WONCA Global Standards for Continuing Professional Development (CPD) for Family Doctors

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The following document is an adaptation of the Continuing Professional Development (CPD) of Medical Doctors, World Federation for Medical Education (WFME) Global Standards for Quality Improvement documents. (WFME, 2003; WFME, 2015) It may be helpful to review the original document, available at https//www.wfme.org/. These World Organization of Family Doctors (WONCA) standards have been modified to fit the requirements of the family doctor and general practitioner, as those of the World Federation for Medical Education standards discussed continuing professional development in general terms. The term Continuing Professional Development (CPD) has been selected for the purpose of this document as it encompasses Continuing Medical Education (CME), dealing with medical knowledge/clinical skills and extends into the wider context of how this learning exists as an interplay between the individual physician and the profession. Specific content areas and learning modalities relevant to Family Medicine are therefore included in the WONCA standards. These standards have been developed over several years, and at world, regional and rural meetings of WONCA.

The term family medicine is used in this document to define the discipline: however, general practice, family practice and primary care are also appropriate terms that are used in some settings for this profession. It is the standards that are important rather than the terms that are being used. Regardless of the terms used to describe it, the nature of the discipline is that it is based in the community, which it serves and fundamentally is relationship-based care that endures over place and time. Family Medicine is a discipline that provides long term person-centred, comprehensive and continuing care, from pre-natal to palliative care, across all ages in all settings.

OBJECTIVES:

1) Provide a resource for family doctors and/or groups of family doctors to design and structure a program of continuing professional development to reinforce lifelong learning.
2) Optimize current CPD systems such that, through more effective program design and delivery, family doctors are advancing the profession and patient care.
3) Offer a set of globally recognized standards developed through a family medicine perspective to provide feedback on existing CPD programs and systems and encourage international recognition of CPD activities.

BACKGROUND:

Previously the WONCA Global Standards on Postgraduate Education were developed and recognized as a conceptual framework to train the beginning medical doctor to achieve the skills and competencies to become a clinically competent family doctor/general practitioner. It is clear that no training program regardless of its length of training or components of training is able to equip the postgraduate medical trainee with all the skills required for practice. In their seminal work, Dreyfus HL and Dreyfus SE (1986) describe the learning trajectory, starting with the beginning professional with an adequate level of knowledge to perform competent practice. Throughout the family doctor's career, it is expected that the level of knowledge and competence increase to the level of a master practitioner. Strong evidence exists that a commitment to life long learning with a deliberate continuing professional development plan is necessary for the beginning medical professional to achieve an expert level of clinical knowledge and experience. (Martin et al., 2004)

The best available evidence suggests that effective CPD is characterized by the presence of three factors: a clear need or reason apparent for the particular CPD to be undertaken; learning is based on such an identified need or reason; and follow-up provision for reinforcing the learning accomplished. (Grant et al., 1999)

These three factors have played a large role in the development of CPD recommendations/guidelines from various medical associations and organizations worldwide (EQUIP/EURACT 2003; GMC 2011; GMC 2012). They provide a succinct blueprint that any family doctor is able to follow. In simple terms, a family doctor who has completed postgraduate training needs to continually assess his or her own context of practice with both formal and informal needs assessment to identify learning objectives. This is to ensure that future learning may be of benefit to the family doctor practice, patient care, and/or the health of the community at large. The needs assessment should involve getting to know one's own practice, including a practice profile. (Campbell et al, 2010) Family doctors should be aware of their patient profiles, community cultural/social norms, types of pathologies that exist in the communities in which they practice and what are the resources available to the family doctor and patients. Knowing this information will allow the family doctor to identify potential gaps in their knowledge, which could benefit from continuing professional development.

Once learning objectives are identified, the family doctor needs to seek out learning opportunities for continuing professional development. There are a number of well-developed competency frameworks defining what is expected of family doctors in different contexts. (RACGP, 2011; Tannenbaum et al., 2011; EURACT, 2012) Family doctors will need to consider a variety of strategies for learning from traditional modalities such as attending conferences and lectures to new mediums for learning such as Internet based modules or workplace peer assessments. (Kitto et al., 2015) An important consideration is accessibility of CPD, which in the case of the rural family medicine practitioner may be influenced by distance and/or relative isolation (Curran et al., 2010). Family doctors should consider CPD from different providers such as universities and

medical associations to maximize variety and depth of content. However, special attention should be given when choosing learning activities to minimize the influence of vested interests from the CPD provider or CPD material.

After completion of the CPD activity, family doctors should consider reflecting on its impact. Key questions may include whether the learning objectives from the initial needs assessment were met or perhaps how this learning activity may have changed the family doctor's practice. (Davis et al., 2009) Furthermore, formal evaluative scoring systems have been established to evaluate impact of CPD activities. (Kirkpatrick, 1994; Légaré et al., 2014) Family doctors should consider whether there are short term and long-term impact to their practice. An evaluation of the CPD program should be provided back to the provider such that iterative improvements can be made if required. It is recommended that family doctors have access to a system where they can document their CPD activities for the purposes of both accountability and credentialing.

Definitions:

In this document based on the WFME Standards, WONCA recommends the following set of international standards in CPD structured according to 9 areas and 32 sub areas.

AREAS defined as broad components in the structure, process and outcome of CPD cover:

1) Mission and Outcomes
2) Educational Program
3) Assessment and Documentation
4) The Individual Doctor
5) CPD Provision
6) Educational Context and Resources
7) Evaluation of CPD Activities
8) Organization
9) Continuous Renewal

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

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

- Basic Standard. This means that the standard is expected to be met and fulfilment demonstrated during an evaluation of the CPD program.
- Standard for Quality Development. The implication is that the standard is in accordance with international consensus about best practice of CPD. Fulfilment of – or initiative to fulfill – some or all of such standards should be documented. Fulfilment of these standards will vary with the stage and development of CPD activities, their resources, the educational policy and other local conditions influencing learning priorities. Even the most advanced programmes might not comply with all standards.
- ANNOTATIONS are used to clarify, amplify and exemplify expressions in the standards.

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1. MISSION AND OUTCOMES

1.1 Statements of Mission and Outcome

Basic Standards

The family medicine discipline, in consultation with relevant authorities and employers, must define the mission and intended outcomes of CPD for family doctors and make them publicly known. The mission and outcomes should arise from the health priorities and needs of the society served.

Quality Development

The mission should encourage and support family doctors to improve their practice performance and should address the obligation of the medical professional to improve the conditions for effective CPD and include explicit linkage to positive health outcomes.

Annotations

- Statements of mission and intended outcomes would include general and specific issues relevant to national and regional policy and would describe what is expected from family doctors about their maintenance and development of competencies.
- With due regard to national traditions, the discipline would in general act through their professional organizations such as the medical associations, scientific societies, medical colleges, medical academies, etc.
- Relevant authorities would include local and national bodies involved in regulation of the medical profession.
- Statements should include specific reference to addressing health inequities.

1.2 Professionalism and Autonomy

Basic Standard:

CPD must serve the purpose of enhancing the professional and personal development of the family doctor.

Quality Development:

The process of CPD should serve to strengthen professionalism of family doctors and enable them to act autonomously in the best interests of their patients and society while fulfilling the social contract between family doctors and society.

Annotations:

- Professionalism encompasses the knowledge, skills, attitudes, values and behaviours expected of individuals during the practice of their profession and includes literacy, ethical behaviour, integrity, honesty, altruism, service to others, adherence to professional codes, justice, and respect for others.
- Autonomy implies access to the knowledge and skills training doctors need to keep abreast of, to meet the needs of their patients, and that the sources of knowledge are independent and unbiased.
- Personal Development in this context is limited to what is relevant to practice and the profession.

1.3 Outcomes of CPD

Basic Standard:

Family doctors, in consultation with peers and professional organizations, should define the competencies or benefits to be achieved as a result of CPD. Family doctors must ensure that CPD activities undertaken are adequate to maintain and develop competencies necessary to meet the needs of their patients and society and to link them to the health outcomes of their patients insofar as this is feasible.

Quality Development:

Family Doctors should – in consultation with professional organizations ensure that learning from CPD-activities should be shared with peers.

Annotations:

- Competencies can be defined in broad professional terms or as specific knowledge, skills, attitudes and behaviors. Competencies relevant for CPD should reflect the defined roles of the physician for that setting and may include the following areas:
    - Patient care that is appropriate, effective and compassionate for dealing with health problems and health promotion.
    - Medical knowledge in the basic biomedical, clinical, behavioral and social sciences and medical ethics and medical jurisprudence and application of such knowledge in patient care.
    - Interpersonal and communication skills that ensure effective information exchange and healing relationship with individual patients and their families and teamwork with other health professions, the scientific community and the public.
    - Appraisal and utilization of new scientific knowledge to continuously update and improve clinical practice.
    - Knowledge of how to use an electronic records system and other electronic/online tools to assist in patient care.
    - Function as supervisor, trainer and teacher in relation to colleagues, medical students and other health professions.
    - Scholarly capacity to contribute to development and research in the chosen field of medicine.
    - Professionalism.
    - Interest and ability to act as an advocate for the patient.
    - Knowledge of public health and health policy issues and awareness and responsiveness to the larger context of the health care system, including e.g. the organization of health care, partnership with health care providers and managers, practice of cost-effective health care, health economics, and resource allocations.
    - Ability to understand health care, and identify and carry out system-based improvement of care.

  - Development of competencies would include broadening and deepening of existing knowledge and skills besides activities undertaken to meet broader learning needs or purposes.
  - There are well-developed competency frameworks that could be consulted to guide the outcomes of learning.

1.4 Participation in the Formulation of Mission and Outcomes

Basic Standard:

The statement of mission and intended outcomes of CPD must be defined by its principal stakeholders including the patients and communities being served.

Quality Development:

Formulation of the mission and outcome statements should be based on input from a wider range of stakeholders and focus on health system improvement.

Annotations

- Principal Stakeholders would include individual doctors, professional associations or organizations, medical scientific societies, medical schools/universities, postgraduate institutions, employers, relevant CPD providers, governmental authorities, patients and communities.
- A wider range of stakeholders would include representation of supervisors, trainers, teachers, other health professionals, patients, the local community, voluntary health organizations and health care authorities and may include external reviewers of the CPD program.
- The wider focus should embrace health system improvement with specific reference to health equity.

2 EDUCATIONAL PROGRAM

2.1 Framework of CPD Activities

Basic Standard:

CPD must be tailored to the needs of the individual family doctor and carried out on a continuous basis. The learning must encompass integrated practical and theoretical components in order to enhance medical practice. Family doctors must ensure that CPD activities are conducted in accordance with the policies of representative professional organization and include the commitment to ethical considerations.

Quality Development:

CPD should take advantage of a variety of learning modalities. Family doctors should engage with colleagues in learning networks to share experiences and benefit from collaborative learning.

Annotations:

- Framework of CPD Activities refers to the specification of the educational programme, including a statement of the intended educational outcomes, content, learning and assessment methods.
- Integration of practice and theory can take place in didactic learning sessions and supervised patient care experiences as well as through self-directed and active learning.
- Learning modalities could include courses conducted (face to face, online or through video conferencing), lectures, seminars, participation in conferences and individual reading, self-assessment of knowledge base and practice performance, research projects, peer review and clinical experiences.

- Networks would include meetings with colleagues and net-based information exchange, discussions and counseling. They could also include other health care professionals and relevant other persons/groups.
- Modalities that provide point of care reference and application of new skills and knowledge are useful.

2.2 Scientific Methods

Basic Standard:

CPD content must, whenever possible, be based firmly on science and practice evidence.

Quality Development

Through CPD, family doctors should be able to improve their practice, drawing on data from emerging scientific evidence. In the learning process doctors should acquire the knowledge of appropriate scientific methods to improve their critical appraisal skills for future learning.

2.3 Content of CPD

Basic Standard:

CPD must be diverse and flexible in content to enable family doctors to develop their practice.

Quality Development:

Family doctors should select CPD content based upon self-assessment (based on personal reflection and external indicators of performance) and plans for learning that are consistent with their various professional roles.

Annotation:

- Diverse CPD refers to broader or narrower needs of doctors depending on the nature and context of their practice, and also allows for personal interests and development.
- Flexible implies meeting emergent needs as soon and as far as possible.
- Self-assessment refers to the process of gathering internal and external data that contributes to learning, assessment, improvement, and self-regulation. (Epstein et al., 2008)
- Content would include:
    - Basic biomedical sciences
        - To understand the body in health and in states of disease.
    - Clinical sciences
        - To apply that understanding to the benefit of patients being treated.
    - Behavioral and social sciences
        - To comprehend the influences of social determinants of health.
    - Humanities
        - To understand both self and patient.
    - Ethics and professionalism
        - To understand and apply requirements for ethical behaviour and adherence to professional codes.
    - Health Systems
        - To understand how the family doctor is best able to provide care to their community given potentially limited resources.

- Various roles of family doctors would include functions as family medicine/medical expert, teacher, researcher, health advocate, communicator, collaborator, and team worker, scholar, administrator and manager.

2.4 Relation between CPD and Service

Basic Standard:

CPD must be recognized as an integral part of medical practice reflected in budgets, resource allocations and time planning.

Quality Development:

CPD should be tailored to 1) enhancing knowledge, skills, attitudes, and management, identified through self-reflection of practice and 2) personal interest in a particular domain of care within family medicine. CPD should be used to translate scientific developments and improvements in the organization and practice of the health care sector.

Annotations:

- Recognition as an integral part of medical practice refers to optimizing the use of different clinical settings, patients and clinical problems for training purposes, seamlessly integrated in the provision of clinical care.
- To ensure that gaps in knowledge, skills, attitudes and management are identified and adequate action taken - needs assessment by peers and/or self-assessment is recommended.

3. ASSESSMENTS AND DOCUMENTATION

3.1 ASSESSMENT METHODS

Basic Standard:

The Family Medicine discipline must formulate and implement a policy on the assessment of individual physicians' progress and achievement in their CPD activities.

Quality Development:

The discipline should formulate and implement a policy on assessment of family physicians' CPD activities. Appropriate assessment methods should be developed and promoted.

Annotations:

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

3.2 DOCUMENTATION OF CPD ACTIVITIES

Basic Standard:

Systems must be established to document and monitor recognized CPD activities in a systematic and transparent way. Documentation of CPD must be used as a formative learning tool as well as providing feedback on relevance and quality of planning CPD.

Quality Development:

The objective of any system of documentation of CPD should be to acknowledge actual learning and where appropriate enhanced competence and stimulate further learning, not mere participation in CPD activities. Doctors should create personal learning portfolios that can be shared with peers and used for guided self-assessment.

Annotations:

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

- Formative learning tool would include different types of self-assessment.

- A system of documentation would include the use of different types of certificates and diplomas.

4 THE INDIVIDUAL DOCTOR

4.1 Motivation

Basic Standard:

CPD programs must stimulate the individual doctor to participate, and to judge the individual educational value of the available CPD activities in order to select activities of high quality, appropriate for their learning needs. Delivery of high quality patient care must be the driving force for family doctors participating in CPD activities.

Quality Development:

CPD activities should enhance motivation to learn and improve and be recognized as a meritorious professional activity.

Annotations:

- High quality care means health care delivery according to generally accepted principles, stated by e.g. medical scientific societies or national and international health boards.

- Motivation and skills for lifelong learning are developed during basic medical education and enhanced as part of postgraduate medical training with an emphasis on improving patient outcomes.
- Recognition of meritorious professional activity can be recognized by personal satisfaction, rewards, promotion and/or remuneration.

4.2 Learning Strategies

Basic Standard:

Family doctors, assisted by their professional organizations, must develop their ability systematically to plan, execute and document practice-based learning in response to defined learning needs. Tools to guide self-assessment must be developed to help family doctors identify their learning needs.

Quality Development:

CPD activities of family doctors should be based on learning strategies, which have the potential to eventually lead to the enhancement of quality improvements and patient safety indicators and include interdisciplinary team learning when appropriate.

Annotation:

- Practice-based learning implies a systematic use of data from one's own practice to stimulate learning and improvement, e.g. Analyze practice experience and perform practice-based improvement activities using systematic methods, and locate, appraise, and assimilate evidence from scientific studies related to the patient population.
- Quality Improvement is defined as a systematic approach to making changes that through a robust continuing professional development program leads to better patient and community health outcomes. (Batalden and Davidoff, 2007)
- Family doctors should ensure that quality improvement and patient safety indicators are developed and reviewed such that the impact of CPD can be assessed and recognized.

4.3 Working Conditions

Basic Standard:

Working conditions in the practice of medicine and employment of family doctors should provide the time and resources for them to participate in CPD.

Quality Development:

Systems of remuneration for doctors should both allow and support their participation in broad range of CPD activities relevant to their needs.

4.4 Influence of family doctors on CPD

Basic Standard:

Family doctors must be given the opportunity to discuss, review and provide feedback on their learning needs with CPD providers.

Quality Development:

Systems should be developed to involve family doctors in planning and implementation of their CPD activities.

Annotation:

- CPD providers would include primarily the professional associations and organizations, national and international medical scientific societies, medical schools/universities, postgraduate institutions, employers in the health care system and other providers such as health authorities, the pharmaceutical and medical device industry, companies in information technology, consumer association, etc.
- Involvement with process of planning and implementation would include participation in groups or committees responsible for program planning at the local or national level.

5 CPD PROVISION

5.1 Recognition Policy

Basic Standard:

There must be an agreed system for recognition of CPD providers and/or the individual CPD activities. This must include clear guidelines to reduce access and influence of providers with pecuniary or other interests that are not explicitly centred on the primacy of patients' welfare.

Quality Development:

All CPD providers should be able to describe the educational basis of their activities including access to educational expertise. Any conflicting interests of CPD providers should be declared and minimized.

Annotation:

- Conflicting interest could include inappropriate promotional activities and biased educational delivery.
- CPD provision would include all types of CPD engagement, not only formalized CPD activities.
- Recognition of CPD provision would include establishment of national accreditation institutions.
- Educational expertise would deal with problems, processes and practice of medical education and would include medical doctors, educationists, educational psychologists and sociologists with experience in medical education. It can be provided by an education unit of an educational institution or be acquired from another national or international institution

5.2 Obligations of Providers

Basic Standard:

The providers of CPD activities must meet agreed educational quality requirements.

Quality Development:

The providers, in planning and conducting their activities, should demonstrate use of appropriate educational methods and technology based on objectives and focused on desired outcomes.

5.3 Feedback to Providers

Basic Standard:

Constructive feedback to CPD providers on the performance and learning needs of family doctors must be given on an ongoing basis.

Quality Development:

Acceptable norms for the provision of CPD should be established and adhered to by all providers. Systems for systematic feedback to organizers of and responsible bodies for CPD should be developed with the goal of iterative improvement of CPD programming. Periodic external review could include a variety of quality improvement activities including an accreditation process.

Annotation:

- Feedback would include planned communication between participating family doctors and the CPD providers/facilitators with the purpose of ensuring learning objectives and goals necessary to enhance competence development.
- Systems for systematic feedback could be data on planning execution and outcome of CPD for a certain cohort of doctors. (ie. attendance rates to learning events)
- Periodic external review could include a variety of quality improvement activities including an accreditation process.

5.4 Role of Medical Schools

Basic Standard:

Medical schools must provide leadership for continuous quality improvement of CPD. Medical schools must through the curriculum in basic medical education initiate motivation and ability to engage in CPD by preparing their students for life-long learning.

Quality Development:

Medical schools should, when appropriate, provide CPD activities. Medical schools, in cooperation with other stakeholders, should undertake research on CPD activities.

6 EDUCATIONAL CONTEXT AND RESOURCES

6.1 Physical Facilities and Learning Settings

Basic Standard:

CPD activities must be provided in learning settings and circumstances that are conducive to effective learning. In order to carry out CPD, doctors must have protected time and opportunities for reflection on practice and for in depth studies with access to tools for

knowledge enhancement and skills development such as professional literature and skills training equipment. The learning environment must be one of safety and comfort.

Quality Development:

Physical and virtual learning spaces, skills training equipment and work schedule should be evaluated and updated regularly for their appropriateness in providing adequate context and conditions for CPD.

Annotations:

- Learning settings would include primary, secondary and tertiary care facilities in both rural and urban environments with a wide context of patient care in ambulatory and inpatient environment.
- Physical facilities of the training location would include lecture halls, tutorial rooms, laboratories, libraries, information technology equipment, skill laboratories and recreational facilities where these are appropriate.
- Family Doctors can support formal and informal collaboration with stakeholders in order to obtain a broad spectrum of learning settings.

6.2 Information Technology

Basic Standard:

Relevant use of information and communication technology must function as an integrated part of the CPD process.

Quality Development:

Doctors should have access and be competent to use information and communication technology for self-directed learning, for communication with colleagues, information searching, and patient and practice management.

Annotation:

- Appropriate access will require recognition of the evolution and contribution of web-based learning modalities and social media to CPD learning.
- Competence in using web-based learning modalities and social media for learning will include awareness of possible implications on personal and patient privacy in their unique context of practice.
- Family doctors should consider using point of care information to optimize patient care where appropriate and seek out CPD in this area as required.

6.3 Interaction with Colleagues

Basic Standard:

CPD must encourage experiences in collaborating with colleagues and other health professionals.

Quality Development:

To enhance CPD doctors should have the opportunity to establish or join educational networks, or communities of practice. Doctors should engage in the development of competence of their colleagues, including doctors in training, students, allied health personnel, etc.

Annotation:

- Networks would include meetings with both junior and senior colleagues and net-based information exchange, discussions and counseling. Communities of Practice may be a useful concept for family doctors, including those in rural areas.
- Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly. (Wenger, 1999)

6.4 Formalized CPD Activities

Basic Standard:

Family doctors, in collaboration with other stakeholders, must develop systems that encourage and recognize participation in local, national and international CPD courses, scientific meetings and other formalized activities. Doctors must have opportunities to attend such CPD activities.

Quality Development:

Family doctors should have opportunities to plan and execute CPD activities as in-depth studies to reach a higher level of competence (such as courses, certificates and advanced degrees)

Annotations:

- Formalized CPD activities would include attending courses or lectures, e-learning, institutional. National and international conferences, participation in research and organizational activities.

6.5 Medical Research and Scholarship

Basic Standard:

The discipline must be provided with opportunities to participate in quality development activities as part of CPD.

Quality Development Standard:

The discipline should allow for participation in research projects as part of CPD, if relevant.

Annotation:

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

6.6 Educational Expertise

Basic Standard:

There must be a policy on the incorporation of relevant educational expertise in the planning, implementation and evaluation of CPD.

Quality Development:

Access to family medicine educational expertise should be available and be used in CPD activities.

Annotations:

- Educational expertise would deal with problems, processes and practice of medical training and would include medical doctors with experience in medical education as well as educationalists, educational psychologists and others with training in medical education.

6.7 Experiences in Alternative Settings

Basic Standard:

The discipline must formulate a policy that ensures freedom of movement in order to promote the ability of family doctors to obtain experience by visiting other settings within or outside the country (such as conferences, sabbaticals, as well as clinical visits)

Quality Development:

The discipline, in collaboration with other stakeholders, should facilitate national and international study visits for doctors. The relevant authorities should establish relations with corresponding national and international bodies with the purpose of facilitation provision and mutual recognition of CPD activities.

Annotations:

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

7 EVALUATION OF CPD ACTIVITIES

7.1 Mechanism for Programme Monitoring and Evaluation

Basic Standard:

CPD evaluation must involve family doctors and establish and apply mechanisms to monitor and evaluate process/outcomes of CPD activities.

Quality Development:

Family doctors should establish a comprehensive CPD monitoring and evaluation process reflecting on the educational programme, learning outcomes and assessments. The discipline should make use of data to monitor and evaluate acquired outcomes with a goal of ensuing practice improvements quality patient care in order to optimize future learning activities.

Annotations:

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

7.2 Feedback from CPD Activities

Basic Standard:

Feedback from participants in CPD activities must be systematically sought, analyzed and acted upon, and the information made available to stakeholders.

Quality Development:

CPD participants should be involved actively in CPD evaluation and in using the results for future CPD activity planning.

7.3 Monitoring and recognition of CPD

Basic Standard:

The formal structure of CPD activities must be authorized by the discipline, in consultation with relevant authorities based on agreed criteria.

Quality Development:

Documentation of relevant CPD activities, as defined by the participant, should play a significant role in systems for competence assessment, irrespective of the system in use for recognition of the doctor in practice.

Annotations:

- Agreed criteria for authorization of CPD activities deal with the educational value and would include consideration of number of participants, clinical data, equipment, library and IT/e-learning facilities, training staff and program.

- Recognition of the doctor in practice would – dependent on national rules and relations – include maintenance of licensure.

8 ORGANIZATION

8.1 Documentation and Needs for Planning of CPD

Basic Standard:

CPD must be conducted in accordance with the policies of representative professional organizations, including the recognition of activities and their evaluation.

Quality Development:

The discipline should develop systems that provide documentation on practice quality tracking outcomes and comparing peer groups for alerting family doctors and stakeholders.

8.2 Professional Leadership

Basic Standard:

General Practice and Family Medicine organizations must take responsibility in terms of leadership and organization for CPD activities.

Quality Development:

The professional leadership should be evaluated regularly with respect to achievement of the mission and outcomes of CPD activities.

Annotation:

- The leadership and organization would include medical associations, medical societies and other professional organizations.
- Numerous others would also provide CPD activities, not directly accountable to the medical profession, including the for-profit health-care companies, the pharmaceutical/medico-technical industry, consumers and consumer organization and for-profit CPD providers.

8.3 Funding and Resource Allocation

Basic Standard:

Funding of CPD activities should be part of the expenses of the health care system. Doctors' working conditions must enable them to choose and participate in CPD activities. All presenters and funders must declare conflict of interest statements to participants.

Quality Development:

- Funding systems for CPD should ensure independence of family doctors in their choices of CPD activities. Influence on content and presentation from the health and pharmaceutical industries should be limited and mitigated.
- Family doctors should be educated about the ethical dilemmas and conflicts of interest that may arise from their relationships with industry.

Annotation:

- Non-profit organizations such as medical schools and family medicine associations should take a lead role in the development and delivery of CPD activities such that family doctors are not dependent on industry-funded activities.

8.4 Administration

Basic Standard:

The discipline must ensure that CPD activities are adequately managed.

Quality Development:

The discipline should ensure that the administrative structures for formalized CPD activities facilitate quality assurance and improvement.

Annotation:

- Adequately managed would mean sufficient description, evaluation and documentation of CPD activities and their organization and depend on efficient interaction between the family doctor and the CPD provider

9 CONTINUOUS RENEWAL

Basic Standard:

The discipline must initiate procedures for regular review and updating of the structure, function and quality of the CPD activities and rectify deficiencies.

Quality Development:

The process of renewal should be based on research. In so doing it should address the following issues:

- Adaptation of the mission and outcomes of CPD to the scientific, socio-economic and cultural development of the society.
- Re-examining and defining the competencies required incorporating medical scientific progress and the changing needs of the people.
- Reviewing learning approaches and training methods to ensure that these are appropriate and relevant.
- Development of methods of (self) assessment and practice-based learning to facilitate doctors' life-long learning.
- Development of the organizational and managerial structures to help doctors to meet their patients' emerging needs and to deliver high quality care.
- Reflection and continual improvement of CPD contents and methodology.
- CPD should be reviewed and (re)evaluated regularly, guided by the views of the various stakeholders.

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