CPD portfolios as structured tools for learning and assessment

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This paper discusses CPD portfolios, now widely adopted by Medical Royal Colleges and their Faculties in the UK to promote learning that meets intrinsic professional development and external regulatory functions. Early experiences of portfolio-based learning are reported, drawing upon semi-structured interviews with a cross-section of UK public health physicians in various roles and subspecialties.

Interviewees felt that the CPD portfolio assisted reflection and learning from experience, but that they needed to acclimatize to this new learning culture. Tensions resulting from its multiple purposes were noted: for example, between reflective learning and the assembling of performance evidence. Interviewees preferred a portfolio to have greater flexibility to accommodate diverse modes of reflective practice and personal learning. Analysis of learning needs and professional development plans were seen as useful in giving a direction to learning and aligning it with professional practice. The difficulty of pressing education into rigid recording formats could be minimized by simplifying the forms and broadening CPD categories and credits. But participants felt they would still need mentoring and support in coming to terms not only with the practicalities of portfolio building but also with its educational aims and principles. Continuous review by the Faculty and its CPD co-ordinators was recommended to assist adaptation of the CPD in the light of emerging anomalies.

Key words: continuing professional development, reflective learning, portfolios, professional change

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Introduction

Doctors in the UK have traditionally been under a professional obligation to update their clinical knowledge and procedures for the benefit of patients and to advance professional practice in their discipline.[1,2] In recent years, this voluntary education activity has been subject to formal control of professional bodies and to external accountability pressures. Participants in what is now called continuing professional development (CPD) have to conform to specialty frameworks for the accreditation and monitoring of professional educational activities. The CPD aspect of good medical practice has become inextricably linked to procedures for the formal revalidation of doctors in the UK.[3]

Alongside these developments, a revolution has been taking place in CPD at ground level. New educational ideas have challenged traditional approaches by which CPD is viewed as the transmission of knowledge using didactic methods. With the adoption of wider professional development goals and principles of adult learning has come the recognition that doctors learn not only from attendance at formal educational 'events', but also from individual and joint reflection on clinical experiences.[4] Learning that is service-based and sometimes multidisciplinary is widely valued by doctors but does not sit well with the requirements of external accountability. Learning in practice tends to be transitory and diffuse, and therefore difficult to capture in concrete evidence of the type required by formal schemes of accreditation.[5]

The introduction of CPD portfolios in the UK's health professions represents one attempt to integrate these conflicting and uncertain purposes in a single format. A portfolio is a collection of evidence of learning and professional development achieved over time. This

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evidence can be freely selected and presented (e.g. in a loose-leaf file) in any way that will demonstrate having met the portfolio criteria. Portfolios are distinguished from practice logs, records of achievement and performance profiles by their emphasis on self-directed learning by recording and reflection. Through this process, coherence is achieved among disparate elements of personal, professional and career development.

Portfolios vary in the degree to which their structure, contents and presentation are prescribed. The broad criteria of a loosely structured portfolio would allow participants a wide degree of choice over 'found' items, reflective writing and other contents that are seen to meet the criteria. The point is to analyze experience and reflect on practice in ways that alert participants to learning of significance to them. It is also important to allow sufficient flexibility to capitalize on 'stream of consciousness' learning that accompanies encounters with patients. This will enhance the informal theorizing – fresh, context-sensitive connections among concepts, facts and procedures – that is a dynamic influence on every clinician's practice.[6]

With emphasis on the accountability function, CPD portfolios typically include performance criteria, standardized formats and specific guidance on their completion. Consistent and uniform presentation of evidence in the portfolio may help doctors who feel uncomfortable with a loose structure, but does not necessarily improve assessment.[7] Various models and templates are available to enable progress in reflective learning,[8] but they assume models of adult and experiential learning that can seem formulaic and incompatible with clinicians' learning in practice.[9] In pressing learning into tightly structured formats, the sense of personal significance and ownership of CPD may be diminished. Deliberation, reflective learning and presentation of evidence in portfolio learning ultimately seem to be matters of professional judgment.

A CPD Portfolio for Public Health

In 2002, the UK's Faculty of Public Health replaced its CPD record book with a portfolio in an attempt more properly to reflect its members' educational goals and provide evidence of maintaining professional competence. A particular focus in the document was the analysis of learning needs as these relate not only to the public health specialists, but also to their employers and the populations they serve. To assist breadth and balance of learning, the categories for recording CPD were adapted: they now covered accredited meetings, supervised learning, self-directed learning and publications.

The portfolio scheme permitted CPD credits to be gathered by those involved in service work, academic activity, professional and career development or person skills. Within the portfolio, there were forms for: personal details, a professional development plan (PDP), reflections on the relationship of CPD activities to practice, recording audit and ongoing learning activities and the annual CPD return. A central CPD unit and regional CPD co-ordinators were to assist members to adapt to this new learning format.

EVALUATION OF THE CPD PORTFOLIO

An evaluation was mounted at an early stage to review practitioners' use of the CPD portfolio and suggest improvements. The evaluation was formative and included a focus upon the aims of the portfolio, its influence on methods and content of learning, the role of reflective practice and experiential learning, learning and practice outcomes, and identifiable areas for future support.

An initial questionnaire was posted to 37 public health practitioners who had been identified by the Faculty's CPD co-ordinators as early adopters of the portfolio. The respondents represented a cross section of roles and sub-specialties in public health practice. The questionnaire findings were used to set up semi-structured telephone interviews with a sub-set of 20 respondents. Interviews were transcribed and subjected to thematic analysis. The sample selected for the study inevitably was skewed towards CPD enthusiasts whose portfolios were at different stages of development.

BENEFITS OF THE CPD PORTFOLIO

As is common with portfolio schemes, the Faculty's CPD portfolio was seen to signal a potential transformation of professional learning.

- Ongoing reflection on practice represented a forward-looking approach to professional development.
- The portfolio framework was sufficiently broad and flexible to reflect everyday professional activities and needs of public health physicians.
- It encouraged deliberation on how new knowledge and competence contribute to professional standards and practice development in public health:

  Yes, that's the most helpful I think, in that it actually asks you to reflect and that's something that I think is valuable.
- It highlighted the importance of exploring the rationale for specific CPD activities and adopting a planned approach:

  I found it much more difficult filling in [the CPD record] without a personal development plan. It made me think "Oh no, I really do need to think about why I'm doing these things."
- There was a change of emphasis from learning at external educational events to 'on the job' learning and learning moments within practice experience.
- The new approach brought about deeper reflection on learning outcomes and its encapsulation in a cumulative record:

  Whenever I've been to a meeting or done an audit I write down how I think it went… whereas previously I would just do it. …So I would spend an hour on a literature search. Now I write down what I've learnt from the literature search.
- It encouraged a less simplistic view of the relationship between CPD and professional or practice development.
- Rather than have an immediate impact, new learning sometimes was seen to remain latent and subject to further deliberation.

  Well of course a lot of learning, you don't change your practice particularly…You know, you acquire knowledge which you need to have or you confirm that what you're already doing is the right thing.

  Often, you know, you come away from something and you have really learned something but… you'd have to mull it over and have a think for quite a long time, maybe a few months about where that would fit in anyway.
- Peer learning and professional collaborations dovetailed well with the portfolio: they validated portfolio content, stimulated further learning and supported the management of personal learning.

DEVELOPMENT ISSUES

A number of development questions were raised in these discussions of the CPD portfolio. These were related to theoretical issues of reflective learning and to its practical implementation.

- Personal learning, i.e. learning that is by, with and for the practitioner, generally implied a *gestalt* switch in doctors' views of education.
- Some were unable to give up their view of knowledge as externally imposed and tested in favor of the assumption that knowledge is internally constructed and validated in practice.
- There was some confusion as to 'what counts' as a genuine learning moment, how to reflect on it how to record such reflections.

  Everybody's saying, 'Well, does this actually count, and in terms of on the job learning, is it really new learning and how can I reflect on it and is it real?'
- Practical problems - the increased complexity and time-consuming nature of the portfolio - compounded conceptual difficulties:

  There was a feeling that the presentation of learning could be manipulated when recording it in the portfolio (as in the earlier record book).

  I mean what happens is I have to try and fit what I do into the system, rather than the system influencing me, because I don't have enough time to do extra CPD because of the system…so I have to try and fiddle it basically to fit in with what's done.
- Participants wanted more experience and guidance in the analysis of learning needs and in designing PDPs.
- Because of continual shifts in health policy and organizational priorities, some interviewees felt it was pointless to draw up learning plans.
- The developmental aims of the portfolio could be undermined by the pressure to accredit and monitor participants' CPD.

It's not easy to know how something fits in which category, how much time you're there, or how many credits you're allowed to claim for it or whatever.

- The task of fitting valid learning experiences into the newly defined categories was a potential distraction.

Preparation to teach 'training the trainers' courses and to write academic papers involved learning that was not adequately valued in the scheme.

In real life, you may have to teach a program which has been established but you may well have to learn teaching techniques or learn a whole load of new stuff in order to do that.

SUPPORT FOR PORTFOLIO LEARNING

Given the above issues, participants perceived considerable scope for support to portfolio learning that brings together the Faculty, its members, mentors, co-ordinators and advisors. The Faculty was recommended to:

- Simplify the portfolio guidance, loosen recording formats and remove the requirement to log changes in performance that follow CPD activities
- Allow greater flexibility in recording learning to make the portfolio applicable to all sub-specialties in public health
- Provide alternative examples of learning needs assessment, learning plans and formats for reflection, and support individual approaches to recording, reflection and assessment in the portfolio
- Clarify precisely what the monitoring process requires of participants in their portfolio returns
- Set up courses, workshops and sessions by external experts that will increase the educational value of the portfolio
- Give regional co-ordinators responsibility for guiding individuals on their portfolios, commenting especially on how well they have met the regulatory criteria
- Foster regional peer support networks, e-discussion groups and talklines that will help to alleviate members' uncertainties and draw in isolated public health specialists

Discussion

The great promise of the Faculty's CPD portfolio was that it would upgrade the continuing education of doctors by its flexibility in use, its varied formats and associated ability to meet both learning and assessment purposes. Public health interviewees highlighted the many and varied emphases that could be achieved in portfolio learning as a consequence of its personal and non-prescriptive approach. Not only could outcomes of learning be practice-based and multidisciplinary, the portfolio supported reflective and (in some cases) collaborative learning.

Most participants felt the CPD portfolio was a progressive development, and better suited to reflective approaches and practice-based learning than the Faculty's previous framework. Reflection on learning needs could be effectively translated into learning objectives in the PDP. Explicit criteria, such as performance standards, key areas of work and good public health practice, helped to focus this reflection. Learning objectives were tangible outcomes of reflection and indicators of learning and practice development that could guide self- and peer appraisals.[10] Also portfolios have been shown to stimulate the writing up of critical reflections and follow up in learning based upon those reflections.[11]

In some cases, experiential learning and reflection were seen by interviewees to benefit from peer support groups, e-discussion groups and learning sets. Dialogue in learning sets helps to allay concerns about what evidence participants should select for assessment and ultimately how it will be used by the authorities for appraisal and revalidation purposes.[12] E-portfolios have stimulated reflection and feedback in postgraduate health professionals and have illustrated the importance of mutual trust in relation to formative and summative assessments.[13] Because of the high stakes of revalidation, none of the interviewees felt able to ignore formal CPD requirements as they assembled portfolio evidence to demonstrate their learning. Few, however, treated the portfolio merely as a paper exercise: the simple logging of hours and types of CPD activity to satisfy the Faculty's monitoring process.

Within the portfolio framework and with varying degrees of alacrity and success, members were trying to balance personal learning and practice development (that they viewed as integral to their professionalism) with the

regulatory aspect (that they felt was essential to their accountability). The Faculty may have under-estimated the sea change that such innovations often imply in the learning culture of medicine. The portfolio scheme would allow doctors, if they so wished, to complete a minimal portfolio, i.e. evidence of accredited activities and the overall points returned. Learning in practice, however, must be evaluated with reference to criteria that lie outside the bureaucratic framework and relate to educational process as well as outcomes.[5,14]

Participants in the portfolio recognized that excessive preoccupation with the categorizing and weighting of educational events could detract from intrinsic learning and practice development. The multiple purposes of the portfolio – essentially, to uplift the quality of all forms of learning and to offer formats to 'count' accredited learning – suggested to some that anomalies would continue to arise. Thus, the Faculty was advised to keep the portfolio scheme under review. To realize the learning potential of recording and reflective activity, participants would need to build experience of portfolio learning, highlight necessary refinements and receive effective guidance and support.

Training in the use of portfolios for learners, their mentors and assessors was seen to be needed, and is consistent with other studies.[4,15] Exploitation of the flexibility of the CPD portfolio ultimately demands that participants develop a working understanding of the educational aims and principles that underpin this approach. Thus, in its portfolio induction and guidance, the Faculty would need to address members' doubts about the nature of reflection, its relationship to learning in practice and whether it exists when no change in practice is obvious. The concept of personal learning implies awareness in the learner of the role of subjectivity in defining the limits, relevance and value of CPD. As those who were well advanced with the Faculty's portfolio had begun to discover, personal learning is what they themselves see as meaningful and appropriate to their practice.

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