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REVIEW ARTICLE

Vive la Différence: A Comparison of CPD Quality Assurance Systems in France and The United States

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ABSTRACT

Offering relevant, evidence based continuing professional development (CPD) to ensure the continued competence of health professionals is a universal concern. This concern will become even more crucial in a world facing global health threats and in a context of internationalisation of learning environments. While accrediting systems (i.e. external quality assurance systems for CPD) share a common goal to promote high quality CPD, each system is shaped by national history and contexts. An international movement is working to enhance the convergence of accrediting principles and processes. One of the first steps is to know and understand each other. This article serves this goal by offering a descriptive comparison of two seemingly different CPD quality assurance systems – in France and in the USA of America. The descriptions were developed by members of the accrediting bodies in both countries. The main finding of this descriptive study is that, despite stark differences in historical contexts and governance schemes, both regulators share principles of quality and independence of CPD and have endorsed a leadership role in promoting effective strategies, including interprofessional continuing education and practices. The commonalities of goals and values revealed in the study support the efforts of the International Academy for CPD Accreditation related to the globalisation of both health issues and learning environments.

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Introduction

In this article, we use the term *accrediting bodies* to designate organisations with an official mandate to recognise CPD and assess its quality and independence, whether or not the word *accreditation* is used.

As healthcare delivery systems continue to rapidly evolve around the world and the learning environment for health professionals becomes more global, it is increasingly important for the accrediting bodies responsible for overseeing continuing professional development (CPD) to identify challenges and share lessons learned with their colleague regulators. Rather than being perceived solely as regulatory authorities, accrediting bodies have the opportunity to demonstrate their leadership role through collaborations that leverage the power of education to respond nimbly to emerging health priorities.

External quality assurance standards for CPD of health professionals, which we will refer to as accreditation standards, are intended to ensure that continuing education addresses the needs and practice gaps of health professionals; is founded on adult learning principles, offering the opportunity to combine diverse activities and formats [1]; is based on evidence-informed content; is independent of external influences and free from bias; and contributes to healthcare quality improvement. With the rapid renewal of scientific knowledge and the acceleration of innovations and societal changes, access to up-to-date health education content at the international level is crucial. It is therefore important for accrediting bodies to collaborate across borders to advance our shared goals of improving professional competence, practice, and patient care. We believe that a key responsibility for accrediting bodies and other regulatory bodies is to create connections between nations, systems, and professions. Although there are differences in systems within and between nations, there is also a commonality of goals (See Table 1) [2,3].

Towards that end, the International Academy for CPD Accreditation (IACPDA) [4] an international network of CPD leaders has created a framework for substantive equivalency that enables accrediting bodies to formally recognise each other's systems [5]. These standards are intended to support the mobility of learners; provide more flexibility, diversity, and choice in

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Table 1. Key Points of Comparison.

Areas	France	US
Governance	Government-led system A unique system for all health professions	Professional governance Specific systems for each profession
Financing	Mainly: « socialised » National Health Insurance funds and employers	Mainly: out of pocket payment by individual professional
Type of accreditation	Assessment of CPD providers and activities	ACCME: accreditation of CPD providers
Quality assurance standards	Alignment with recognised quality priorities Appropriateness of formats and learning strategies Scientific validity and independence of content Competency and independence of faculty staff Assessment of the effectiveness the CPD activities Recently: incentives to develop interprofessional continuing education and practices	

education; allow clinicians to access accredited educational activities that are recognised by various CPD accreditation systems; and reduce burdens by enabling clinicians to participate in educational activities that meet multiple professional requirements. With this approach to equivalency, accrediting bodies can contribute to motivating clinicians and teams to engage in lifelong learning.

The purpose of this article is to advance the dialogue by describing two very different external quality assessment/accreditation systems for CPD: a government-run system in France and a voluntary, profession-regulated system in the USA. We look at key aspects of each system, to show how each has approached the development and evolution of CPD accreditation. Our hope is that by opening this exchange, we encourage other accreditation systems to communicate their history and perspective. By building mutual understanding, we can work towards a global approach to CPD that identifies core values and respects differences.

Background

In both France and the US, engagement in CPD has historically been viewed as the ethical duty of each individual healthcare professional. Through CPD, healthcare professionals were expected to maintain the skills they needed to deliver quality care for their patients. The expectations of CPD have progressively evolved; CPD is now considered a system for ensuring that the healthcare workforce is equipped to respond competently not only to the needs of each patient, but also to the changing health needs of the population and constant evolution of practice. No longer only an individual, ethical responsibility, CPD, regulated through systems of accreditation, is designed to assure that education meets established standards for quality and independence from industry. Although France and the US share these common goals and values, each country has traversed its own path to arrive at the CPD systems in place today.

France

The French CPD system is part of an education continuum largely defined by national regulations: public authorities have a major role in the governance of CPD and assessment of CPD providers and activities. Over the years, a national, mandatory CPD system, controlled by the state, was established by a series of legal acts. In 2016, the Health System Renovation Act[1] further defined the objectives, scope, and content of CPD (educational activities, practice review, and patient safety activities) [6,7]. It created a unique centralised CPD system for all the 31 health professions[2] and the public body already in place became the National Agency for CPD (Agence Nationale du DPC), a new public body in charge of the overall governance of CPD system in close partnership with professional stakeholders.

The Agency ensures that CPD is effective, evidence-based, independent, and aligned with public health imperatives and professional priorities for practice improvement. It is responsible for the external quality assessment of CPD providers and CPD activities for all health professions [8].

Currently, there are approximately 2,500 CPD providers registered with the Agency [9]. Registered organisations include hospitals, universities, learned societies, non-for profit organisations,

[1]Loi n° 2016–41 du 26 janvier 2016 de modernisation de notre système de santé

[2]Health professions defined by law and concerned by CPD obligation are: physician (general practitioner and all specialists), dental surgeon, midwife, pharmacist, Medical laboratory specialist, medical physicist, nurse, advanced practice nurse, nursery nurse, anaesthesia nurse, operating nurse, nursing assistant, nursery assistant, physiotherapist, speech therapist, orthoptist, psycho-motor therapist, dietician, occupational therapist, chiropodist, dental surgeon assistant, pharmacy assistant, medical laboratory technician, medical imaging technologist, episthesist, ocularist, hearing-aid maker, optician, ortho-prosthetist, pedorthist, orthopaedist-orthotist

and education companies which have demonstrated complete independence from the pharmaceutical industry.

USA

The CPD system in the USA is based on the principle of professional self-regulation. Each health profession has its own system or systems of CPD accreditation. The Accreditation Council for Continuing Medical Education (ACCME), a private, non-profit corporation, is responsible for setting standards to ensure that CPD for physicians is effective, relevant, responsive to the changing healthcare environment, independent, free from commercial bias, and designed to promote healthcare improvement.

The ACCME accredits organisations, not individual activities. Currently, there are approximately 1,700 accredited CPD providers including hospitals and health systems; government and military agencies; speciality societies; publishing and education companies; medical schools; and insurance and managed-care companies; and non-profits such as foundations.

Although many CPD activities include other health professionals, they are not specifically designed to promote team collaboration or advance team-based care. To advance interprofessional continuing education, the ACCME joined with its colleague accreditors in nursing and pharmacy to create Joint Accreditation for Interprofessional Continuing Education™ [10]. Joint Accreditation, a collaboration that now includes accrediting bodies representing 10 professions, established the standards for continuing education planned by the health care team for the health care team.

Definition, Scope, and Content of Cpd

France

The objectives of CPD are defined as maintenance and updating of knowledge and competencies and improvement of professional practice.[3] Health professionals are expected to achieve those objectives through a diversity of activities, including educational activities, practice review, and patient safety activities.

During a three-year cycle, each health professional is expected to undertake at least two activities aimed at updating knowledge and skills, and/or evaluating professional practices/practice review, and/or managing risks/patient safety. CPD activities must also meet the requirements of one of the CPD methods defined by the National Authority for Health (Haute Autorité de Santé) [11] and respond to CPD national priority goals. Although the law underlines that "each professional chooses the CPD activities he/she will participate in" at least one activity per cycle must meet a national priority goal.[4]

The CPD national priority goals[5] are established through extended consultations with the public health authorities (Ministry of Health, National Insurance Fund, health agencies) and the national professional boards (CNP: Conseils Nationaux Professionnels) every three years and are intended for all health professionals. The entire list of CPD priorities combines cross-cutting public health objectives with specific goals defined per speciality or profession. For each national goal, the objectives and programme content expected are defined in a precise framework [12].

Clinicians may also fulfill their CPD requirements:

- By participating in the *Physician Practice Accreditation Programme* for high risk medical specialities
- By following the CPD curricula defined by their national professional board (called "CPD pathways") that go beyond the minimum CPD threshold requirements and highlight specific recommendations for maintaining knowledge, skills, and competence within the scope of each profession or speciality

The law states that the individual CPD obligation is enforced and controlled either by professional chambers/councils for professionals who are regulated by an *Ordre*, employers, or regional government bodies for the other health professions. But as of this date no systematic enforcement of compliance has been put in place by the professional regulators or the authorities. Control should be made progressively easier thanks to the development of the personal online tool "my dpc", which helps health professionals manage and

[3]Objectives are defined in the law: loi n° 2016–41 du 26 janvier 2016 de modernisation de notre système de santé; article L.4021–1 du Code de la santé publique

[4]Décret n° 2016–942 du 8 juillet 2016 relatif à l'organisation du développement professionnel continu des professionnels de santé

[5]Arrêté du 31 juillet 2019 définissant les orientations pluriannuelles prioritaires de développement professionnel continu pour les années 2020 à 2022

document their participation in CPD, and establishment of partnerships between the Agency and professional councils.

It is also expected that the recertification process introduced by a law[6] in 2019 for doctors, dental surgeons, midwives, pharmacists, nurses, physiotherapists and chiropodists will promote professional development and stimulate the implementation of effective enforcement mechanisms of CPD in the years to come.

USA

Professional requirements in the US, including requirements for CPD participation, are overseen by each profession separately. For physicians, participation in accredited CPD helps meet requirements for relicensure, maintenance of certification, credentialing, employment, membership in professional societies, and other professional privileges.

Each state has a medical board that oversees licencing for physicians; most of these boards require physicians to earn a certain number of CPD credits for relicensure. Physicians are expected to choose educational activities that are relevant to their practice, although some state legislatures and medical boards have mandated that physicians complete specific content, such as education about opioids, domestic violence, cultural competency, or other topics that the legislators have identified as important for the health of people in the state. Medical speciality boards set the standards for physician competence in each speciality and hold physicians accountable for demonstrating it. Additionally, employers may set their own standards for completion of CPD.

Accredited CPD in the US addresses every medical speciality and type of practice, and is utilised by physicians who work in clinical care, research, healthcare administration, executive leadership, or other areas of medicine. The ACCME defines continuing medical education as activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. This definition of CPD is intentionally broad, to encompass education that assists physicians in carrying out their professional responsibilities more effectively and efficiently.

Financing

France

It is the responsibility of the public authorities and the employers to provide resources for CPD, but above a certain threshold individual health professionals may contribute as well. This funding system limits the influence of the pharmaceutical industry in CPD.

There is a mixture of funding sources that vary widely across professions and the different employment statuses of health professionals. For example, the National Agency for CPD is responsible for the funding of CPD activities and the allocation of CPD compensation fees for self-employed professionals who are members of these 10 professions: medical laboratory specialists, chiropodists, dental surgeons, doctors, midwives, nurses, orthoptists, pharmacists, physiotherapists, and speech therapists. The National Health Insurance Fund provides the resources (about 200 million euros a year). In another scenario, CPD costs for health professionals employed in clinical care settings, such as hospitals, nursing homes, laboratories, and pharmacies, or in other fields, such as school health services, are covered by mandatory contributions made by the employers. These contributions are usually collected in pooled funds and redistributed.

The National Agency for CPD also solicits and selects high-quality CPD activities through targeted requests for proposals to respond to public health priorities [13,14]. In 2019, a request for proposals was launched to select team-based, interprofessional CPD programmes for multidisciplinary primary care teams. This initiative was part of a wider effort at the national and regional level to enhance collaborative practices and coordination of care. In 2020, a similar request for proposal concerned the early detection of cognitive impairment among aged patients by general practitioners; in 2021, another one was launched to improve the detection, referral, and diagnosis of children with a neurodevelopmental disorders by general practitioners and paediatricians. In 2022, another one will be launched to support the fight against antimicrobial resistance.

USA

The CPD system is supported mostly by health professionals' registration fees. In 2019, accredited providers reported that the majority of their CPD income (55%) came from participant registration fees. Commercial

[6]Ordonnance n° 2021–961 du 19 juillet 2021 relative à la certification périodique de certains professionnels de santé

support (industry funding) accounted for 25%, advertising and exhibits for 18%, and private donations and government grants 1% each. The vast majority of CPD activities (92%) did not receive commercial support, accounting for 87% of participants [15].

Some providers, such as hospitals, offer CPD as an employment benefit, providing free access to CPD offered by the institution and paying for staff to attend CPD offered externally.

Quality Assurance, Enforcement, and Sanctions

France

The National Agency for CPD in healthcare is the public body responsible for the recognition of CPD in all health professions. Although the word *accreditation* is not used, the Agency assesses all CPD providers and all activities in a way that is similar to accreditation bodies around the world. It must be noted that The National Agency provides accreditation both for CPD providers and for CPD activities, in contrast with other accreditation systems that tend to target either one or the other. The National Agency applies quality standards for independence, educational design, and scientific content to evaluate provider registration and assess programs.

To register with the National Agency, CPD providers submit an application covering general and administrative information about the organisation and information on their activities, faculty, scientific programming committees, planning and evaluation processes, policies for managing conflicts of interest, and faculty development. To be registered with the Agency, CPD providers must in particular demonstrate their independence from pharmaceutical companies and have a scientific board.

Once registered, CPD providers also submit an application for each CPD activity describing the educational and scientific content, including the objectives, target audience, summary of content, scientific evidence underpinning the program, delivery methods and formats, faculty profiles, conflicts of interest disclosures and assessment methodology. Quality assessment of activities takes place on two levels.

All activities are reviewed internally and compliance is checked by the Agency staff. In addition, eight Independent Scientific Committees composed of healthcare professionals perform a more in-depth review of about 20% of CPD activities. The activities are either randomly sampled or chosen because of specific concerns regarding quality and/or independence. The Independent Scientific Committees are organised by profession: physicians, dental surgeons, midwives, pharmacists, allied health professionals, medical laboratory specialists, medical physicists, and an interprofessional committee. Approximately 150 members serve on committees. The activities are evaluated using quality criteria that are similar to the standards found in most of the CPD accreditation frameworks: independence from commercial interests, scientific validity of the content, effective educational methods and formats as defined by the National Authority for Health (HAS), and evaluation of the benefits of the CPD activity.

In 2020, after these two levels of quality assessment, 11,481 CPD activities out of the 15,535 applications were authorised and published. Those activities generated 293,916 registrations. CPD activities are accredited for a maximum of three years [9]. It must be noted that the Agency's catalogue of CPD accredited activities [16] does not encompass all life-long learning activities available to French health professionals.

If a CPD provider has been found to be repeatedly non-compliant with the requirements on quality and independence, the Agency can remove its registration. In addition, a feedback and complaints process allows any stakeholder and any health professional to raise concerns about a registered CPD provider or an activity previously approved by the National Agency.

USA

The ACCME is responsible for setting educational standards for CPD activities and monitors accredited providers' adherence to those standards. Providers that wish to be accredited must demonstrate their eligibility and their adherence to accreditation requirements. After an organisation achieves accreditation, the ACCME uses a *trust and verify* system to oversee compliance. Accredited providers are evaluated at two, four, or six year intervals, depending on their accreditation status. Accreditation decisions are based on three sources of data: a self-study report, a review of selected activities, and an interview. Accreditation recommendations are made by a volunteer committee, with the support of ACCME staff, and then are reviewed by a second volunteer committee, which recommends an accreditation decision; the final decision is made by a committee of the Board of Directors. This multilevel process provides the checks and balances necessary to ensure fair and accurate decisions. Accredited providers are judged compliant or noncompliant with each accreditation requirement; this criterion-referenced decision-making system is designed to ensure consistency and objectivity.

In addition to the accreditation review process, the ACCME oversees a complaints process. The complaints process is open to all stakeholders, including members of the public, allowing them to communicate concerns about CPD. These concerns are investigated by the ACCME.

If an accredited organisation is found to be non-compliant with accreditation requirements, either through the accreditation or complaints process, the ACCME gives the organisation the opportunity to correct the problem. If the problem is egregious or the organisation does not correct the problem, the ACCME may place the organisation on probation or remove its accreditation.

Discussion

From this cross-description of two CPD accreditation systems we see a contrasting image of two systems whose historical trajectory and choices in terms of governance are very different, and in some respects opposite. On the one hand, the French model of CPD accreditation is characterised by the role of the public authorities. On the other hand, the accreditation system of the CPD in the USA is founded on a tradition of professional self-governance. Although the US system has remained relatively free from government oversight, there have been occasions when legislative committees have investigated areas of concern, such as industry influence; however, there have also been important collaborations between the government and the US CPD system around public health priorities.

Despite these differences, there is a striking similarity of objectives and principles. In both systems, the fundamental aim of the CPD quality assurance system is to support improvements in competence, performance, and patient care. The same principles are defined and implemented in both systems to ensure the quality and independence of CPD programs:

- Alignment of the programme with recognised clinical gaps and priorities in patient safety and population health
- Appropriateness of formats and learning strategies
- Scientific validity and independence of content
- Competency and independence of faculty staff
- Assessment of the effectiveness the CPD activities

The differences can be illustrated by examining the approaches to interprofessional learning. In France, a national accreditation body acting as single platform for all health professions has been established. Although imposed from above, this approach nonetheless fostered an authentic interest in interprofessional education, especially by the Interprofessional Independent Scientific Committee. This led the Agency to identify interprofessional education to support coordination of care as a strategic priority and launch a specific initiative to further those goals. In the US, each profession developed a specific recognition and quality assurance system for CPD over the years, each at their own pace, and only after those systems were well-established, did the accrediting bodies build a collaboration for joint accreditation to remove barriers and promote interprofessional continuing education. Despite the different trajectories, both systems recognise interprofessional collaboration as a priority and steps are being taken by the accreditors to promote high quality interprofessional continuing education and practice.

Each system has its strengths and challenges. In France, the value of CPD is recognised by the government and enshrined in public authority. This provides a framework for CPD to respond to public health priorities identified at the national level. In the US, the CPD system needs to demonstrate its value to healthcare policymakers and leaders. On the other hand, the US system, because it is independent of government authority, can be more flexible. The pandemic offers one example: since there are no restrictions or special rules related to activity formats in the ACCME system, there was no need to change the rules for educators adapting to virtual environments. The ACCME responded quickly, offering resources and training for educators transitioning to online activity formats. In France, the National Agency also supported the shift from live events to virtual activities and online formats and is setting new standards for online CPD activities.

Conclusion

As this comparative study shows, there are many approaches to creating and evolving a CPD accreditation system. Each system faces its own challenges, each has demonstrated growth and advancement. While there are many differences between accreditation systems, each can benefit from understanding how others work. By building consensus and collaboration, the community of accreditors can aim to achieve a shared strategic vision – we can better meet the needs of upcoming generations of clinicians, drive quality in medical education, and improve care for the patients and communities we all serve.

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