

The learning plan as a reflective tool for trainers of family medicine registrars

Van Deventer C, MBChB(Stell), MFamMed(MEDUNSA)

Principal Family Physician and Senior Lecturer, University of Witwatersrand

Conradie HH, MBChB(Stell), DCH(SA), MPraxMed(MEDUNSA)

Senior Family Physician and Senior Lecturer, University of Stellenbosch

Moosa SAH, MBChB(Natal), PHC Mgmt(Wits), MMed(FamMed)(MEDUNSA)

Family Physician and Lecturer, University of Witwatersrand

Morris G, MBChB(Pret), DTM&H(Wits) MPraxMed(MEDUNSA)

Family Physician and Lecturer, Nelson Mandela Medical School

Smith S, MBChB(UOVS), MPraxMed(Pret)

Family Physician and Senior Lecturer, University of Pretoria

Van Rooyen M, MBChB(Pret), MMed(FamMed)(Pret)

Family Physician and Senior Lecturer, University of Pretoria

Derese A, MD, PhD

Centre for Education Development, Department of Family Medicine and

Primary Health Care, Faculty of Medicine and Health Sciences, Ghent University

De Maeseneer J, PhD

Head of Department of Family Medicine and Primary Health Care,

Chairman Interuniversity Co-operation for Family Medicine training in Flanders

Correspondence: Dr Claire van Deventer, PO Box 1197, Potchefstroom, 2520; Tel: 018-297506, E-mail: cvandeventer@nwpg.gov.za,

Keywords: reflection, critical incidents, diary, portfolio

(SA Fam Pract 2005;47(10): 17-21)

Introduction

Having visited Flanders to benchmark with the training of trainers' programme, an effort has been made by the participating South African delegation to translate some of the processes into relevant and useable alternatives in South Africa. One of the educational initiatives that interested the South Africans was the learning plan with its core of reflection leading to a focused plan of ongoing professional development for both the trainer general practitioner (GP) and the trainee registrar.

In the ICHO (Interuniversitair Centrum voor Huisartsopleiding) model of training of trainers, there are the "staflid" or academic support person, the "stagecoördinator" who deals with theoretical knowledge in two weekly seminars and supports the GP trainer as well as the "praktijkopleider" or GP trainer, who are all involved with the family medicine trainee or registrar. These categories and their relevance are discussed in

other articles. However, a great deal of work has been done in terms of educational competencies of the trainers of registrars in primary care and the emphasis in this article will be on these reflective, educational aspects.

It is an observed fact that "apprenticeship" trainers focus more on the transfer of practical skills and are grounded in delivering a service, therefore their support in terms of the more theoretical aspects eg educational principles and skills is often lacking.^{1,2}

Based on the Flemish educational inputs regarding the training and support of trainers, a number of possible initiatives could be taken to strengthen the trainers of the future registrars in family medicine in South Africa. These would learn from the gaps encountered by the traditional apprenticeship approach and there will have to be adjustments to such plans and their preceding tools, in order to contextualise them. Examples

of such educational support structures and tools which are used in the Belgian programme are the preparatory steps, learning plan and portfolio.

Preparation and reflection by both trainer and trainee

The introductory part or first preparatory step of the "learning cycle"³ for the development of the learning plan as well as the portfolio, is an exercise in reflection which involves both the trainer Family Physician and trainee or registrar in Family Medicine.

There are different types of learning situations where reflection is useful and the tools developed by ICHO³ are appropriate. These may be based on individual patient encounters, general academic needs or on critical incidents with deeper emotional issues, when these occur.

All the reflective tools are used to compile the eventual learning plan which is an on-going and dynamic document.

Addendum 1: PUN/PAN/DEN diary

Detail of consultation	PUN	DEN	Action
Example: lower abdominal pain in young woman.	The possibility of a “cultural” self-diagnosis	To learn about Tswana explanatory models regarding abdominal pain	Speak to Tswana nurses, read book or articles on dealing with inter-cultural interpretation
1			
2			
Detail of consultation of PAN			

PUN/PAN/DEN diary

The process of identifying learning needs in the Belgium programme, is based on the Canadian^{4,5} system of

- a) reflection between trainer-trainee or trainee alone after the doctor-patient encounter, using patient actually met needs (PAN), patient unidentified needs (PUN), doctor’s educational needs (DEN) and
- b) reflection between the trainer-trainee or trainer alone after the trainer-trainee discussion, using trainees actually met needs (TAN), trainee’s unmet needs (TUN) and trainer’s educational needs (TEN).

This system should however be used critically and the mentioned needs should be relevant and therefore be prioritized in some or other way by both the trainer and trainee.

The limitation of the PUN, PAN and DEN tool is that it looks largely at the

clinical-based needs and may not include other areas e.g. educational or personal needs. See Addendum 1 as example of a PUN/PAN/DEN diary.

The DEN or TEN has been refined for the trainer by considering knowledge, attitude and skills that are lacking and deals more with educational issues and the methods used by the trainer to best capacitate the registrar or trainee supervised by him/her.

Examples of the trainer’s support role may be teaching an evidence based approach, dealing with conflict between the registrar and colleagues or patients and other process-related issues.

A further reflective tool is the so-called “position card” and SWOT analysis. This is an indicator of the trainer’s perception of his/her competency on various levels and includes a strengths and weaknesses

analysis. See Addendum 2. Linked to the outcome of the exercise, there is an opportunity to note which areas need attention and to prioritise these. This is then also integrated into the learning plan.

“Critical Incident” or “Significant Event”

Another reflective document is the so-called “critical incident” or “significant event”³ analysis. The idea with this document is to be able to deal with emotion-laden incidents in a thoughtful and constructive way, by

- Describing the incident
- What worked well
- Fishbone – to analytically understand the incident and its causes
- What were weaknesses?
- Which alternatives could have worked better?
- Identify personal learning areas (action points)

Addendum 2: Position card/SWOT

Professional family medicine issues	Unknown – very well known	Do you want to work at this? Y/N	Prioritise 1,2,3
Developments in F.M Do you follow developments? Do you implement them?	1 2 3 4 5 6 1 2 3 4 5 6		
Skills Do you comply with the skills list? Is there a possibility to refer registrar if unable?	1 2 3 4 5 6 1 2 3 4 5 6		
Consultations Have you had training? Do you have a mentor to consult with you?	1 2 3 4 5 6 1 2 3 4 5 6		
Medical record Is there an electronic med record? Do u use med records as part of training? Do u audit records?	1 2 3 4 5 6 1 2 3 4 5 6 1 2 3 4 5 6		

Addendum 3: Critical incident report

Description of occurrence:		Date:
What was managed well?		
Fishbone		
What went well/ not so well?		
How could it have been otherwise managed?		
Identification of main learning needs (transfer to learning plan)		
CONCLUSION OF REFLECTION		
Important Points from discussion		
Suggestions, recommendations		
Actions	by whom	when

Everyone involved should be given a chance to air their opinions and clarification must be found regarding what was lacking e.g. knowledge, skills, information, and systems. The important points should be summarized and captured in the critical incidents document. See Addendum 3.

Example of a critical incident. On a morning ward round, the trainer discovers that the registrar smells of alcohol. He is so angry and upset by this that he confronts the registrar in the nurse's presence and there is an unpleasant incident where the registrar insists that it is sour milk (Umkamasi) that he has drunk and he then accuses the trainer of victimisation. The process is followed as indicated in the tool in Addendum 3 in order to understand and improve upon the process. The trainer may need to go for training in

conflict management, a network of rehabilitation or counselling services for staff may have to be established or tapped into etc.

Once the learning priorities have been finalized, colleagues (trainers) meet and share their reflection instruments. This is a type of validation (or not) of the trainer's perception of himself/herself. The facilitator of this peer group should ensure that the tone of the discussion is that of "critical friends".³ There must be enough information available about the context of the trainer in order to understand the resources and limitations in his/her practice. The discussion should contain the elements of a good consultation e.g. clarification, summary and reflection. The skill for the facilitator and peers is in listening well, reading between the lines and confronting discrepancies in a positive way.

Summary of steps⁶

1. The learning need chosen and how it was discovered to be a need
2. The objective(s) for the learning plan – these should be congruent with family medicine in particular and the educational expectations of a trainer.
3. Time lines – reasonable
4. Smaller steps to reach the goal eg deadlines, themes
5. How to present the achieved goals
An analysis of barriers and resources

The personal learning plan can be drawn up once all these preliminary steps have been completed. The tools would be used to identify ongoing learning needs and facilitate continuous reflection. However, from the bulk of prioritized needs, certain significant and important ones would be chosen to be integrated into the learning plan over a two year period.

The learning plan³

This is essential for both the registrar and the trainer. The plan depends on clear overall objectives based on the preparatory work, the steps in realizing these and a time frame. Hindrances and possible resources should also be identified.

There also needs to be an evaluation of the objectives once they've been reached and a system of reporting the progress achieved..

The Flemish programme requires three learning plans per trainer every two years. This has been achieved only partly as most of the trainers are general practitioners who do not have the time for what is at present a fairly complicated educational expectation.

Portfolio

The Flemish idea of the portfolio differs from that used in South Africa and the United States of America, where any learning activity could be captured in a portfolio.⁵ The ICHO portfolio is specifically linked to the learning plan and reflections preceding it and comprises all the foregoing as well as additional reflective tools e.g. the personal journal (addendum 4). The portfolio also contains "successful educational moments"³ or occurrences. This includes personal development, skills development, and improvement in systems and processes in the learning environment etc. There is also a general reflection on academic support during the process.

The South African situation

There is currently a performance management agreement in the public

Addendum 4: Personal journal

Date:.....	Learning objective: Management of older woman with osteoporosis	
Activity:	What did I learn?	How did I use this?
Read BMJ article	Calcium not helpful in current doses, ?hormones but risky	1. identified all patients c o/p 2. stopped calcium 3. did further search re hormones 4. Advising pat. accordingly
Date:.....	Learning objective:	
Activity:	What did I learn?	How using this knowledge

Addendum 5: The Performance Management Agreement (PMA)

Performance Management Agreement

- JOB DETAILS AND DIMENSIONS:** Persal number, salary level, Notcs, occupational classification, designation, job holder etc.
- DEPARTMENTAL AND REGIONAL STRATEGIC FRAMEWORK** – vision and mission
- JOB PURPOSE:** To take responsibility for clinical quality pertaining to primary health care and family medicine. To advise regarding all matters pertaining to the performance of the above-mentioned.
- JOB FUNCTIONS** – in essence, actual job description
- REPORTING REQUIREMENTA/LINES AND ASSESSMENT LINES** – explanation
- PERFORMANCE APPRAISAL FRAMEWORK-** under which the Key Performance Areas (KPA's) fall. The KPA's during the period of this agreement shall be as set out in a table, for example:

KEY PERFORMANCE AREAS (KPA's) Weight	Weight
1. For example: Clinical quality care	40%
Etc.	
	100%

TOTAL

- DEVELOPMENTAL REQUIREMENTS:** The requirements are aligned with the personal development plan. For example:

Competency	Action	Responsibility	Time frame	Expected outcome
1Emergency medicine	BLS/PALS/ ATLS	Supervisor –for budget	2005	Improved performance in management of emergencies and training of doctors and nurses

- TIMETABLE AND RECORDS OF REVIEW DISCUSSIONS AND ANNUAL APPRAISAL.**
- MANAGEMENT OF PERFORMANCE OUTCOMES:** According to Departmental policy and PMDS.
- DISPUTE RESOLUTION**
- AMENDMENT OF AGREEMENT:** Amendments to the agreement should be in writing and can only be effected after discussion and agreement by both parties
- SIGNATURES OF PARTIES TO THE AGREEMENT**

Addendum 5: PERFORMANCE WORK PLAN

Kpa'S	Kp INDICATORS/ ACTIVITIES/OUTPUTS	Performance measures	Resource requirements	Enabling conditions	1 st quarter	2 nd quarter	3 rd quarter	4 th quarter
		Target date person						

service which should be part of the contract of each doctor. (Addendum 5) This includes elements like the job description and work plan as well as the learning needs of the doctor and is based on the performance management agreement (pma) of the doctor's supervisor. The supervisor's pma is derived from the district director whose is a template of the chief director's and this is based on the annual performance management agreement used currently within the District Health System.

The learning plan as described in the Flanders training could be adjusted in order to become the flexible annual pma of each doctor.

In terms of the development of the pma, the reflective process could be followed as above, or slightly adapted. This would help the registrar and the supporting family physician to be very clear about their job descriptions, working plan and areas of learning.

The critical incidents register is related to a trend in medicine where more attention is being given to clinical mistakes and near misses. This would need to be managed very sensitively by the trainer or the trainer's mentor. It is also relevant where difficult interactions in a complex primary care team may be managed in a meaningful way.

Conclusion

In order for a very good educational initiative to be contextualized in South Africa, the suggestion of a performance management agreement which

is collaboratively developed with both trainer and registrar is a viable option. It should be based on reflection and validation of current strengths and weaknesses and the objectives need to be captured in the daily work plan of the family physicians.

The area in which there is a constraint, is where private practitioners are involved in the training as they do not have pma's. However, the development of a pma may be one of the criteria used in choosing private general practitioners as university appointees, for the envisaged registrar training. ✎

Acknowledgments to Sandrina Scholl from whose doctoral studies most of this material comes

Kindly contact the author to obtain electronic files of the addendums.

References

1. Goldstein I. Training: program development and evaluation. Belmont, California: Wadsworth Publishing Company, 1974.
2. Kolb DA. Experiential learning. Experience as a source for learning and development. New Jersey, Englewood Cliffs, Prentice Hall Inc., 1984
3. Scholl S. Agogische Bekwaamheid van Praktijkopleiders in de huisartsgeneeskunde. Vrije universiteit Brussel, 2003
4. Rughani A. The GP's Guide to Personal Development Plans, Radcliffe Medical Press, 2000.
5. Eve R. Learning with PUN and DENs – a method for determining educational needs and the evaluation of its use in primary care. Education for general practice 2000;11:73-82
6. Scholl S. Persoonlijk Leerplan en Portflio voor praktijkopleiders en stage-coördinatoren. ICHO, 2002

When your patients cannot hold back any longer



R
Detrunorm[®]
propiverine hydrochloride

Detrunorm Tablets. Each tablet contains 15 mg propiverine HCl
Reg. No.: 36/5.4/0019
Pharmatrica (Pty) Ltd.
Tel: (011) 493-8970



ULTRASOUND SKILLS TRAINING

Medical aid approved HANDS ON TRAINING with 8 CPD points

•
Basic, Abdominal, Obstetric and Pelvic in one SUNDAY!

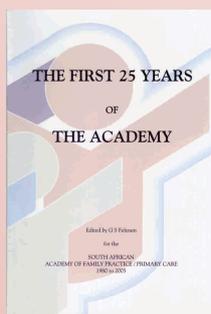
•
Optional VIDEO (VHS or DVD) and ATLAS of ULTRASOUND

FOR DETAILS PLEASE CALL:
(012) 650 0128

OR
082 786 4870

info@ultrasoundtraining.com or
www.ultrasoundtraining.com

1980-2005: The first 25 years of the South African Academy of Family Practice/Primary Care



"To raise the self-esteem of the general practitioner by demonstrating that his/her field is as intellectually demanding, as emotionally taxing (and rewarding), as socially necessary and, requiring a training as rigorous as for any other medical field or discipline" ...this was perhaps one of the most important aims of the SA Academy of Family Practice/Primary Care.

The perfect gift for only R100.00 per copy

Edited by Prof Sam Fehrsen.

Order your copy from Jeanette Pritchard at (011) 807 6605.