OCCASIONAL PAPER 63

Portfolio-based Learning in General Practice

ROYAL COLLEGE OF GENERAL PRACTITIONERS

Published by
The Royal College of General Practitioners

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Report of a Working Group on Higher Professional Education

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Charter

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"To encourage, foster, and maintain the highest possible standards in general medical practice and for that purpose to take or join with others in taking steps consistent with the charitable nature of that object which may assist towards the same."

Among its responsibilities under its Royal Charter the College is entitled to:

"Encourage the publication by general medical practitioners of research into medical or scientific subjects with a view to the improvement of general medical practice in any field and to undertake or assist others in undertaking such research.

Diffuse information on all matters affecting general medical practice and establish, print, publish, issue and circulate such papers, journals, magazines, books, periodicals, and publications and hold such meetings, conferences, seminars, and instructional courses as may assist the object of the College."

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Editor's Preface

HIGHER education in Britain has been fairly clear cut for most of this century consisting largely of a Bachelor's degree in Arts or Science awarded by an institution of higher learning and obtained for most adults between the ages of 18 and 22 after attending a university or polytechnic for three, sometimes four years. The degree is based either on an examination, usually taken at the end of the course, or on continuing assessment. Previous experience at home or at work has traditionally been disregarded and failure in the examination, after a second attempt, has usually left the student with no recognition or qualification at all. After a first degree, a few adults move on to Master's degrees, usually taught but occasionally by research thesis, and some to doctoral theses, most commonly the PhD or in medicine the MD, MS or MChir.

This system has many strengths; notably it has produced a quality of graduate respected around the world and superior to those in some other countries. In medicine, heavy emphasis on the examination and a system of external invigilators and examiners have led to consistent performance so that in Britain it is virtually never suggested that the graduates of any particular medical school are superior to those of other schools. The university system was best when encouraging reflective seminars, and for most of those attending university it was a pleasant important transitional time in which many of what are today called 'intellectually transferable skills' such as the use of literature, critical analysis, and précis and report writing skills were first obtained.

However, during the 1970s and 1980s the system was increasingly challenged: first because it provided an education for a small minority (10%–20%) of the population, when the demand for more places was real; secondly, because it concentrated the intense experience of higher education predominantly on young adults over a short period; and thirdly because it devalued or ignored what for some students were important learning experiences obtained earlier in their lives.

The traditional systems came to be seen as somewhat rigid, and possibly biased against women, who may need more flexible options, in both time and place. Learning in one institution was not easily shared or transferred to another, although medicine has traditionally been more flexible in this respect. The main criticism of the traditional degree, however, has been that it has to be taken in three or four year bites and at an age when not all adults are maximally able to benefit. It is generally recognized that mature students both benefit greatly themselves and also enrich the courses they attend.

Modularization

The theoretical and practical response to these issues has been the steady development, especially within the newer universities, of modular courses for adults. These provide greater flexibility, both in terms of choice of topic and relevance to learners. Each module is separately assessed and learners build up a series in order to achieve degrees that they see as more related to their needs at times more suitable to their circumstances.

Modularization of first degrees and Master's degrees is developing quickly and is likely to become the main, perhaps predominant, method of learning since its flexibility is so attractive to adults and its cost control so attractive to government. The increasing proportion of adults now attending the hundred odd universities who are aged over 22 has challenged the Government, which is unable to finance students on the same basis as before and is slowly but steadily privatizing student fees and course expenses. Thus the proportion of fee-bearing, self-financing students is steadily rising with a greater number living at home to save costs.

These educational developments have a significance far beyond university degrees. Modularization of higher education builds a new bridge with the professions which are themselves seeking more flexible ways of helping members to keep up to date in a society characterized by ever increasing change (Toffler, 1970).

Separately and independently but for ever more powerful reasons, all the professions have decided that continuing education needs to be more formal and needs to be systematized. Most professional people cannot go away for long periods to distant institutions, however exciting or however challenging the education they offer—most people have to obtain their continuing education within reach of their home and work.

It is the special role of registered charities to promote good works and the professional bodies which are registered charities have a special duty to give a professional lead. Royal colleges, whether in music or in medicine, set standards and so naturally the intellectual leadership and emotional drive for making more sense of the educational arrangements for general practice has come since 1952 from the Royal College of General Practitioners and the university departments of general practice.

Having toyed initially with undergraduate education the College fought for vocational training and achieved success by Act of Parliament in 1977 (Gray, 1982). From then on the College concentrated on continuing education for established principals which resulted in: the drive for quality (Irvine, 1983), the delineation of

the parameters of quality (RCGP, 1985), and culminating in the measurement of quality in general practice through fellowship by assessment (RCGP, 1990a). Once there was national agreement on what constituted excellent general practice then immediately a new logic for all continuing education was set in place.

In its Educational Strategy for General Practice (RCGP, 1990b) the College set out its stall and placed great emphasis on higher professional training. In an appendix to the Strategy, it argued the logic of the case for higher university degrees and for the first time defined the modular approach, specified the endpoint of higher professional training, and offered a framework of core modules and optional modules with the dissertation becoming for the first time an integral part. In this way College and university thinking was harmonized.

The College's Educational Strategy was led by Dr W McN Styles, then Chairman of the Education Division, now Chairman of the Council of the College, who writes the Foreword to this *Occasional Paper*. As divisional chairman he formed a number of working groups and asked Dr Roger Pietroni to lead one in order to explore the practical aspects of higher professional education, to see how it could best work in practice and in particular how it could fit in with the real life working conditions of a general practitioner in the NHS.

This working group has now produced a report which clarifies and takes far further the concept of modularization, setting it in a framework that has come to be widely known as 'portfolio-based learning'. The essence of this is that the doctor completes a series of units of learning, modules or portfolios which are built up over time and accumulated in a form which is appropriate to the learner and which can ultimately be recognized by a professional body such as the College. Furthermore, these ideas have been tested in practice.

A major problem in adult continuing learning is support and advice and the Higher Professional Education working group rightly places great emphasis on a colleague, friend or 'mentor' fulfilling this role. Thus a new kind of educational partnership between colleagues can be encouraged.

It is however unfortunately true that even educational advances as important and original as this carry the danger of educational side-effects. This *Occasional Paper* did not have an easy ride among its assessors, not because anyone doubted the importance of greater flexibility, of modularization or portfolio learning, nor the particular importance for general practitioners spending a professional lifetime in one practice. The educational questions which arose came from a different direction and related particularly to the question of how far continuing education in any form for any profession could be separated from the needs of 'consumers' and the needs of society—whilst acknowledging, of course, that the professions must organize their own education. Nevertheless, the particularly close relationship between medicine, and especially general practice, with the National Health Service meant that some clear relationship between continuing education, the needs of patients and the improvement of patient care would sooner or later need to be established.

The second issue of principle is the one of standards. Some of the assessors took the view that whilst encouraging adult learners to move and to improve was an entirely laudable objective, there was nevertheless a need to relate that movement and the standards of care achieved for patients to some external objective standard appropriate to a Royal Institution. In music the academic Royal Colleges define standards of performance quite specifically for a number of instruments and qualifications: in medicine the issue is the patient. Even a happy learner who believes he has improved, or hopes that he has improved, cannot in effect judge himself or herself: there will need to be some relationship with external standards of practice. That relationship has not yet been resolved in the College and is now open for discussion.

It is thus possible for different general practitioner enthusiasts coming from different educational positions to take quite different views on this document. While some believe that it is an enormous and dramatic advance, others believe that it might weaken the standards issue. Yet others take an intermediate position and see the College as pioneering a new form of education which will have to be refined and developed over the years.

Occasional Papers are discussion documents which seek to bring to general practitioners new ideas and challenges. Whatever the views of individuals, it is important that these issues are debated not just in 14 Princes Gate but in surgeries up and down the land. This interesting document is well placed to initiate that debate.

November 1993

DENIS PEREIRA GRAY
Honorary Editor

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Foreword

In its educational strategy, published in 1990, the Royal College of General Practitioners identified the development of higher professional education as an important priority. In doing this it recognized the limitations of current arrangements for basic medical education and vocational training in preparing doctors for careers in general practice. As a response, the Education Division of the College established a working group, under the chairmanship of Dr Roger Pietroni, to explore how higher professional education might be provided and how participation in it might be recognized. The group spent over two years considering educational developments in professions other than medicine, and obtaining information and views from those directly involved in the training and education of established general practitioners throughout the United Kingdom. It arranged three workshops during which it was able to test its thinking with those interested in medical and other forms of adult education.

The group quickly recognized the importance of ensuring that doctors were able to acquire and retain skills in maintaining their own continuing learning throughout their professional lives. The concentration of their work was on what is learnt rather than what is taught, and the need for general practitioners to be able to continue to learn and to adapt in order to take account of increasing and rapid change in clinical practice and in health service organization.

Principles of adult learning

Early in its work, the group highlighted the importance of incorporating the principles of adult learning into higher professional and continuing medical education. Members recognized the need for adults to act and learn autonomously and for educational activities to utilize the past experience of participants so that they can build upon past learning. They recognized the importance of education and learning in relating directly to the day-to-day responsibilities of the general practitioner so that lessons learned can be translated directly into improved care of patients. The active participation of learning was also recognized as important, not only in promoting learning but in ensuring that it is an enjoyable experience.

Central to the group's work was the recognition that portfolio-based learning fulfils many of the essential principles of adult education and also recognition of how it might be adapted for the continuing education of established doctors. The group devoted a substantial amount of time to relating portfolio-based learning to general practice, and in introducing it to a wider audience of general practitioner teachers and learners. These ideas were well received at the group's workshop meetings and many of those attending quickly began to incorporate them into their own educational repertoires.

The essential features of portfolio-based learning are clearly presented in this *Occasional Paper* together with concrete examples of their application, both in vocational training and as part of continuing medical education.

Portfolio-based learning should not be regarded as an easy option in comparison with more traditional forms of medical education. It makes demands upon the learner and its success depends considerably upon individual effort. It is a very individualized form of education and, as the group has highlighted, fulfils all the principles of adult learning. A key element is providing opportunity to reflect on the learning process. This is enhanced when undertaken at regular intervals, when progress can be reviewed with another person or mentor. Suggested arrangements for the guiding of learning by mentors were presented by the group.

Looking forward

Roger Pietroni and his colleagues are to be congratulated for the way in which they have shown how the principles of adult learning can be introduced into continuing medical education through the concept of portfolio-based learning. This *Occasional Paper* provides an excellent opportunity for their ideas to be presented to a wider audience. The hope must be that this publication will stimulate others to pursue and to explore further this, and other forms of learner-centred education. There is a danger at present that continuing medical education will become locked into a formalized and rigid system which the contractual arrangements for the postgraduate education allowance (PGEA) may reinforce. Portfolio-based learning provides an opportunity to break free from such incipient inflexibility for there are opportunities for individual portfolio plans to be approved for PGEA purposes, as has started in some parts of the United Kingdom, for example Leicester, North West Thames, South East Thames and Yorkshire.

The work done by the higher professional education working group of the College's Education Division, presented in this *Occasional Paper*, represents a considerable achievement. It should be of benefit to regional advisers and associate advisers and to general practitioner tutors as they develop a range of opportunities for postgraduate and continuing medical education in their own localities. They will be able to build upon the foundation created by the working group in extending further the ways in which portfolio-based learning can be adapted and in promulgating its widespread use by individual doctors.

DR W MCN STYLES
Chairman, Education Division 1989–1992
Chairman of Council 1993

Reference

Royal College of General Practitioners (1990) An Educational Strategy for General Practice for the 1990s. In *A College Plan. Priorities for the Future. Occasional Paper 49*. London, RCGP.

Introduction

THE Working Party on Higher Professional Education was established in 1990 by the Education Division of the Royal College of General Practitioners, under the chairmanship of Dr W McN Styles. Its remit was to research into aspects of higher professional education (HPE). It focused on three areas: the provision of higher professional education, educational strategies, and assessment and accreditation. In exploring learner-centred educational strategies, the working group focused on portfolio-based learning at three successful workshops. As a result, a great deal of interest has been stimulated in portfolio-based learning and it is currently being used in vocational training and continuing medical education, as well as undergraduate medical education.

What is it?

Portfolio-based learning is a technique of personal learning. 'Portfolio' is a term derived from the graphic arts and is a collection of evidence which demonstrates that personal learning needs have been fulfilled. The technique is learner-directed and hence particularly suited to autonomous adult learning and the postgraduate education of professionals.

Portfolio-based learning emphasizes the importance of experience as an opportunity for learning and recognizing learning needs. It is recommended that the learner should work with a mentor to clarify these needs and formulate learning plans. The mentor will also facilitate the process of learning and validate the material presented in the portfolio. Mentoring requires skills and training akin to those of non-directive counselling.

Assessment can be carried out in portfolio-based learning using the completed portfolio as evidence of the work undertaken and the learning achieved. The standards applied must take into account the learner's objectives rather than an externally set syllabus. Accreditation can be awarded for a study of sufficient quality and quantity for the purpose for which it was submitted. This might be, for example, to qualify for postgraduate education allowance, or to receive credits towards a diploma of higher professional education.

Practical applications of portfolio-based learning in vocational training and continuing medical education are described in this paper and suggestions are made for its use in fulfilling the requirements for the postgraduate education allowance.

Principles of higher professional education

This paper is founded on two basic tenets. The first affirms the imperatives of professionalism, and the second asserts the validity and relevance of the principles of adult learning.

General practitioners as a professional group have a responsibility to maintain high standards in all aspects of their work. Definitions of clinical competence for general practitioners include the ability to engage in self-directed learning, self-evaluation and quality assurance. Professional good conscience demands the pursuit of clinical excellence and the ultimate aim of all professional learning is to improve the care of patients.

> Continuing education should respond primarily to the needs of the health system, which in turn should respond to the needs of the people. It should also answer the needs of health workers striving to maintain and improve their professional competence (Katz and Snow, 1980).

Thus the individual professional has a responsibility for his own continuing education and this responsibility is consonant with the principles of adult learning. The principles most relevant to learning in general practice include the following (Knowles, 1980; Popper and McIntyre, 1983; Brookfield, 1986):

- Adults are competent to choose what and how to learn. They have the ability to initiate and carry out learning tasks independently of their teachers.
- The most potent motivation of learning comes from the need to know, which arises from the problems exposed by everyday experience.
- Adults wish to apply newly acquired knowledge and skills to their immediate circumstances in order to improve their performance.
- Experience is a rich resource, but exposure alone does not guarantee learning. Reflection, recording and discussion with peers are ways of enhancing the depth and quality of the learning that ensues.
- Uncertainty and the challenges which it poses are not an obstacle but rather a stimulus to adult learning. Mistakes are not seen as the learner's failure but valued as a powerful means of identifying further learning needs.
- The teacher's role is to facilitate the processes of adult learning rather than to direct and provide the content. A relationship of mutual respect and trust is necessary for this facilitation to be effective.
- Facilitation may involve assisting the learner in the definition of learning needs and the formulation of learning plans by clarification, challenge and approval. It also involves validation of learning which has been achieved.
- Adult learning may be assessed against personally set standards which can be more appropriate but no less stringent than external criteria. This requires explicit learning objectives to be set and evidence of learning achieved to be provided.

Professionals need to develop skills of self-education as well as training. The word 'training' implies specific skills to be learnt and goals which are narrow and fixed; it addresses the need to achieve minimum standards of performance. Training implies learning a set of predictable responses to predictable situations. An established practitioner needs to move beyond training to develop skills of self-education, and needs the skill and competence to generate appropriate responses to unpredictable situations. In this paper, we do not talk of continuing medical training: we have therefore found it preferable to use the wider concept of education.

CHAPTER 1

The present state of continuing medical education

If the licence to practice meant the completion of his education, how sad it would be for the practitioner, how distressing to his patients! More clearly than any other, the physician should illustrate the truth of Plato's saying that education is a life-long process (Osler, 1900).

THERE exists, within the United Kingdom, a defined structure for both undergraduate and immediate postgraduate education in all the component crafts of the medical profession. Criticism may be levelled at the specific construction of this education. For example, is undergraduate education over inclusive and are the educational aims and techniques outdated? Do junior doctors really receive adequate training in supposed training posts when much of their time is taken up with service commitment to the NHS? Nonetheless these criticisms do not detract from the existence of a structure and a common aim, which is to produce a competent doctor and craft specialist.

In general practice, after vocational training has been completed, there exists no formal career structure and no clear plan or pattern to ensure continued educational progress and professional development. This deficiency is a matter of considerable importance within the Health Service. The quality of provision of care by general practitioners will, to a great extent, be determined by the success or otherwise of continuing medical education after vocational training has been completed. Since the time spent in general practice after vocational training often exceeds 75% of a doctor's career (from entering university to retirement), it is important to address the existing ad hoc arrangements for continuing medical education and, if these are found wanting, to propose methods which may offer better quality and more relevant learning opportunities and, as a consequence better opportunities for personal educational progress and professional development, and ultimately better patient care.

At present a major limitation of the mandatory three-year vocational training programme is that, normally, it provides only one year's experience within the setting of general practice. Inevitably, much remains to be learnt after the general practitioner has become an established principal. The College of General Practitioners (1966) and the Royal Commission on Medical Education (Todd, 1968) recognized this particular problem when they recommended a five-year period of training for general practice, three years of which should be in general practice and two in hospital posts. A commitment to, and progress in, professional development by the provision of relevant continuing medical education for general practitioners after the completion of vocational training is a matter of some national importance within the Health Service and one that requires careful planning. Indeed so important was it seen to be at the foundation of the College of General Practitioners (General Practice Steering Committee, 1953) that involvement in continuing medical education was made a condition of continuing membership (although this has never been monitored).

Early approaches to continuing medical education

Although regional advisers in general practice were appointed in the late 1960s, their time was occupied with the growing emergence and development of vocational training. As a consequence, the provision of continuing medical education (CME) for general practitioners was organized by clinical tutors who laid on programmes for general practitioners which had little input from general practitioners themselves. Despite this, the number of educational activities grew and were accompanied by good attendances. The disappearance in 1977 of the financial incentive of linking attendance to seniority payments led to falling attendances (Wood and Byrne, 1980). Reviews of programmes of continuing medical education revealed that they were often inadequate and inappropriate. Wood and Byrne (1980) and Pickup et al. (1983) identified many shortcomings for general practitioners and showed that basic adult educational principles were being ignored and "rarely applied". They found that continuing medical education programmes did not "focus on general practitioners' specific learning needs" and were "unsystematic". The learning methods did not "take into account learners' preferences" and evaluation was "not widely accepted" and essentially absent.

During the 1980s, an attempt was made to structure and supervise continuing medical education programmes. A review by the Department of Health and Social Security (1984) led to the development of regional general practice subcommittees which became responsible for CME policy under the overall responsibility of the regional postgraduate medical committee and the regional postgraduate dean. Regional advisers were given the task of implementing the subcommittee's policies and became budget holders. This dual role has led to an unresolved debate and conflict between the provision of continuing medical education and its accreditation and regulation. Often, continuing medical education is still being seen as something to be provided to essentially passive learners.

Postgraduate education allowance

The influence of the successful vocational training programme and the gradual emergence of the general practitioner tutor (Berrington and Varnam, 1987) has led to attempts at defining priorities and strategies for continuing medical education (Berrington, 1987; Branthwaite et al., 1988; Regional and Associate Advisers in General Practice, 1989). The introduction of the postgraduate education allowance as part of the general practitioner contract (Health Departments, 1989), linked participation in a rolling

programme of continuing medical education over a five-year cycle with a doctor's level of remuneration. At first glance, this would suggest a recognition within the Department of Health of the need for protected time with appropriate financial support in the general practitioner's contract to allow for professional development and an organized system of continuing medical education; unfortunately, this does not appear to be the case for a least four reasons:

1. The postgraduate education allowance was created from money redistributed from the pool of seniority payments, and was seen by the profession as merely a renaming of an allowance already received and earned.
2. The *Statement of Fees and Allowances* sets out an approval system and set of regulations (DoH and Welsh Office, 1989; paras 37.1–37.22) but does little or nothing to foster continuing medical education on accepted principles of adult learning. For example, it does little to encourage small group learning, or to emphasize the importance of involvement in performance review and medical audit, and certainly does not address a general practitioner's personal educational needs and the consequent necessity of planning to meet those needs.
3. The postgraduate education allowance merely provides a limited financial reward for time served attending an 'educational activity' and not for the learning and subsequent appropriate professional development.
4. There is no specific provision within the new contract for protected education time in the general practitioner's working week.

At present, in most regions, the large number of applications for approval of postgraduate education allowance activity has meant that this is based in the main upon the scrutiny of written applications. The flood of applications that greeted the new general practitioner contract almost overwhelmed the existing regional adviser structure, which was ill-prepared for the uncontrolled explosion of applications that occurred. Approval systems had to be constructed overnight, and, not surprisingly, these could not guarantee anything other than minimum standards based upon the written evidence presented to them—it was a re-active not pro-active situation. At the same time a multiplicity of organizers sprang up overnight creating large volumes of unrelated educational activities, of very variable quality, and this led to a fragmented approach to continuing medical education in some regions. Many regions are now attempting to retrench by constructing, in broad terms, their plans for continuing medical education in the immediate future. These plans are concentrating on improving the quality of events approved for postgraduate education allowance by:

1. Increasing general practitioner involvement in the planning and running of meetings; for example, insisting that a local general practitioner must be involved in setting up all PGEA-accredited events in a region or subregion.
2. Improving the relevance of content, which previously tended to be orientated towards hospital practice, by attempting to insist that the areas covered are relevant to general practice.
3. Encouraging learner participation by creating pressure to avoid teaching methods that are too didactic.
4 Preventing late changes in programmes that will affect the relevance of the material to those who have elected to attend.
5. Preventing pharmaceutical and other commercial agencies using PGEA activities as a primarily promotional, rather than educational exercise.

New initiatives

Progress is being made but much more needs to be done if continuing medical education is to become genuinely responsive to the needs and aspirations of general practitioners. There is still too little emphasis on current theories of adult education which underwrite the view that education should be based on the previously acquired knowledge and experience of the learner and take into account the learner's needs and preferred learning styles (Knowles, 1980; Brookfield, 1986). Much of the present system of continuing medical education provides education based on the teacher or educator, rather than the learner and does not allow the learner to participate, easily, in the design of the learning.

Young principals' groups (Rhodes, 1983; Holmes, 1984; Stott, 1984; Edwards et al., 1988) have already identified one way forward, organizing continuing medical education in small groups based upon the perceived needs of the members of each group. In the Republic of Ireland, Boland (1991) has had considerable success organizing similar groups for established principals.

These are important initiatives but there remains an urgent need to develop alternative models for providing a structural framework for appropriate education which meets general practitioners' needs and reinforces or enhances their perceptions of their need for further learning. One model already exists (outside undergraduate and postgraduate medical education) and this offers a possible solution to many of the existing deficiencies within the postgraduate education system for general practice.

CHAPTER 2

A way forward

Freedom to learn is the first necessity of guaranteeing that man himself shall be self-reliant enough to be free (Franklyn D Roosevelt, 1938).

I have learned throughout my life as a composer chiefly through my mistakes and pursuits of false assumptions, not by my exposure to founts of wisdom and knowledge (Stravinsky, 1966).

CONTINUING medical education should help doctors reflect creatively on their learning. The content should match the needs of the learners, who should feel sufficiently motivated to return to their practices and appraise their work critically. These recommendations on continuing medical education were made by the Leeuwenhorst European Working Party (1980) over ten years ago; they also reflect current views on adult education (Knowles, 1980; Brookfield, 1986; Boud, 1988).

The familiar and traditional model of medical education has emphasized the content, rather then the process of learning. In this model, goals are made explicit and broken down into operational objectives. Assessment is then carried out by measuring the attainment of these objectives. Such an approach has been termed "freedom from distraction" (Boud, 1989).

An alternative approach provides a wider perspective and a focus on the learner rather than on specific content or the completion of a course. When personal and professional development are viewed as goals, considerable responsibility and autonomy are expected of the learner. This model of adult education has been expounded by a number of writers: Knowles (1980), Brookfield (1986), Boud (1988) and Hammond and Collins (1991); it embraces the concepts of androgogy and self-directed learning (Knowles, 1980, 1986). It builds on the concepts of humanistic psychology (Rogers, 1983; Boud, 1989), emphasizing both the importance of viewing the learner as a whole person and the role of the peer learning community. The value of work in small groups and the creation of a safe and trusting learning environment are highlighted. These schools of thought recognize the importance of prior learning which the learner brings to each new learning opportunity. This prior learning derives from life and work as well as from formal education experiences.

Portfolio-based learning

Since 1984, portfolio-based learning (Boud et al., 1985; Redman and Rogers, 1988; Simosko, 1991) has been introduced successfully into various areas of adult learning (Bainbridge, 1988; ASSET, 1991; Tallantyre, 1991). The term 'portfolio' was taken from the graphic arts and describes the collection and storage of evidence gathered by an individual in his or her role as a learner. The collection of experiential evidence by the individual learner is relevant as a potential source of learning, but the critical intellectual task is that of moving from a description of an experience to the identification of the learning derived from that experience and ultimately to deciding what further education is required to fill in gaps revealed by the analysis of the described experience. This is a demanding exercise and, in the model under discussion, may well require the skill of a mentor to promote the process.

Portfolio-based learning recognizes:

1. The value and significance of past learning and experience for the individual
2. The ability of adults to act and learn autonomously
3. The centrality of reflection in the learning process
4. The need for meaningful links to be made between experiences, learning opportunities and role requirements.

The steps in the process of portfolio-based learning are:

1. Identification of experiences which the learner defines as significant, namely important sources of learning
2. Identification of what learning arose from these experiences, and
3. How that learning can be demonstrated in practice
4. Identification of further learning needs, and
5. Ways in which these can be met.

Portfolio-based learning is relatively new to medical education but already its potential is being realized at all levels from undergraduate training to continuing medical education. It refects the philosophy of adult education and the models of experiential learning contained in the work of Kolb and Fry (1975) which emphasize the central role of reflection in the learning process: learning experiences are followed by a period of critical reflection; this leads to the formulation of abstract concepts and generalizations. These in turn give rise to new learning which may be tested through active experimentation.

Kolb and Fry (1975) have emphasized the importance of reflection in learning and two methods that encourage reflection are debriefing (through the use of a mentor) and keeping a diary or log. A log may form part of the portfolio but it is not synonymous with a portfolio. The portfolio needs to document not only the experiences but also the evidence that learning has taken place.

The portfolio approach is being used in other areas of adult learning. The nursing profession produced a framework for postregistration education and practice—the PREPP report (UKCC, 1990) and later the English National

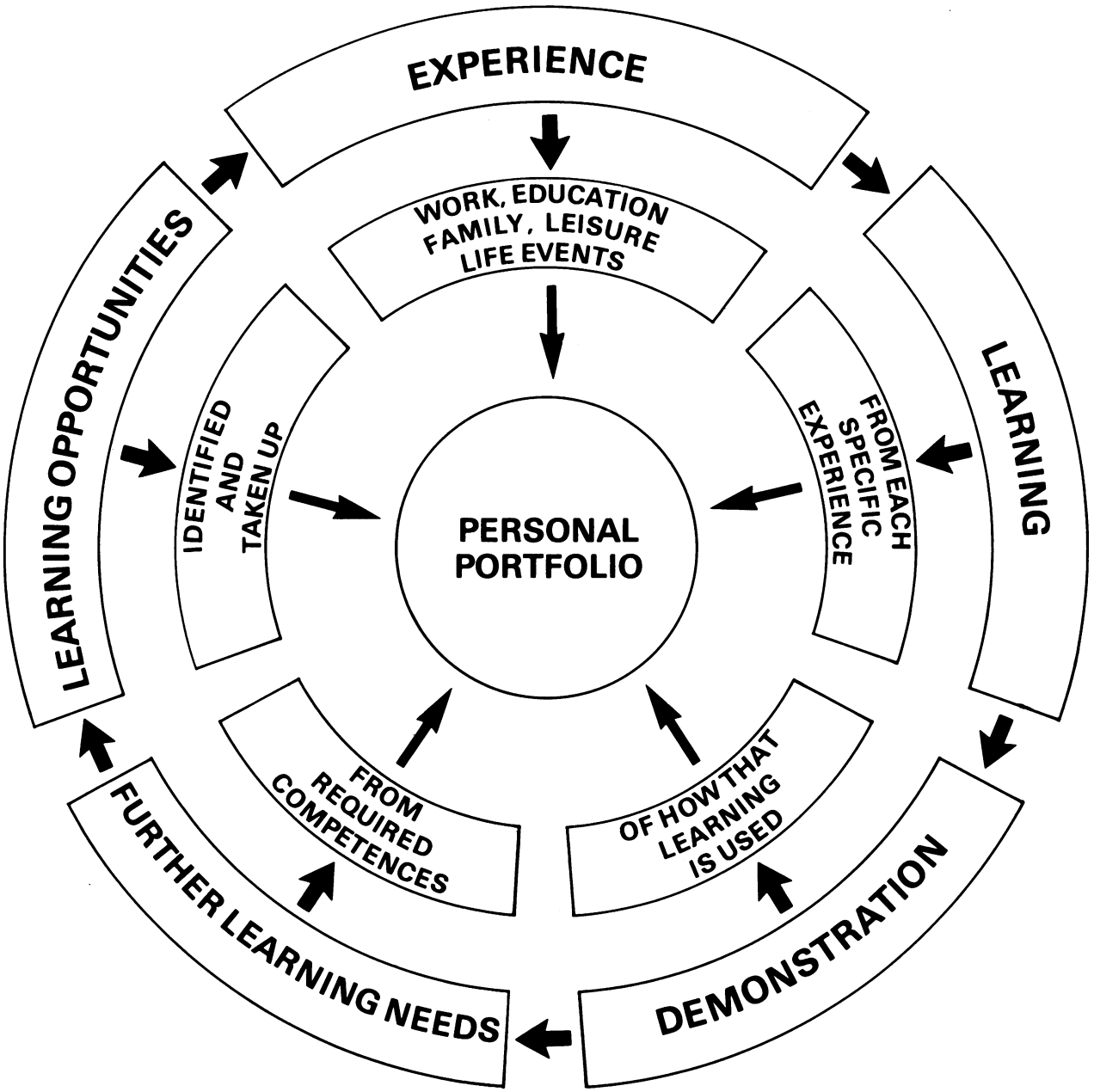

Figure 1 The complete portfolio model.
Source: Redman W and Rogers A (1988). Reproduced with permission of Warren Redman and the National Youth Bureau.

Board for Nursing, Midwifery and Health Visiting (1991) produced a professional portfolio. Its purpose was to help its members plan and implement their continuing professional education through record keeping and encouraging the development of critical and reflective practice. It is also a method of accreditation. It adopts a rather prescriptive approach and seeks to define the content of the portfolio.

Other exciting developments include the MOCOMP project in Canada (Parboosingh J, personal communication) and the triadic approach in New Zealand (Thomson et al., 1993). Both systems are methods of accreditation. The former encourages a wide range of learning methods but gives more weight to learner-centred methods. The latter is based on three participants—learner, mentor and assessor—and attempts to measure the outcomes of the learner-directed programme.

The personal portfolio model is shown in diagrammatic form in Figure 1.

Documentation

The learner must attempt to document experiences or learning opportunities at or soon after they occur—otherwise they can be lost to reflection, either because the individual distorts them owing to the simple passage of time or, alternatively, they are diluted by subsequent experiences.

Evidence that learning has taken place comprises the portfolio itself. Thus one can distinguish between the portfolio-based learning process and its physical expression, which is the material contained in the portfolio. Any materials which can provide evidence that learning has been translated into practice are acceptable. For example, a general practice portfolio may include any of the following together with analysis of the learning which has derived from them:

- Workload logs
- Individual case descriptions
- Family profiles
- Videos
- Tapes
- Patient satisfaction surveys
- Audit projects
- Research projects
- Account of change or innovation within a practice
- Description of teaching experience
- Commentary on books, papers, reports, including imported learning from novels, poems, and so on
- Evidence of relevant learning from personal as opposed to work experience.

Examples of some of these are shown in Chapter 6.

An educational plan

The building of a personal portfolio will, of itself, be a demanding exercise and should be considered part of the educative process. It will allow an individual doctor, at a particular point in time, to make an estimate of his or her existing strengths and weaknesses and from there progress to creating an educational plan to promote further professional development (see Chapter 6).

An education plan is similar in concept to a learning contract (Knowles, 1986). It is devised by the learner and for the learner. It may include details of learning objectives, learning resources and strategies and how that learning might be accomplished and assessed. It encourages self-directed learning by giving the learner major responsibility for planning, managing and evaluating the learning. It differs from the traditional educational model where the curriculum is set by the teacher or organization.

The educational plan will include not only topics to be covered but also the rationale for the choice of educational methods to be used. For example, a doctor wishing to learn more about the provision of community care for a patient with rheumatoid arthritis may choose to accompany an occupational therapist on a domiciliary assessment visit. Another doctor who is interested in the immigrant cultures of patients within his or her practice may decide that educational time should be taken to read books which were not written for a medical educative purpose but which will allow the doctor an insight into that culture. This should improve doctor/patient communication by virtue of better understanding of those patients' ideas, beliefs and expectations, and result in a more sensitive service, with potential for increased patient satisfaction.

The educational plan should cover a defined period of time. During that time a careful check on the progress being made within the plan will be required, and adjustments or change in emphasis may need to be made from time to time.

Portfolio material will act as a record of the learner's educational activities and should also provide evidence of whether initial objectives have been met by tasks undertaken. As can be seen, this method becomes self-perpetuating in that reflection on learning achieved and new goals will lead to recommencement of the cycle. Ultimately, this can produce a continuity of professional development which starts during vocational training and progresses right through to retirement from practice.

CHAPTER 3

The role of the mentor

If he is indeed wise he does not enter
the house of wisdom, but rather leads you
to the threshold of your mind (Gibran, 1923).

THERE are a variety of ways in which portfolio-based learning can be organized, for example:

1. One learner can work partly alone, partly with a mentor.
2. A group of two or three learners can work with a mentor and individually. Other members of the group may provide some mentorship.
3. Small self-help groups can work together, as above but without a separate mentor.
4. Individual learners can develop a portfolio with or without the support of distance-learning materials and/or occasional 'tutorials'.

The process of building the portfolio benefits from the assistance of a 'mentor' who enables and facilitates it.

Tough (1979) points out that "learning can proceed very effectively when guided by the appropriate person interacting with the learner in a one-to-one situation" and "for certain subject matter . . . this is the most effective way of learning". The role of the mentor is valuable in helping to identify learning activities and how learning can be demonstrated, in clarifying further learning needs, and in offering support and challenges to the learner. The mentor is not a teacher but a facilitator. He or she will need to resist the need to 'tell' but develop challenging and supportive skills. In the portfolio-based learning process, learning occurs all the time, throughout the process, and not only with the mentor. It is important to realize that each learner can tailor the contents of his or her own portfolio to his or her own learning needs, but the facilitator or mentor will help the learner to avoid the all too common trap of avoiding those areas of greatest need by conveniently denying their existence. There is a great temptation to seek further education in those fields where personal expertise already exists rather than in those areas where pronounced deficiencies are present. It is important that the learner is made aware of this risk even if it does not significantly alter the learner's education plan.

The mentor will need to apply educational theory and principles; one such principle is that adults will only learn what they believe they need to know. Miller (1967) wrote: "the first step . . . is not to tell them what they need to know, it is to help them to want what they require . . . Until they recognize a need to know, it is unlikely that they will learn. If there is no perceived need to change, then neither new information nor vigorous instruction will alter their basic behaviour."

The mentor:

- should offer free and undivided attention and "unconditional positive regard" (Rogers, 1961)
- should respect and be respected by the learner
- should aid and facilitate the learner's honest appreciation of his or her personal professional strengths and weaknesses with relation to his or her work as a general medical practitioner
- should be able to provide counselling when appropriate
- should maintain an objective overview of the learner's performance
- ideally, should have undertaken a portfolio-based learning exercise himself or herself (this may be rather difficult in the early days)
- should document each contact with the learner and feed back this information, and be prepared to discuss it at the beginning of the next meeting
- should be prepared and able to report on the success or otherwise of the learner's initial assessment, education planning and subsequent execution of the education plan
- could belong to a group of mentors who attempt to set uniform standards for facilitating education, who attempt to ensure that these are applied appropriately, and who provide mutual support.

The portfolio learning process

The following presents an idealized account of how the portfolio learning process might take place.

Stage 1

The learner identifies and describes an experience. The mentor facilitates this process by active listening with verbal and non-verbal encouragement, accepting and valuing and being non-judgemental, avoiding interpretation, being sensitive to the learner's non-verbal cues and, if necessary, challenging statements if they are at odds with behaviour.

Stage 2

The learner reflects on his experience trying to identify the learning that occurred; the mentor will facilitate this process, then clarify, summarize and reflect back what the learner has said. At this point it is appropriate for the learner to state whether he feels the mentor has appreciated the points made. It is still very important for the mentor to refrain from interpretation.

Stage 3

The learner looks at ways to go forward by identifying new learning needs and devising a plan to meet these. The mentor facilitates this process using the counselling skills detailed in stages 1 and 2. It may be appropriate to provide interpretation and/or advice at this stage. The mentor may suggest answers but if he does, he should make it clear that they are his answers and not necessarily the answers most appropriate to the learner.

Obviously there are some problems with this non-directive approach to facilitation, and it may be that in certain circumstances the mentor will need to be more rather than less interpretative than the ideal model set out above. Nonetheless it is a model which maximizes the learner's involvement in the education process, and actively promotes the search and acquisition of new knowledge and behaviours.

Alternative models

The mentor/learner model of portfolio-based learning is potentially expensive mainly because of the time commitment the mentor must make to the learner. Equally if portfolio-based learning is to become a widespread educational activity in general practice, there may well be an initial shortfall of mentors with the required skills, especially if, as seems likely, the majority of mentors are general practitioners. Alternative models of applying portfolio-based learning to a wider audience of general practitioners are therefore worthy of careful consideration.

The following examples provide models for alternative portfolio-based learning structures.

1. Co-mentoring

In this model two or possibly three individual practitioners provide one another with peer support, facilitation and encouragement. The intrinsic danger within the system, of explicit or covert collusion to avoid areas of mutual or individual difficulty is a concern that is not easily resolved. Occasionally contact with an external mentor (who could be responsible for several groups—see below), inter-group review or the occasional interchange of co-mentors all provide safeguards.

In the long term, however, if the principles of portfolio-based learning are applied with sufficient rigour, then it would not be unreasonable to expect the process itself to avoid the majority of these difficulties.

2. Small group mentoring

Two possible models present themselves in this area. First, a single mentor could provide support and facilitation to a group of general practitioners who have opted to work together on portfolio(s) but were not enthusiastic about the prospect of co-mentoring one another. This model may be of particular interest to general practitioners working in the same or 'neighbouring' practices. A mentor could then provide support to several such groups of general practitioners.

Secondly, groups of portfolio-based learners could form and resolve to deal with specific areas of mutual need. A mentor's main role would then be to identify groups of general practitioners with similar needs and organize initial contact between group members. The group itself could be expected to provide the majority of support and facilitation. The group would then dissolve when its members felt that their mutual educational need had been fulfilled, and new groups formed to deal with new educational needs.

Interesting innovative projects on mentoring in continuing medical education have been carried out or are about to be carried out in South East Thames (David Whillier), North West Thames (Roger Pietroni), Yorkshire (Jamie Bahrami) and Trent (David Sowden).

CHAPTER 4

Assessment and accreditation

If we wish to discover the truth about an educational system, we must look into its assessment procedures (Rowntree, 1987).

Assessment

ASSESSMENT is an attempt to measure the achievement of a learner. It may be formative, designed to guide the learner towards setting fresh objectives during the learning programme; or it may be summative, designed to establish the quality and extent of learning achieved at a given point in time, often with a view to accreditation. Assessment may be conducted by the learner as self-assessment, or by others as external assessment.

Self-assessment

Self-assessment is a necessary component of independent or autonomous learning (Boud and Lublin, 1983). It is also a necessary part of the process of portfolio learning, and to achieve rigour may need facilitation by the mentor. It is integral to the generation of the portfolio and occurs at all stages of the learning cycle. The learner is saying: "I have acquired this knowledge or mastered this skill and here is the evidence to demonstrate it." The discipline of the portfolio is to make this self-assessment explicit and tangible. The function of the mentor is to facilitate the learner's assessment, challenging the learner whilst at the same time providing support, encouragement and help towards identifying gaps. Self-assessment is also the basis for the identification of further learning needs and the subsequent setting of learning goals for the next cycle of the portfolio-based learning. "You need to know where you are, before deciding where you are going."

External assessment

External assessment is not a necessary part of portfolio-based learning but can be used by any doctor as a method of improving the focus and effectiveness of his or her own continuing education. Mandatory external assessment could remove the self-motivating nature of portfolio-based learning, which is one of its most valuable attributes. External assessment should therefore be voluntary, the learner choosing to submit his work for appraisal. A learner may make this choice for a variety of reasons. For some learners, external assessment provides a goal that encourages perseverance when competing pressures for time would otherwise lead to abandonment of the portfolio. Others may have a need for external recognition of their educational attainments, which may be expressed in a desire for accreditation.

Accreditation

Accreditation implies the application of a consistent standard in the assessment of learning achievement. This may appear to be difficult in portfolio-based learning where the content varies and learning objectives are set by the learner himself. It will require a commitment to separate the concept of achieving a standard from that of reaching a set of benchmarks within a defined syllabus. New and imaginative criteria need to be devised to recognize, for example, the effort expended and 'distance travelled' by the learner, the exploitation of learning opportunities and the recognition of new learning needs. It is important also that the assessment is not confined to looking only at fulfilment of the initially stated objectives; to do so would be to neglect the continuing growth in scope which should occur during a successful portfolio-based study. Objectives may need to change, reflecting unforeseen ease or difficulty and the learner's shifting perspective of what is important. The learner needs to be responsive to his or her own learning. Assessment should also take account of the assiduity and imagination with which the learning exercise was undertaken. "It is not enough merely to have travelled to one's destination, one must also demonstrate the value of the journey itself."

Credit should be given not only for the quality and thoroughness of the work undertaken but also for the level of mastery which is demonstrated. The assessment should be made not just on the portfolio alone but on a dialogue between the learner and assessor. The portfolio is not a thesis but a collection of evidence on which the learner can call to show what has been learnt.

Accreditation need not involve a pass or fail judgement, as used in examinations. Rather the assessor's judgement is whether the study is sufficient in extent and quality to merit accreditation. The portfolio remains 'work in progress' until accreditation is achieved. If accreditation is not awarded, the assessor should discuss with the learner what further work is required to achieve it. Alternatively, different levels of credit ratings could be awarded for work of differing standards.

Use of portfolio within educational institutions

Portfolio-based learning has the potential to be a way of:

- accrediting learning from experience (such experience may or may not include formalized learning programmes)
- providing evidence that learning has improved performance
- identifying further learning/training needs and opportunities.

The concerns of the learner and/or those of any accrediting body which may be involved will determine which of these functions receives most attention. Thus whilst portfolio-based learning may be used solely as a tool for

personal development, it may also be used as a means of external accreditation in so far as all or some of the contents of the portfolio may be externally assessed. These two functions are of course not necessarily mutually exclusive. However, it is important to recognize that they are different types of functions and that emphasis on one will affect the nature of the portfolio-based learning process and the type of 'product' included as evidence in the portfolio. For example, a major part of a portfolio focused on personal development might be a detailed and very personal learning journal. Such a document might not be appropriate to offer for external appraisal; or external guidelines might be used to determine what would count as acceptable documentary evidence within a portfolio; these would reflect the need for clear, shared criteria of assessment and would therefore exclude extremely subjective and personal items.

If portfolio-based learning were to be used as part of continuing education in general practice, there are organizational elements to be considered. Amongst these are:

- The need for a policy statement on the role of portfolio-based learning within the context of the organization (for example, the Royal College of General Practitioners)
- If portfolio-based learning is to be used as a means of assessment, the need to make explicit and public within the organization criteria which will inform this assessment
- The establishment of a process whereby both policy and criteria can be developed through negotiation with appropriate members of the organization.

Without these, the portfolio remains an invaluable tool for personal development but it is unlikely to be able to provide a means of accreditation of the individual by the organization.

If a demand for accreditation of portfolio-based learning emerges, it is clearly within the College's remit as the academic standard-setting body to provide the methodology and personnel to undertake it. This will require the development of new assessment criteria sensitive to this form of learning and training for assessors. It would provide a function for College district tutors that would be distinct from the course organizing role of existing general practitioner tutors.

Valid and reliable external assessment of portfolio-based learning is possible and can be as rigorous as its purpose requires. It should remain voluntary to avoid the danger of assessment distorting the learning. However, acknowledged and respected accreditation should be available to those who seek it.

Such accreditation could be given at the level of a certificate of completion of a portfolio study, or it might consist of credits towards a diploma of Higher Professional Education or a degree such as MSc. The certificate could be recognized by regional advisers as equivalent to a number of hours required for the postgraduate education allowance (PGEA). An example of a PGEA-approved portfolio-based learning plan is shown in Chapter 6. PGEA-approved personal educational plans have been used in the Yorkshire region since 1989 (Bahrami J, personal communication).

CHAPTER 5

The use of portfolio-based learning in vocational training

Four things come not back:
the spoken word,
the spent arrow,
time passed,
the neglected opportunity

Omar Ibu Al Halif, 7th Century Muslim

THE diversity of general practice and the relative professional isolation in which it is carried out means that the general practitioner needs to be self-reliant and self-critical. A training that encourages these qualities will give responsibility to the learner. What is learned and how it is learned should be selected by the learner on the basis of an honest assessment of needs. The teacher's task becomes that of a facilitator, helping the learner to identify problems, tackle them and decide when the problems have been understood or solved.

The change from teacher-led to learner-led general practice education is most likely to succeed if time is made available to develop the required skills, preferably away from the pressures of work. Support, identification of learning resources, and ways of assessing progress are some of the skills needed.

Vocational training is ideally suited to making this change towards a learner-led approach, as time for learning is built into the trainee year and the half-day release course. Trainees bring their own unique knowledge based on at least two years of postgraduate experience.

Trainers are already funded for teaching trainees and they have responsibility for only one trainee in their practice at a time. The personal relationship between trainer and trainee allows the trainee to develop skills to define personal learning needs. General practice is an ideal setting for shifting the emphasis from learning content to learning process.

There is no lack of potential guides or mentors: the trainer or other partners in the teaching practice, peers on the half-day release course and others outside the medical fraternity could all be enlisted by the trainee to support learning ventures.

Learning skills of assessment is an integral part of the training year. Formative assessment given throughout the year by the trainer encourages development of skills of self-assessment. The half-day release course provides further feedback and trainees learn to appreciate the assessments of their peers.

Trainees on the half-day release course welcome the responsibility of controlling the content and conduct of the various sessions (Savage and Savage, 1994). Course organizers may find this change more difficult as it means accepting that learners are capable of assuming responsibility for their own learning and assessment. It may be difficult to surrender to the learners the responsibilities traditionally invested in the teacher.

Personal learning in general practice

The St Thomas's Hospital Vocational Training Scheme, based on a half-day release course, was started 16 years ago and was one of the first schemes in London. It has a tradition of problem-based, small group learning. After several years' experience, trainers and trainees have co-operated with the course organizer to produce a booklet, which is handed to the trainees at the start of their training year in general practice. It includes a section on portfolios (No. 3).

The aims are:

1. To provide a choice of structures that provide a systematic approach to exploring general practice problems from the learner's perspective
2. To help trainees reflect on their learning while they are working
3. To make it possible to explore areas of work and working relationships that might otherwise be difficult or not attempted.

THE BOOKLET

These ideas aim to help you get the most out of your training year. What matters most is not what you are taught but what you learn. Your motivation to learn and develop must now come from yourself. The learning environment has changed from the lecture theatre and wards to the surgery and the need to know comes from the problems you identify while working rather than the external pressures of teachers and examinations.

Many trainees approaching the end of their training say: "I wish I had . . . kept those interesting articles I found . . . kept my first video of a surgery . . . kept a diary of what it felt like starting work as a trainee." They have identified new ways of learning while they are working that would have helped them.

This booklet is offered to help you discover new ways of learning early in your training so that you can map your progress, identify your strengths and weaknesses, and decide on topics for further learning.

Simply following a formula in order to learn is not the answer; indeed the approaches offered here may not suit your way of learning. They attempt to provide a practical structure for identifying learning needs and learning resources which you can modify to suit the way you learn best and that can be used when time is available.

The training year gives you the opportunity to experiment in safety—try some of these ideas so you can form your own opinion of their usefulness.

Aims

1. To develop ways of sustaining life-long professional learning
2. To promote self-directed learning skills
   — identify learning needs
   — formulate learning objectives
   — identify learning resources
   — plan learning strategies
   — assess own learning
   — validate own assessment of learning
3. To concentrate on the process of learning as well as the content
4. To refine knowledge acquisition by:
   — observation
   — examining the understanding and meaning we ascribe to events
   — examining ourselves, our values, feelings and how we are influenced by our experience.

What do I value in my past experience?

You may wish to reflect on your past experience to acknowledge skills you have learned. You may like to identify some important learning episodes in the way described below:

What did you learn?

How did you learn?

- What stimulus made it happen?
- How did it happen?
- What helped it happen?
- What people were involved?
- Why were you receptive?

How did you use what you learned?

- What have you done with the learning?
- What skills have you gained?
- How did you build on this experience?

What do I value in my present situation?

General practice may be very different from your past experience: what strengths, help and support can you identify in your present situation?

Personal strengths

- What are you good at?
- What do you find easy to do?
- Can you list your personal strengths?
- What do you find difficult?

Outside strengths

- What is good about your present situation?
- What people and resources might be helpful?
- What don't you like about your present situation?

How can you contribute?

- What contribution can you make to this situation?
- Don't be modest—this is a rare chance to blow your own trumpet!
- It may help to reflect on what others think about you—if this is difficult talk to someone you trust.

What more do I need from my present situation?

How can I build on my strengths?

1. A personal diary

A personal diary provides a record of your experience. It reminds you of what happened, how it came about, what you were thinking and feeling, and what its consequences were. It can also record your version of the emotion generated in others. It can help you to reflect on the people you work with, their strengths and weaknesses, and your reaction to them.

You can learn from your diary. The act of writing allows you to have a 'conversation with yourself' so that you can understand the situation better.

Re-reading your diary gives you insight into how you are changing. It is like an ECG, it will tell you only what happened at the time of writing but it will allow you to see how you have changed since then and it can therefore allow you to plan or influence future changes.

2. Learning with a mentor

'Mentor' means a wise and trusted adviser, counsellor or teacher.

A mentor is a guide, someone whose reputation, knowledge and experience you value. You choose your mentor and you both agree to work together to identify and tackle a task. Your mentor may not teach you but help you to tease out the problem and find ways of working on it. You do the work, your mentor enables you by:

- helping to clarify difficulties
- supporting
- identifying resources
- encouraging
- praising
- challenging
- reminding you of your strengths and weaknesses
- helping you decide when the problem is solved.

A mentor may be utilized for a single learning episode or

for several different episodes over a long period of time. Eventually you will no longer need the mentor as you outgrow the need for support, but you may remain friends.

The mentor:

- may be any age
- may or may not have experience of the specific problem
- may be a group of trusted peers.

Your trainer may be your mentor for part or all of the trainee year or for longer. But not all trainers can be mentors and trainees may choose different mentors for different problems at different stages of the trainee year.

The trainer has dual responsibility: he is contracted to be a teacher and to ensure the standard of the training received but he may also be able to enter into an open relationship (not governed by contractual responsibilities) that is based on the qualities already described. As a mentor the trainer acts as a witness (rather than a judge) to the actions of the trainee, although the mentor may be involved in assessment if both agree.

3. Portfolio-based learning

A portfolio is a collection of evidence. It may include:

- resources such as articles, videotapes, books and novels, notes about people or situations
- items that jog your memory, for example a theatre programme, a cinema ticket, the name of a patient, a tape of a song, a poem
- opportunities taken or missed
- evidence of learning in progress
- evidence of completed learning
- feelings and emotions generated while learning
- the experience of being a trainee in general practice.

It can:

- become a history of your developments and achievements
- be used to demonstrate evidence of development and achievement to others.

By studying this collection of evidence it may be possible to:

- identify a learning task
- set a learning goal
- identify ways of achieving a goal
- identify learning processes that suit you best
- identify learning resources
- monitor learning tasks as they are carried out
- assess learning achievements
- validate your assessment, for example by discussion.

As a result of this new learning, tasks may be identified and the cycle repeated.

This approach allows learning while working. It values important learning that occurs even if it is peripheral to the task set. It allows for the widest possible variety of learning experience to be used. If documented it could be used as evidence of learning to submit accrediting bodies (but only if *you* want it to be accredited).

This is an important process that incorporates learning into everyday practice. It is not an automatic process and the portfolio could be used to collect information as evidence of change.

The processes the portfolio seeks to aid can be expressed thus:

- Unconscious incompetence
- Conscious incompetence
- Conscious competence
- Unconscious competence.

The processes that portfolio-based learning can demonstrate are shown in Figure 2.

As this may be a new venture for you, here is some advice taken from comments made by students who have kept a portfolio:

- Make a definite time each day or week to work on the portfolio.
- Write, write, write. Write anything. It is the key to success as it makes you start to examine what you are doing.
- Review the portfolio periodically. This will help you to start to focus on areas having got used to recording evidence.
- Start at the very beginning of the trainee year so that you record all changes that may occur.
- If a theme emerges in your writing, examine it and work on it.
- As the portfolio grows, think more and write less; edit it if you want to so you focus on main themes.
- As you make connections with different areas of knowledge you may want to develop your own method of indexing or cross-linking within the portfolio.
- Humour is encouraged, learning is fun, and can easily occur from the absurdities of life.
- Share your portfolio with a trusted peer or mentor. This helps you to reflect and gives another perspective from which to view your progress.
- Concentrate on the good experiences to avoid becoming too introspective.

4. Small groups

General practitioners have found that meeting in small groups to support and learn together has been very helpful. An atmosphere of trust allows difficulties, errors and frustrations to be aired and makes it less likely that they will be ignored, denied or explained away. Doctors become less defensive and better able to cope with the pain of making a mistake when it is shared with others who like and respect them. Mistakes can then be valued so that they become powerful learning experiences.

In this atmosphere it is also possible to acknowledge what is known. This is an advanced state of knowledge that provides an opportunity for learning. It also allows more openness to develop new ideas and approaches to patient

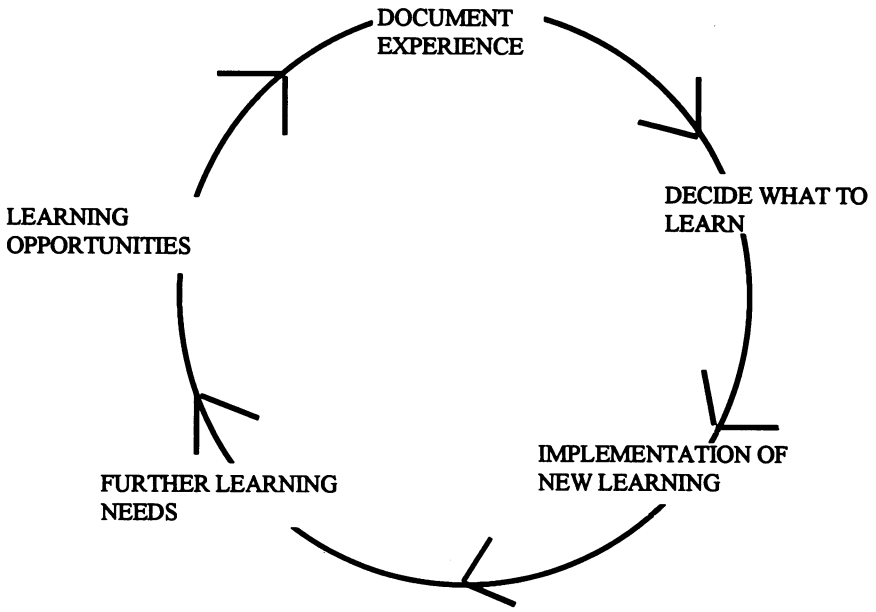

Figure 2 The processes that can be demonstrated by portfolio-based learning.

care. Counselling by the group about difficult relationships (patients or partners) is often valuable, and sharing knowledge of local services is helpful. Small groups can also help awareness of the need to find a balance between professional and personal responsibilities.

The uses of a group can be summarized under three headings:

SUPPORT

- Difficulties with
  —patients
  —staff
  —colleagues
  —self
- Allows risk taking to
  —accept feedback
  —attempt next learning task

RESOURCES

- External
  —new ideas
  —information
- Internal
  —celebration (of positive personal attributes and feelings)
  —witness (self expression)
  —review

PROCESS

- Our own functioning with other people can be examined.

5. Lectures, courses and PGEA

Lectures and courses provide a good way of learning about subjects you know little about.

The learning from a lecture could be incorporated into a portfolio. Some prefer to learn content but it is important to weigh received wisdom and be discriminatory before incorporating new information.

Many doctors attend lectures on subjects they already know a lot about. Are you attending lectures to learn, or are you confirming what you already know?

Most feedback given by those attending courses focuses on the social interaction and the quality of the speakers—don't forget the educational input.

Compare, for instance, the differences between lectures and personal learning with respect to content and choice of method:

LECTURES

- Content chosen by the teacher
- Style of delivery chosen by the teacher.

PERSONAL LEARNING

- Content chosen by the learner
- Method and process chosen by the learner.

6. Learning in the consultation

The most undervalued learning resource available to trainees is the patient.

You learn from patients when you listen and observe. Listening is hard work because you have to give the patient your full attention. It is easy to be distracted by other things, for example, thinking what the diagnosis might be or what potential treatments you might be able to offer. It helps to minimize interruptions and other stresses such as being in a hurry.

We learn best from patients if we suspend judgement about them and their condition. Making a judgement too early on in the consultation puts other agendas (such as

treatment or management) into your mind and makes it more difficult for you to listen to the patient.

The patient will reveal much more information if she/he is held by you in positive regard. An attentive, respectful, interested doctor gleans much more information from patients.

Is what is heard in agreement with what is observed? If there is a mismatch, explore the reasons.

You will learn a great deal from patients if you ask them what they think. If you really want to know what they are thinking, they will, with a little encouragement, tell you. This opens the fascinating field of patients' ideas of illness, support mechanisms, and lay treatments that are just as sophisticated and complicated as medical treatments.

Involvement with patients undergoing momentous events can teach admiration and respect through observation of courageous behaviour. Observing your reactions to patients' dilemmas can give the opportunity for insight into your own attitudes and emotions. This can be humbling as well as uplifting. Sharing part of a patient's sorrow can be very harrowing but, with support, can allow you to cope without becoming hardened or depressed.

Learning from patients can be helped by audiotaping consultations and playing them back to listen to the content and process of the consultation. Videotapes allow non-verbal communication to be included in the analysis. Listening to an audiotape or watching a videotape of a consultation with a group of trusted peers, having first agreed rules for discussion and constructive feedback, is a powerful method of learning from patients about your performance in the consultation.

Asking the patients how the consultation went, or asking them to fill in a questionnaire relating to aspects of communication, could be another method of gaining insight.

7. The Johari Window

The Johari Window (Luft and Ingham, 1955) offers a way of examining our interactions with others (Figure 3).

What others know about you is different from what you know about yourself. If you reveal more of yourself to others they will be more likely to reveal more of themselves to you. You will get to know more about each other and will therefore learn more about yourself.

If you want to learn more, you have to take risks. You may decide to work with a mentor and explore your strengths and weaknesses. This can be rewarding when done in a trusting and supportive atmosphere. You may find that some weaknesses are not seen as such by others and that you have hidden strengths also.

You will share only when you want to and when you are ready to. But if you do, you will be rewarded by being valued and by learning more and in more varied and even surprising ways.

8. Reading skills

New skills are required to deal with the enormous diversity and load of general practice reading. Here are some suggestions you might like to try:

- Set aside some protected time each week for reading.
- Find out about your current reading habits by keeping a log of everything you read for one week.
- Concentrate on how you read: pair up and watch each other reading to find out what slows you up, what you miss and what your reading style is (videotaping yourself reading has been tried).
- Make a decision about what is worth reading and what is a manageable amount to read. Ignore the rest, bin them to be recycled without feeling guilty.
- Build up a file of useful articles. This is a fruitless task unless you develop your own retrieval system that works for you.
- Keep a booklet to note down problems you come across. This can serve two purposes: as an *aide mémoire* when you have time to look it up and to allow larger problem areas to be discovered from patterns of problems that build up.
- Develop an authoritative reading style. Attack books—they often contain only one or two main messages that may even be written on the fly sheet or back cover and that may be all you need. Skim books to assess their worth: by scanning the contents page, by skimming the introduction, by reading a page at random. Use *your* books as your notes: write in them, highlight or underline key sentences, scribble connections with knowledge you already have.
- Identify reading resources: the practice library, your partners' personal books, postgraduate centre library (the librarian is a valuable resource). Computer databases and *Index Medicus* can be useful resources, as can your local bookshop. Good review articles will have references that will give you a quick start for a literature search.

Research articles make many general practitioners feel inadequate yet of all those published there are few that warrant serious attention. A quick method of scanning papers needs to be developed. I ask myself:

- Is the subject important to me? If not, bin it.
- Read the summary. Still interested? If not, bin it.
- Read the last paragraph of the introduction that invariably contains the research question. Still interested?
- Read the first part of the discussion. Are the shortcomings of the paper fairly discussed? If not, it is probably not great research.
- Scan the results. Do they address the research question?
- Scan the method. Does it seem adequate to answer the question posed?
- If I get this far, then I'm going to read the method carefully and study the results in detail.
- If I know about the subject already, then the author's reputation and the references may also influence my assessment of the paper.

Review articles can be a useful way to keep up to date but the authors' opinions will bias the conclusions. A recent American review on the impact of treatment of raised serum cholesterol (Task Force, 1990) reached the opposite conclusion to the English reviewers (Ramsey et al., 1991) reviewing the same research data on the same subject!

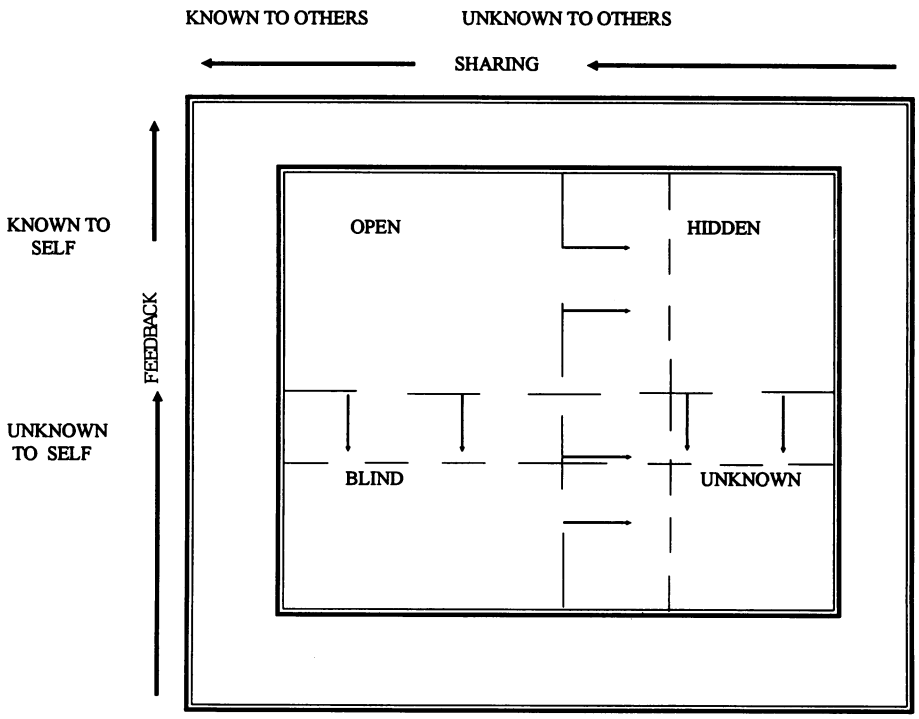

Figure 3 The Johari Window. Source: Luft J and Ingham H (1955).

ONE TRAINEE'S EXPERIENCE

The following are examples of learning using a portfolio compiled by a trainee on the St Thomas's Hospital Vocational Training Scheme.

"As a record of my trainee year to date, I have been keeping an A4 file in which I have recorded tutorials, topics of interest, problematic patients, courses I have attended and important personal learning experiences.

I found it difficult to develop a suitable way of keeping information about quite a variety of things, for example medical facts, discussions regarding patients and the occasional thoughts I have felt compelled to write. After trying to use a small blue hardback notebook and finding it impractical, I settled on using an A4 ring file to which I can add interesting articles and other material and also hand write on A4 paper. To help me find things later and also to keep track of what I have learnt, I have compiled a subject index. I find this system the most practical, although since I have been reading for the MRCGP exam I have accumulated several journal articles which I now file separately rather than in the portfolio.

Although it is sometimes a hassle keeping the portfolio up to date, I have found it worthwhile as:

- By writing things down I reflect on what I have learnt which helps consolidate information.
- Again, it is a useful way of reflecting and thinking about problem patients and developing a plan regarding management.
- It helps me keep track of what I am learning and, therefore, I can see what gaps there are.
- It keeps track of things that need my action, for example, looking up or doing things.
- It is nice to look back and see what sort of things were important at different times over the year and how I have changed.

Although some entries in the portfolio have been totally self-initiated, the majority have been following tutorials or discussion with my mentor (my trainer) or other members of the practice team.

I have really enjoyed my trainee year and in this time have learnt a great many things: diseases and illness, a practice-orientated approach to disease, dealing with people and their lives, my own personal feelings and altered view of life.

My learning has been heightened by my keeping a portfolio which not only houses a factual record of tutorials, discussions about patients, disease and other learning experiences but also contains my thoughts and reflections and the outcome of trying out new ideas learnt. Here are some examples:

Addiction

I regularly saw a patient with anxiety and depression. Relatives phoned to report violent behaviour. Over a period, having discussed him with the partners and having written about these discussions in my portfolio, I realized he was probably addicted to benzodiazepines and alcohol.

I felt uncertain how to use my new insight. I also realized that I knew very little about drugs, dependency or drug withdrawal. I organized a tutorial with my mentor to discuss these problems and how to manage my patient. I decided that I should confront him about his addiction. This was successful in that he admitted to his addictions: in addition to benzodiazepines he was also using cannabis and other illicit drugs. This made sense of his reported violent behaviour and of his manipulative behaviour in the surgery. While being unable to stop his addictions I understood the situation better and was able to modify my role to supportive counselling, sickness certification and to stopping all prescribing.

A little while later I met another young man addicted to benzodiazepines and used ideas from the tutorial to help him reduce his daily intake of 25 mg of nitrazepam to his current level of 2.5 mg on alternate nights. He now feels very well. I have found this experience very satisfying and it has given me confidence to work with other addicts.

Painful red eye

I felt I knew very little about ophthalmology, so I organized a tutorial about diagnosis and management of the painful red eye.

A while later I saw a 30-year-old gentleman with sudden onset of a red painful eye. With great enthusiasm I examined his eye thoroughly, even using fluorescein drops. Being uncertain of the diagnosis I asked one of the partners.

He too was uncertain and hence the patient was referred to the eye clinic. He came back with a diagnosis of conjunctivitis which was somewhat disheartening and left me feeling a lack of confidence and skill.

I reflected on this in my portfolio and in subsequent discussion with my mentor. This showed me that contrary to my initial impression I had learned a great deal; I had been able to examine the patient's eye and had been able to make an accurate differential diagnosis. I continued to lack confidence and this stimulated me to read more about the acute, painful, red eye.

Child sexual abuse

I attended a course on child sexual abuse (CSA) after which I wrote some notes in my portfolio. This included statements from the police inspector and consultant paediatrician stressing the importance of listening to children. Suspicious comments should be taken very seriously and the child should be referred to social workers or police who would call a case conference.

I accepted this advice at face value. Soon afterwards I came across a 4-year-old child with vulvitis. The mother and her boyfriend had itchy anuses; I examined and took swabs from the mother and daughter and both reacted normally and the child did not seem distressed. I thought the diagnosis was probably threadworm and treated the family accordingly. Whilst I was examining the mother her daughter was outside playing with the receptionist, who reported her as saying: "I slept with T while mummy was at the pub". T was the boyfriend. I therefore decided the statement should be taken seriously and discussed what her daughter had said with her mother. Her mother admitted that her boyfriend T sometimes did baby-sit her daughter. She was certain her daughter was not in danger and she was not concerned that she was at risk of sexual abuse.

All swabs and results were normal and the child's symptoms settled with threadworm treatment.

After much thought and discussion with the practice, our social worker and with my trainee group I decided that, despite advice given on the CSA course, I would record the story very clearly in the notes and wait and see what transpired.

Recently I heard that she had presented again with vulvitis. She had been seen by another partner, she had been frightened of being examined, and her mother was also tense and anxious. She was subsequently referred to a consultant paediatrician, a member of the CSA team, and we are awaiting the outcome of her assessment.

It has been a confusing and quite emotional learning experience so far. I think that my actions were correct at the time and I feel angry with the specialists for making such a complex area seem so cut and dried—real life just is not like that.

I found that writing things down at the various stages of this difficult event helped me in my decision making and has provided me with an insightful way of reviewing what happened and what my thoughts were as events unfolded.

Allergic rhinitis

I had problems believing that allergic rhinitis was a real condition, as it was not a readily accepted diagnosis in my hospital jobs. I discussed this with my mentor, who encouraged me to read various relevant articles. This allowed me to begin to accept that such a condition might exist.

Since then I have diagnosed allergic rhinitis and prescribed treatment for it. At least two patients came back to say how much better they were feeling.

Elderly patients

Not having done a geriatric SHO post I felt inexperienced in dealing with the elderly and my portfolio showed few entries concerning the elderly. As a result I had a really inspiring tutorial with a partner in the practice and another with our practice nurse. As a result I became really enthusiastic to get involved with the elderly.

Now, four months later, I find I am seeing many more elderly people at the surgery and regularly visit various housebound patients. I have discovered that once I become interested in something I start seeing many more patients with that something. Individual patients have stimulated my reading for the particular problems concerning the elderly, for example if they have been suffering from dementia, Parkinson's disease or have been in need of social security benefits.

Breaking bad news

In my 'communications' group we looked at a video of a consultation where I gave a very confused message to a lady with a nasty looking lesion on her scalp. I was caught in a dilemma of wanting to be honest about my worries but not wanting her to feel anxious and upset. We discussed ways of approaching this and concluded that giving potentially bad news is often very difficult and that the key things were to:

- Check the patient's worries.
- Be truthful regarding one's own concerns but give a positive message, for example: "I am not sure what this is . . . possibly a cancer but it is great that you have come to see me early and we can get an urgent appointment. If the specialist can see you quickly and remove it . . . the prognosis is good."

I wrote this episode in my portfolio and having pondered on it think that the 'honest but positive approach' can be applied in many other situations.

I have had to write a court report on a fairly volatile benzodiazepine and alcohol-dependent man who is fighting for access rights to see his children. I was anxious about his response to my report but followed the 'honest but positive approach'; in other words, I was honest about his alcohol binges and agitation but positive about the great progress he had made in coming off regular alcohol and drugs in the last three months. I think it was largely seeing the positive things I had written about the hard work he had done recently which helped him to accept my need to be honest about his relapses.

This approach had also worked in telling a lady about finding a CIN III lesion on her cervical smear."

CHAPTER 6

The use of portfolio-based learning in continuing medical education

. . . if, at the moment of our presence there, we could define the results of our experience—if the passage from sensation to reflection—from a state of passive perception to voluntary contemplation were not so dizzying and so tumultuous, this attempt would be less difficult (Percy Bysshe Shelley).

THE present arrangements for postgraduate education allowance (PGEA) do little to encourage a planned programme of continuing medical education for general practitioners. Too often, constraints of time, energy and finance lead to the choice of the nearest and cheapest PGEA-accredited course without any assessment of its educational relevance to the particular learning needs of the individual practitioner. Many courses are of poor quality, and learning, where it occurs at all, is often passive. The circle of portfolio-based learning has the potential to make continuing medical education much more active and relevant to individual needs and aspirations, but regional advisers and general practitioner tutors will need to give positive encouragement in the early stages and be prepared to be realistic, even generous, in their assessment of the amount of work involved in the discipline of portfolio-based learning, in terms of qualifying for postgraduate education allowance.

A network of mentors will be needed and the potential for co-mentoring in pairs or within small groups, and even 'distance mentoring' will need further exploration. The mentor will encourage the practitioner to review his recent work experience and, no less importantly, experience derived from wider life events to identify what has been learnt from that experience and what further learning needs have been found. The learner, again encouraged by the mentor, will then develop an annual plan to begin to meet those learning needs. The plan will include details of the evidence the learner intends to provide to demonstrate that the ensuing learning has occurred and so qualify for the allowance. The development of the plan is time-consuming but educationally valuable in its own right, and should be recognized and rewarded as such if the learner is not to be discouraged at the first hurdle.

The approval of portfolio-based learning for the purpose of PGEA is subject to the discretion of each individual regional adviser. The *Statement of Fees and Allowances* does imply some constraints in the recognition of time spent on private study (DoH and Welsh Office, 1989). It is hoped, however, that the portfolio approach to continuing medical education will be encouraged by regional advisers, by recognizing and rewarding the active engagement in learning and the production of a tangible result. Some regions are already taking a lead.

Once the discipline of portfolio-based learning is established for the purposes of qualifying for PGEA, there is the potential for the learning momentum to be sufficient to foster aspirations towards a higher degree. The learner would then have the option of requesting external accreditation of the learning demonstrated in the portfolio with a view to accumulating credits which would count towards the final degree.

A successful application

The following is a successful application for a year's portfolio-based learning to be approved for PGEA on the topic: "Primary health care of ethnic minority communities".

Evidence from experience and resulting learning tasks

1. Y-YC is a Chinese patient in her late forties who has lived in this country for more than a decade. She is married and has five children, the youngest of whom is now 12. She does not work outside the home; her husband works in a Chinese restaurant. Her command of English is hesitant. Over recent years she has consulted frequently with apparently minor symptoms of indigestion and purulent postnasal drip. Initially I treated these with simple symptomatic remedies but with no benefit. Finally, when she came with an interpreter, I took a more detailed history and discovered that her mother died at the age of 45 of a nasopharyngeal carcinoma. Subsequently I referred her for endoscopy and the examination of the postnasal space. Nothing abnormal was found and her symptoms abated to some extent. The further history provided a breakthrough in my understanding of Y-YC's illness, but because of the linguistic and cultural gap between us I feel that I have been unable to communicate my insight and understanding to her and she has not been able to express fully her fears and anxieties. **I need to learn more about the perception and interpretation of psychosomatic symptoms within different cultures.**

2. LK is a black Caribbean woman in her mid-forties who teaches social work. She has longstanding severe hypertension which has proved difficult to control adequately. The situation is further complicated by her history of recurrent thyrotoxicosis. I already know that hypertension tends to be more severe and is more difficult to control in black Caribbean patients but **I need to learn in more detail about the relative efficacy of the various anti-hypertensive medications in patients of different ethnic groups.**

3. GA is a Bengali man in his fifties who registered with his wife, SA, in her mid-twenties, and four sons, all aged under five years old. SA and the children had all arrived from Bangladesh shortly before registering and spoke no English. GA would either consult on his own for a succession of apparently minor physical problems such as cough,

indigestion or musculoskeletal strains, or book appointments for the whole family. Often these appointments were not kept, wasting a quarter of the available surgery time, or they all came together. When this happened everyone had to rely on GA's very abbreviated translation and it seemed impossible to give any individual more than the most cursory attention. My feeling was that members of this family were having considerable difficulty adjusting to living together as a single unit after years of separation across different continents. GA certainly reported that SA felt very isolated and was missing her extended family. After several months this family left my list and registered elsewhere, presumably agreeing with me that my care had been less than it might have been. I still see GA in the area walking the little boys to school and he gives me a friendly wave, a symbol of lost opportunity. **I need to learn to adjust my consulting style to a range of different cultural expectations and to be prepared to invest more time in making things work and involving advocates and translators.**

4. Recently it was a shock to hear colleagues in the primary care team who are black Caribbean discussing, over lunch, how often their elderly male relatives, fathers, uncles, are stopped and hassled by the police when they are driving around London. I have also been impressed by accounts of my black patients, born and brought up in the UK, describing their first visits to the Caribbean and what a wonderful feeling it is to be in the ethnic majority. **I need to learn more about how deeply racial prejudice affects the daily lives of my patients.**

5. I work as part of a six-partner practice (three men and three women, two from ethnic minority groups) in a large primary health care team in an inner city area. We care for patients from a wide range of different ethnic groups but have not yet made any attempt to assess whether we are providing an equitable service to patients from different groups. In the process of researching and writing a recent editorial, I learnt that this audit could be done by implementing a system of ethnic monitoring within the practice, but **I now need to work with my partners and the rest of the primary care team to learn about the practicalities of implementing such a system.**

Proposed ways of achieving the learning goals

1. *Reading*

I will read *Ethnic Factors in Health and Disease*, by JK Cruickshank and DG Beevers, Cecil Helman's *Culture, Health and Illness*, and John Black's *Child Health in a Multicultural Society*.

Literature, novels and poetry give the reader, who is also a general practitioner, an opportunity to explore different personalities and different situations, which are later echoed in the consulting room, increasing the doctor's understanding and empathy. I will therefore seek to increase my knowledge of, and sensitivity to, different cultures, and my understanding of the experience of migration by reading prose and poetry of, for example, C L R James, Orlando Patterson, Derek Walcott, Caryl Philips, Ben Okri, Buchi Emecheta, Shimmer Chinodya, Rohinton Mistry and Timothy Mo.

2. *Project*

In the practice, I plan to work with my partners and the primary health care team to pilot the introduction and audit of a system of ethnic monitoring.

3. *Practice visit*

I will visit other inner city, ethnically mixed practices to see how they deliver care across potential ethnic and cultural barriers.

Demonstration of learning

The evidence presented in the portfolio will demonstrate what learning has been achieved in each of the three areas and how this has been translated into improved patient care.

1. *Reading*

Evidence of learning could include:

- Individual case descriptions and/or family profiles, with account of how reading has increased understanding of the patient's situation or improved management of a particular problem
- Commentaries on books found to be particularly useful, highlighting their relevance to work in the surgery.

2. Project

Evidence of learning could include:

- A written progress report of the first year of implementing a system of ethnic monitoring with copies of questionnaires used, etc. (I hope this will be 'an account of change and innovation' rather than of defeat and disillusion but either will be an account of learning)
- A survey of staff attitudes
- A patient feedback survey
- Initial audits of ethnic equity.

3. *Practice visit*

Evidence of learning could include:

- A written report of the visits made
- Assessment of written materials used in practice to facilitate work with patients from ethnic minorities.

Glossary

The following abbreviations and conventions have been used:

APL (Assessment of prior learning) or **APEL** (Assessment of prior experiential learning) is a process that enables formal recognition of skills and knowledge already possessed by learners.

CATS (Credit accumulation transfer system) provides for the award of certificates, diplomas, degrees or masters by the accumulation of credit points.

CME (Continuing medical education) is used to denote continuing medical education undertaken by general medical practitioners working as principals in the NHS.

Higher professional training (HPT) **or higher professional education** (HPE) is voluntary continuing medical education activity usually undertaken by young principals.

A mentor is an individual who facilitates the process of learning and provides support and counselling.

A portfolio is a collection of evidence that learning has taken place. Such evidence may include workload logs, case descriptions, videos, audit and research, commentaries on books and papers, as well as evidence from personal as opposed to professional experience.

PGEA is postgraduate education allowance, which is a sum of money payable to general practitioners who have completed 25 days on courses or learning activities in approved subjects over a 5-year period.

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