Contesting the freedom to learn: the role of the Practice and Professional Development Plan in a British General Practice

Paul Milne

Paul Milne [mailto:pmilne@doctors.org.uk]

Introduction

In 1998 the Chief Medical Officer (CMO) recommended the introduction of the Practice and Professional Development Plan (PPDP) in response to the lack of evidence for learning from the postgraduate educational paradigm for general practitioners at that time (Calman, 1998). The CMO's report highlighted that there was little evidence that attendance at courses and lectures by general practitioners produced changes in practice for the benefit of patients (ibid pg.3). Calman's report went on to consider the future of continuing professional development (CPD) in general practice. In his report 'A review of continuing professional development in general practice' (1998) CPD was defined as

> a process of lifelong learning for all individuals and teams which enables individuals to expand and fulfil their potential and which also meets the needs of patients and delivers the health and health care priorities of the NHS (Calman 1998,pp.6).

The definition fused the individual's learning needs and development with the development of the NHS. It implied that the learning and development needs of individual and the organisation were the same.

As a precursor to the CMO's report, the evidence for the effectiveness of CPD in medicine had been reviewed by Stanton and Grant (1997). The report discussed different models of CPD and their learning outcomes. In their concluding comments, Stanton and Grant concluded that no one method of CPD had been shown to be most effective but recommended that more attention needed to be given to the '*conditions* for effectiveness of CPD activity,…..that is by *establishing process and culture* rather than specifying particular educational experiences or types of education' (Stanton & Grant 1997, pp.34) (my italics). Their conclusions appeared contrary to the CMO's definition which was prescriptive and subsumed educational autonomy to the needs of the National Health Service (NHS) organisation through the use of a PPDP.

This paper has three aims. First, an overall aim is to contextualise and consider the socio-cultural perspective of this change in postgraduate medical education in general practice. Subsequently part of some

empirical data from an ethnographic study of a general practice (Milne 2007) are used to illustrate and situate the PPDP's role within general practice. Finally, the PPDP as an artefact within the practice's culture is considered in relation to a social model of learning derived from the research.

Background to the development of the Practice and Professional Development Plan (PPDP)

The CMO's report highlighted the lack of coordination in terms of use of the resources available for CPD and in particular the lack of focus. The postgraduate educational allowance (PGEA), available as a financial incentive for general practitioners' educational development, was criticised for failing to show any change in medical practice which would benefit patient care (Kelly 1996). General practitioners were able to claim this allowance by attendance at courses and lectures. Postgraduate meetings for general practitioners were often consultant led and had a lecture format with little opportunity for interaction. Their educational content was influenced by pharmaceutical company sponsorship and little consideration was given to any quality agenda. There was no incentive for multi-disciplinary learning or for the development of practices as learning organisations. From this, the report recommended the introduction of the Practice Professional Development Plan (PPDP) within general practice. The report described the purpose of the plan as providing a framework which would

> develop the concept of the whole practice as a human resource for health care; increase health authority involvement in the quality development of practices; be professionally led at all levels and be monitored through peer review(Calman 1998, pp.18)

Its content would be based on an amalgamation of individual practice team members professional development plans and the service development plans of the practice. These plans in turn would be influenced by local assessment needs and objectives. Emphasis was placed on the use of clinical audit data, clinical governance and practice based learning methods.

The introduction of the PPDP with its emphasis on practice based learning was a significant change in terms of learning method for general practitioners. The change was met with an ambivalent response, reflected in Tudor Jones' survey study of 202 general practitioners (2003). The study highlighted the practitioners' resistance to the offer of external facilitation and the difficulties expressed by the general practitioners to engage with multidisciplinary team learning.

Cornford critiqued the assumptions within the concept of the PPDP in terms of the underpinning learning theory (Cornford 2001). His view was that the PPDP attempts to fulfil several functions and that these did not always have a synergy in terms of its overall purpose. He recognised the inherent political tension in the PPDP between the learning needs of the individual and that of the institution. In addition the application of androgogic learning theory which underpins the PPDP appears flawed when the PPDP also seeks to measure outcome and, as Cornford

observes, this could lead to only measuring outcomes which are easily measured. This leads to the important but 'softer' areas of learning in the workplace being ignored. Cornford exemplifies these through the learning influences of the social contacts that health professionals make during externally facilitated educational courses. Implicit within Cornford's paper is the politicisation of the PPDP which distract from its educational purpose as a developmental tool. As already noted in Tudor Jones' work there were significant tensions as to the underlying purpose of the PPDP. This political subtext is further highlighted in McKee and Watt's (2003) evaluative study of PPDPs in East Anglia where their main finding was that the PPDP was seen as 'the growing threat to the freedom of professional learning as education is seen 'as a means of managing compliance to national performance targets.'

In summary, the PPDP in primary care formed part of the NHS strategic management policy to develop a learning organisation culture. This strategic shift is considered in the next section.

National Strategic Policy

In 2001 the Department of Health published Working Together –Learning Together. A Framework for Lifelong Learning for the National Health Service (DOH 2001a). This document described how lifelong learning was to be embedded within the National Health Service and its vision for the NHS as a learning organisation. Its emphasis was to help staff 'realise their potential' and take 'advantage of wider career opportunities'. There was an expectation that NHS staff will 'take responsibility for their own development' (DOH 2001, pp.vii) and envisaged NHS staff would have the necessary support and opportunities to progress their career. The document set out a 'skills escalator' approach to staff development. This included the creation of the NHS University but this initiative was disbanded at a later date. There was particular emphasis on the provision of training opportunities for those who traditionally have been omitted from educational opportunities in the NHS (e.g. health care assistants, clerical, reception and catering staff).

The notion of a learning culture within the workplace was to be encouraged and it proposed that the development of a learning organisation would benefit the recruitment and retention of NHS staff.

> Delivering this vision means that all NHS organizations and those with a contractual relationship with the NHS, need to develop and foster a learning culture. Investment in learning benefits the organisation, patients and carers, local communities, society more generally and individuals. To be effective, lifelong learning also depends on a strong relationship between individuals and their immediate world of work and in shared values and skills (DOH 2001, pp.6)

This development was structured through utilizing the 'Improving Working Lives' standard (DOH 2001b). This standard required the employer to use modern employment practices. Amongst these was the provision of 'personal and professional development and training opportunities that are accessible and open to all staff irrespective of their working patterns'

(DOH 2001b, pp.12). The learning organization is given a structure in terms of all health professionals having a professional development plan (PDP) and that the effectiveness of a NHS organization would be enhanced by having a learning strategy and a system of appraisal for all staff. This would be achieved through the use of a 'variety of development methods' which would include 'coaching on the job, mentoring, learning sets, secondments, project work, sabbaticals as well as formal education and training' (DOH 2001b, pp.14).

These policy documents provided the background to a report commissioned by the DOH on work based learning.

Work based learning

A report commissioned by the DOH (Caley 2002) considered the influencing factors in work based learning in the NHS. It summarised the outcome of a series of workshops with NHS managers in primary and secondary care settings. The emergent factors emphasised the need for long term planning for learning within an organisation and that informal learning should be facilitated in the workplace so that experience can be shared. These factors were recognised as requiring development of the infrastructure in terms of financial and technological support and that the overall culture in an organisation should promote openness and sharing.

Learning in general practice and the research of culture in general practice has received some attention. Rutherford and McArthur (2004) used a qualitative phenomenological approach to explore the 'lived experience' of team learning among professionals across several general practices. Their research reflected the issues related to team learning and especially the existence of true team working. Their results were similar to those of Tudor Jones where the issues of hierarchy, leadership and trust were prominent in their informants' narratives.

These changes for postgraduate general medical practice education and the strategic policy which were intended to embed 'lifelong learning' within the NHS workforce formed the background to the empirical research which forms the next part of this paper.

Empirical data

An ethnographic study was undertaken in a general practice in the North East of England. The ethnographic method and framework was as described by Spradley (1979).

The author was a partner in the practice which was a husband and wife two partner training practice. The partners owned the purpose built premises. There were thirteen informants who were drawn from the practice's nucleus team and the attached members of primary care team (e.g. health visitor, community psychiatric nurse, district nurse). Three members (midwife, practice cleaner, GP registrar) were not included as they were judged to have only a transient influence on the timeline of the practice's culture. Their presence was judged to be intermittent,

peripheral or transient. Through an iterative process five key informants emerged. These were the partner, practice manager, practice nurse, practice receptionist and the district nurse. For the purposes of this paper I focus on the empirical data related to the PPDP and situate it within the emergent cultural values.

The Practice and its PPDP

The PPDP as an artefact within the practice culture was situated at the interface or boundary between the practice and the external body of the Primary Care Group (PCG) (subsequently known as the Primary Care Trust). Its intention was to bring synergy between the practice's own development and that of the individual health professional. Initially for the practice in 1998 this was a voluntary activity encouraged by myself in order to further the process of learning through reflection. It became formalised with the practice's change to a different form of contract (Primary Medical Services) with the PCG. The PPDP was discussed in practice meetings. These were attended by all the practice nucleus staff but not by the extended team. However the meeting to introduce and consider the development of the PPDP included members of the extended primary care team represented by the district nurse and health visitor. The meeting was externally facilitated and held in the local primary care development centre. The facilitator asked the group to use metaphor in order to link the purpose of the PPDP with the concept of the 'learning organisation'. The group divided into mini groups and produced several flip chart pictures.

Examples of these are

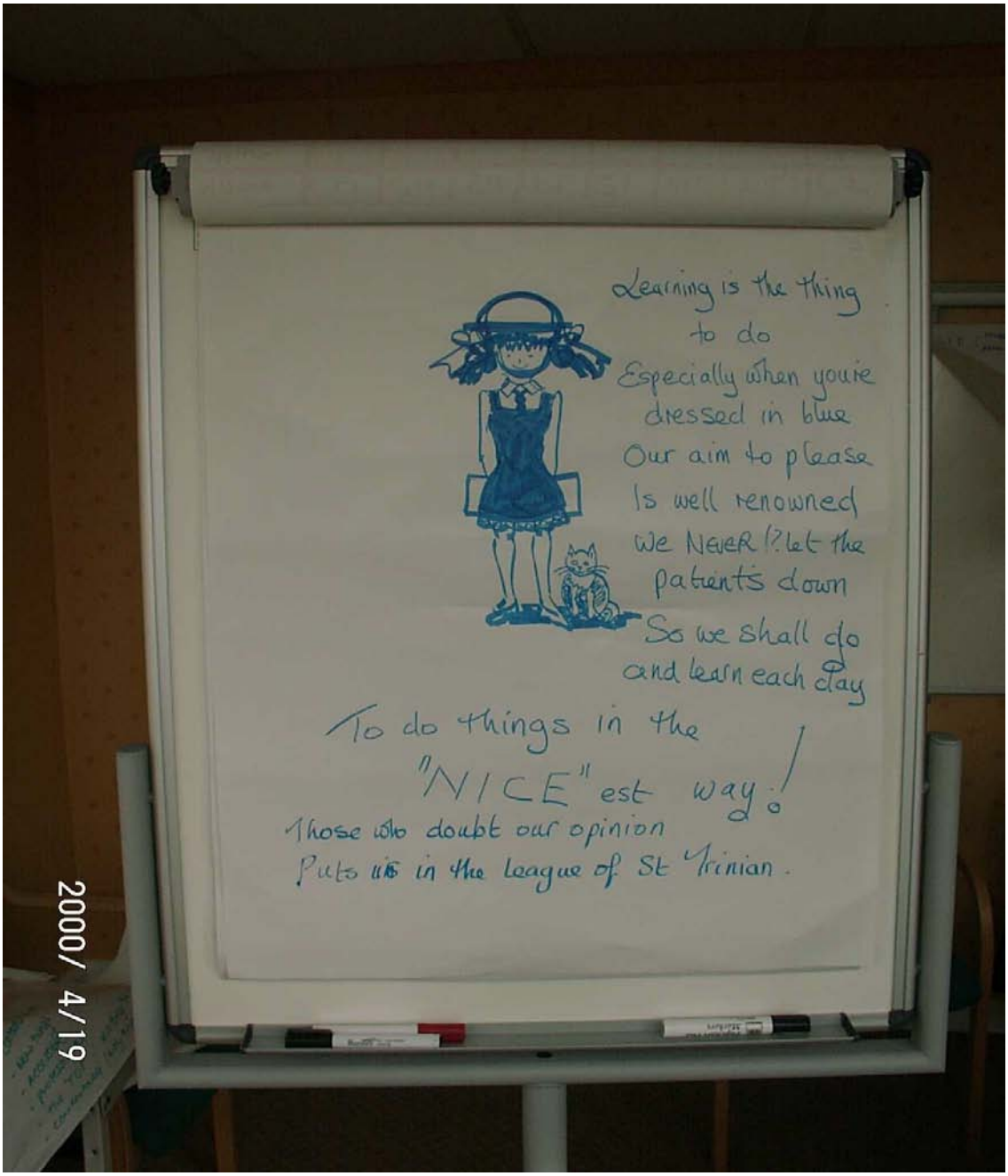


Figure 1 Metaphor One: Learning, patient care and NICE (National Institute for Health and Clinical Excellence)

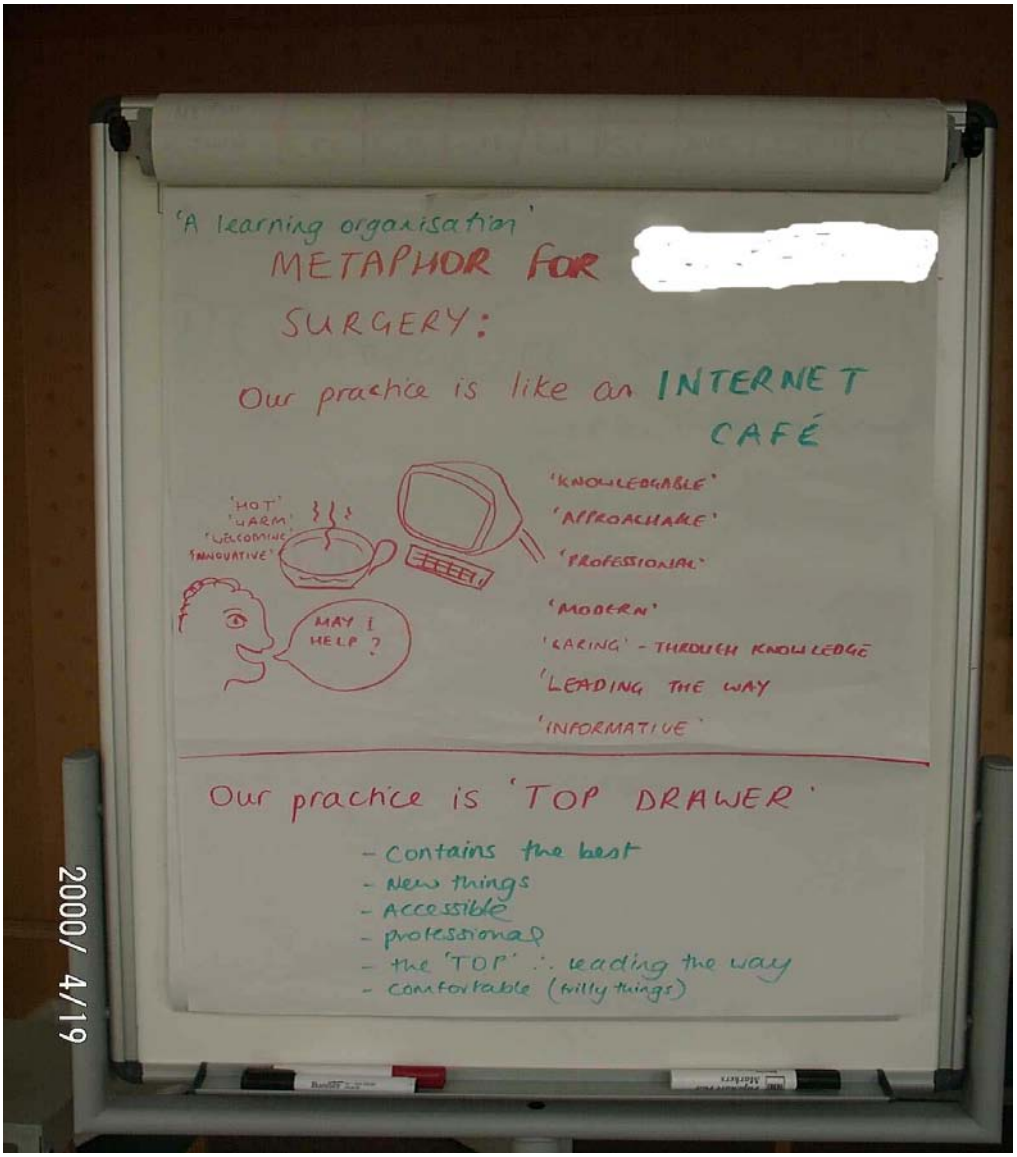


Figure 2 .Metaphor 2: The 'internet café'

Although there was a sense of reaffirmation for the internal milieu of the practice both metaphors wished to reflect to the outside world the pride in their place of work ("contains the best"), and their desire to care through "being approachable, knowledgeable, accessible, warm, inviting and fulfilling".

The practice as a learning organisation was described as having the value of *caring* in addition to having knowledge. This appeared to be an internal individual desire as well as a group expression, the ability to learn through being "accessible" to each other as much as it was to the patients the practice served.

Over the next six months, the practice had two more meetings which worked on the process of 'going paper light' and the clinical details of the PMS contract. These meetings involved the practice nucleus group and members of the extended practice team. These meetings were again for

a half day but were held in the practice seminar room and were facilitated by myself. I do not intend to describe these subsequent meetings in detail but highlight some of the empirical data related to the PPDP and the PMS contract.

PPDP and the informants

Over the following months I recorded comments from the informants that related to the PPDP. These were of interest of understanding how the PPDP was situated within the practice culture and its role and influence on practice learning.

The **practice receptionist** informant on thinking about the PPDP

> Part time people try to be efficient, caring for the hours that they are there, full time people would be committed to the PPDP".

> Don't feel involved, carried along, not had anything to do with it; reception doesn't generate ideas for PPDP. In reception (we) think of ways to solve problems in our own little world

The practice manager and the practice nurse grumble about the need for extra meetings to manage / discuss the content of the PPDP.

At a practice meeting some months later, the PPDP appeared as an agenda item. The practice meetings were concerned with the business of the practice and were held in the seminar room. None of the informants including myself were able to find a paper copy of the PPDP. The secretary eventually found an old copy. At that practice meeting, the practice nucleus group (the partner was absent) commented generally about the PPDP. I did not identify the individual informants for these comments.

They saw it as

> Repetitious, Government led, a political football, negative press, lack of connection, should be doing it, see it as a business plan, made to do it by inaccessible faceless people, they (i.e. the faceless) think they know what we do, haven't clue what we do

The PPDP became linked in the practice nucleus group's mind set with anxieties about their roles e.g. "What it means to my job, financial concerns." In my diary, whilst listening to their questions at this point to the introduction and evolution of the PPDP, I record that this concern appeared to be central to their thoughts and relationship with the concept of the PPDP.

One year later the individual members of the team volunteered to outline their Professional Development Plans in a practice meeting and to relate it to the PPDP. Their content is listed below.

Practice manager	1.NHS pension training 2.Health and safety 3.Paperlite 4.Caldicott training
Secretary	1.PaperliteTraining 2.Windows IT course 3.EMIS training
Practice Nurse	1.Practice nurse prescribing 2.Coronary heart disease diploma 3.Travel medicine Diploma 4. COPD certificate. 5.Diabetes update 6.IT training
Partner	1.Diploma in geriatrics
Reception staff	1. EMIS training 2.IT training 3.Rewrite reception protocols 4.MIquest data analysis training 5.Reception skills course 6.AMSPAR course7.Communication skills
Author	Review Fellowship By Assessment Standards.

Table 1 Practice Professional Development Plans

My field diary notes record that this part of this meeting was rushed and that although the learning needs were written down, the act of writing was difficult and that the group preferred to “hold it in their heads”. This reflected the oral tradition within the group of relaying codified and experiential knowledge. Another six months was to pass before the PPDP resurfaced on the practice meeting agenda.

The partner supplemented her comments on the concept of the PPDP/PDP.

> I'm not sure what the PDP/PPDP is all about? Service demands are so great that it is adding work to what we have to do, i.e. writing up audits, writing them up for someone else. Learning goes into your head, you don't have to write it, it's like riding a bicycle" and on another occasion "it feels as if I'm being mistrusted, doesn't stimulate depth of learning

The practice manager viewed the PDP/ PPDP as

> the nuts and bolts of development /learning. (They are)..used to demonstrate progress with PMS, clinical governance, to use as a way to show what we are learning

The practice secretary thought the topics within the PPDP were

> too wide, (I) want to do my work, OK as long as GPs (General Practitioners)get something out of it

Finally, the PPDP and its production were done because of financial necessity. A £1500 fine could have been levied against the practice if the PPDP was not produced. It therefore became a task to complete much as for the completion of other PMS contract claims paperwork for immunisations, cervical smears which, having been done, generated income for the practice.

Discussion

I have dwelt on the PPDP, its development and evolution since it was a significant change for the practice. To a neutral observer it does have face validity in terms of its potential to encourage work based learning.

The PPDP over the two to three year period studied had a tenuous place within the practice. Initially it had little or no regard and then once it became part of the practice's Primary Medical Service (PMS) contract and therefore part of the practice's financial needs, it assumed a place within the practice's financial artefacts rather than as intended as an educational tool. At best the practice team worked on the PPDP to complete the paperwork in order to satisfy external management (PCG). Their learning needs were listed but this was to satisfy the external organisations and as demonstrated elsewhere (Milne 2007) bore little resemblance to the reality of their learning.

Through the initial workshop and its metaphors as a learning organisation the health professionals' cognitions were about finding a synergy with their reaffirmation of caring and the notion of the concept of a learning organisation. Caring and learning were situated together with notions of professionalism. The values expressed could be read as those that they wished to show to others outside the practice and for reaffirmation when looking inwardly on their workplace. In particular for reception staff there was 'pride in their practice'.

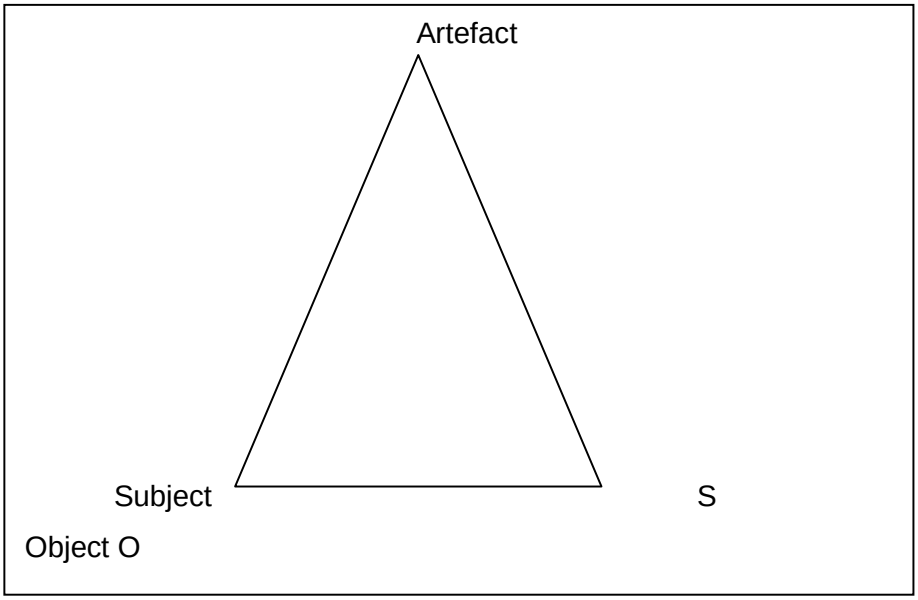
In parallel with the task driven activity there was a discourse for the practice nucleus team about its purpose as described in the learning organisation exercise. This reflected the practice team's learning which was situated and driven by a fluid social group 'mind'. The group had a strong sense of caring through delivering quality care ("the NICE-est way"). This had been assimilated within the group through their common purpose but this produced a boundary when it became necessary to reify it through an artefact like the PPDP.

The boundary was only partially crossed through persistence from leadership and financial coercion. Formal learning or training was situated within the mini communities of practice as per their personal development plans and linked with their negotiated meaning or purpose within their work area. The topics listed were sensed as 'offerings' to satisfy the external organisations (both Primary Care Group and professional bodies). The PPDP became a tool which having been completed, existed as an artefact within the boundary between the practice and external management (the Primary Care Group or as it subsequently became the Primary Care Trust). It was reified with mistrust and existed at the periphery of the practice team's culture. It did not link with the team's oral tradition of relaying and reflecting upon codified and experiential knowledge.

The empirical data challenges some assumptions about collective learning in the policy documents described. These assumptions appear to be based on a individualistic cognitive model in terms of the individual's development and runs counter to the empirical data where the observed learning phenomena had a social and situated bias.

The PPDP and a social model of learning

In this section the discussion considers in what way the data related to the PPDP can be explained by a sociocultural learning model. It focuses on the socio-cultural model proposed by Activity theory (Engeström 1995, 1999). This theory proposes a dynamic relationship between artefacts or mental models which mediate activity. They can be internalised from the culture in which *the person is taking part* and externalised *by their use and development in the person's environment.* In its simplest form mediation by an artefact is expressed in diagrammatic form as (Daniels 2004)



To clarify the diagram, subject S refers to the unit whose actions are ‘the focus of analysis’ (Daniels 2004). The unit can be a person or an organisation. The object is ‘the focus of the activity’ (Daniels 2004). In the example of the practice studied and its PPDP the subject S is the practice team, the object O is quality of care and practice development.

Engeström then develops this model into ‘second and third generation’ models. These have been reproduced below from Daniels (2004).The variables within the activity system are ‘rules and regulations that are both internal and external to the organisation, division of labour, and community. Division of labour describes the internal administrative organisation and community comprises the people that the individual works with or for an organisation other organisations.

In the research, division of labour is understood through the individual roles of the health professionals and community is the practice team. Rules and regulations for the practice were both internal (e.g. employment) and external (e.g. Primary Medical Services Contract, professional regulatory bodies). Engeström gives the relationship between the ‘variables’ a dynamic interpretation and I have added arrows to the model to represent this.

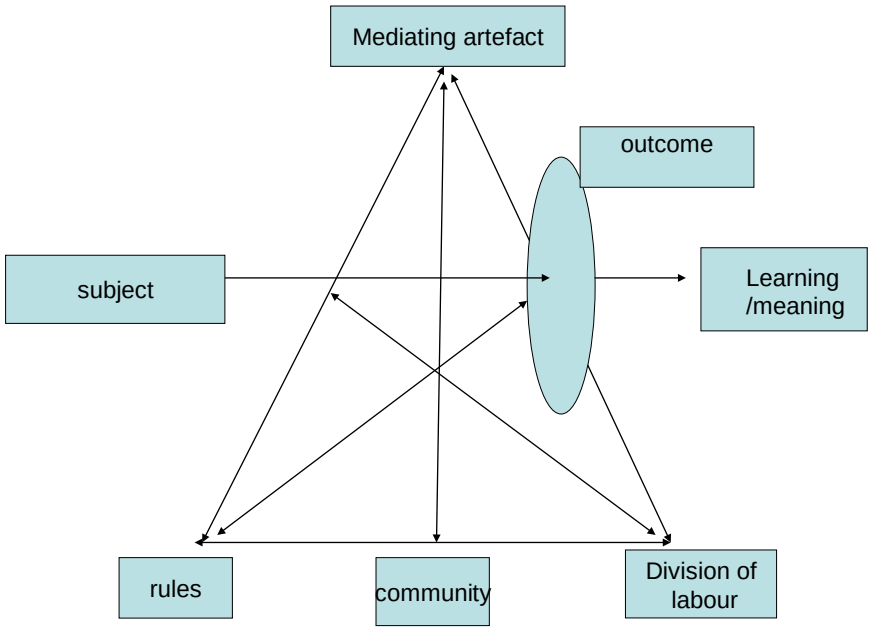


Figure 3: Activity theory model (Daniels 2004)

With the addition of arrows which symbolise the dynamism of the system and the introduction of an additional activity system, then the overall system is complex at both an intra and inter organisational level.

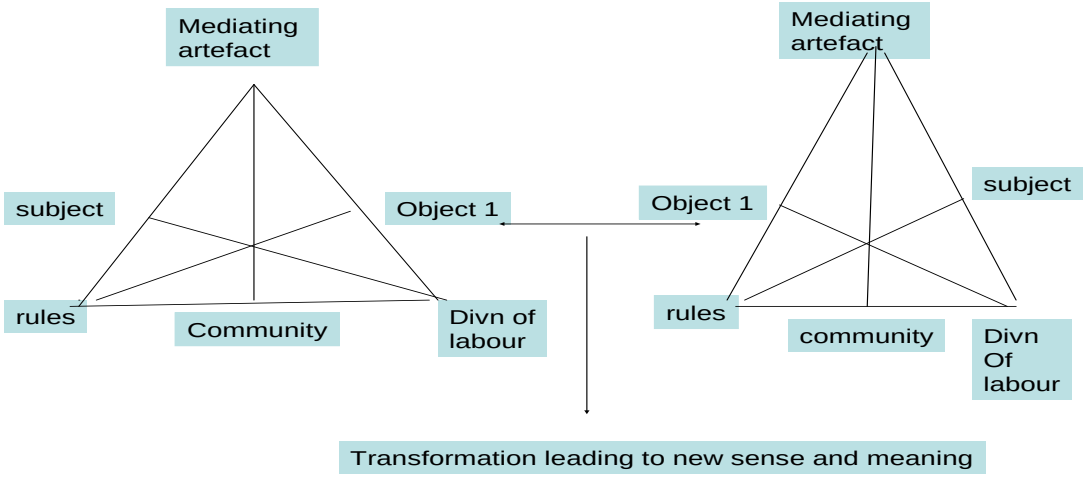


Figure 4: Interaction between individual activity theory systems (Adapted from Engeström 1999 and Daniels 2004)

The interplay between these two imaginary systems not only produces new knowledge as individual systems but has the potential to generate

new knowledge through the interaction of the two systems. The communication between each facet of the system (e.g. rules – subject-community) is at any point in time a mediational process which will have implicit tensions and contradictions. In turn, these will be mediated by the other facets of power and hierarchy within the system or organisation. The latter were implicitly present within the practice and are in part reflected in the empirical data for the PPDP.

If considered as an artefact the PPDP will interact with the other components of the health professionals' activity system and their complex interaction both within the individual and with the collective sense of a practice activity system. Activity theory acknowledges the complex interaction but does not include the notion of trust that is required for the system to remain in homeostasis. The model can be conceptualised as a dynamic system which has a trajectory. For the practice this was sensed in the metaphors used by the informants. The outcome of this trajectory cannot be predicted but does follow the 'simple rules' proposed by complex adaptive system theorists ((Kendrick D 2004, Sweeney and Griffiths 2002, Pampling 1998). The PPPD for the informants was reified with 'rules and regulations' from outside the practice 'boundary' and therefore distracted the learning trajectory for the individual and the practice and as such did not become part of the practice culture in terms of its intention as a reflective practice learning tool.

Summary

The Chief Medical Officer's report on continuing professional development and 'Working together –learning together' were published in 1998 and 2000 at a time of uncertainty for the National Health Service. The PPDP as described appeared to have multiple influences acting upon it. Principally these are political and this is reflected in this and other studies. The purpose of the PPDP as an educationally formative and developmental tool for the practice team is lost or distracted by these pressures. 'Working together –Learning together' sets out worthy aspirations for the NHS as a learning organisation but paradoxically is mechanistic in its approach to the development of the workforce and gives little value to experiential learning. The inherent contextual uncertainty in the NHS militates against the sharing of knowledge and reflectivity as envisaged by Senge's ideal in the 'The Fifth Discipline' (1992).

In the model outlined in this paper, the PPDP is reified as an artefact which is concerned with 'rules and regulations' and as such assumed a management role as a boundary object between the practice's sense of 'educational autonomy and the accountability role intended by the external organisation. It created dissonance for the practice informants torn between its initial purpose as a formative tool and to paraphrase the informants' reification 'something to do with management'. Work based learning remains an important part of primary care development in the NHS. The experience with the PPDP in this practice would suggest that further empirical research needs to be done in order to develop other

tools which should address the tension between organisational accountability and professional responsibility.

References

Calman, K. (1998). A Review of Continuing Professional Development in General Practice, *Department of Health.*

Caley, L.R.S., Reid, S (2004). Key influencing factors of work-related learning, University of Cambridge Programme for Industry, on behalf of the NHS Leadership Centre**:** 12. *Department of Health*

Cornford, C. S. (2001). The development of practice professional development plans from the postgraduate education allowance: a discussion of the causes and implications. *Medical Education* 35(1): 43-48.

Daniels, H. (2004). Activity Theory, Discourse and Bernstein. *Educational Review* 56(2): 121-132.

Department of Health (2001a). *Improving Working Lives* Department of Health. London. Department of Health.

Department of Health, (2001b). *Working Together - Learning Together*, Department of Health. London. Department of Health.

Engeström, Y., Engeström, R and Karkkainen, M. (1995). Polycontextuality and Boundary Crossing in Expert Cognition: Learning and Problem Solving in Complex Work Activities. *Learning and Instruction* Vol.5: 319-336.

Engeström Y., M. R., Punamaki R-L. (1999). *Perspectives on Activity Theory,* Cambridge University Press.

Grant,J, Stanton,F(1997). *The effectiveness of continuing professional development. A literature review for the chief medical officer's review of continuing professional development in practice,* The Joint Centre for Education in Medicine. Open University

Illeris, K. (2002). *The Three Dimensions of Learning*, Roskilde University Press.

Kelly, M. H., Murray T. S. (1996) Motivation of general practitioners attending postgraduate education. *Br. J. Gen. Pract.* June; 46(407): 353–356

Kendrick, D., Ed. (2004). *Complexity and healthcare organization a view from the street*, Radcliffe medical press.

McKee A, Watts M. (2003). Practice and Professional Development Plans in East Anglia: a case of politics, policy and practice. *Work Based Learning in Primary Care* 1(1): 33-47.

Milne P. (2007). Contesting the freedom to learn. Culture and learning in a British General Practice. An ethnographic study of the culture and learning process in a British General Practice. Thesis (PhD) Newcastle University

Pampling, D. (1998). Looking forward: Change and resistance to change in the NHS. *British Medical Journal* 317(7150): 69-71.

Rutherford, J. McArthur, M (2004). A qualitative account of the factors affecting team-learning in primary care.*Education for Primary Care* 15: 352-60.

Senge, P. (1992). *The Fifth Discipline: the art and practice of the learning organisation,* Century Business.

Spradley, J. P. (1979). *The Ethnographic Interview*, Harcourt Brace Jovanovich College Publishers.

Tudor Jones, R., Hood, G. E. K., Matthews, S., and Houston, H. (2003). Professional and practice development plans: a survey of general practitioners' views. *Education for Primary Care* 14: 25-33.