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Reflection, self-assessment and continuous professional development: an opinion paper

Hesta Friedrich-Nel *Dip Rad (D), Dip Rad (Ther), M Rad (Therapy), PhD HPE*

Assistant dean: Faculty of Health and Environmental Sciences, Central University of Technology, Free State

Abstract

The Health Professions Council of South Africa (HPCSA) introduced the continuing professional development (CPD) system for all practitioners in 2007. The HPCSA did however identify shortcomings to the current CPD system and has proposed a maintenance of licensure (MOL) model. This article unpacks what the MOL entails in terms of clinical competence, reflection, reflective practice, and self-assessment. The MOL proposal intends to verify that each HPCSA registered practitioner maintains and improves professional knowledge, skills and performance for improved patient outcomes and health systems. Evaluation of competencies and performance through self-assessment would be required. A reflective practitioner is actively involved in their own personal development, and uses ongoing reflection-in-action and identifies development needs through self-assessment. Reference is made to other studies to analyse the implementation of reflective practice, reflection and self-assessment linked to CPD activities. In view of reflection, reflective practice and self-assessment described in the literature to self-report on CPD, it is apparent that it may or may not be the panacea to address the criteria of being 'sufficiently experienced', 'clinically competent' and a 'reflective practitioner'. Ethically, practitioners should not have to depend on any CPD model to best serve the needs of the patient and provide optimal patient-centred care.

Keywords reflection, clinical competence, maintenance of license

INTRODUCTION

The Health Professions Council of South Africa (HPCSA) introduced the continuing professional development (CPD) system for all practitioners in 2007.[1] To earn continuing education units (CEUs), a practitioner has to attend accredited events such as seminars, conferences and reading programmes. The goal is to update a practitioner's knowledge and skills and to support ethical clinical practice. The reality, based on relevant literature, is that there are indications that this system has shortcomings. By merely signing an attendance register without verification of identity documents and collecting a CPD certificate at the end of an event, delegates can obtain the allocated CEUs. Cole refers to this CPD verification process as 'input-led' because there is little emphasis on output and outcomes.[2] Another limitation linked to this specific CPD system is failure to commence each CPD event with the attendees doing a self-assessment on each of the papers to be presented and then, at the end of the event, for them to do another self-assessment to determine whether they did gain additional knowledge and skills. The assumption is that each CPD event contributes to enhancing healthcare practitioners, such as radiographers' knowledge and skills and thereby improve service delivery to patients.

The above scenario raises questions, such as: Was the specific content of the CPD event relevant to the work content of the delegates? Can the delegates claim that there was an addition to their clinical competence at the end of the event? And if so, how can the evidence be provided? With these questions in mind, the Society of Radiographers of South Africa (SORSA) in 2017 suggested that it would be of value to determine whether CPD events did address and improve service delivery to patients. Members, and non-members, were invited to participate in a Survey Monkey© survey and online questionnaire on the application of ethics principles in their daily practices.[3] Some of the questions that the 292 radiographers responded to, were whether they agreed that the content of ethics CPD activities enabled them to enhance patient-centred care. The result was that most respondents (77%) agreed that they indeed could apply the principles of patient-centred care.

The HPCSA CPD committee, once a year, randomly selects the portfolio of evidence of registered practitioners to verify compliance with the annual required 30 CEUs (25 general and five in the category ethics, human rights and medical law). Compliance and competence should perhaps not be regarded as synonyms. And so, the HPCSA believes that a model mirroring real learning and reflecting improved professional competence and performance is needed to complement the current CPD system based on 'input' and compliance.[1]

MAINTENANCE OF LICENSURE

Upon critical reflection on the CPD process, informed by relevant research and international trends, the CPD committee of the HPCSA "decided that all practitioners will be required to have a license to practice their professions" thus the HPCSA has proposed implementing the maintenance of licensure (MOL).[1] See Figure 1.

The proposal intends to verify that each HPCSA registered practitioner "maintains and improves professional knowledge, skills and performance for improved patient outcomes and health systems."[1] This article unpacks what the MOL entails in terms of reflection, reflective practice, and self-assessment.

The MOL depicts that practitioners, when applying this model, will need to reflect on their own practice and then add a self-assessment of their professional competencies to their portfolio of evidence. Based on the self-assessment of competence, own learning needs would be defined, and an individual learning plan compiled. Practitioners would then im-

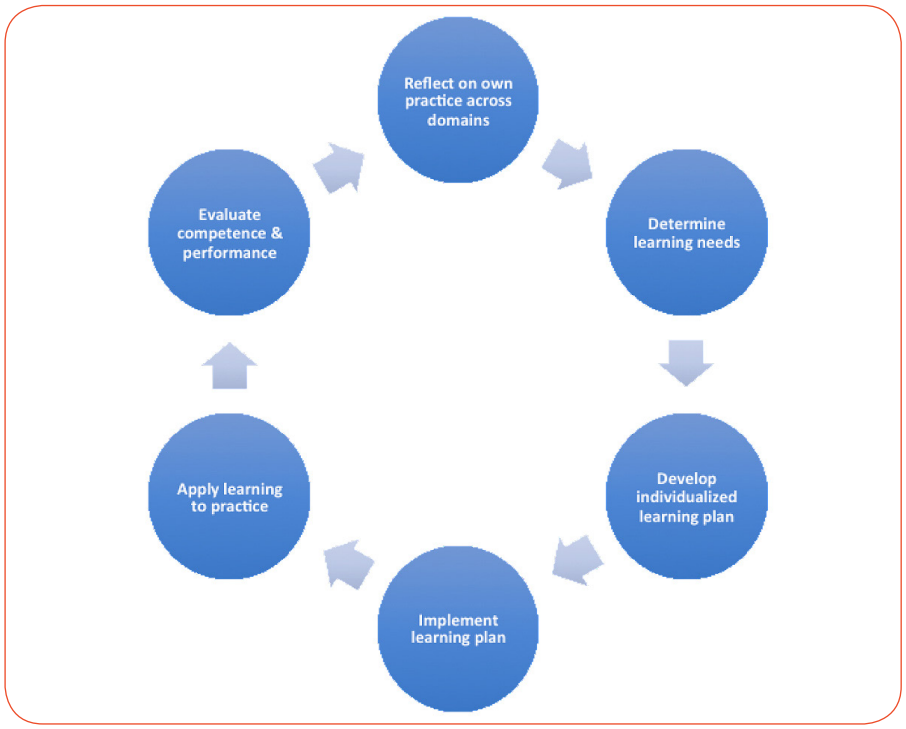

Figure 1. HPCSA model for maintenance of license to practise.

plement the learning plan and apply it in their respective clinical practices.

An individual learning plan can be attained through a variety of accredited and/or non-accredited events, leaving practitioners with the flexibility to design their own CPD programme. Examples of events are 20 hours of continuing education to improve performance; accredited events such as conferences, seminars and publications; and non-accredited activities such as journal readings and self-directed reading programmes. There is also the option to participate in peer review activities for 10 hours per year. Lastly ethics-related learning for a minimum of five hours per year is necessary. A practitioner must evaluate his/her own practice once a year, either by a systematic critical analysis or request a senior manager to do so.[1]

Evaluation of competencies and performance through self-assessment is required. These will include: an audit of practice or work ethic; feedback from peers in the same profession; feedback from patients and co-workers, families, and from other colleagues who work with the practitioner who are not necessarily from the same profession. In addition, the reflection on practice includes four domains: professionalism; safety and quality; communication; and knowledge, skills and performance.[1]

The HPCSA explains the domains as follows. Professionalism refers to good practice, integrity and intercultural competence. Safety and quality relate to systems to protect patients (e.g. radiation safety), responses to safety risks, and how patients are protected from risks posed by colleagues. Communication entails effective processes, working constructively with colleagues and, where necessary, delegate effectively. Professional knowledge, skills and performance refers to the development and maintenance of professional performance, to apply knowledge and experience to own practice and to maintain accurate records of all the above.[1]

Since all practitioners register upon obtaining a prescribed qualification from an HPCSA accredited training facility, the professional body can assume that each practitioner has 'sufficient experience' as stated in the HPCSA's 2016 general ethical guidelines for the healthcare profession: Booklet 1 section 5.[4] To be 'sufficiently experienced', a practitioner must perform a minimum number of interventions annually and have undergone appropriate accredited further training to practice new interventions within each practitioner's scope of practice. Interventions on patients must only be performed when it is in the best interest of the patient, considered safe for the patient and under optimal conditions and surroundings.

In addition to the portfolio of evidence, the HPCSA states that a practitioner's competence and performance will be evaluated once every five years.[1] This evaluation can be a competence (summative) assessment, an online assessment through a training institution and feedback from specific and relevant role-players on a practitioner's performance and capabilities. To the best of my knowledge a document that lists either the minimum number of interventions that each practitioner, such as a radiographer, must perform annually, does not exist. Also, the assessment criteria to guide the performance assessment are not yet available or published. The Professional Board for Radiography and Clinical Technology (RCT) Board manager confirmed this assumption in writing after SORSA questioned the matter. In addition, the RCT Board confirmed that a list with the minimum number of interventions to determine if a practitioner is 'sufficiently experienced' was not yet populated. In fact, the RCT Board manager re-iterated each practitioner's responsibility to maintain knowledge and competence through CPD.

On the one hand, practitioners need to applaud the HPCSA for recommending a more flexible and individualised CPD system, aligned with international trends. However, the incomplete guidelines, vague criteria, non-defined procedures, interventions, procedures to monitor, evaluate, and assess or validate the addition of clinical skills once the MOL is implemented, may cloud these good intentions. And so, the question how the HPCSA intends to verify that a practitioner is 'sufficiently experienced' and 'clinically competent', remains without a valid response. A sound beginning is to explore possibilities and unpack concepts referred to. In the next section clinical competence, reflection, reflective practice and self-assessment are considered to create awareness and to better comprehend the HPCSA's proposed MOL.

CLINICAL COMPETENCE

In the literature on medical education, Miller's[5] framework for clinical competence assessment is commonly used as the baseline to describe, define and determine clinical competence. The framework is illustrated in the shape of a triangle or pyramid. The base is depicted as knowledge (knows), followed by competence (knows how), performance (shows) and

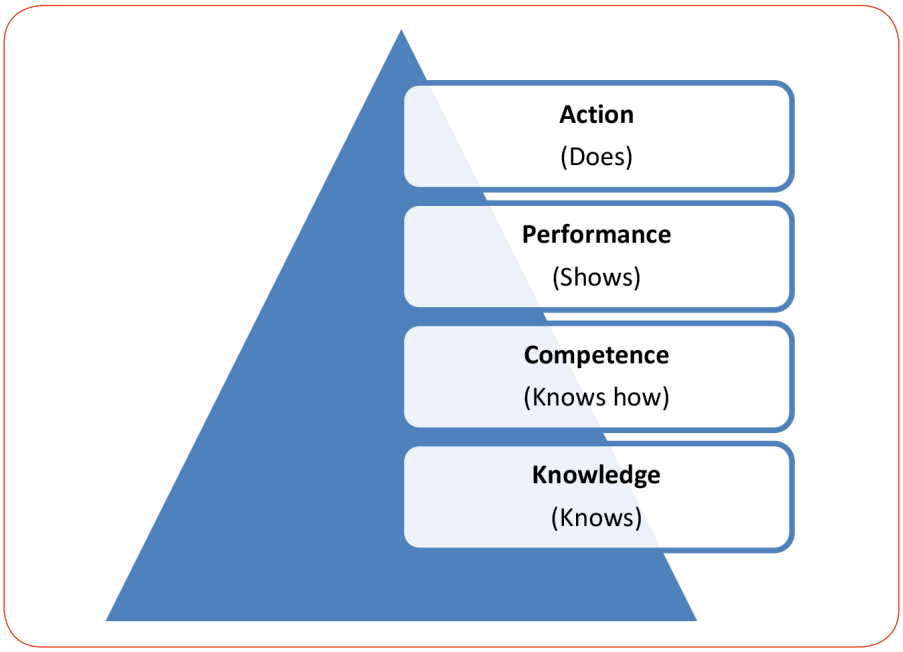

Figure 2. Miller's framework of competence (adapted from Miller[5]).

action (does) is at the apex (Figure 2). The assumption is that HPCSA registered practitioners, because of their qualification, are declared clinically competent and have 'sufficient experience' to operate in the 'does' domain of the framework. The HPCSA intends to confirm ongoing learning by implementing the MOL. Authors who interpret Miller's framework are also clear that to determine competence, performance must be measured using clear criteria. In addition, feedback is needed to indicate the strengths and address shortcomings in clinical competence.[5]

In South Africa, the Medical and Dental Professional (MDP) Board implemented roles with key and enabling competencies for a healthcare practitioner. These are applied in undergraduate students' education in clinical and dental programmes in South Africa.[6] The roles, adopted from the CanMeds Physician Competency Framework 2005,[7] are: healthcare practitioner (central) and communicator, collaborator, leader and manager, health advocate, scholar, and professional. The MDP Board will therefore be able to determine and verify competence in these specific professions based on these competencies. Regrettably, the roles and enabling competencies are limited to MDP practitioners and not defined or universally apply to all the healthcare professions in South Africa. This scenario creates a potential knowledge gap and the RCT Board will have to address this shortcoming to assure the correct implementation of the MOL.

REFLECTIVE PRACTICE, REFLECTION AND SELF-ASSESSMENT

Several authors linked CPD activities and practices to reflective practice, reflection and self-assessment.[8-10] The advantage of using a reflective model in CPD, such as the MOL, is that practitioners are actively involved in their own personal development.[10] In this section, an attempt is made to provide a practical, rather than technical and academic, explanation of these terms. Cole[2] indicates that CPD needs to encourage practitioners to become reflective practitioners. The intention of reflective practice (first used by Schön[16]) is to constantly analyse actions and/or decisions.[10] O'Loughlin and coworkers indicated that self-reflection is at the core of clinical practice with the ultimate aim to improve clinical skills and patient care.[10] Reflection, embedded in reflective practice, is known as a conscious and active processing of thoughts.[2] It is a method to analyse thoughts and create an awareness through the ongoing process to review, plan and do.[10] Cole's opinion is that health practitioners use ongoing reflection-in-action.[2] Reflection, linked to CPD activities, answers to questions such as 'what did I learn'? It requires a practitioner to write and structure thinking[9] by 'thinking about thinking,'[10] and aims to facilitate deep learning.[14] Cole cautions that reflective practice can be vague[2] since practitioners often are not sure where to start to develop skills for a meaningful reflection[14] and what structure to use. It takes time to acquire the habit to reflect and find out what method works best for each individual practitioner.[9]

SELF-ASSESSMENT

While reflection is a thinking process looking back at experiences, self-assessment involves a discovery of own performance and how to improve.[8] It is the process to analyse and evaluate the self.[17] Harvey-Lloyd[14] developed a wheel for self-assessment. This tool gives direction and structure to reflection. The link between reflection and self-assessment is further explained in a comparative study by Desjaralis and Smith.[8] These authors concluded that both reflection and self-assessment processes can be applied with CPD in mind. Their argument is that both processes are meaningful and they result in deep learning. However the purpose and process of each is different.[8]

Several authors have analysed the implementation of reflective practice, reflection and self-assessment linked to CPD activities. The Cochrane paper[11] discusses audit and feedback on clinical competence over a specified period as a strategy to improve professional practice. The authors reviewed 118 studies and concluded that feedback on performance is required to improve clinical practice. The study revealed that an audit and feedback may improve professional practice, although with a variation in the outcome. In support, Fereday and Muir-Cochrane[12] indicated that practitioners need feedback on their performance to inform self-assessment. Without clear instructions, a proposed template and transparent criteria, self-assessment of competence may become a questionable practice. So, Davis and coworkers performed a systematic review of the 725 published articles to determine the accuracy of physicians' self-assessment compared to the external observation of competence.[13] Their findings confirmed the limited ability of physicians to self-assess their own competencies.

RECOMMENDATIONS

- For proper implementation, the HPCSA RCT Board will need to provide practitioners with a list of competencies and a framework or template for reflection and self-assessment of own practice.
- CPD events should be structured in such a way to engage participants, to

encourage application and therefore allow attendees to improve their clinical practice.

- For flexibility, different methodologies need to be explored to implement reflective practices such as the online platform, diaries and journal clubs.
- Practitioners need to start to include reflection in their daily practice and explore reflection methods that work best for them to become reflective practitioners.

CONCLUSION

The HPCSA applied forward thinking with the proposed MOL to enhance the current 'input-based' CPD system after learning about the limitations after engaging with relevant literature. However, there are unresolved questions and a gap in the knowledge regarding the clarity of the terminology and criteria associated with the MOL. This article explored the terminology used in the MOL such as reflective practitioner, reflection and self-assessment to empower practitioners and create awareness. Reflective practitioners are actively involved in their own personal development, use ongoing reflection-in-action, and identify development needs through self-assessment.

In view of reflection, reflective practice and self-assessment described in the literature to self-report on CPD, it is apparent that it may or may not be the panacea to address the criteria of being 'sufficiently experienced,' 'clinically competent,' and a 'reflective practitioner' Ethically, practitioners should not have to depend on any CPD model to provide the patient with optimal patient-centred care.[15] In the end, the most important aspect is to be 'sufficiently experienced and clinically competent' to best serve the needs of the patients.

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