MAKING THE MOVE FROM CONTINUING EDUCATION TO CONTINUING PROFESSIONAL DEVELOPMENT  

Douglas Hancox introduces our new section, entitled “Continuing professional development”, which replaces “Continuing education”. He explains why CPD is of greater practical value than continuing education and encourages pharmacists to embrace it so that they can be learning on a day-to-day basis.

The past four or five decades have seen an explosion of new knowledge relevant to the practice of pharmacy. In addition, particularly in the past decade, there has been a vast change in the practice of pharmacy. The old model of community, hospital, industry, and academia, with pharmacists engaged in one or other of these areas, has been replaced by one incorporating a wider range of practice in primary care. Moreover, many pharmacists are now engaged across two or more areas of practice. In community practice faithful response to prescriptions written by general practitioners, coupled with relevant advice to patients, has been extended to cover prescribing advice to general practitioners and the delivery of pharmaceutical care to patients in the pharmacy and to those in residential homes and nursing homes. And, without a doubt, we can expect even more change in the future.

Keeping our knowledge and skills up to date and addressing new concepts in the delivery of pharmaceutical services have been major challenges. But the challenge is not by any means over. Indeed, it will probably grow even more.

Over the past 40 years we have responded to this challenge with continuing education (CE), and pharmacy CE has been a notable success. There is no need to knock it.

Initially, evening meetings, study days and short courses were organised by local branches of the Royal Pharmaceutical Society and by a number of the schools of pharmacy. In the 1980s, the College of Pharmacy Practice and the UK Clinical Pharmacy Association were established to promote the development of pharmacy practice and to provide further CE opportunities for their members. Regional support for pharmacy education and training became available within the National Health Service. This provided further CE activities and the development of structured training programmes within the managed service. Schools of pharmacy further responded by introducing postgraduate qualifications in hospital and clinical pharmacy extending to the broad range existing today. Within Wales, Scotland and England the centres for pharmacy postgraduate education were established to provide both face-to-face workshops and distance learning courses to update pharmacists’ knowledge and to encourage the development of pharmaceutical services in line with NHS and Society aspirations.

As part of this emphasis on CE, the Society encouraged us to engage in a minimum of 30 hours of CE each year and the College of Pharmacy Practice required this of its members. The issue of mandatory CE was debated within the profession. Pharmacy was not alone in these matters. A somewhat similar emphasis on CE was to be found in medicine and nursing, in engineering, in law and in other professions.

SHORTCOMINGS OF CONTINUING EDUCATION

However, by the early 1990s it became clear that an emphasis on CE, as a means of keeping up to date and of identifying pharmacists who were “fit to practise”, had serious shortcomings. A different response and better and more extensive advice and support were needed.

So what is the problem with CE? First, the focus on CE had marginalised the significant learning and development that occurs as we attend to day-to-day practice activities, from finding solutions to everyday problems, from following up questions asked and comments made by others, from training preregistration trainees, technicians and assistants. Such learning and development needed to be recognised, encouraged and supported.

Secondly, it had also neglected the contribution that the study of articles in The Pharmaceutical Journal and other professional and scientific journals made to our learning and development; this aspect was similarly neglected in respect of the self-directed study of relevant textbooks and reading. Other ways of learning and development, such as shadowing another pharmacist or other health professionals, were also not being recognised.

With CE, the content and direction and the aims and objectives of the workshops, packages and courses was determined by the CE providers — albeit after consultation with practitioners. Although this met the general needs of many pharmacists, it was not tailored to individual pharmacists. Many therefore found that the CE activities in which they engaged did not fully meet their requirements; indeed, for some of their needs relevant CE activities were not available. Moreover, pharmacists who relied solely on the CE activities were often unaware of the gaps that existed in their knowledge and skill.

A further shortcoming lay in the area of assessment. With the exception of the postgraduate certificate, diploma and masters courses provided by the schools of pharmacy there was rarely any assessment of the impact of the CE activity on a pharmacist’s knowledge or skill. In no cases was there any assessment of the impact on a pharmacist’s practice.

THE CONCEPT OF CONTINUING PROFESSIONAL DEVELOPMENT

It was from considering such issues that the concept of continuing professional development (CPD) emerged.

CPD has been defined by the Society as “the process by which pharmacists continuously enhance their knowledge, skills and personal qualities throughout their professional careers”. The concept was a much broader and deeper concept than that of CE. CE became but one part of the continuum of learning experiences in which we were encouraged to engage. Furthermore, CPD required us to take personal responsibility for the identification of our learning and development needs and, importantly, for subsequent evaluation of our success in meeting those needs. We, not others, were to be the drivers of our learning and development.

Critically, we were encouraged to plan our CPD individually, to relate our current levels of competence, knowledge and skill to those expected by the profession and to identify where further enhancement was needed to extend our roles and responsibilities. Hence the inclusion of professional audit, performance appraisal and related activities was included within the advice given by the Society from the mid 1990s.

Clearly, the concept of CPD is intimately linked with that of lifelong learning. In both cases they are personal behaviours; they are not curricula imposed by a professional body or government department.

In advising on CE, within the concept of CPD, the Society encouraged activities such as self-directed reading and study of journal articles and textbooks, participation in local study groups and the keeping of a practice diary or journal.

Advice and support has continued to grow in respect of CPD and we are all now familiar with the Society’s structured CPD.
cycle of reflection, planning, action and evaluation. Reflection leads to the identification of our learning and development needs. This is followed by the prioritisation of those needs and the matching of an appropriate way in which they can be met. Following completion of the learning activities we evaluate their success. The recent pilot study of CPD carried out by the Society identified that many pharmacists would benefit from having access to facilitators. This issue is currently being addressed by the Society, the national centres for pharmacy postgraduate education and education and training pharmacists within the NHS and multiple pharmacy organisations. However, we should not lose sight of the need for personal responsibility for CPD. Many of us will be able to undertake CPD alone without accessing facilitators; others will gain support by discussing their CPD with friends and colleagues.

EMBRACING CONTINUING PROFESSIONAL DEVELOPMENT

Embracing CPD will put us in a “learning” mode on a day-to-day basis; we will no longer separate “learning” from “practice”. We will be able to integrate the informal learning and development that occurs from attending to day-to-day practice activities with the structured learning and development that we undertake to meet specific learning and development needs that we have identified within the practice setting.

The outcome of embracing CPD must surely be our personal growth, greater career satisfaction and enhanced service to the communities we serve. It is applicable to every pharmacist in all areas of pharmacy practice. It applies to academic, industrial and research pharmacists as much as to those in community, hospital and primary care practice. It applies to those in journalism and administration. We will all benefit from its adoption. Collectively the profession will achieve its vision for pharmacy, and employers’ goals and the Government’s goals for the NHS will be effectively addressed.

In addition, while its primary role is that of facilitating our personal growth CPD will also enable us to demonstrate our “fitness to practise” to the individuals and organisations that we serve.

Professional and scientific journals make a valuable contribution to our CPD. They provide us with comment, news, reviews, summaries, descriptions of practice innovations, original research papers and opportunities to enter into debate on pertinent issues.

All pharmacists receive The Pharmaceutical Journal every week; for some this is the only journal they receive. Regular reading of the PJ keeps us aware of professional developments such as the Pharmacy in a New Age, medicines management and pharmacist prescribing initiatives. It also keeps us aware of Government policy for the NHS, of the national service frameworks and of the work of the National Institute for Clinical Excellence. All of these issues need to be considered when determining our personal learning and development needs.

Within its pages there are numerous other triggers in respect of CPD. Some examples of recently published news items have been:

- Passive smoking associated with development of adult asthma
- Large study shows esomeprazole more effective than lansoprazole at healing erosive oesophagitis
- No good evidence for popular PMS treatments

How familiar are we with these items? How strong is the evidence? Do we need to follow up these items? Are they applicable to our practice? From consideration of such questions we might seek further references or discuss the issues with medicines information departments. The outcome from such actions might be in us giving proactive advice to physicians.

Some other recent news items were:

- Older people with depression or dementia need pharmacists’ support
- OTC medicines misuse and addiction: what can pharmacists do to help?
- Patients not warned about side effects of psychiatric drugs by their doctors
- Pharmacists can play an important role in preventing falls in older people

Are these issues that we need to address? Do we need further knowledge and skills to address them? Again, from such questions we might be led to seek further comment from pharmacists who have addressed the issue already or to work conjointly with fellow pharmacists and other health care professionals to address the issue.

The PJ also regularly publishes CPD articles. These have a triple role. They can reassure us that our knowledge is up to date, they can act as triggers alerting us to areas that we need to follow up and they can also be a major source for meeting identified learning and development needs. Examples include the series on pharmaceutical care and on nutraceuticals, those on cystic fibrosis and on motor neurone disease and those on travel medicine. Finally, there are articles on the concept and process of CPD. Undoubtedly more will follow as the Society’s CPD pilot is rolled out and the Society provides us with appropriate guidance and support.

In conclusion, CPD is not an optional extra; it is part of being professional, of being a pharmacist, part of our normal behaviour and practice. This is reflected in the PJ and in other professional journals; regular reading and study of these journals should be part of our CPD and the professional journals will, we hope, continue to identify ways in which they can provide us with appropriate support.

FURTHER READING

- Hancox D. We need to rise to the challenge of CPD. Pharm J 2001;266:887.
- Steel S. Competence-based practising rights — we need the right tools to deliver the goods. Pharm J 2001;266:505.

Continuing education articles, volume 267, January to June, 2001

- How dietary interventions could ameliorate the symptoms of autism (P. Shattuck and P. Whiteley), 7 July 2001, p17.
- Continuing professional development: Find out about learning styles to learn and teach effectively (R. McGuire), 14 July 2001, p53.
- Travel medicine: (10) Medical kits for travellers (L. Goodyer), 4 August 2001, p154.
- Enteral feeds explained (P. Murphy), 1 September 2001, p297.
- Vitamin and mineral supplements (C. Waine), 15 September 2001, p352.
- Personal development planning (R. McGuire), 27 October 2001, p998.
- Diseases of the skin and their treatment: (1) Acne (B. Canliife), 24 November 2001, p749; (2) Rosacea (B. Canliife), 1 December 2001, p782; and (3) Eczema (B. Canliife), 15 December 2001, p855.

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