<sup>92</sup>

The Dental Board of Australia defines CPD as the

... means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives.<sup>93</sup>

The Dental Council of Ireland defines CPD as the

... systematic maintenance of your knowledge and skills across all areas of your practice throughout your professional life. It is a continuing, lifelong learning process that complements formal undergraduate and postgraduate education and training ... CPD includes formal activities such as lectures, courses, conferences and workshops as well as self-directed reading and study clubs.<sup>94</sup>

These health regulator definitions are also reinforced by research stating that CPD is:

- study, training courses, seminars reading and other activities undertaken by a dentist or dental professional, which could reasonably be expected to advance their professional development, as a dentist or dental professional<sup>14</sup>
- any education or training that takes place after initial qualification that aims to advance professional development in the field of dentistry, either clinical or nonclinical, and is not part of a formal programme towards becoming a specialist<sup>95</sup>

- the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence and develop the personal qualities required in their professional lives<sup>33</sup>
- the wide-ranging competencies needed to practice high quality medicine, including medical, managerial, ethical, social and personal skills. CPD therefore incorporates the concept of continuing medical education, which generally is taken to refer only to expanding the knowledge and skill base required by doctors.<sup>16</sup>

## What can we learn from the literature about the definition of CPD?

Regardless of the regulator or the profession that is being regulated, some common themes relating to CPD have emerged from the literature.

These themes are that:

- the majority of practitioners are being asked to participate in and complete a prescribed amount of CPD and peer contact activities<sup>14 89 96 90</sup>
- the majority of practitioners are being asked to prove both participation in CPD activities as well as prove that the CPD activities undertaken were carried out by an approved CPD provider<sup>96 16 63 19</sup>
- CPD is an active and ongoing process of lifelong (often self-directed) learning<sup>48 97 35 98</sup>
- CPD takes place after initial qualification (formal undergraduate and postgraduate education and training)<sup>65 90 95</sup>
- CPD often includes clinical (e.g. medical skills) and nonclinical (e.g. managerial and ethical skills) education or training<sup>57 60 62</sup>
- CPD often uses multiple learning approaches and activities to achieve positive change in practitioner behaviour.<sup>11 84 95 12 15</sup>

On the issue of accreditation systems, the literature discusses two points. These are that accreditation systems verify:<sup>96 19 16 8</sup>

- the quality and relevancy of CPD activities for practitioners
- practitioners are meeting their CPD requirements.

It should be noted only Sutherland and Leatherman talked about the impact of accreditation, their study stating there:<sup>8</sup>

- is no evidence to suggest accreditation is linked to improved quality
- are few evaluations that assess the effectiveness of accreditation as a lever to improve quality in healthcare because most evaluations focus on perceived benefits for participants rather than objectively assessing the impact on outcomes.

While there is evidence that questions the following assertions (and these are discussed in this literature review), most regulators state that participation in:

- study, training and other CPD activities is expected to advance a practitioner's professional development<sup>31 14 95 65 99</sup>
- CPD helps to keep practitioners up to date, including when they are not practising<sup>19 16 100 101 63 102</sup>
- CPD is a means to maintain, improve and broaden the knowledge, expertise and competence required in a practitioner's professional life.<sup>32 7 33 96</sup>

## Five points from the literature about continuing professional development

Five points can be taken from the literature about CPD. These are:

- there is a growing trend in the use of mandatory approaches to CPD
- there is growing recognition of informal CPD activities
- there is a move towards outcome-based systems that link CPD activities with development and/or improvement in practice
- practitioners face a range of barriers that prevent or inhibit participation in CPD activities
- participation in CPD may contribute to maintenance and improvement in competence and fitness to practise issues.

These five points are discussed in further detail below.

## Mandatory approaches to CPD

From the outset, it should be noted there is no consistent approach to the way that health regulators (in New Zealand and overseas) are thinking about and using CPD as part of their recertification frameworks.

In some countries, there are no rules about the amount of CPD regulators require practitioners to complete. In addition, some frameworks are entirely self-directed, in that they allow practitioners to choose the CPD activities they undertake.<sup>11 32</sup>

Nevertheless, there is a growing trend towards the use of mandatory approaches to CPD. For some professions this typically means participating in a mix of voluntary and/or preset topics in order to meet CPD requirements.<sup>103 95 15 19 96 31 10</sup> For other professions, it can mean voluntary rather than mandatory CPD topics.

The research shows that even where activities are not prescribed, regulators may strongly encourage practitioners to include specific subjects/topics that are relevant to scope of practice as part of meeting CPD requirements.<sup>16 57</sup>

For some regulators adopting a mandatory approach to CPD (as well as developing corresponding standards and guidelines on the use of CPD)<sup>16 96</sup> is based on two interrelated assumptions. First, that CPD activities will help practitioners keep their knowledge and skills up to date.<sup>101</sup> Second, that by keeping their knowledge and skills updated, practitioners are able to provide patients high-quality healthcare.<sup>32</sup>

On this issue, the literature indicates that, even where regulators have adopted mandatory CPD, there is limited clear-cut or hard evidence to suggest this approach improves practitioner competence.<sup>10 101 14 31</sup> Researchers have also noted that despite a lack of clear evidence, no profession has returned to a voluntary policy having adopted mandatory CPD.<sup>101</sup>

## Growing recognition of informal CPD activities

The literature suggests there have been moves to recognise informal activities within the CPD environment. Examples of informal activities include self-directed reading and self-reflection of journals, peer networks and work-based activities.<sup>95 96</sup>

Even the Dental Council's CPD policy states

... it expects dental practitioners to participate in non-verifiable activities, however, practitioners are not required to maintain written records of these activities nor make an annual declaration regarding their participation in these.<sup>71</sup>

Nevertheless, the literature also highlighted the difficulty of quantifying, assessing or easily accrediting informal CPD activities.<sup>96 100 63</sup>

## Linking outcome-based systems and CPD

The evidence also refers to a growing move to use systems and approaches that link CPD activities with qualitative outcomes such as practitioner reflection that leads to improved practice.<sup>96 48 32 57</sup> This shift in regulator thinking is driven by the idea that assessing the quality rather than the quantity of CPD activities is a more useful measure of positive change in practitioner actions, behaviours and attitudes.<sup>101 67 8</sup>

In theory, the flow on effect is that a move to qualitative measures means regulators (and the public) will be better assured of a practitioner's ongoing competence and fitness to practise.

There are four messages that can be taken from the literature about the importance of measuring the link between CPD activities and improved practice. These messages are that:

- effective monitoring of practitioners for compliance with CPD is a major challenge for professions
- the current focus on hours of participation in CPD activities is not consistent with a move towards outcomes-based approaches
- outcomes-based approaches require practitioners to identify opportunities to improve professional development and match these to appropriate CPD activities
- a shift to an outcomes-based approach may result in the need for additional support for practitioners.

Researchers have expressed concerns that effective monitoring of CPD compliance is a major challenge for regulators and practitioners. In part, this challenge centres on the mechanisms available to regulators (and practitioners) to assess the impact (i.e. outcome) of CPD activities.<sup>90 14</sup>

On the other hand, it goes beyond CPD activities to include mechanisms such as licensing and registration examinations. In addition, it raises the question of whether an assessment undertaken at 'one point in time' can be an effective way to measure practitioner competence or predict later behaviours and professional practice.<sup>82</sup>

Traditionally, regulators have relied on information such as counting the number of completed hours of CPD activities; numbers of practitioner incidents, accidents or violations; or number of inspections to measure performance.<sup>67 103 86 100 101 14</sup> However, researchers have argued that the move from quantitative to qualitative measures (especially the use of numerical points or credits for attending and completing CPD activities and using systems of accreditation for CPD activities) is prompted by several questions.

These revolve around the effectiveness of quantitative approaches (including recognition of the expense and high level of resources, which can be spent on accreditation) and whether these adequately measure practitioner learnings, changes in practise or improved patient outcomes.<sup>19 11 8</sup>

The Royal College of Surgeons on England stated in their 2007 report that

Attendance at a course or conference is not a guarantee that learning has taken place. A reflective statement can therefore be a better indicator of learning than an attendance certificate.<sup>19</sup>

The research is therefore critical of the value and purpose of quantitative measures as a means of determining practitioner competence and fitness to practise. Moreover, researchers have argued that if the goal of CPD is to improve practice, then practitioners need to identify professional development opportunities and match these to the types of learning activities that will achieve this goal.<sup>48 32 29 31</sup>

It should also be noted that the Royal College of Surgeons of England report states that

... a points-based system could be effective if it is linked with appraisal to ensure the relevance of the learning and to enable reflection on the courses attended. However, such a system should be as flexible as possible in order to enable the individual to choose learning activity that reflects [practitioners] speciality and sub-speciality, current issues in practice, the stage in their surgical career and their personal choices and interests.<sup>19</sup>

Researchers also highlighted the difficulty of implementing learning from CPD in isolation. They contend that practitioners will require more support if they are being expected to actively apply their learnings or have confidence that professional development plans are appropriate and will meet regulatory requirements.<sup>90 100</sup>

This point was highlighted in the 2011 Murgatroyd study, which cited observations from the Continuing Professional Development Institute that

... monitoring and compliance are the most difficult aspects of implementing CPD policy ... In particular, professions face difficulty in ... ensuring compliance across the majority of membership [and] dealing with the increased complexity of monitoring the more varied and self-managed CPD being undertaken.<sup>16</sup>

## Barriers to continuing professional development

There is a significant amount of literature on the topic of CPD. Some of this research focuses on the barriers to participation in CPD activities. For the purposes of this literature review, the main barriers referred to in the research have been grouped as transaction costs for practitioners; access issues; and work-related challenges.

### Transaction costs for practitioners

The literature on transaction costs for practitioners concerns three main barriers—time, cost and practitioner attitudes. Time-related transaction barriers include practitioners:

- needing to find time to participate in CPD activities<sup>29 32 100</sup>
- having to travel to participate in activities (sometimes long distances if they are geographically isolated or outside main centres where most CPD activities are offered)<sup>103 104 102</sup>
- finding the time to document participation in activities in order to meet regulatory requirements and having to backfill clinical requirements as a consequence of participating in CPD activities<sup>29</sup>
- underestimating the time and effort required to implement learnings from CPD activities (which sometimes resulted in the need for unplanned administrative support).<sup>100 90</sup>

On the issue of cost, the types of barriers practitioners have to consider are the:

- financial cost of enrolling/registering for CPD courses and activities (including additional costs such as travel and accommodation and financial costs relating to actual/potential loss of earnings and the knock-on effects if all staff within a practice participate as a group in CPD activities)<sup>32 102 15</sup>
- personal cost if participating in CPD activities outside work hours and perceived value (financial or relevancy to scope of practice) of CPD activities.<sup>103 14 102</sup>

On the issue of attitudes, lack of, or having poor motivation was highlighted by researchers. Having a tick-box mentality was also seen as an issue. Should a regulator move to an outcome-focused system, these attitudes would need to be addressed.<sup>100 29</sup>

### Access barriers for practitioners

On the issue of access, the types of barriers identified in the literature are practitioners:

- lack of choice or suitable activities, either in their scope of practice, speciality or areas of interest and seeing CPD activities as unnecessary or irrelevant to their scope of practice<sup>102 14 97</sup>
- wanting activities that are hands-on, technically instructive (include expert input) and educationally meaningful<sup>102 14</sup>
- having to utilise online or e-Learning CPD activities, which create additional issues if a practitioner is isolated (for whatever reasons) from their peers and colleagues, or if they have limited computer literacy skills<sup>103</sup>

- choosing to keep within their comfort zones when selecting CPD activities, especially if the alternatives are to undertake activities that are unfamiliar and might take more time and effort to master.<sup>63</sup>

## Work related barriers for practitioners

Work-related barriers that may inhibit or prevent practitioners from participating in CPD activities include having to find additional time after working long hours and lacking support from employers. The 2011 literature review by Eaton et al on the impact of CPD on dentistry found that

Factors motivating practitioners to undertake CPD and barriers to CPD appeared to be influenced by work-related factors such as environment, working patterns, and employment status, which are all specific to each healthcare professional group, as well as individual perceptions of CPD.<sup>14</sup>

## Does CPD contribute to maintenance and improvement in competence and fitness to practise?

The research presents a contradictory picture on the question of whether CPD contributes to the maintenance and improvement of a practitioner's competence and fitness to practise.

For some researchers the issue of effectiveness is linked to two factors. First, is that participation in CPD activities is only an indicator that a practitioner engaged in an activity. Second, and arguably the most crucial factor, is that engagement in an activity does not necessarily indicate level of performance (whether positive or negative); ensure public safety; nor indicate whether a practitioner will experience skill fade after participating in a CPD activity.<sup>31 33 19 100 21 105 82</sup>

Often the messages which can be taken from the evidence range from categorical statements that CPD has no effect<sup>14 31 95 33 100</sup> through to qualified statements about its effectiveness. On the latter message, these include that:

- there is no singular or correct way of doing CPD and that the content, context and process depends on a practitioner's scope of practice and/or specialties, learning style and personal preferences<sup>63 64 13</sup>
- CPD can be a more effective tool if practitioners engage in a reflective process that helps them to actively apply what they have learned in their practise<sup>32 48 7 19</sup>
- CPD can be more effective when paired with other mechanisms such as a practitioner developing a professional development plan and appraisal that identifies areas for improvement and links these to participation in CPD activities that specifically address or respond to those needs<sup>15 63 62 64 106</sup>
- some elements of CPD (i.e. sustained, repeated or longer-term activities involving interactive education) were found to be effective when paired with other multifaceted approaches (e.g. audits and feedback) to competence<sup>14 57 33 84 7 70 73</sup>
- practitioners who engage in high quality CPD activities have been found to demonstrate better clinical performance than those who do not<sup>59</sup>
- in order for CPD to be effective, practitioners must be incentivised in a way that focuses on and reveals good rather than bad practices to the public.<sup>90</sup>

## What does the literature say about CPD and what this means in terms of recertification?

There is a disconnect between what the literature says about the effectiveness of CPD (i.e. there is no evidence that CPD works and contributes to the ongoing maintenance of practitioner competence and fitness to practise).<sup>14</sup> Yet, it continues to be used by the majority of health regulators in New Zealand and around the world.

Coupled with the literature about the growing movement towards mandatory CPD and the possibility that CPD will be more effective if it is used in conjunction with other assessment tools or approaches;<sup>14 15</sup> it could be argued that the evidence does not provide definitive guidance on whether CPD should or should not be included in recertification frameworks.

The literature on self-directed learning and self-reflection is also unclear. Some researchers definitively link the approach to positive improvements (if not changes) in practitioner knowledge, skills, attitudes and behaviours, while others dispute this finding.

The literature also highlights that practitioners do not have the capability, or are incredibly poor in assessing their own competence and professional needs.<sup>64 106 15 63 73</sup> From a regulator's perspective, this raises rather than answers more questions about whether:<sup>64 106</sup>

- practitioners having poor self-awareness can be adequately mitigated against if a regulator chooses voluntary over mandatory CPD
- practitioners poor self-awareness can be adequately mitigated against if a regulator adopts a multifaceted approach to recertification
- a condition of CPD (if the regulator accepts this is a core component of recertification) is the need for the practitioner to demonstrate self-reflection in their practise
- it is possible to shift from a quantitative to qualitative approach to measuring the effectiveness of CPD given the current limitations of tools that would assure the regulator of practitioner competence and fitness to practise.

What the literature reviewed does not discuss is what regulators should do if they choose not to include CPD in their recertification frameworks. For example, is it okay for the regulator to omit this requirement? Does the regulator need to consider tools or mechanisms (including the availability of these tools) that would fill the gap left by the absence of CPD? Moreover, if CPD is not included, what other tools does a regulator have at hand to fulfil their roles and responsibilities and assure the public of a practitioner's competence and fitness to practise?

## Reference List

Please note that the majority of the references listed in this discussion document are hosted on external websites and Council cannot guarantee the links will remain current. Please contact us on [comms@dcnz.org.nz](mailto:comms@dcnz.org.nz) if you require any of the referenced documentation.

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