"Effectiveness of Continuing Professional Development" Project: a summary of findings

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Abstract

This paper reports on a study examining continuing professional development for consultant doctors. Using a mixture of qualitative (interviews, letters, observation) and quantitative (online questionnaire) methods, the views of CPD providers and users were surveyed. The study met the following objectives: comparing and contrasting the experiences of CPD across the range of specialties; identifying and describing the range of different models of CPD employed across the different specialties and clinical contexts; considering the educational potential of reflective practice in CPD and its impact on professional practice; and exploring how different professionals judge the effectiveness of current CPD practices.

The effectiveness of CPD, as inferred from the comments made by interviewees and questionnaire respondents, relates to the impact on knowledge, skills, values, attitudes, behaviours and changes in practice in the work place. The quality of CPD was seen as inextricably linked to any improvements in the quality of the professional practices required for service delivery. There was widespread consensus as to the value of learning in professional settings. There was recognition that there needs to be a move away from tick boxes to the in-depth identification of learning needs and how these can be met both within and external to the workplace, with learning being adequately enabled and assessed in all locations.

"Effectiveness of Continuing Professional Development" Project: a summary of findings

Introduction

One of the primary aims of the "The Effectiveness of CPD"[1] project was to explore how both new consultants and those established in post, across a wide range of medical specialties, understood their own learning, or the learning of other doctors within their organisations, as well as how this learning related to conceptions of CPD, its provision and its uptake.

A second primary aim was how the respondents, from a range of professional perspectives, evaluated of the *effectiveness* of CPD. Therefore the design of the research process incorporated doctors from staff grades to senior consultants, including those primarily involved in management, CPD provision and assessment, as well as institutional officials, such as those in Deaneries and Universities. Qualitative and quantitative methodological approaches were used in collecting these data[2].

Defining Continuing Professional Development

A literature review[3] indicated that CPD can be viewed as a) gaining knowledge by keeping up-to-date clinically, managerially and professionally (Peck et al. 2000; NIMDTA (undated); SCOPME 1998; Parboosingh 1998; GMC, 2001; Guly 2000) and b) improving patient care. However, gaining knowledge does not necessarily translate into changing clinicians' behaviour (Lang et al. 2007). Closely associated with appraisal and revalidation, and often linked to performance, CPD was described as "*aspirational*" (Bouch 2006), as owned by the individual and not "*run by any agency*" (Academy of Medical Royal Colleges 1999). The literature review indicated that CPD was considered to go beyond what doctors do. Moreover, there was *"no single, singular or correct way of doing CPD"*. Despite this, CPD was defined in operational terms as consisting of attendance at conferences and workshops at internal, local and national levels. In short, most CPD activities were constructed as taking place outside of the everyday workplace settings.

There was little literature on the effectiveness of CPD, even when this was defined in terms of 'efficiency' and a cost-benefit analysis (Belfield et al. 2001; Brown et al. 2002). This literature was primarily quantitative with a strong focus on measuring visible and tangible outcomes: education interventions (Davis et al. 1992; Freudenstein & Howe 1999; Kerse et al 1999); education-enabling outreach visits (Avorn & Soumerai 1983, Davis et al. 1995) and reinforcing strategies such as chart review (Everett et al. 1983) for example. No qualitative, in-depth analyses of the key processes, mechanisms and procedures that affect complex professional practices and the workplace were found.

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[1] This article has been adapted from the Executive Summary of the "Effectiveness of Continuing Professional Development" project report, commissioned by the General Medical Council in association with the Academy of Medical Royal Colleges.

[2] For full details: see Final Report of "The Effectiveness of CPD" on <insert meducation address>

[3] A Literature Review was conducted throughout the lifetime of the project; for full details: see Final Report as above

Objectives, research design and methods

The main aim of the research was to identify what promotes or inhibits the effectiveness of CPD. This was explored in terms of four broad objectives:

1. To compare and contrast the experiences of CPD across the range of specialties
2. To identify and describe the range of different models of CPD employed across the different specialties and clinical contexts
3. To consider the educational potential of reflective practice in CPD and its impact on professional practice
4. To explore how different professionals judge the effectiveness of current CPD practices.

- The research design itself was specifically developed to address two fundamental needs: cover the range of medical specialties, and posts within those
- focus on what happened in the clinical setting.

Data were therefore collected by:

1. Methods to cover and ensure range of experience and opinion:

(i) *A questionnaire* was conducted online using Surveyor. In addition to free comments, respondents were asked to rank preferences for various CPD modalities and providers using a Likert-type scale. The Presidents of the Colleges and Faculties alerted their members to the questionnaire to be found on a linked website in one of their e-bulletins in spring/early summer of 2008;

(ii) *Letters to CPD leads* took the form of a semi-structured email letter consisting of 13 questions to elicit information about how the particular College or Faculty viewed, managed, monitored and assessed its CPD activities. Two mail shots were undertaken, in October 2007 and in January 2008.

2**.** In-depth strategies to elicit data from clinical settings:

i) *Interviews* were conducted either face to face or by telephone. Most interviews lasted for approximately one hour, and each was recorded and transcribed. A few opportunistic interviews of ten to fifteen minutes were conducted, recorded and transcribed with delegates between sessions at three different conferences: at the College of Emergency Medicine, the Royal College of Physicians and the Association of Surgeons of Great Britain and Ireland;

ii) *Research in clinical* settings: shadowing and observation took place in the following clinical settings: four shifts over four days in an Emergency Department in a district general hospital (DGH), an outpatients clinic in another DGH, and a post-take ward round in a third DGH.

The questions asked in the questionnaire, letters to CPD leads and the interviews were all informed by key insights from the review of the literature.

Results

The results from the questionnaire responses (902 returns) and from the responses to the letters to CPD leads (10 responses[4]) are summarised below.

Questionnaire
The highest scores for positive CPD experiences over the previous 12 months were conference attendance, local events and reading journals and the determinants of those with highest scores were interest, knowledge/skills gap and reflection on practice. The majority of respondents agreed that the greatest impacts of CPD were changes in clinical practice, knowledge acquisition and learner satisfaction.

The highest scoring attitudes towards CPD were that it was a natural part of professional life which was necessary for patient safety and the extent to which it was considered rewarding. Colleges or Faculties were thought to be the most appropriate origins of both content and responsibility for CPD. Consultants were thought to learn best through experience. Barriers to participation included: study leave availability, cost and work-life balance[5].

Respondents gave College conferences, medical society conferences and speciality associations the highest scores as the most valuable contributors to CPD.

Responses to letters to and interviews with CPD Leads
The guidelines and advice given to members about CPD included recommendations on reflection, blended learning and details of the credit point systems. Provision of guidelines and advice was listed as being through one of three modalities: online, postal delivery or personal contact with designated member[s] from the College or Faculty.

Members reported being able to provide feedback in informal meetings, using the Directorate of CPD as well as the organisational infrastructure, and the range of educational opportunities provided were local and national course provision, e-learning modules, seminars, workshops, conferences, journals and trainer training programmes.

Encouraging doctors to cover specific CPD topics was described in terms of "signposting" and "kite-marking", while the range offered was depicted in terms of "flexibility". The overall aim was to foster high quality CPD. This type of guidance was communicated online, through mailings, at meetings and through allocation of credit points for specific CPD activities. If uptake was measured, the mechanism used was described by a variety of auditing procedures of annual CPD returns. The use of diaries/journals (paper or online) was described as the most frequent method by which members recorded their CPD, with e-portfolios as the second.

Methods used by the organisation to evaluate the effectiveness of CPD were variously described as *"none"* to *"an open culture encouraging feedback in general"* to *"an audit of*

[4] The October 2007 and January 2008 each yielded 10 responses; the same 10 Colleges and Faculties responded in both cases
[5] For example, female respondents with pre-school age children often chose local CPD events in order to maximise time spent working and the balance with home life

members' activities". Respondents were unaware if their organisation had any literature pertaining to effectiveness of CPD (see below).

Interviews, shadowing and observation
The themes and issues that emerged during the analysis of these data are shown below. They illustrate the ways in which the aims and objectives given above were explored in order to elicit the effectiveness of CPD.

Doctors' understandings of learning and CPD
Doctors perceived CPD as learning and inextricably linked to *"doing the job"*. This learning took two forms: i) the addition of something new and ii) verifying that practice was similar to other people's and so a marker of good practice. However, just because everyone is doing something does not necessarily mean it is good or indeed the best practice possible. It does however provide a quasi-public base-line from which to reflect upon evidence and assess practice. This description was generic across the respondents. It suggests that CPD could be employed to make this process more systematic[6], rigorous and robust in terms of formulating procedures for *"validity checking"*.

"Keeping up-to-date" and *"confirming practice"* ranged from attending conferences, workshops, external meetings, in-house meetings, through *"sharing surgical theatre sessions"* to interactions with colleagues in order to engage in learning activities that might involve something new, or something to be *"re-learned"* because it wasn't *"quite at the front of your brain"*, or it might have involved looking at something from *"a different angle"*. The nature of what was newly learned varied according to professional roles and from specialty to specialty. This applied to knowledge, psychomotor skills, managerial skills, leadership skills, technological skills, implementation, appraiser of literature, screening of research proposals and mediation.

Respondents suggested that professionals may stay within their *"comfort zones"* rather than *"using CPD as an opportunity to uncover their unknowns"* when selecting their CPD. However, it is questionable whether they would continue to do so if the scoring by which CPD is assessed were to change. It was suggested that alternatives to the scoring system need to be identified and explored, and professionals should be able to appraise and critique their own practice. Making the distinction between performance, and the judgements and decisions that led to that performance, is a subtle but necessary act for professionalism as performance is a visible entity, which in itself, enables mechanisms for measurement and standardisation to be put in place. Judgements and decisions are *"invisibles"* (Fish & de Cossart 2007) and thus compatible with more qualitative assessment procedures.

All respondents agreed the term 'CPD' had an accreditation/formal dimension to it. All respondents agreed it involved learning, but that it was not to be equated with the term 'learning'. Rather, CPD was seen as essential to effective practice and to an individual's development within the profession, whether or not that results in career progression. It was

[6] This is a form of professional triangulation, that is, a process of comparing experience about similar activities across a range of professional perspectives in order to find what is common, what is different and what is contrasting. It is not carried out in a systematic manner as would be the case in research procedures

linked to *"personal learning needs"* that would *"result in learning outcomes that are mostly translated into practice"* and it was frequently associated with appraisals which were typically seen through the perspective of *"gap filling"* in skills (clinical, managerial, etc.), attitudes/behaviours (leadership, communication, etc.) or knowledge. Shortcomings could then be addressed and remedied. This may be called the engineering model of CPD. But nevertheless, it may be that the simple logic of seeing a gap and filling it is not actually appropriate for all learning opportunities.

The continuous nature of CPD was often articulated as *"moving on"* and *"continuing to develop"*. However, the medical profession is very heterogeneous and it is vital that CPD providers and assessors address how to formulate learning to encompass this diversity.

Distribution of CPD across institutional and more personal (individual) settings

Doctors perceived national provision of CPD opportunities as favouring those who lived in London and the Home Counties because of difficulties with finances, time, job demands and work-life balance. In contrast, local external events were judged to provide a wider diversity of CPD learning opportunities.

It was also noted that hospitals and general practice surgeries varied from teaching to non-teaching, from large to small, from being *"educationally active"* to being neutral or disinterested. In terms of learning experiences, *"learning there and then"* was seen to be significant, but the question remains as to how to assess this rigorously and robustly.

What counts as CPD?

Being fit to practice is different to being safe to practise. This distinction leads to questions of whether the purpose of CPD is to raise everyone to a minimum standard or to allow individuals to pursue learning interests more generally. In the context of quality assurance of CPD activities, these are contentious issues. Moreover, some users of CPD, whilst aware that their particular accreditation body accepted reflective notes as a valid method for recording CPD activity, chose to redefine it as a non-valid activity because of their reluctance to spend time writing reflective notes, preferring instead to *"just tick a number for turning up at sessions"*.

Networking and peer review of practice provided professionals with ways of comparing the quality of their practice. There were some clear differences, however, between what users considered CPD to be, compared to those with some role in quality assurance, whose language was of a more institutional nature. For example, one interviewee, talking about CPD and work-based learning explained: *"I guess CPD has become a label and something that you get boxes ticked and certificates for, so, under that formal title of CPD session, [then], it's that",* but as continuous professional development, in lower case then, of course it's essentially *"on the job training"*. In other words, when used *"with its capital letters, it's become known as the stuff that goes in your portfolio but, with small letters, any learning is CPD"*.

This comment articulated the contrast between the quality assurance discourse used by the institutions, and that of the clinicians arguing the case for more personalised settings, in relation to CPD assessment procedures.

What counts as effective CPD?

Effective CPD involves *"learning" and* being *"fit to practise"*, knowing both the *"why"* and the *"how",* and putting both into practice. Effectiveness is facilitated when professionals are able to determine their own learning needs, through reflection, within the totality of their practice. Capacity for both insight and reflection is required, which means being able to go beyond what is quantifiable; something the professionalism of medicine and clinical practice demands: *"it's all about qualitative things, it's not about time spent* per se*, rather it is about the gestalt of the entire learning experience."*

The status of workplace learning

Many interviewees and questionnaire respondents expressed a desire to get away from the *"tick-box"* approach, to go beyond the notion of *"scoring points"* and escape gross generalisations. There was a perceived danger that the tick-box method evoked a feeling of *"being regulated"* and that this in turn fostered an autopilot response to attain the *"credit rating",* rather than a reflective learning experience that led to a deeper and more enriched understanding of practice. They also wanted to get away from a *"reductionist"* approach towards something that could reflect *"the complexity of practice".* With this in mind, occasions for feedback and dialogue as a basis for CPD in the workplace could be developed, since *"most of what doctors do is talk."*

Culturally embedded learning challenges: scientific and medical knowledge shaping conceptions and conduct of interactions

Expressions, modes of articulation and the metaphors[7] used by professionals, provide insights into the ways of seeing, thinking, doing and speaking, and these interlink into developing medical concepts and the conduct of professional interactions.

The ways in which people talked about their styles of learning influenced their strategies for learning, and changing the metaphors employed may change the way they think about (and undertake) learning. Although doctors are scientists, they do not deal with interactions between substances in a controlled environment; rather they deal with patients who vary widely, experience illness in varied environments, have free will and may exercise it in unexpected ways. One way of conceptualising the process of applying theory and knowledge to practise, is to employ the metaphor of *"a reality filter".* In other words, as theory meets practice, the pure scientific gaze encounters what may be called *"interruptions"*[8] when faced with making a clinical diagnosis and managerial plan for the patient in the day-to-day reality of the clinical consultation. There is a need to *"steer a fairly cautious middle course*" and be able to balance *"knowing the evidence"* and one's *"own personal experience",* while

[7] Note earlier discussion of the use of the engineering model of learning and the prevalence of the metaphor of filling the *"gap"*

[8] The word *"interruption"* has been chosen as a metaphor to signify a break in the flow and continuum of the theory of science due to reality impinging upon and unsettling theory.

recognising that this delicate balance is difficult to achieve. This is an issue for both CPD and appraisal and the relationship between them.

Organisational perspective shaping conceptions of CPD needs
From a commercial perspective, providers of external CPD need to offer a wide range of events of high quality to attract a broad spectrum of professionals. They must also ensure that the audience keeps returning, whilst balancing those factors against costs in terms of finances and staff availability.

Factors that limit attendance of external CPD events included difficulties in securing time away from clinical work and service delivery. This depended upon the number of clinicians within the particular specialty. Trusts also varied, from being generous in allowing time off for CPD, to being uninterested in CPD opportunities for their staff. In addition, the annual study leave budget was considered too small to cover costs incurred by attending external CPD events.

On-line learning and CPD opportunities have become very popular with clinicians and significant investments have been made in developing these both by Colleges and the Department of Health.

The organisational perspective favours CPD activities that are recordable in some measurable and quantifiable way, in order to be seen to be conducting a transparent and rigorous assessment procedure. Interviewees did not question the importance of CPD, but some questioned whether or not it could be recorded *"accurately"* and *"usefully"*.

A conception of CPD: a single scale or an ideologically shaped alternative option
A common response was that *"learner-led CPD is the most successful because it encourages engagement and acknowledges professionalism"* and thus is most valid from an educational perspective. However, CPD was understood differently by those with organisational responsibilities compared with those who saw it as part of their professional development. For CPD to be effective, it must address the needs of individual clinicians, the populations they serve and the organisations within which they work, as well as broader system-wide, national policies.

A reported difficulty was that the focus upon the acquisition of new or updated medical content knowledge in formal settings divides CPD needs and practice from everyday professional life. The complexities of clinical areas can require delivery of care when there is incomplete information upon which to form judgements and take decisions. Thus, an algorithmic approach to learning is not always effective. Medical professionals form judgements, make decisions and execute them whatever their clinical specialty. Nevertheless, differing roles and contexts within their posts, make different demands upon their CPD needs, and the apparent ease of fulfilling these needs for the purposes of assessment.

The fact that CPD can take place in the workplace is not in question. Rather the question is: can CPD in the workplace be systematically assessed in terms of quality of experience and actual effectiveness? This is a challenge to the system, along with reports that formal CPD

provision was perceived as undergoing changes in line with the proposed implementation of revalidation. These changes were perceived as industrialising CPD in order to make it more uniform.

Reflection and its impact
For many doctors, reflective learning tended to be regarded as superfluous and a nuisance whilst actually doing it, but it was regarded positively in retrospect. Others saw themselves as having incorporated it into their day-to-day work and not as something they did as extra.

Competition between the busy nature of service delivery and time for reflection was often cited. However, a number of interviewees made little distinction between reflection and audit. Within the group who identified a distinction, understandings of reflection proved to be significantly different. For example, one consultant believed that, for the most part, reflection was "*laundering*" and "*sanitising*" decision making because it allows the doctor to think calmly and objectively without emotion. However, another consultant, saw it as means for both self-learning, and creating a learning environment for others.

Differences between specialties
A common response was that what doctors do is talk and thus, communication in all its complexity, is core to the entire profession of medicine and *"the art of history taking"*, examining the evidence and forming judgements provide prime examples of the vital importance of communication for medicine.

However, some specialties, e.g., anaesthetics and emergency medicine, have *"very clear behaviour objectives"* while specialties such as Psychiatry, adopt approaches based on different learning models, that are better adapted to enabling *"a vast array of intellectual tying-together"* in all its *"complexity"*.

The significance of these differences cannot be emphasized enough in relation to the effectiveness of CPD embedded, as they are, in a culture in which behavioural objectives are *"visibles"* that can relatively easily be measured, whereas the judgements and decision making processes are *"invisibles"* and qualitative.

The impact of revalidation on CPD needs
Many respondents predicted that CPD assessment was more likely to become more quantifiable as revalidation is introduced, and both interviewees and questionnaire respondents welcomed the flexibility that currently exists in the system. Some believed revalidation to be a positive move towards greater accountability, whilst others spoke negatively of a process that would reduce the flexibility they valued in the current CPD system. Moreover, many expressed concern that perhaps acknowledgement of on the job elements will be even more reduced. Though the reality also could be that the opportunities for external CPD will reduce further through service pressures – these are potentially in competition with the requirements for revalidation. This is a tension that has emerged clearly from this study and one that deserves further consideration as to how it might best be resolved.

Conclusion

CPD is a valued activity. Its effectiveness, if this is defined as impacts on knowledge, skills, values, attitudes, behaviours and changes in practice in the work place, however, can only be inferred from the comments made by interviewees and questionnaire respondents. There seems to be widespread agreement on the value of on-the-job learning but also that there are considerable difficulties in evaluating it. This is because strategies for effectiveness need to be tailored to the practice and workplace context of an individual doctor. This in turn means that there needs to be a move away from tick boxes to the in-depth identification of learning needs and how these can be met both within, and external to, the workplace. There is, however, a further difficulty located in the tension between service delivery needs and CPD opportunities. The former, given scarce resources, takes precedence over the latter but the quality of CPD is inextricably linked to any improvements in the professional practices required for service delivery.

The aspirational and personal nature of CPD results in open-ended definitions. This presents a formidable challenge to assessment and accreditation systems. A definition of CPD in closed operational terms[9] is widely adopted as the simplest workable option for provision, assessment and accreditation.

With flexibility seen as the key, the range of providers of CPD was *extensive and diverse* but with indistinct boundaries resulting between CPD and quality assurance. Other factors that contributed to effective CPD were active modes of learning, the linking of CPD with learning needs analysis and the integration of knowledge with everyday practice.

The challenge for CPD is in the dynamic relation between clinical practice and the complexities of the clinical settings where educational opportunities and service delivery requirements interact with each other sometimes positively, and at other times vie with each other for resources.

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[9] 'Closed operational terms' is used here to signify CPD activities as 'visibles', i.e, as attendance of conferences, of workshops and the use of tick-boxes

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