

Continuing professional development

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Summary

It would be unlikely that many of today's practicing family doctors have not been involved in Continuing Medical Education (CME) activities. It would be equally unlikely, however, that these activities were part of any contextually structured educational plan towards professional development. Often driven by external need towards a reaccreditation procedure, CME can be seen as a burden upon the average practitioners working day, or more usually evening.

The concept of Continuing Professional Development takes the practitioner away from these short-term goals and moves them into a planned educational environment. Using the principles of adult education, this article supports the concept of Continuing Professional Development and demonstrates the value to the practitioner of an educational activity that is both relevant and purposeful towards daily practice, hopefully equally beneficial to the practitioner and patient alike. This article considers some of the theory that underlies the change from Continuing Medical Education (CME) to Continuing Professional Development (CPD), the evidence for its effectiveness, and the ways in which CPD interacts with the processes of appraisal and assessment of medical practitioners.

"If I have seen further, it is by standing on the shoulders of giants" **Isaac Newton 1676**

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The concept of continuing medical education is not a new one. Doctors have taken part in meetings and read scientific journals for many years. However only recently has the right of a doctor to practice from registration to retirement without any independent appraisal of his / her ability been called into question. As interest in the fitness of individual doctors to practice has increased, CME has become the focus of attention.

In 1998, the Standing Committee on Postgraduate Medical and Dental Education in the United Kingdom (SCOPME)¹ stated that CME was no longer adequate to meet all the educational and career needs of doctors / dentists in modern health care. It recommended that CME needed to be set into a wider context of continuing professional development (CPD). Similar committees throughout the world held similar opinions and thus CPD developed from the earlier concepts of continuing professional education (CPE) and CME².

In essence, CPD is broader educationally than CME. It recognises that a doctor is involved in more than clinical work, for example: management, teaching, audit and research, and that all these areas need to be addressed when considering an individual's professional development. It also recognises the changing needs of the

practitioner in a changing environment. Before the change to CPD, most doctors had an informal approach to their continuing education, going to meetings (mainly lectures) as they occurred without considering their particular professional needs. CPD replaces this relaxed approach with a structured system that ensures that educational activities take place on a formal, regular and above all planned basis. The Professional Development Plan (PDP) is central to the CPD process. This allows individuals to direct their own learning schedule and is firmly based in adult learning theory.

Although there is much debate among educationalists³ as to whether adults really learn differently to others and apply their style to their personal learning and despite the lack of empirical evidence to support the theory, the concept of learning styles is useful. Applied to the concept of learning styles are five principles⁴ :-

- As people mature, their learning becomes more self-directed.
- Adults' previous experiences act as a learning stimulus and resource.
- Adults become ready and willing to learn because they experience a need to know something in the course of their daily and professional lives.
- Adult learning is often problem centred, rather than subject centred.

- Internal motivators are more potent for adults than external assessment i.e. their learning tends to be self directed.

In short, the reasons that tend to motivate adults to learn are different to those that motivate children. Whereas children (and students) are largely motivated by assessment, adults identify their own need to know for various reasons. This autonomy is important and valued by individual learners. Adults tend to favour self-directed learning. They also tend towards problem centred learning and that which is meaningful to their life situation with immediacy of application⁵.

Other important concepts in adult learning are experiential learning (or learning by doing) and self-directed learning.

The theoretical basis for adult learning theory is mainly founded in constructivism, which includes learning through experience, and will strike a familiar chord with clinicians. The other theories that relate to learning are known as rationalism or idealism, and associatism. They are discussed in more detail in other appropriate reading material³, but can summarised as follows: -

- a. *Constructivism*. This is based on the work of the philosopher Kant, and was then taken up by the 20th century educationalists Bruner and Piaget,

amongst others. It depends on new experiences building on previous understanding and knowledge (structures). This concept led to the notion of a spiral curriculum where knowledge is revisited at increasing levels of understanding. It has influenced all curricula for medical undergraduates, whether problem-based or not, as well as influencing current ideas about experiential learning for postgraduates and the importance of reflection as part of the Personal Development Plan.

- b. *Rationalism* or idealism was proposed by Chomsky but is now less popular than Constructivism. Rationalism is based on the idea that there are predetermined directions for a biological plan, thus representing a more linear and directive model of learning.
- c. *Associatism*. Also now less popular than constructivism. It relies on establishing in the learner an association between certain stimuli and responses. Pavlov was a proponent of this type of learning.

Experiential learning has become increasingly popular in modern medical practice in the United Kingdom as well as in South Africa. It is based on the concept that ideas are not fixed, but that they develop and are changed and reformed through experience. One familiar example is the audit cycle. The cyclical educational model based on experience was developed by Kolb in 1984 and is known as the Kolb Learning Cycle³.

The steps are as follows:

- The learner gains new (concrete) experiences
- The learner takes time to reflect on the experience, a stage that is influenced by feedback from others
- The learner forms, reforms and processes (conceptualises) the experience to take ownership of the ideas.
- Finally, the learned concepts are used to make decisions, solve problems, change practice and test the implications, generating new experiences to start the cycle again.

This experiential cycle therefore involves reflection, processing, thinking, understanding and using new ideas. Any cyclical process is continuous, and hence the notion of continuing medical education or professional development.

Although the key concepts in CME/CPD are the importance of reflection and reflective practice, the relationship between professional knowledge and professional competence is also of interest. The latter is generally considered to refer to minimum standards of

knowledge, skills and attitude. It relates to the performance of a task or series of tasks, but the amount of underlying knowledge and understanding that is required is debatable.

From CME to CPD

In 1994 The Department of Health in the United Kingdom proposed the following definition of CPD².

'Promoting high quality and up to date patient care by ensuring that all clinicians have the learning opportunities to maintain and improve their competence to practice'.

As stated earlier, CPD is broader than CME reflecting the range of roles taken on by the modern clinician. It is still concerned with improving patient care but also with improving teaching, communication and team working skills, familiarisation with the law as related to practice, relevant ethical issues, and knowledge of management and information technology. CPD is more learner led than CME. The goals are self directed and planned. Its initiation, organisation, control and evaluation tend to be by the individual, with formal input playing largely a supportive role. It includes different approaches to learning, including seminars, apprenticeship style learning, 'on-line' learning and formal lectures.

Most CPD schemes include the accumulation of credits. In the case of the United Kingdom, as in other European Union States, one hour of CPD activity attended earns one CPD credit. About 50 credits need to be accumulated each year, so that 250 credits over a 5 year period counts as one completed CPD cycle. This credit accumulation has been criticised, mainly because the acquisition of credits does not guarantee quality. In particular, while attendance at a lecture can be monitored, it is not so easy to monitor the educationally more important activity of reflection on what has been learnt and on practice. However, demonstrating that a doctor is taking part in an educationally valid activity is also for the benefit of the public. Although audit of clinical activity is a more valid way of demonstrating that things are "up to scratch", whether or not a doctor is taking part in a CPD programme will also inevitably be seen as one measure of that individual doctor's fitness to practice. Furthermore, by setting up a PDP that has been agreed with the employer / employer's representative, individual doctors should ensure that their education programme is relevant to their work.

Is CPD effective? Attempts to answer this important question have been dogged by problems with experimental design. The randomised control trial, the gold standard that is used to evaluate

drugs, is probably not the most suitable investigative tool for measuring subtle changes in an individual's performance. Learning experiences and requirements vary from individual to individual and appropriate outcomes are difficult to identify. In a literature review, Grant and Stanton (1998)² found 2561 articles relating to CME and CPD. Of these only 62 applied to the medical profession, six addressed specific outcome measures, three considered patient outcomes but all found that improvements had occurred as a result of CPD activities. Grant and Stanton also reported that 13 out of 15 studies concerned with practitioner outcomes showed positive changes in knowledge, behaviour and performance.

Although their review found support for self directed learning rather than formal activities, Grant et al make the point that there is still a place for short educational meetings with both didactic and interactive components. They emphasise that effective CPD must be seen as a process rather than an educational event. They conclude that CPD can take any form ranging from the traditional and formal to the highly innovative and informal, and that the teaching and learning method is not the most important variable. Rather than considering outcome measures that are difficult to define they advise focusing on the nature and management of the CPD process, summarised as a process of planning, doing and reviewing effect. They advocate setting the right conditions for effective CPD and the establishment of a process and culture for CPD. Planning and performing CPD should be seen as relevant to the needs and interests of the individual, the service, the clinical team and the institution, be it Hospital, University or Provincial Authority. ♡

Points to Ponder

- CPD meets broader needs than CME
- CPD matches the requirements of a competent clinician more than CME
- CPD can form the basis of a planned series of educational and developmental activities
- CPD is part of a process rather than an event

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