‘Practice Professional Development Plans’: general practitioners’ perspectives on proposed changes in general practice education

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SUMMARY

Background. *The Chief Medical Officer has presented a report proposing a change in general practitioners’ education towards a ‘Practice Professional Development Plan’, which, in principle, is based around formal needs assessment, practice-based learning in areas identified by those involved, and with the potential for multiprofessional learning. This aims to replace the present system of a financial allowance earned by attending a certain amount of educational activity.*

Aim. *To study the opinions of a group of general practitioners attending a course that included workshops that introduced and considered this educational initiative.*

Method. *Semi-structured interviews four weeks after the course.*

Results. *Educational benefits were clearly seen, while issues such as funding and time will present difficulties in implementation.*

Conclusions. *This proposal was seen as an improvement to the existing postgraduate educational allowance system. To maintain enthusiasm, successful introduction will depend on the issues of support and resources.*

Keywords: continuing medical education; general practitioners; financial allowance.

Introduction

IN the area of continuing education for general practitioners (GPs), evidence for effective learning is limited and few studies show change in clinical behaviour.[1-3] The imposed Contract of 1990 represented a threat to GPs’ income; for example, through the reduction of seniority payments and the requirement of ‘targets’ for certain activities to be met before income could be maintained.[4] At the same time, GPs then had to attend 30 hours per year at educational sessions to claim the postgraduate education allowance (PGEA). Originally conceived as a grant through which GPs could purchase high quality education, this was regarded as ‘stolen money’ through being tainted with the Contract, and was generally regarded as earned income. ‘Education’, therefore, was achieved as cheaply as possible and usually followed a non-interactive lecture format.[5] It also disenfranchized the growing numbers of non-principals and tended to be uniprofessional in focus.[6]

In 1997, the Chief Medical Officer (CMO) published a draft consultation document proposing a change in general practitioners’ education towards a ‘Practice Professional Development Plan’ (PPDP), based around formal needs assessment, practice-based learning in areas identified by those involved, and with the potential for multiprofessional learning. In other words, this is an approach supported much more by principles of effective adult learning[7,8] that has now been formally accepted by the government.[9] It is important that this initiative is welcomed as a valuable one, and in the longer term must be shown to improve patient care. A possible stumbling block to such a culture change, at a time of low professional morale, is that this may be seen as further imposed, rather than negotiated, change, and therefore resisted.

In May 1998, the first two days of the annual five-day GP refresher course (advertised nationally and run by the Bath GP Educational Team) contained presentations by two of the educational leaders who contributed to the CMO’s report (a copy of the draft document was sent to participants as pre-course reading), and involved small group sessions to discuss participants’ reception of the idea of PPDPs. Other sessions addressed ‘significant event auditing’[10] as a means of needs assessment, and included a ‘critical appraisal skills’ workshop. A final small group session developed further ideas for participants’ own PPDPs.

This project proposed to explore the perceptions about the introduction, implementation, management, and evaluation of PPDPs of participants who attended these two days.

Method

Qualitative methods were used as these are seen as appropriate for in-depth explorations of experiences and expectations of the individuals to be studied.[11]

The subject group comprised 19 GP principals from throughout the United Kingdom (UK). All agreed to participate, and 15 were interviewed within the timescale of the study. Seven were female, eight were male, and the mean age was 41 years (range = 29–63). The GPs were interviewed via the telephone; these calls were carried out at a prearranged time in surgeries or at home by AC and recorded by a Geemarc TR5 Telerecorder. Data were collected using semi-structured interviews focusing on areas identified as important by the researchers and also regularly publicized as problems for GPs today. Participants were encouraged to share their perceptions, while the researcher could influence the direction. Interview questions were open-ended and non-directional in order to focus on the perspectives of the participants. Most interviews lasted 15–25 minutes and were audiotaped and transcribed verbatim.

Analysis was carried out using qualitative data analysis, which included coding and categorizing to identify recurrent themes and key issues important to the participants. Such thematic

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analysis is specifically designed to obtain rich data and to gain the perspectives of the participants.[12] Transcripts were scrutinized and analysed through the constant comparative method: each section of data was compared with every other. The data were examined for patterns and variations in ideas.

Consent for tape-recorded interviews was sought. Anonymity was guaranteed and participants were assured that they could withdraw at any time. Any data were kept confidential on request.

To ensure that the study reported a true reflection of the participants' beliefs, a summary of their comments were presented to participants at the conclusion of the interview to confirm that their ideas and perceptions were accurately recorded. Further triangulation of the results was conducted through comparisons and discussions between the interviewer and two researchers (JP and IH) to enhance validity.

The project took one month to complete.

Results

First impressions

All participants regarded the means of introduction of the proposed change as informative and stimulating. The contributions of the speakers, from their position of involvement, were particularly valued, and comments about the course supported the positive responses to an independent evaluation:

'It was interesting to hear it from "the horse's mouth" so to speak. I thought the fact that the people who were talking were actually on the working group meant that what you got was undiluted, what people really thought should happen.' (G7.)

'I found it very stimulating. It fired up enthusiasm for PPDPs and significant event auditing. I stayed awake the whole way through!' (J10.)

'When I first saw "practice development plans", I thought I'll never be able to do that, but we were led through it very well, and it made a lot of sense.' (N14.)

Advantages of the proposed system

Benefits to patients, the population, and the practice team, as well as individual doctors, were well recognized:

'It's going to take one hell of a lot of work to organize, and there is the time and cost implications of that, but the advantages are that you can see it's going to be relevant to the needs of the local population and individual's concerns.' (D4.)

'The new scheme is more about a team and vision, with the involvement of all members of staff with various levels of ability and requirement.' (H8.)

Being encouraged to reflect on performance within a sphere of 'ownership' was recognized as a potential benefit:

'It forces you to look at what you are doing at present and set yourself targets, rather than independent targets which have been set for you. It makes you look at what we do now and try and make some goals; PGEA doesn't necessarily do that at all.' (M13.)

'PPDP, I think, will encourage people, because they will feel that they're being given back a sense of being in control of their own education. I think previously they have felt frustrated that a lot of what they do is not recognized.' (E5.)

The PGEA was generally seen as a point-collecting exercise, not linked to meaningful needs-based education:

'The present system is narrow-minded in its thinking. It doesn't necessarily identify people's strengths and weaknesses, it just asks GPs to carry out educational activities which they may or may not be good at choosing for themselves.' (L12.)

'I think PGEA is all about "bums on seats", unfortunately. The future is about addressing your weaknesses and trying to do something about them.' (B2.)

Disadvantages of the proposed system

The ability to attend courses further afield and meet GPs from other parts of the country was valued by the majority. 'Good' education could be selected by motivated individuals under this system, and concern was expressed that this could be lost in the change:

There are good things going on … this is a good course. What would happen to courses like this? Would they still exist in the future? This course existed because I paid for it — my money went towards it. Will that be possible in the future? Nobody knows where the money for this work is going to come from.' (C3.)

I wouldn't want all my learning to be practice-based because I think the good side of PGEA is actually the courses I've been on at other centres … you meet other people and exchange views… A benefit of the existing system is the opportunity to get away from your practice.' (E5.)

However, as a means to an end, the PGEA could be obtained relatively simply;

'The advantage of the old scheme is that you simply notch up the 30 hours and that's it. The advantage of the new scheme is that if you truly are interested in developing an idea within medicine, it can, in a way, develop yourself more.' (A1.)

Needs of the proposed system

Inevitably, concerns were focused around the availability of protected time in which to carry out this work; the issue of funding locum cover for both doctors and attached staff was a real worry.

'The only block would be finding time for the meetings … we are a very 'bread and butter' sort of practice, doing an awful lot of day-to-day stuff.' (A1.)

Other concerns related to attitudes of 'other people' involved. Interestingly, all doctors felt that, while this was an important potential problem, this was likely to apply to practices other than their own:

*'People don't like doing things differently, and are fearful of change, so they need to know what it's about.' (*C3.)

'I don't like to use the word, but "cynicism" springs to mind, expressions like "old habits die hard", and people being in a groove and not keen to get out of it.' (B2.)

Fear of change imposed for unclear reasons, without consideration of resource implications, was strongly identified by many participants; for example:

'If you are going to introduce change, it has to be seen in its best light. I think audit was introduced in absolutely the wrong way, as a kind of punitive thing, and all the negative

sides of doing audit seemed to be advertised, rather than the potential gains… It has to be adequately funded and explanations made, because if it's just, "Look boys, this is another change; you've got to do it; there's no time or money set aside for it" you'll have a zero response to it.' (D4.)

Two-thirds of responders felt that outside assistance to guide the practice would be important, particularly in smaller practices. The majority identified the general practice tutor as the most relevant person, although concerns were expressed about the need for people seen as more qualified:

'I think the provision of an accessible mentor is important. You have to have sufficient people with the educational skills, and to some extent, general practice experience … an important point is not that they work it out for you, but that you work it out for yourself, and, in association with an external assessor, adviser, or mentor, work out whether it is appropriate, whether you have missed things, and plan the implementation and resourcing.' (G7.)

'I like the idea of having a mentor to guide and encourage me. In a bigger practice, it might be easier to do it in-house, but we're just a small two-person practice — not big enough to encourage each other.' (J10.)

The future — moving forwards

There was a general strong hope and expectation that the new system was 'an opportunity to be grasped', and could, given adequate resources, achieve what PGEA has failed to do;

'I suppose if you are acting collectively as a practice looking after each other's personal development, it's going to be an extra catalyst to keep momentum going, and hopefully will have a "knock-on" effect on patient care.' (A1.)

'In our particular practice, we wouldn't have a problem because we are very forward-looking, enthusiastic doctors, always trying to raise our standards … we would sit down, work it out, sort it out, and do it. Although sometimes perhaps with some resentment, but we would do it.' (H8.)

'I suppose it [draft document] is very open, and we have an opportunity of trying to paint on a "blank canvas" to start with. I think the profession has an opportunity to try different pilot schemes and do different things — it's not a didactic paper, and that's quite an exciting opportunity.' (L12.)

Looking beyond the practice towards larger primary care groups was identified by one responder:

'In the future, it's going to be what's going on in the primary care group. Perhaps there will be a "primary care group development plan", and the primary care group may identify weaknesses in certain practices that they would wish to change.' (C3.)

In summary, the main emergent themes, derived from the majority of participants, are listed in Box 1.

Discussion

Although by the nature of this course this group cannot be seen as representative of all GPs in the UK, the changes in education proposed by the CMO were generally seen as welcome and valuable. Furthermore, as a group supportive of the proposal, *their* perceptions of the needs and difficulties of this approach are particularly noteworthy.

Various themes clearly emerged. The proposal was believed to be educationally sound and was received positively. The difficulties were centred around the nature of and dealing with change; the need for planning; the issue of resources, especially the need for funding to allow the time commitment; and involvement of the practice team as a whole, including GP non-principals and part-timers presently excluded from PGEA. The existence of different employment conditions and perceptions about 'rewards' may contribute to a lack of commitment from non-medical team members, highlighting the need for rationalization of the many funding streams for continuing development of practice team members.[6,13] Concern was expressed about the role of health authorities in 'approving' plans that could conflict with the individuality of practices. It was felt important that opportunities to attend high-quality 'formal' courses should not be lost.

The medical educationalists most frequently identified at the heart of this proposal were GP tutors, who themselves will have educational needs to be addressed. With the coordination of GPs into primary care groups (PCGs)[14] (identified in the context of the study area by one participant), there is scope for each PCG having a dedicated educational lead.

Many attempts to introduce change into general practice are less successful than intended because theoretical principles[15] and knowledge about the psychological aspects of change are either violated or ignored.[16] While the implementation and subsequent effectiveness of such principles may vary with the nature and

Advantages of the proposed system:
- Personal and active involvement
- Emphasis on teamwork
- Identification of needs
- Addresses weaknesses
- Collective benefit; e.g. pooling funding
- Potential for 'ownership'

Disadvantages of the proposed system:
- Uncertainty about resources
- Time-consuming
- Difficulty in accessing support
- Speed of change
- Fear of change
- Information/communication gaps
- Risk of conflict with GP educators
- Risk of conflict with health authorities
- Uncoordinated funding for team members

Needs of the proposed system:
- Availability of trained mentors
- Enthusiasm
- Funding for time and resources
- Administrative support
- Communication channels
- Overall primary care development plan
- Recognition of weaknesses
- Fitting in with team aspirations
- Evaluation of effectiveness

Moving forwards — views:
- 'A system likely to deliver'
- 'Will help learn about patients'
- Possible need for arbitration
- Responding to suggestions
- Achieving relevance
- Need for change in existing system
- Success will relate to team effectiveness

Box 1. Emergent themes

type of practice, a few common recommendations appear to persist for effective change, which requires ingenuity and wisdom in responding to the needs of those involved, including co-workers, clients, and related personnel.[17] Perceived risks must be examined in detail against benefits, and the speed of feedback about the change process to all stakeholders is of great importance.[18] Finally, techniques for encouraging collaboration in innovation based on explicit team member involvement, trust towards colleagues in working towards the change, receptiveness to positive and negative feedback, and a realistic approach to benefits and costs to individual team members should be considered fully.[19]

Conclusions

The PPDPs were seen as an advance in general practice education; this approach was perceived to be feasible, relevant, of potential benefit to patient care, and likely to encourage team-based learning; in other words, as intended by its proposers. The limitation of the study through the self selected nature of the study group creates, as a strength, high validity to their perceptions of the disadvantages and blocks. After recent professional difficulties stemming from imposed change, it would be unwise for planners and policy-makers to ignore the real obstacles identified by a group of 'allies to the cause'.

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