The Professional Development Program of the Australian College of Rural and Remote Medicine

Melissa Crampton, *BAS, MPH, is Program Manager (Standards), Australian College of Rural and Remote Medicine, Brisbane, Queensland.*
David Wilkinson, *MBChB, MSc, MD, PhD, MRCP, FAFPHM, FACRRM, FRACGP, is Professor, Pro Vice Chancellor and Vice President, Division of Health Sciences, University of South Australia.*

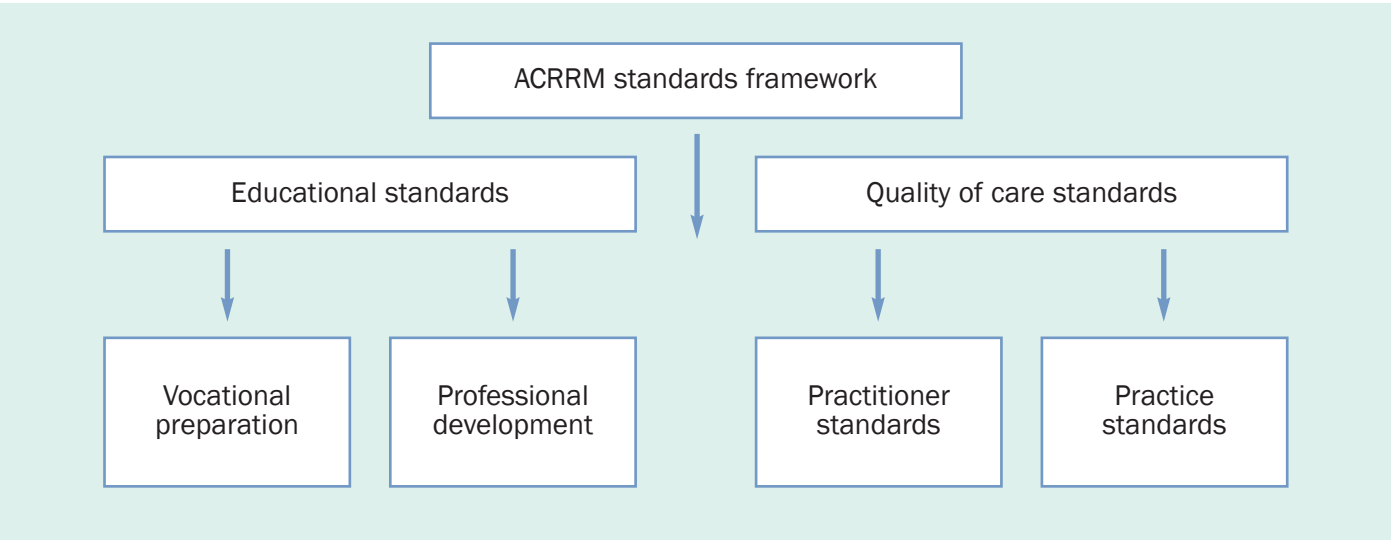
BACKGROUND The case for doctors' performance and maintenance of competence are issues of increasing importance for the profession, governments and communities. There is also increasing public expectation that the profession will be pro-active in protecting patients from under performing doctors. The Australian College of Rural and Remote Medicine (ACRRM) positions itself as the arbiter of standards for rural and remote medical practice and has assumed responsibility for providing a mandatory Professional Development Program (PDP) for its Fellows.
OBJECTIVE This paper outlines the steps taken by the ACRRM to design and develop a PDP.
DISCUSSION The PDP aims to enable doctors to participate in a range of continuing education activities that enhance their clinical, management and professional skills. Participation is mandatory but the program is designed to be flexible and responsive to the range of practice characteristics in rural Australia as well as to individual needs. The PDP includes categories on continuing medical education, quality assurance and clinical assessment (with minimum compulsory requirements), practice assessment, educator activities and educational development activities. The PDP will evolve over time to meet the needs of doctors and communities in rural and remote Australia.

Doctors' performance and the maintenance of competence throughout their careers are issues of increasing importance for the profession, governments and communities. In addition, there is increasing public expectation that the medical profession will be pro-active in protecting patients from under performing doctors.

The Shipman case in the United Kingdom[1] provides a high profile and extreme example of the failure of the profession to police itself. A less extreme example of the profession failing to maintain adequate standards is that of avoidable mortality in paediatric cardiac surgery in Bristol.[2] Both of these examples expose critical systematic failings. The majority of learned medical colleges in the developed world have established continuing medical education (CME) or professional development programs (PDP) for their members and fellows[3] in response to a recognition that modern medicine develops at a very rapid rate.

Without structured programs it is difficult for doctors to remain up to date with their knowledge and skills. Documented participation in a PDP offers a learned medical college the opportunity to demonstrate to government, peers and communities that members are working to maintain standards. Some colleges provide voluntary CME, others mandate PDP participation and others have introduced recertification.[3,4]

As an arbiter of standards for rural and remote medical practice in Australia, the Australian College of Rural and Remote Medicine (ACCRM) has developed a PDP for Fellows of the College. This paper provides an account of how this program was developed and describes the program.



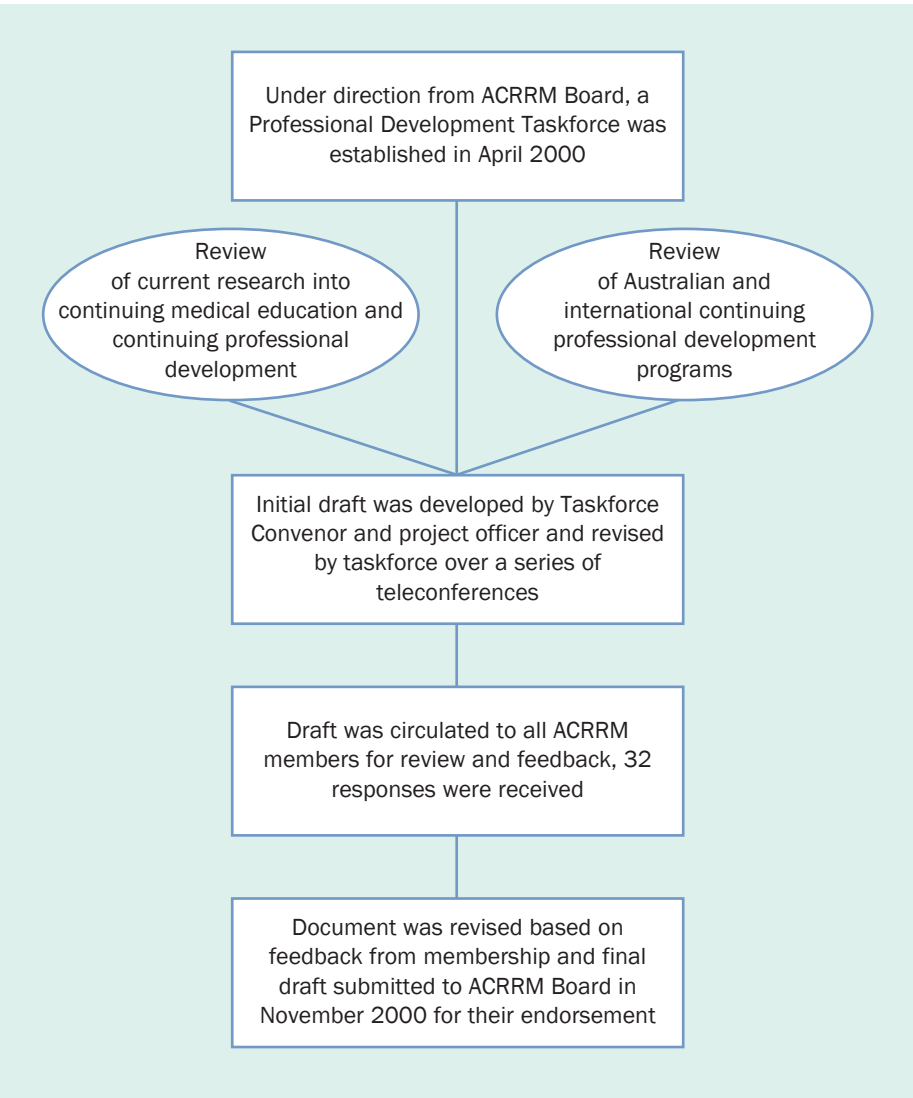


Figure 2. Overview of the PDP development process

Program development

The ACCRM Board has developed and endorsed a framework for the development of professional standards (Figure 1) that includes educational standards and quality of care standards. Using this framework, the ACRRM Board developed terms of reference for a taskforce to develop the PDP.

The PDP is the result of a substantial planning and consultation process (Figure 2). The ACRRM Board selected the Taskforce Convenor and assigned a project officer and administrative support for the taskforce. The taskforce comprised of ACRRM members who had responded to a request for expressions of interest, and who are located in a broad range of locations in Australia. Taskforce members included both general practitioners and specialists in rural practice.

Initially a detailed and critical review of the international literature on CME/PDP programs was done. This was followed by a study of the experience of most learned medical colleges in Australia, New Zealand, United Kingdom and North America, through review of their websites, published program information and contact with relevant staff.

The taskforce met regularly by tele-

conference over several months to work through the key principles and issues and to develop a series of drafts of the PDP. Broad input from rural doctors was obtained in late 2000 through circulation of advanced drafts of the program to the ACRRM membership base and via discussion in open forum at the 2000 ACRRM Annual General Meeting.

National and international trends in PDP

Our literature review confirmed the wide variation in methods of professional development in different countries and health care systems. However, as shown by Peck et al,[5] common features do occur in these programs.

- There is a move away from CME (or clinical update) to continuing professional development (CPD) that includes medical, managerial, social, and interpersonal skills.
- CPD is a process of lifelong learning in practice.
- Although international systems vary in detail, there are common features of content and process that permit international mutual recognition of activities in professional development.
- Most systems are based on an hours related credit system.
- Where revalidation or recertification of practitioners is required, demonstration of CPD is an integral part of the process.

A number of critical issues emerged from the review and consultation process that followed.

How can CPD best be achieved?

Self directed learning

Recent studies on adult learning and behavioural change of medical practitioners have concluded that PDP should be learner centred and should facilitate learning based on educational needs identified by the individual.[5,6] Self directed learning involves the individual taking responsibility for initiating and directing their own learning. This is in contrast to traditional teacher centred, didactic approaches that concentrate on the delivery of educational events, instructing the doctor on what should be known.

The literature also widely advocates the use of tools such as learning planners or learning portfolios to assist doctors to define their learning needs and to identify appropriate strategies to meet these needs.[5-9]

Educational activities

Over the past decade, systematic reviews of the literature have been conducted by Davis et al,[10-12] Oxman et al,[13] Freemantle et al,[14] and Thomson O'Brien et al[15-18] which have evaluated the effectiveness of CPD activities in changing physician behaviour and improving patient outcomes. The cumulative evidence clearly indicates those methods that are effective in bringing about change in behaviour and those which have limited usefulness. Generally, educational activities should be linked to the work that doctors do and should incorporate adult learning principles.[19,20] The most effective methods identified include: interactive educational meetings, outreach visits, the use of opinion leaders and multifaceted activities (eg. outreach visits plus reminders). Less effective strategies include: audit with feedback, distribution of educational materials and local consensus processes. The least effective methods are also the most commonly used and include formal CME conferences and lectures that do not include a range of enabling or practice reinforcing strategies.

Program outline

The design of the ACRRM PDP has been based on a consideration of the best available evidence from the literature, current best practice of modern learned medical colleges regionally and internationally, and strategies that meet the unique lifelong learning needs of Australian rural and remote doctors. Thus, the program sets out to achieve the following objectives:

- ensure rural and remote doctors participate in a range of continuing education activities which enhance their clinical, management and professional skills throughout their careers
- be flexible and responsive to the range of styles of rural and remote medical practice in Australia and the individual needs of the practitioner
- provide a formal record of ongoing educational activities which demonstrates to patients, peers, government and the community that rural and remote doctors are active participants in continuing education and quality assurance activities
- provide formal documentation for rural and remote doctors to demonstrate their participation in professional development activities for purposes such as maintenance of vocational recognition, licensure, clinical privileges and revalidation.

Key features of the ACRRM PDP

A perfect method for assessing performance and maintenance of competency does not yet exist. However, the best evidence recommends practitioners develop a planned program of ongoing learning based on assessment of practice needs, using a variety of learning tools and incorporating continual reflection on, and adjustment to, the learning plan. The ACRRM PDP has been designed with these principles in mind:

- participation is mandatory for Fellows of the College
- the program occurs over a three year cycle with a minimum of 100 PDP points to be accumulated within this period
- the program is based on a points credit system to encourage professional development activity that is of proven benefit and demonstrates participation

Table 1. Activities and credits among categories of the PDP

Category	Activities	Credits
CME (maximum 60 points)	Scientific meetings	1 point per hour (max 30)
	Local meetings	1 point per hour (max 30)
	Remote learning	1 point per hour (max 30)
	Self directed learning	1 point per hour (max 30)
	Planned learning projects	1 point per hour (max 50)
QA and clinical assessment (Minimum 20 points, maximum 90 points)	Clinical audit	20 points per completed audit
	Clinical attachment	2 points per hour
	Peer review groups	20 points per completed cycle
Practice accreditation/reaccreditation		40 points per triennium
Educator activities (Maximum 70 points)	Teaching medical students	1 point per hour (max 40)
	Supervision of registrars	1 point per hour (max 40)
	Development of education programs	1 point per hour (max 40)
	Formal research project	1 point per hour (max 40)
	Publication of work	20 points per work (max 40)
	Scientific presentation	oral 10 points(max 40)
		poster 5 points (max 20)
	Presentations to nonmedical audiences	10 points first presentation (max 30)
Educational development (Maximum 70 points)	Masters and PhD	50 Masters, 70 PhD
	Other university courses	maximum 40
	Nonclinical short courses	1 point per hour (max 30)

in the program to key external stakeholders
- individuals will use a learning planner to qualify and quantify the scope of their professional practice in three domains: clinical, academic, and management
- the learning planner will be used to identify learning needs defined by the individual's current and future professional directions
- educational activities to address these learning needs are to be chosen from five categories:
  - continuing medical education
  - quality assurance and clinical assessment
  - practice assessment
  - educator activities
  - educational development
- all Fellows must obtain a minimum of 20 points over three years in quality assurance or clinical assessment activities
- to ensure the ACRRM PDP is not burdensome, and recognising that many ACRRM members are Fellows of other colleges, there will be substantial cross accreditation with similar programs run by other medical colleges which are recognised by the Professional Development Committee.

Recognised professional development activities

In recognition that the PDP needs to cater to a broad range of doctors working in varying practice situations, a diverse range of activities is included in the educational component of the program. Participants are generally free to participate in the educational activities of their choice, however, the ACRRM has attempted to encourage the uptake of evidence based educational activities through the use of a weighted points system and the inclusion of some mandatory components (Table 1).

Future directions

The ACRRM PDP will be gradually implemented in 2001 with the first triennium formally commencing in 2002. All Fellows will be automatically enrolled and required to participate in the program from 2002 onwards. Fellows subsequently admitted to the College will be enrolled in the year following admission.

Over the next 1-2 years the ACRRM envisages the operation of a web based PDP with electronic registration and submission of reports, together with information and linkages to a wide range of PDP opportunities, including online distance education activities. Additionally, the ACRRM intends to

expand the PDP to include a broader range of quality assurance and clinical assessment options, designed specifically for rural and remote doctors.

Conclusion

The introduction of the PDP by the ACRRM reflects the high priority the College places on CPD. The PDP demonstrates the ACRRM's commitment to ensuring rural and remote doctors are able to maintain and enhance their performance and competence throughout their careers and, in turn, deliver high quality care to their patients. Participation in the ACRRM PDP ensures Fellows are engaged in a process designed to keep them abreast of the clinical, technological and structural changes facing doctors. Importantly it provides the ACCRM with a means of formally recognising practitioners who pursue quality in their professional lives. The ACRRM PDP will undergo continuous review and improvement, based on experience and feedback, and will also be formally evaluated.

Acknowledgments

Members of the ACRRM Professional Development Taskforce included: Dr Greg Down, Dr Juliusz Buras, Dr Chris Pearce, Dr Louise Baker, Dr Bob Noll, Dr Chris Turner, Dr Peter Love, and Ms Vicki Sheedy. Thanks to Anna Nichol and Chris Pearce for reviewing earlier drafts of this manuscript.

References

1. Horton R. The real lessons for Harold Frederick Shipman. Lancet 2001; 357(9250):82-83.
2. Smith R. Regulation of doctors and the Bristol inquiry. Br Med J 1998; 317:1539-1540.
3. du Boulay C. From CME to CPD: getting better at getting better? Br Med J 2000; 320:393-394.
4. Peck C, McCall M, McLaren B, Rotem T. Continuing medical education and continuing professional development: international comparisons. Br Med J 2000; 320:432-435.
5. Schon D. Educating the reflective practitioner. London: Jossey Bass, 1987.
6. Fox R, Bennett N. Continuing medical education: learning and change: implications for continuing medical education. Br Med J 1998; 316:466-468.
7. Holm H A. Quality issues in continuing medical education. Br Med J 1998; 316:621-624.
8. Mathers N J, Challis M C, Howe A C, Field N J. Portfolios in continuing medical education: effective and efficient? Med Educ 1999; 33:521-530.
9. Stanley I, Al-Shehri A, Thomas P. Continuing education for general practice. Experience, competence and the media of self directed learning for established general practitioners. Br J Gen Pract 1993; 43:210-214.
10. Davis D A, Thomson O'Brien M A, Freemantle N, Wolf F, Mazmanian P, Taylor-Vaisey A. Impact of formal continuing medical education: do conferences, workshops, rounds and other traditional continuing education activities change physician behaviours or health care outcomes? JAMA 1999; 282(9):867-874.
11. Davis D A, Thomson O'Brien M A, Oxman A D, Haynes R B. Changing physician performance. A systematic review of the effect of continuing medical education strategies. JAMA 1995; 274(9):700-705.
12. Davis D A, Thomson M A, Oxman A D, Haynes R B. Evidence for the effectiveness of CME. A review of 50 randomised control trials. JAMA 1992; 268:1111-1117.
13. Oxman A D, Thomson M A, Davis D A, Haynes R B. No magic bullets: a systematic review of 102 trials of interventions to improve professional practice. CMAJ 1995; 153 (10):1423-1431.
14. Freemantle N, Harvey E L, Wolf F, Grimshaw J M, Grill R, Bero L A. Printed educational materials: effects on professional practice and health care outcomes. Cochrane Library, Issue 3. Oxford: Update Software, 2000.
15. Thomson O'Brien M A, Oxman AD, Haynes R B, Freemantle N, Harvey E L. Audit and feedback versus alternative strategies: effects on professional practice and health care outcomes. Cochrane Database of Systematic Reviews. Cochrane Library, Issue 3. Oxford: Update Software, 2000.
16. Thomson O'Brien M A, Oxman A D, Haynes R B, Freemantle N, Harvey E L. Audit and feedback: effects on professional practice and health care outcomes. Cochrane Database of Systematic Reviews. Cochrane Library, Issue 3. Oxford: Update Software, 2000.
17. Thomson O'Brien M A, Oxman A D, Haynes R B, Freemantle N, Harvey E L. Local opinion leaders: effects on professional practice and health care outcomes. Cochrane Database of Systematic Reviews. Cochrane Library, Issue 3. Oxford: Update Software, 2000.
18. Thomson O'Brien M A, Oxman A D, Haynes R B, Freemantle N, Harvey E L. Educational Outreach visits: effects on professional practice and health care outcomes. Cochrane Library, Issue 3. Oxford: Update Software, 2000.
19. Cantillon P, Jones R. Does continuing medical eduction make a difference? Br Med J 1999; 318:1276-1279.
20. Knowles M S. The modern practice of adult education: from pedagogy to andrologogy. 2nd edn. New York: Cambridge Books, 1980.

AFP

CORRESPONDENCE

Professor David Wilkinson
Pro Vice Chancellor and Vice President
Division of Health Sciences
University of South Australia
North Terrace
Adelaide, SA 5000
david.wilkinson@unisa.edu.au