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COMMENT

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Stakeholder Involvement in Lifelong Learning: Lessons Learnt from Various Countries and Approaches to Recertification and CPD

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Much can be learned from exploring different countries approaches to recertification and Continuing Professional Development (CPD) [1–3], especially from how they incorporate opportunities for learning that arise from or are closely linked with clinical practice and relevant stakeholders. In this commentary, we shed light on different approaches to recertification and CPD of select healthcare professions from the United Kingdom (UK), the Netherlands, New Zealand, Australia and Canada. We believe that there are potential lessons learnt from these cases regarding expanding voices in CPD. While we highlight components of these countries' approaches, we do not wish to provide a systematic review of the intricacies of their systems, nor do we intend to portray their systems as perfect or flawless examples. We emphasise that each of these systems are contextually and culturally bound, which is why a copy and paste approach is likely to neither be feasible nor desirable. Nonetheless, we consider these examples as interesting cases that emphasise the supportive nature of recertification and CPD in healthcare professionals' lifelong learning, illustrate how different stakeholders can be involved, and demonstrate a performance assessment component – admittedly to varying degrees. We hope they provide food for thought when thinking about how to expand voices in recertification and CPD.

Examples from the United Kingdom (UK), the Netherlands, Australia, New Zealand, and Canada show how annual appraisals or individual performance evaluations, stakeholder feedback processes and external evaluation of a group can be incorporated in the process of recertification to support of lifelong learning [4–6].

In the UK, physicians are required to collect "supporting information" for discussion during annual appraisals [4]. This supporting information includes evidence of CPD and quality improvement (QI) activities that are tailored to the individual's practice and focus on outcomes and improvement, reflection on significant events, and feedback from peers and patients. Patient feedback may be obtained through questionnaires, formal feedback or structured interviews, and clear criteria are provided on how to develop and administer feedback tools in ways that are accessible for patients [7]. All this information is then discussed annually with an appraiser [4]. Instead of counting credits or hours and relying on unguided self-assessment which is known to be inaccurate [8,9], this facilitated appraisal approach is guided by performance data and feedback, therefore making it more congruent with lifelong learning processes (e.g. self-directed learning). The focus of the supporting information is twofold: demonstrating the quality of learning work, not the quantity thereof, and demonstrating how learning needs have been met and the resultant changes to practice. This information is then captured in a personal development plan [4].

In the Netherlands, a similar approach is used for physicians, with additional requirements for general practice and community medicine [6]. The Royal Dutch Medical Association requires an evaluation of a physician's competence and external evaluation of group performance by a committee of the respective National Specialty Society for recertification [5]. In keeping with the UK approach, the results of their group and individual performance evaluations are incorporated in a personal development plan. Regular

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self-reflection sessions serve to reflect on individual and group performance and on feedback received from different stakeholders. This group of stakeholders is not fixed and may include but is not limited to fellow physicians, nurses, staff members and patients [10]. While physicians are also required to complete a specified number of CME points, their individual and group evaluations ensure that different voices are included in the recertification processes. Physicians also need to prove that they worked a minimum number of patient-related hours (on average, ≥ 16 hours per week, over 5 years), highlighting the attached value to patient contact and workplace learning.

Professions across the globe also provide insights on the incorporation of workplace learning into their recertification programmes, and how these provide opportunity for increased stakeholder engagement. For example, the New Zealand Dental Council requires oral health practitioners to select and regularly interact with a professional peer; create a professional development plan acknowledging that one size does not fit all, and suggesting that a combination of patient feedback, complaints, clinical audit, peer review, multi-source feedback and practice evaluations inform the plan; and reflect on their professional development [11]. The Psychology Board of Australia requires psychologists to undertake peer consultation, which is defined as "supervision and consultation with peers in one-on-one or group format, for the purposes of professional development and support in the practice of psychology, and includes a critically reflective focus on the practitioner's own practice". [12] This approach relates closely to the UK and Dutch approaches described previously. Additionally, the Royal College of Physicians and Surgeons of Canada's acknowledged CPD activities include: reviewing peers or colleagues, and completing a 360° assessment or any other type of workplace assessment [13]. The College of Family Physicians of Canada's linking learning approach allows physicians to get credit for learning opportunities in daily practice such as journal club, specialist consults, and coaching [14].

The presented approaches serve as examples of how recertification systems can include opportunities for recognising workplace learning activities that include input from various stakeholders. The different approaches used to involve stakeholders in recertification and CPD remind us that there is no one-size fits all approach when it comes to involving stakeholders and supporting lifelong learning. As do the respective systems themselves, by allowing flexibility in the way performance data and feedback are sourced. These examples show us that when involving different voices in healthcare professionals' lifelong learning contextual aspects need to be considered. For example systems issues and resource constraints such as time or finances need to be considered – changing requirements without supporting the healthcare professionals to meaningfully engage in these changes may result in tokenistic involvement of different voices. Cultural aspects such as power dynamics in treatment relationships or healthcare teams need to be considered so that patients do not feel pressured into giving positive feedback, and practice related issues such as sole practitioners needing more support to obtain feedback from peers or other health professionals [15–17]. While the selected examples would therefore likely not directly fit other contexts, perhaps variations of these approaches could be developed that would help healthcare professionals engage in lifelong learning that is supported through the involvement of others. Future research could look into programme evaluation of distinct approaches, particularly giving attention to questions around who decides if stakeholders will be involved, if they're involved the different roles they play, and how stakeholder involvement is implemented and regulated.

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