Personal Development Plan (PDP)

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Abstract

This paper outlines the processes followed in an Individual approach to developing a Personal Development Plan (PDP).

Key words: Personal development plan, trainers, trainees

Introduction

As said by Benjamin Franklin, ‘‘By failing to prepare, you are actually preparing to fail.’’ Planning is the most important stage before an individual aims to do anything. Planning is required in every stage of an individual's life no matter how big or small the aim is. This makes the work go better as the individual has an outline or a map in their mind as to what they want to achieve from this objective. Here we outline how to set PDP for a new GP who is training to become a trainer.

With the recent development of modern education and training in medicine, personal development planning has taken the key role in helping the trainers as well trainees to attain their educational goals and demonstrate the evidence of continuous professional development (CPD). Hence, PDP has taken a core place in all the medical portfolios of doctors in training as well as senior doctors in the UK. The development of (Personal Development Plans) PDPs and the evidence of their completion has become an essential part of doctors' portfolios as directed by General Medical Council (2012). This is now an essential requirement for revalidation. ‘’Revalidation is a process, by which doctors demonstrate that they are up to date and fit to practice’’ (RCGP). It has also been highlighted in the good medical practice report by GMC that all doctors are legally responsible to keep their knowledge and skills up to date through CPD and PDPs (GMC CPD for all doctors 2012). So, PDP has become an integral part of RCGP Toolkit (Clarity).

Despite the popularity of PDP, it is not without arguments. Greenan (2016) proved in a case study, that there is an orientation in the participants to choose their favourite areas of skills and direct their PDPs in the same line. Some participants found it a laborious and time wasting exercise. However, these pitfalls can be rectified in the medical profession with yearly appraisals and the appraisers and trainers guiding the appraisees and the GP trainees towards areas which need more professional development than their own areas of interest. A good trainer should be able to learn this behavioural propensity in his / her trainees quite early.

According to Beausaert et al (2011), PDP is a cyclical process which requires setting goals, then setting out an action plan for it, recording the outcome, evaluating it and then identifying further areas of development and setting up the next plan (Figure 1).

Keeping this model of PDP, now we will move onto the three main areas of my personal development plan as an educator. The PDP is summarised in tabulated form at the end of the essay.

Science of Learning Behaviours

In any form of teaching, it is natural and very important for a teacher or trainer to understand the learning behaviour of each trainee along with their educational background. This is key information which is required to deal with the huge educational diversity, a GP trainer has to deal with all the time. In the same surgery, under the same trainer, there could be trainees from ST1, 2 or 3 years and all of those could have a different level of previous clinical experience, knowledge and skills. Moreover, they could all be from different cultural backgrounds, i.e., International Medical graduates or UK medical graduates, etc. It is a well-accepted fact that learning behaviours can differ on the basis of the background of a learner.

There are various learning theories described in literature, however broadly speaking, the theories include the behavioural theories, cognitive learning theories and developmental learning theories. The behavioural learning theories involve learning through the environment. They are more likely to focus on the stimuli and the response (Pedler, Burgoyne, and Boydell, 2013). They tend to believe in the phenomena of learning through observation. Learning through observation is done in the environment a person lives in.(Figure 2)

The implication of this theory to the medical educator is that the educator can make the students learn on specific subjects by planning certain activities through which the students are likely to learn by observing the people around them or by reacting to the stimuli presented to them. The medical educator can reward those who perform well. This will make the students repeat the same behaviour in the future (Dowling, 2014). This way they will get first-hand experience of what they are learning and what the educator is trying to teach them.

Another theory which can be used by the medical educator is the cognitive learning theory. The cognitive learning theory states that the individuals tend to learn only by the mental inputs and processes present within them (Kolb, 2014). The role of environment in the learning process is very minimum and the cognitive processes and inputs presented to the individuals contribute to their learning to a great extent.

The cognitive learning theory can be implicated by a GP trainer. The trainer can make the students learn through the verbal lectures given in the class. The students can listen to the lectures carefully and input what the educator has taught them with the aid of their mental processes (Beausaert, Segers, and Gijselaers, 2011). The mental processes present within the students will help them retain the elements of the lecture within their mind so that whenever they need to use the required knowledge in their professional life they are able to recall.

Figure 1

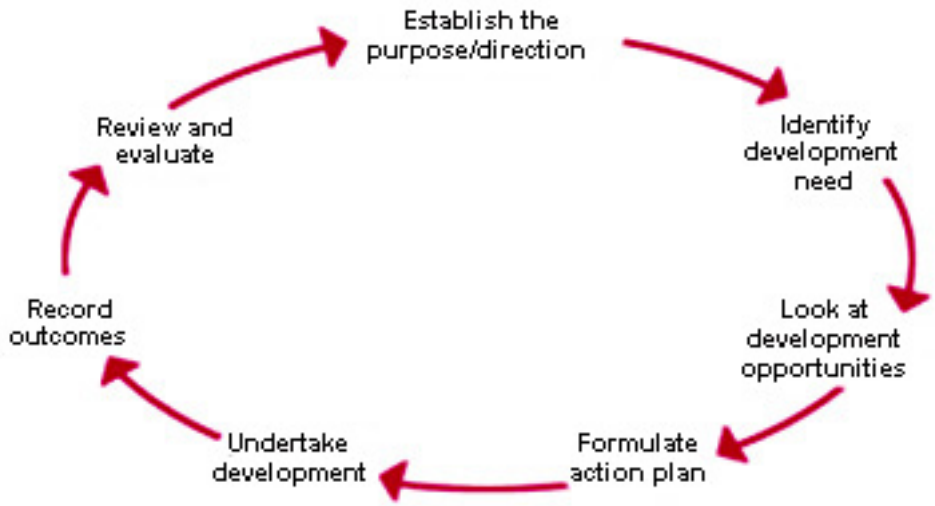


Figure 2

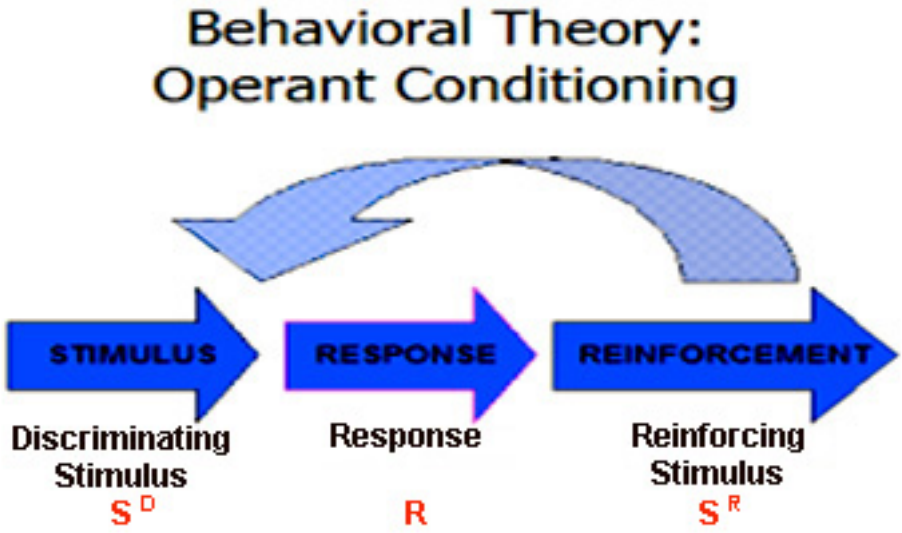
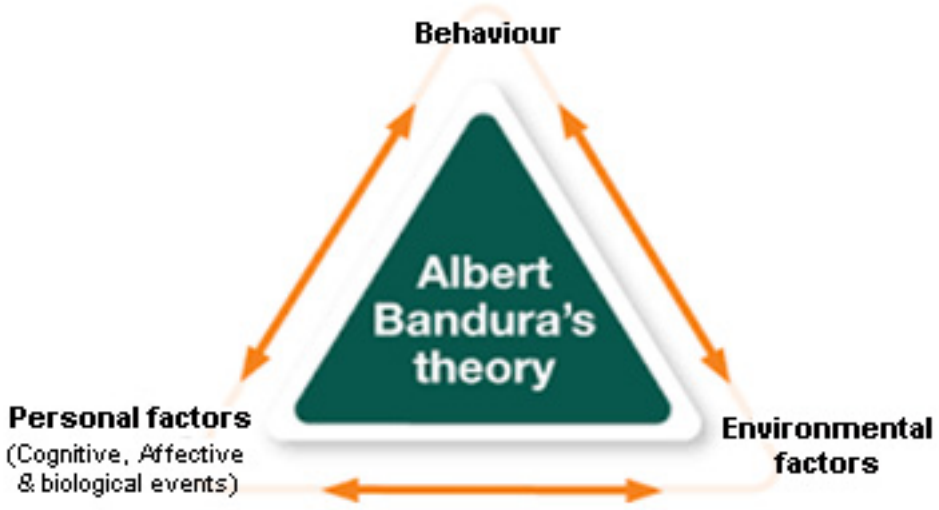


Figure 3



PERSONAL DEVELOPMENT PLAN:

Personal Goals	Learning Objectives	Time Scale	Activities to be used	Outcomes or evidence
To make myself well educated about learning behaviours of various trainees with various cultural and educational backgrounds (Diversity).	Knowing the individual learning behaviour and habits of trainees is the key to deliver any sort of education or training. Improving this key skill then can help me tailor the delivery of training according to the individual needs of the trainees with diverse backgrounds.	18 months	Attending 3 courses on education and learning behaviours. National Resource Centre for Supplementary Education offers a number of courses	Attendance at the course. Discussion with senior trainers in the practice. Feedback from trainees.
Improving my tutorial skills (Small Group teaching skills).	Tutorial is an important tool of delivering training to GP trainees. This helps delivering clinical knowledge and skills as well as giving an opportunity to the trainer to understand educational and cultural diversity of various trainees. Improving this skill will improve me as a GP trainer.	12 months.	Attending tutorials with senior trainers and learn the tips from them. Inviting the senior trainers to supervise my tutorial sessions. Recording the tutorial sessions.	Feedback from the senior trainers as well as from trainees Watching, comparing and analysing the recorded tutorial sessions with senior trainers and recording the feedback.
Improving my feedback skills	Delivery effective and constructive feedback is perhaps the most important educational skill. Improving on this skill, not only helps with the delivery of day to day training but also with writing up the educational reports for trainees.	12 months.	Attending workshops on feedback skills Attending and recording at least 2 ESR / CST meetings with senior trainers.	Collecting feedback from trainees. Collecting feedback from senior trainers.

The implication of developmental theory of learning to the medical educator is that the students in GP training are mature enough to learn things as they exhibited in the environment on their own. They are likely to grow more when they reach their professional career. During their professional career, they will be able to exhibit a lot of new things which they will not able to get experience of during the GP training (Beausaert, Segers, and Gijselaers, 2011). The educator can leave some of the learning parts for their actual professional career which the students will enter. With time their minds will develop and they will be able to learn new things.

Another theory which the medical educator can use is the Humanistic theory of learning. The humanistic theory of learning was developed by Albert Bandura. The theory states that the individuals are likely to learn by observing each other i.e. through modelling (Busse, Aboneh, and Tefera, 2014). The individuals are likely to adopt a certain behaviour if they see another person doing the same behaviour. The individuals are more inclined towards learning the desired behaviour if they see someone similar to them doing that behaviour (Figure 3).

The implication of the humanistic theory of learning to the medical educator could be that the medical educator can arrange a pseudo model as their classmate (Ward, 2016). The classmate can act accordingly to the desired behaviour and the students will copy the behaviour of this pseudo model as they are likely to learn more from each other by observing. This purpose can be achieved by mixing GP registrars during their half day release sessions and arranging some small group learning sessions where they may have an opportunity to learn from each other.

Similar concepts pertaining to learning theories are also well explained and well supported by Bloom's taxonomy (Bloom et al 1956). As we found a number of examples of evidence in literature about the importance of learning the learning behaviours of students to educate them better; no evidence was found against it. This further signifies how important this skill is in the personal development of a GP trainer.

With this brief introduction to various learning theories, I plan to attend few training courses on this topic to develop this skill in myself as a future GP trainer and medical educator. There are a number of institutions that offer a large number of courses With these learning courses, I plan to discuss the summary of each course with senior trainers in the practice and take feedback from them as well as from the trainees.

Improving Tutorial (Small Group Learning) Skills

Small Group Learning or tutorial sessions are no novel teaching tool. They have been under use since the time of Socrates more than 2,000 years ago. This method allows a closer relationship amongst the participants of the group and enhances contribution from the participants. This is a more interactive way of teaching and learning. It encourages reflective practice. Especially in GP settings, teaching a group of GP registrars with massive educational and cultural diversity, tutorial is a very helpful tool to promote self-directed learning amongst registrars. Jones (2007) defined it as a small group of learners demonstrating three common characteristics; active participation, a specific task and reflection.

Rotem and Menzie (1980) described the role of small group learning in medical education. While describing the underlying issues with small group learning, they also gave practical suggestions to facilitate the learning activity. Jones (2007) rightly posed some limitations to small group learning as this is an expansive tool of teaching due to the high tutor: student ratio. Hence if the teacher is not well skilled, the activity is not only a waste of time but money also. In fact, if this type of teaching activity is held by an inexperienced teacher or facilitator, it may actually become a didactic lecture (Jason et al 1982). However, the lecture still remains the most popular way of delivering education in most institutions. This is because, this is the most suitable way of delivering knowledge in large groups. However, a well-skilled teacher can make even the lectures, more interactive and interesting (Mehay R, 2012).

In small group learning, a teacher should behave as a facilitator and not as a lecturer. All the participants should be encouraged to participate in the discussion or the activity. There is always a risk of some difficult questions posed by the participants which could be difficult for the facilitator to answer. However, the facilitator need not to be able to answer all the questions, and the un-answered questions can highlight the areas of further development and can be a topic for the next session.

In order to achieve this PDP, I will first, observe few tutorials delivered by senior trainers, and if possible, with permission, will film those sessions. Then while organising my own sessions, I will invite my senior trainers to supervise the session and again, possibly record it. Then collecting the feedback from the senior trainer as well as the trainees, this session can be viewed again at a later time and discussed with the colleagues and senior trainers. An overall improvement should be evident after around 5 sessions. This may take up to twelve months.

Improving Feedback Skills

I chose this as a third part of my PDP, because giving effective feedback has a key role in motivating the trainees and guiding them in a positive direction. It is easy to give good feedback to a good trainee, however, dilemma comes when it is time to deliver difficult feedback to a trainee in need. When I was a GP trainee, my trainers used to give feedback in a somewhat good-bad-good style.

Effective feedback skills are not only useful for trainers but have utmost importance for trainees to guide them in positive direction and avoid negative behaviour. On the contrary, bad feedback can seriously affect the trainee, by undermining his / her confidence and can create a negative attitude. Brukner et al (1999) and Krackov (2011) conducted large studies which concluded that a negative experience of feedback was a result of cultural hierarchy, where feedback was a one-way delivery of information from teacher to student. Ramani and Krackov (2012) set out twelve tips for delivering useful feedback (Table 2).

This list looks exhaustive and a bit difficult to put fully into practice. However, the gist is simple. The feedback should be based on facts, delivered as close to the event as possible, and the way of delivery should be constructive and non-judgemental. Using neutral language, it should conclude with a mutually agreed plan for further development (Mehay, 2012).

In another study done by Hattie et al (2007), four levels of feedback are mentioned. Level-1 is about the subject or the case discussed, level-2 is about trainee's strategies to perform the task. Then level 3 and 4 were about the trainee himself / herself and his / her confidence level. Dweck el al (2006) also supported this idea and further emphasized that praise and admiration in levels 3 and 4 can actually be a negative factor on performance. Daniels et al (2001), however, differed from this opinion and proved in their study that the more positive feedback a trainee received the more self-confidence he / she develops towards achieving mutually agreed goals. I guess, this is all based on cultural and educational diversity and learning behaviours.

Although numerous feedback models have been described by various authors, however, Pendleton et al (2003) simplified the process of delivering feedback, based on his study about the consultation model. The study suggested mainly three areas of delivering feedback; firstly, clarifying the facts with the trainee, secondly, focussing on what went well (both, what trainee thinks went well and what trainer thinks went well), lastly, focussing on a mutually agreed improvement plan. Pendleton's work is not without criticism. Mehay (2012) stated that in Pendleton's rules, trainees are allowed to give their feedback on their own performance in a judgemental way which should be discouraged by the trainers.

As a conclusion, feedback should be based on facts and not personal opinions; it should be tailored according to individual trainee's needs and cultural and educational diversity. It should be delivered as close to the event as possible, so both the trainer and the trainee remember the events well. The goal of feedback should be positive, appreciating the good work however, keeping the language neutral and non-judgemental while delivering the feedback regarding areas of improvement. Both the trainer and the trainee need to agree towards the end on further development plans and common goals.

Conclusions

• In my personal development plan (PDP), the first domain (learning behaviours) holds the key role in the whole process which then can help in improving the small groups learning practice as well as developing effective feedback skills.
• By attending the training courses as mentioned earlier, and participating in feedback sessions, tutorials and ESRs (Educational Supervisor's Report) and CSRs (Clinical Supervisor's Report) will certainly help me to achieve all domains of my PDP.
• Requesting senior trainers to supervise my sessions and then getting feedback from them along with feedback from the trainees can improve my personal skills to a great extent which would eventually improve me as medical educator.

Table 2

Practice points
Establish a respectful learning environment.
Communicate goals and objectives for feedback.
Base feedback on direct observation.
Make feedback timely and a regular occurrence.
Begin the session with the learner's self-assessment.
Reinforce and correct observed behaviours.
Use specific, neutral language to focus on performance.
Confirm the learner's understanding and facilitate acceptance.
Conclude with an action plan.
Reflect on your feedback skills.
Create staff-development opportunities.
Make feedback part of institutional culture.

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