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Bringing medicines to *life*

CPD for Doctors 2013–2023

Report of a joint ABPI–BMJ conference held at BMA House on 26 June 2013

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Preface

Continuing professional development (CPD) has become an integrated part of doctors' working lives. However, the extent to which it achieves its aims, and how it should best be organised, are the subject of active debate.

The pharmaceutical industry is a major contributor to doctors' CPD, through its marketing and medical functions. The 'CPD for Doctors 2013–2023' conference was convened by the BMJ and the ABPI to explore the current state of CPD in the UK, how it compares with other countries, and where it might be heading, with a particular emphasis on pharmaceutical industry participation.

Executive summary

Continuing professional development (CPD) is an integral part of doctors' working lives. In the UK, each doctor with a licence to practise undergoes an annual appraisal which includes the creation of a personal development plan outlining CPD needs. The appraisal process also feeds into a five-yearly formal revalidation.

CPD opportunities are broad, encompassing updating of medical and scientific knowledge and development of professional skills. CPD can take a multitude of forms, including practice-based meetings, e-learning, courses and travel to UK and international conferences.

There is no one 'correct' type of activity or learning style for CPD. What is most appropriate should be governed by an individual's needs and learning preferences.

CPD activities are accredited by the Medical Royal Colleges. The accumulation of credits to provide evidence of CPD undertaken has widely recognised drawbacks. It may be seen as extraneous to day-to-day work, and may not adequately tackle poor performance. Approaches based on competency or assessment of performance may be more appropriate.

The pharmaceutical industry makes a significant contribution to doctors' CPD, through a wide range of activities from practice visits to sponsorship of international meetings. Its principal aim is to ensure the safe and effective use of medicines.

Some commentators argue that the pharmaceutical industry should not be directly involved in doctors' CPD, as its primary aim will always be to promote use of a company's own medicines. A survey of healthcare professionals suggests that industry-sponsored activities are widely seen as useful and benefiting patients, but there are risks and transparency is essential.

A code of conduct for marketing and medical education activities has been established by the ABPI and is enforced by an arms-length body. It includes detailed guidelines on acceptable practice in areas such as advertising, marketing and hospitality.

International practice varies significantly. Moves are underway to raise the importance of CPD across Europe. In the USA, the pharmaceutical industry is not permitted to be directly involved in continuing medical information, although this is causing difficulties with the communication of scientific findings.

Technological advances are opening up multiple new forms of CPD, and enhancing the diversity of material available.

Introduction

Given the pace of change in science and medicine, it is essential that doctors take steps to update their knowledge and skills. Furthermore, it is now widely accepted that professional groups can benefit from reflection on their performance and how it might be improved, leading to the creation of personal development plans.

For doctors, these principles are now embedded within a formal annual appraisal system. In addition, since 2012, doctors must undergo periodic review of their fitness to practise – revalidation. The stated purpose of revalidation is to 'create public confidence that all licensed doctors are up to date and fit to practise'.

CPD is one aspect of the appraisal and revalidation system, alongside peer and patient feedback and other mechanisms. In theory, a doctor's CPD should be based on the development needs identified in discussion with an appraiser and detailed in a personal development plan. The CPD undertaken can then be reviewed at the following year's appraisal.

Revalidation is scheduled to take place every five years, and draws on information in appraisals, including details of CPD undertaken. Formal recognition of CPD is based on 'credits' which are earned by participation in CPD activities – one hour's participation earning one credit. Although the amount of CPD that should be undertaken is not mandated, it is expected to amount to around an hour a week or 50 credits over a year.

Credits can be obtained only from activities that are formally authorised or 'accredited'. In the UK, the recognised National Accreditation Authority is the Academy of Medical Royal Colleges, which devolves accrediting power to the Medical Royal Colleges and Faculties and the Royal Society of Medicine.

Glossary

CPD: Continuing professional development: activities undertaken by doctors to update and enhance their working knowledge and skills.

CME: Continuing medical education: CPD activities specifically focused on medical knowledge and skills.

Appraisal: An annual assessment of a doctor's performance and development needs, used to generate a professional development plan outlining future CPD needs.

Revalidation: Periodic demonstration that doctors remain fit to practise; in the UK, revalidation takes place every five years.

Credits: Points obtained for taking part in formally accredited CPD activities; typically one credit is obtained for each hour of CPD undertaken.

Accreditation: Formal Medical Royal College recognition of credit-bearing CPD activities.

Current practice

Many types of activity can contribute to CPD. Options include training courses (external events or organised within a practice), conferences, reading specialist literature, 'buddying' or online learning. Multidisciplinary team meetings can also in theory qualify as credit-bearing activities. There is no 'preferred' form of CPD; the most appropriate choice of activity, formal or informal, should be made on the basis of learning needs.

This diversity is matched by the range of organisations that provide CPD opportunities. These include professional bodies such as the Medical Royal Colleges, the BMA, higher education institutions, hospitals and other healthcare facilities, charities and the pharmaceutical industry.

Although CPD has now been embedded with formal working practices, it could be argued that most doctors have traditionally always undertaken CPD-like activities. Furthermore, while it is generally believed to have a positive impact, it has proven difficult to robustly attribute changes in performance or patient care to CPD. There is also little evidence that particular ways of learning are more effective than others.

Hence, there is little empirical evidence to guide what could be considered the most effective form of CPD. This places the onus on appraisers to work with doctors to establish the approach that is most suitable to their own learning needs and learning styles.

In the UK, the Medical Royal Colleges have established 10 principles of CPD[1], including the need to link to personal development plans, and for activities to be undertaken both within and outside normal places of work. It has also published guidelines on standards and criteria for CPD activities[2]. Accreditation is a system designed to give doctors confidence that CPD activities are unbiased and have educational value.

Activities sponsored by the pharmaceutical industry can be accredited. Accreditation is based on the quality and relevance of potential activities rather than the nature of the organisation providing the CPD.

The new system was developed to provide a formal record of CPD, and hence evidence in support of fitness to practise through validation. Although the aim is to encourage personal development so people become better doctors delivering better patient care, there is a risk that administrative systems become an end in themselves. The credit system, for example, may encourage a box-ticking mentality focused simply on accruing credits. A 'parallel universe' system may develop, in which all processes are completed, but bear little relation to doctors' everyday work. Credit accumulation is also at odds with the idea that CPD should be seen as an ongoing, immersive process.

A stronger link to practise is apparent in the potential to obtain double credits for a CPD activity if reflection and change in practice can be demonstrated. In the future, appraisers are likely to play a greater role in assessing the value of CPD undertaken.

1 Academy of Medical Royal Colleges, 2007. The ten principles for college/faculty CPD schemes: www.aomrc.org.uk/component/docman/doc_download/9327-10-principles-of-cpd.html?Itemid=33

2 Academy of Medical Royal Colleges, 2012. Standards and criteria for CPD activities: www.aomrc.org.uk/component/docman/doc_download/9448-standards-and-criteria-for-cpd-activities-a-framework-for-accreditation.html

Industry-sponsored CPD

The pharmaceutical industry is a major contributor to doctors' CPD. Annual expenditure on medical education across the industry in the UK is around £10m a year. Consistent with the pluralistic nature of doctors' CPD, industry-sponsored CPD is highly varied, ranging from marketing-led activities providing specific information about a company's products to 'arm's-length' activities independently delivered by third parties.

An important rationale for such activities is the obligation to ensure that medicines are used safely. The need for effective medical education is becoming increasingly important as both medicines and their use become more complex, through trends such as personalisation.

Other important factors include a desire to ensure that the NHS obtains full value from new medicines, and more generally to prepare the medical workforce for medical and scientific advances that can improve patient care. Rapid take up of new medicines also makes the NHS a more attractive location in which to conduct clinical trials, as new agents can be tested against the latest products, which provides economic benefits to the UK.

Opponents of industry sponsorship of doctors' CPD argue that there is an inevitable conflict of interest, and that activities are undertaken purely to promote the sales of a company's own products. The heavy investment by pharmaceutical companies may also discourage doctors from considering non-pharmaceutical interventions. Alternative models could be envisaged in which CPD is financed directly by doctors, through their employer, the NHS, or through an independent body funded by industry. In the USA, for example, the pharmaceutical industry cannot contribute directly to continuing medical education (see Box 1).

To address concerns about past medical education activities, the ABPI has established a Code of Practice for the promotion of medicines[3]. This code is administered on behalf of the ABPI by the Prescription Medicines Code of Practice Authority (PMCPA), a not-for-profit arms-length body encompassing industry, medical professionals and lay members.

The Code sets out standards in areas such as the provision of promotional materials, which may be considered an inducement to prescribe a company's products, to the organisation of meetings with doctors or other healthcare staff, and conference travel and hospitality. In the past, doctors' travel to international conferences and lavish hospitality have generated a negative public image of industry-sponsored medical education. The Code includes strict guidelines in areas such as the standard of travel that is appropriate, the location of events and the acceptable levels of hospitality that may be arranged. All potential breaches of the Code are published on the PMCPA website, along with adjudications.

Transparency is critical to the Code. The nature of industry's involvement in CPD activities should be made absolutely clear to participants. Industry has a responsibility to quality-assure materials used in directly sponsored activities, but should not influence the content of arms-length events.

Industry is now moving from aggregate to full disclosure, on an individual level, of expenditure on marketing and education activities. Information on sponsorship collected during 2015 will be disclosed on individual healthcare professionals in 2016, across 33 European countries. A similar arrangement will apply to contractual agreements with consultants, with individual details again to be released in 2016. Consultants are already obliged to declare their consultancy and other commercial interests when undertaking speaking engagements and in publications.

Notably, the Code only covers companies in the pharmaceutical industry. No equivalent framework exists for the medical devices industry or private healthcare companies, or bodies in other sectors such as higher education institutions that engage in CPD activities.

3 PMCPA, 2012. Welcome to the Interactive Code - Second 2012 Edition: www.pmcpa.org.uk/thecode/interactivecode/Pages/Default.aspx

Doctors' opinions

To gauge doctors' attitudes to company-sponsored CPD, a consultation has been commissioned by the Ethical Standards in Health and Life Sciences Group (ESHLSG)[4], an umbrella body with representatives from the pharmaceutical, medical devices and diagnostics industries as well as medical professional organisations. While not formal academic research, the project has provided some insight into the views of medical professionals.

Following an in-depth qualitative consultation to identify key issues, an online survey was organised, receiving some 1,500 responses, mainly from doctors in secondary care and with strong representation from psychiatrists.

Secondary care doctors were broadly supportive of industry-sponsored medical education, recognising the value of meetings, conferences and other activities, and suggesting that patient care is ultimately improved. Industry was generally seen to have a significant role to play in transferring knowledge to the medical profession, and medical education was seen as a way industry can 'put something back' into the field from which it derives its profits.

Nevertheless, it was also recognised that industry-sponsored activities have the potential to exert undue influence, particularly on less-experienced colleagues. Transparency was seen as critical, so healthcare professionals could assess the context in which information was being provided.

Technological trends

Events and particularly conferences have been a mainstay of doctors' CPD activities. However, new technologies are providing additional opportunities for doctors to update their knowledge.

Many organisations, including BMJ Online Learning, already provide CPD opportunities through the web. These have the obvious benefit of flexibility – they can be taken at a time convenient for a doctor – and innovative forms of delivery can make for a more engaging experience. Indeed, material can be repurposed in different formats to suit different learning styles. Technologies such as animation can be used to illustrate tricky interventions more clearly than film or text descriptions.

Industry also produces online materials, generally commissioned through specialist providers. It could be argued that such providers have a stronger connection to end users, and hence are more responsive to users' needs, than the marketing and advertising agencies employed by pharmaceutical companies. Initiatives such as the Good CME Practice (gCMEp) initiative[5], run by the not-for-profit European CME Forum[6], have established a set of guidelines to cover their conduct and are developing practical advice on how they should be implemented. The guidelines cover key areas such as appropriate education, balance, transparency and assessing effectiveness.

The web is opening up multiple new CPD opportunities. Academic centres have begun making substantial amounts of material online through massive online open courses ('MOOCS'). Medical education resources are being produced by multiple groups, including philanthropic bodies and commercial entities. A growing trend is for 'peer-to-peer' learning tools and user-generated content, for example cases published for discussion by health professionals for other health professionals.

A fundamental issue raised by such innovations is quality assurance. Doctors may be best placed to know what meets their needs, but as the range of materials grows, forms of authentication become more useful. Furthermore, the need to secure credits for CPD may encourage use of accredited sources. Currently, individual activities are accredited, the cost of which may discourage providers from seeking accreditation from the Medical Royal Colleges. Accreditation of providers of high-quality materials, rather than individual activities, may be a better long-term option.

4 ESHLSG: www.eshlsg.org
5 Good CME Practice website: www.gcmep.eu
6 European CME Forum: www.europeancmeforum.eu

Conclusion

It can generally be agreed that doctors' CPD should be a needs-driven process, and that these needs should relate to the provision of better patient care. CPD forms part of an appraisal and revalidation system that provides a formal mechanism by which doctors' performance can be assessed and developed. Systems based on credit accumulation may not be the best way to track CPD participation, and may not adequately address poor performance. Approaches based on measures of competency and, ideally, actual performance would be more appropriate. The key role of appraisers is likely to become even more important.

The involvement of the pharmaceutical industry in doctors' CPD generates strong opinions. Some commentators maintain that the industry should not be involved in any way. As a whole, the medical profession appears to take a pragmatic view that industry-sponsored CPD is useful and provides a valuable resource for the NHS. Clarity about what is being provided, by whom and for what purpose is essential if trust is to be established between the sponsors of activities and the recipients. This context can help individual doctors to appraise and interpret new information and how it might impact on their practice.

The value of materials or activities is dependent on their quality and relevance. If the origin and purpose of materials or activities is clear, doctors themselves should be best placed to decide on their suitability. With guidance from their appraisers, health professionals ultimately have a responsibility to choose the professional development opportunities that best meet their needs and to apply new knowledge in ways that most benefit their patients.

Box 1: The US system

The US model of continuing medical education does not permit direct corporate sponsorship.

The US model of continuing medical education (CME) aims to be needs-driven, with activities developed to meet the identified needs of physicians. The quality of activities and resources developed to meet those needs is assured by the **Accreditation Council for Continuing Medical Education (ACCME)**, established by the US equivalents of the Medical Royal Colleges in 1980.

ACCME's core role is to license bodies to accredit CME activities. It directly licenses 687 national organisations and delegates authority to some 1,400 bodies that operate at a state level. CME activities are delivered to some 14 million physicians and 10 million non-medically qualified individuals each year. ACCME also establishes standards for assessing CME provision and works on methods to evaluate the effectiveness of CME and accreditation.

To eliminate any potential conflicts of interest, pharmaceutical companies cannot commission CME materials directly. They can, however, support the development of materials deemed to meet physicians' needs. Around 20 per cent of the US$2.2bn annual expenditure on CME is commercially supported. Even in projects receiving commercial support, companies have no say in content.

A potential issue recently emerged with this model. Research related to drug development is typically discussed at scientific conferences. By ACCME criteria, this would be considered a form of CME, meaning that industry employed scientists would not be allowed to participate, but health research funders such as the National Institutes of Health strongly support the open communication of research findings. For the time being, the ACCME is adhering to its criteria , while considering how to develop policy in this area.

More generally, relationships between physicians and the pharmaceutical industry are governed by the **Physicians Payments Sunshine Act**. This Act requires public declaration of all payments to physicians from pharmaceutical and medical device companies, for consultancy, medical education or other purposes.

www.accme.org

Box 2: CPD in Europe

A recent survey has painted a mixed picture of CPD across the EU.

In 2012, the European Union of Medical Specialists (EUMS), which represents more than 50 medical disciplines across 34 countries, carried out a Europe-wide survey of CPD policy.

Although the picture is highly varied, a trend was noted towards greater mandatory rather than voluntary commitment to CPD and revalidation. The revalidation cycle is typically three years or five years, and the required annual number of CPD credits is generally around 50.

The authority responsible for CPD and validation varies between countries, from professional bodies to central governments. The degree of sanctions imposed for non-compliance also varies widely, from none to financial penalties.

There are also signs that the need for CPD and greater harmonisation has been recognised at a political level. For the first time, CPD has been included in an EU professional qualifications directive and a tender has been developed to support an audit of current CPD practice across EU member states.

An important driver has been the recognition that CPD makes a major contribution to doctor performance, and free movement of doctors between countries would therefore benefit from common standards of CPD. There is also a desire to improve attitudes to and provision of CPD, particularly in countries that take a simple time served-based approach to revalidation.

www.uems.net