New strategies for higher professional education

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SUMMARY. Since the original recommendation in 1968 for a period of higher professional education, the development of this form of education has been slow. However, in 1990 a working party was established by the education division of the Royal College of General Practitioners to report on higher professional education. This paper describes some of the early work of the working party and its recommendations with particular emphasis on educational strategies, assessment and accreditation. A flexible, learner centred approach needs to be developed to encourage autonomy. Educational strategies are described which value previous experience and allow for a shift of responsibility for learning from the teacher to the learner.

Keywords: postgraduate education; continuing education; learning needs; educational theories; educational assessment.

Introduction

THE need for further education to fill the vacuum immediately following vocational training has been identified by young principals, medical educationalists and the Royal College of General Practitioners.[1-7] The development of young principal groups, which have been formed throughout the United Kingdom, supports this.[1-4] These groups provide support to young principals, but may lack effective leadership.[3]

In recent years, there has been encouragement to address some of these needs in the form of higher professional training courses (working party of regional and associate advisers in general practice, unpublished report, 1989).[5-7] Progress in the development of such courses is still slow. A recent study in the UK was able to identify only seven courses for higher professional education of which three were MSc courses.[8] Factors hindering the development of courses for higher professional education were found to relate to their expense, to a lack of suitably trained course organizers and to an inadequate administrative structure.

The importance of further research into higher professional training was identified in the RCGP's education strategy document, and a working party was established to '... commission further studies ... and advise Council about the most appropriate methods for assessing completion of HPT [higher professional training]'.[7] This paper describes the initial work of the working party on higher professional education.

Educational theories

The word 'training', as used in higher professional training, may imply a pedagogic approach to learning emphasizing specific skills to be learnt and goals which may be narrow and fixed. The working party therefore preferred to use the term higher professional education which it saw as a constituent of continuing medical education rather than something separate from it. Higher professional education would be a voluntary exercise particularly suited to newly qualified principals whose needs had not been totally met by their undergraduate and vocational training.

The working party carried out two relevant studies in 1990. The first involved a postal survey of faculty secretaries, regional advisers in general practice and heads of university departments of general practice. It revealed that the majority were in favour of a form of higher professional education which encompassed many of the contemporary theories of adult learning.[9] At the centre of these theories of adult learning, lies the concept of andragogy. Andragogy, which contrasts with pedagogy, has four basic assumptions.[10]

1. Adults both desire and enact a tendency towards self direction.
2. Adults' experiences are a rich resource for learning. Adults therefore will learn more effectively through experiential methods of learning such as small group work and problem solving.
3. Adults are aware of specific learning needs generated by real life tasks or problems.
4. Adults are competency based learners, in that they wish to apply their newly acquired skills or knowledge to their immediate circumstances. Adults are therefore performance centred in their orientation to learning.

The contemporary theories of adult learning emphasize learner centred approaches and methods of assessment that do not involve summative examinations. The results of the postal survey reflect an increasing realization that the traditional pedagogic approaches, which often depend on a one way transmission of knowledge with the learner in a passive role, are not suited to higher professional education.

The second study, also a postal survey, identified existing courses for higher professional education. These were predominantly MSc courses, although three or four regions were running non-degree courses for higher professional education. The working party recognized that courses such as those for trainers and those involving distance learning could also be considered as examples of higher professional education. Furthermore, learning that is not necessarily structured within the confines of a course may also be considered as higher professional education. Higher professional education, like continuing medical education, is a continuous process.

Educational strategies

The importance of stating objectives for higher professional education was recognized by the working party, but these objectives should be broad based and designed for the individual. They should not constrain and confine the course organizer to formulate a narrow path of learning. Ideally learners should be involved in describing objectives and the use of learning contracts should be encouraged. The overall aim of higher professional education should be to foster personal and professional development.

The assessment of learning needs is an essential part of curriculum planning. The working party discussed the idea of a core curriculum which might be used as a guideline for higher

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professional education. Ideally, content should be predominantly dictated by the learners, although there may be other influences such as local needs, and the needs of the accreditors and providers. Perceived needs of learners often relate to areas which may be inadequately covered in vocational training, such as communication, ethics, socioanthropology, management, learning and teaching, and the concept of the 'wounded healer'.

There have been few studies of the needs of the young principal. One such study identified areas related to the management of time, change, personnel, patients and stress (Plant G, unpublished report, 1990). Other important areas identified by Plant were personal problems related to counselling and effective small groups. The working party was anxious to emphasize the need for the identification of learners' needs prior to any programme of higher professional education.

Knowles stated seven principles of adult learning which need to be tackled by organizers of adult learning programmes.[11]

1. To establish a physical and psychological climate or ethos to learning.
2. To involve learners in mutual planning and curriculum directions.
3. To involve learners in diagnosing their own needs.
4. To involve learners in formulating their own learning objectives.
5. To involve learners in identifying resources and devising strategies using these resources to accomplish their objectives.
6. To help learners carry out their learning plans.
7. To involve learners in evaluating their learning, principally through qualitative evaluation methods.

In attempting to understand higher professional education, there was a need to return to its origins. The original recommendation for vocational training from the RCGP[12] and the Royal Commission on Medical Education[13] was for a five year programme. The first three years would consist of general professional training, which would be followed by two years of higher professional training. This was never accepted and since this recommendation in 1968, the development of higher professional education has not advanced greatly. Higher professional education has come to be seen as something to be completed after vocational training, within the early years of general practice.

One model of general medical training, general practice training and continuing medical education is shown in Figure 1. Such a model, especially if it imposed a time scale, could be seen to constrain the general practitioner to a series of hurdles to be achieved through completion of courses and the acquisition of diplomas and qualifications. This model utilizes the familiar and traditional approach that emphasizes content as opposed to the process of learning. Goals are made explicit and broken down to operational objectives which learners are expected to exhibit at the end. Assessment should be relatively easy as the completion of the objectives can be measured. Such an approach has been termed 'freedom from distraction'.[14] The working party considered an example of this model in the appendix of the RCGP's educational strategy document[7] but it was felt to be too prescriptive.

Another approach could focus on the learner rather than on specific content or the completion of a course and thus provide a wider breadth of education. It could seek to foster personal and professional development and a degree of responsibility and autonomy within the learner. In contemporary educational terms it would encompass ideas from two schools.

Andragogy (or 'freedom as learners').[14] This utilizes the theories of Knowles and self directed learning.[10,15] The methods of learning may include the setting of individual goals and the use of learning contracts.

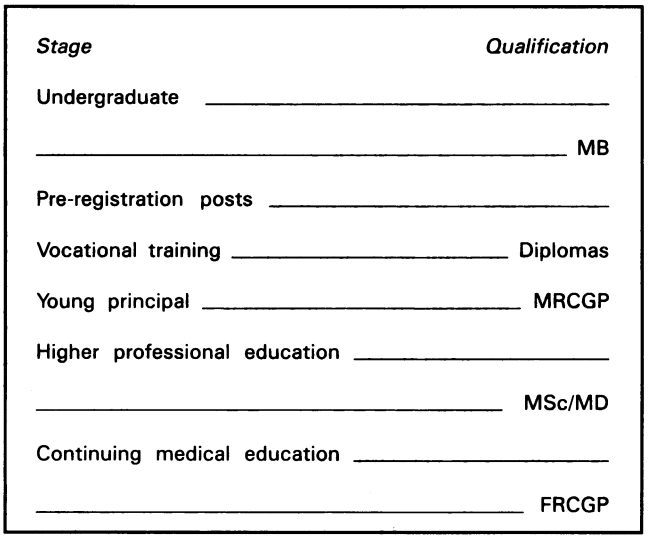

Figure 1. *Model of general medical training, general practice training and continuing medical education.*

Humanistic (or 'freedom to learn').[14] This encompasses the work of Rogers[16] and emphasizes not only the 'whole person' but the concept of the peer learning community.

These two schools value prior experience and learning both from life and work. They may use approaches which are centred on individuals (for example, learning contracts, portfolio based learning, mentors), groups (for example, peer learning communities) or projects. These processes and learner centred approaches are more relevant to higher professional education as they recognize and value previously gained knowledge and experience and encourage reflection. The value of small group work and the creation of a safe and trusting learning environment were emphasized by the working party.

Portfolio based learning

One educational approach considered in some detail by the working party has been portfolio based learning. Since 1984, portfolio based learning has been introduced successfully into various areas of adult learning. The 'portfolio' contains a collection of evidence gathered by an individual in his or her role as a 'learner'. Experiential learning may be considered to be a cyclical process involving: concrete personal experience, reflection on that experience, the formation of abstract concepts and generalizations and testing implications of the learning.[17] Therefore, the experience of the learner is relevant only as a source of learning and the crucial intellectual task is that of moving from a description of experience to an identification of the learning derived from that experience. This process can be demanding, but if it cannot be accomplished there can be no learning to document or assess, however important to the individual that experience may have been. Examples of a general practice portfolio could include: workload logs, individual case descriptions, videos, results of audit or research, commentaries on books or papers, as well as evidence of relevant learning from personal as opposed to work experience.

The portfolio may be used for two purposes. The learner may choose to share it with a mentor or supervisor who will identify, help clarify and facilitate the demonstration of the learning. This reflective process is a learning experience in itself, not only for the the learner but also for the mentor. The second way a portfolio may be used is in a process of assessing and

accrediting experiential learning. In this manner, the portfolio may contain identification of learning needs, details of the learning experience and a demonstration of the new skills learned. The latter may be presented in the form of a regularly kept journal. Inevitably if the portfolio is used for accreditation, then its contents may be governed by the accreditor's criteria and standards.

This method of learning is new to medical education and its role and significance need to be assessed. The working party ran two experimental workshops on portfolio based learning in May and June 1991. These were attended by 40 participants, representing different areas of medical education, and were well received. As a consequence of these workshops, a number of initiatives have taken place, particularly in vocational training and continuing medical education, utilizing the concepts of portfolio based learning.

Assessment and accreditation

Learners may wish to have aspects of their higher professional education assessed or approved. This may be to gain approval of the professional and personal development that has occurred, and to diagnose further learning needs. Assessment should be a voluntary exercise which is continuous and formative rather than one based on a summative examination. It should not be judged by a pass or fail but should be seen to encourage and praise achievements while identifying areas of learning that may need attention.

Two new concepts to medical education have been discussed by the working party which may have an important role to play in the assessment and accreditation of higher professional education: the credit accumulation transfer system (CATS) and assessment of prior experiential learning (APEL). Both of these are perfectly compatible with the contemporary theories of adult learning.

The credit accumulation transfer system is being used in many other areas of higher education.[18] This system seeks to promote a more open and flexible system of higher education. It provides for the award of certificates, diplomas, degrees and masters degrees by the accumulation of credit points. In this way, previous experience and prior learning may be taken into consideration. It is compatible with the ideas of modular courses and portfolio learning and fits in well with the nature of the general practitioner's work, allowing access to higher education for all at an individual pace.

Assessment of prior experiential learning concerns the assessment and accreditation of learning obtained from life and work experiences.[19] Experiential learning refers to learning which has not been validated previously within an educational or professional system of accreditation. Assessment of prior experiential learning focuses on the outcomes of learning and will allow wider access to higher education. It complements portfolio based learning and the credit accumulation transfer system. The portfolio is presented as evidence for learning and used as the basis for accreditation. This has been used successfully in many higher education institutes.[20]

Conclusion

Vocational training is well established. The challenge of the next decade will be to develop learner directed programmes of higher professional education that will be responsive to the needs of general practitioners. Such programmes should be voluntary and available to all general practitioners.

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