Personal Commitment Statements: Encouraging the Clinical Application of Continuing Professional Development Events for Health Practitioners in Low- and Middle-Income Countries

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Abstract

Introduction: Statements of commitment to change are commonly used to evaluate continuing medical education. However, this approach is new to evaluating the continuing professional development of other health care practitioners such as audiology, speech-language-, occupational- and physiotherapy in low and middle income countries (LMICs).This study explored the use of Personal Commitment (to change) Statements (PCS) as an evaluation tool of continuing education for health professionals in LMICs, and its impact on the integration of new knowledge and skills with prior knowledge and clinical practice.

Methods: PCSs were used in a case study conducted at a one-day interprofessional continuing professional development event held for health practitioners in South Africa. A qualitative thematic analysis was made of these PCSs and results were synthesized into main themes.

Results: Thirty-two participants turned in a PCS at the end of the continuing professional development event with a total of 71 text statements. Three main domains were identified: (1) Applying new knowledge in practice (61.97%); (2) Increasing training-related content knowledge (21.12%); (3) Sharing information, skill and resources (16.9%).

Discussion: This study demonstrated that personal commitment statements can be used to describe the outcomes of continuing professional development events for audiologists, speech-language-, occupational- and physiotherapists. Participants engaged in reflection generated by the personal commitment statement, which contained no guiding statements, yet elicited responses showing that participants were more aware of the assessment tools and how they could use them in practice. Further study is warranted into the process and the role of follow-up regarding health practitioners' commitment to change in clinical practice.

Introduction

Continuing professional development (CPD) for health practitioners such as audiologists, occupational therapists, physiotherapists and speech-language therapists can improve professional practice as well as health outcomes for clients,[1] provided that it evolves in keeping with global changes in health needs and priorities. One example is the prioritization of interprofessional collaboration that was identified as a key mechanism to address client-centered practice. Thus, traditional CPD practices that used a silo approach are now required to adopt new content, recognize new knowledge and use new approaches

to ensure transformative learning to promote collaborative practice.[2] The mandatory

emphasis on developing and documenting CPD involvement in the health professions also

influenced the CPD landscape.[3]

To keep abreast of these changes, the evaluation of CPD events evolved over time.

Initially, the emphasis was on learning objectives, educational content and delivery

methods. It was acknowledged that CPD events should employ more interactive methods to

create change in professional practice (for example by providing opportunities to practice

skills)[2,4] and allow adults to learn on their own initiative so as to learn more deeply and

permanently.[5] In their study, Mamede et al.[6] provided empirical evidence to demonstrate

that individual reflection by health practitioners upon their own routine practices was the

only factor that directly influenced their identification of learning needs. This can be

regarded as one of the first steps in ensuring successful CPD as it encourages practitioners

to acquire new knowledge and skills, which will in turn change behavior and ultimately

lead to better practice.

In contrast to physician CPD, evaluation of CPD in other health professions has

paid little attention to how actual levels of learning can be evaluated, how to translate

learning into practice, or how to measure the impact of CPD on actual professional service

delivery outcomes .[3] However, as reflective practice for physician learning, gained

importance,[7,8,9] reflection on learning or change was added as an accreditation standard for

the evaluation of learning activities in some high income countries (e.g. the US and

Canada) to promote transformative learning that resulted in changes to improve practice.

For example, physicians were asked to reflect on their current practices and state their

commitment to change (CTC) using a custom-designed tool to evaluate the effectiveness of CPD.[10-12] Overall, these studies indicated that the physicians who expressed a CTC were significantly more likely to change their actual practices and had successful practice implementation by three to six months. Armson et al.[11] used Bloom's taxonomy to code practice reflection statements and found that reflection proved useful when progressing through increasing levels of cognitive complexity, which reflects deep learning. Although reflection and CTC statements have been used effectively in continuing medical education, they are not commonly used to evaluate the outcome of CPD in health professions such as speech-language therapy, occupational therapy, physiotherapy or audiology in low and middle income countries (LMICs). Therefore, the gap between what is assumed to be true regarding the benefits of CPD and what is known to be true is indeed a wide one.[3]

In summary, health practitioners gain a sense of ownership and commitment to learning when adult learning principles and reflection are integrated into the educational design and evaluation of CPD, and when health practitioners are asked to formulate a CTC statement. A personal commitment to learning can thus provide a means for negotiating reconciliation between existing and newly acquired practice and knowledge.

In this paper we argue that a personal commitment (to change) statement (PCS) is an effective tool to elicitate more meaningful educational outcomes data than traditional satisfaction measures. The main aim of the study was to explore the use of Personal Commitment (to change) Statements (PCS) as an evaluation tool of continuing education for health professionals in LMICs, and its impact on the integration of new knowledge and skills with prior knowledge and clinical practice.

Methodology

Design

A case study design based on a CPD event using a purposive sampling technique was selected, since it provides flexible and open-ended data collection and analysis, and could therefore provide insight into the assessment of a CPD event.[13]

Ethics approval

The CPD event was funded from a research grant between a United States and a South African university and IRB approval was gained from both universities. Participants were informed of the purpose of the research and the PCS form that was used for data collection. By completing the form, 32 of 38 potential participants consented.

Context

South Africa is a country situated at the most southern tip of the continent of Africa with a population of approximately 55.9 million. It is a multicultural multilingual nation. Following a history of apartheid, a process of transformation was initiated to address, amongst others education.[14] Training in audiology, speech-language, occupational and physiotherapy has become more focused on meeting the needs of marginalized populations. This has led to the development of contextually relevant assessment and intervention tools and materials in the 11 eleven official languages of the country. The Health Professions Council of South Africa (HPCSA) which is the accrediting body, implemented mandatory Continuing Professional Development (CPD) for all health professionals as the means for maintaining and updating professional competence, ensuring that the public interest will always be promoted and protected, and ensuring the best possible service to the

community.[15] Every practitioner is required to accumulate 30 Continuing Education Units (CEUs) per twelve-month period and mandatory random audits are conducted to ensure compliance. These events are typically conducted in English, as English proficiency is a requirement for HPCSA registration.

A one-day CPD event entitled "*The International Classification of Functioning, Disability and Health – Children and Youth Version (ICF-CY): A New Global Common Language for Communication Disorders*" was presented in South Africa.[16] This CPD event was accredited as a Level 1 organizational event (workshop) by the HPCSA and was allocated four CEUs. It was developed specifically for health practitioners in the therapeutic sciences and focused on communication intervention for pre-school children. The event had two main aims: i) To introduce health practitioners to the ICF-CY[17], enable them to understand the framework and identify its application in clinical practice; ii) To introduce three new clinical measures developed within the ICF-CY framework – Focus on the Outcomes of Communication Under Six (FOCUS)[18]; Speech Participation and Activity Assessment of Children (SPAA-C)[19]; Intelligibility in Context Scale (ICS).[20] Although all of the participants claimed to have had "some knowledge" on the ICF-CYframework, none stated to have had any knowledge on any of the three clinical measures. The emphasis was on guiding participants in the application of these measures in clinical practice.

The CPD event incorporated andragogy, a theory of adult learning that acknowledges adult learners' prior adult learning experiences, their orientation to learning and desire for new knowledge, as well as motivation and readiness to learn, which is strengthened if the topic at hand has immediate impact and relevance to their learner's occupation.[5] Andragogy also changes the orientation to learning from being content driven

to being problem-centered, collaborative and relevant, thereby allowing learners to integrate their new knowledge with prior knowledge and experiences. The CPD event therefore incorporated role-play, small-group discussions opportunities to share experiences with others attendees, make team-based intervention decisions based on case studies, and videos discussions of "real word" examples.[21]

Procedure:

Participants were not requested to complete a traditional workshop and evaluation form, as literature indicates that the validity and reliability of such evaluation are generally poor.[22] Instead, a PCS was created and participants were encouraged to reflect on how they could apply their new knowledge and integrate it with their existing practice (one of the pillars of adult learning).[5,23] The form was titled "*You can make a difference*". Participants were requested to write a personal commitment following the open-ended statement "*After this workshop, I can and will do the following* ". Sufficient space was allowed for their written responses. To formalize this commitment, they were asked to sign and date the personal commitment. The completed forms were scanned and returned to the participants via email together with their certificates of attendance.

(See Appendix 1 for an example of a completed Personal Commitment Statement)

Participants:

The 32 participants were part of a cohort of 38 professionals who attended a one-day CPD event and consented to participate in the study. These 32 participants consisted of 25 speech-language therapists (SLTs), four occupational therapists, two audiologists and a physiotherapist. Their work settings included university training programs (n=11), school

systems (n=11), private practice (n=9) and hospitals (n=1). At the time of analysis, the case was considered an entity.[13]

Data Analysis Procedure

Two researchers and a research assistant conducted an inductive thematic analysis of the submitted PCSs.[24,25] The six steps entailed i) familiarization with the raw data by exploring the text of each PCS; ii) coding to capture both the semantic and conceptual meanings of the data by creating a coding framework. The text of each PCS was divided into segments using the coding framework and each segment was given a different composite number (e.g. 1.2 represents sentence 1, segment 2); iii) searching for themes that reflect the theoretical interests that guide the research[25] by grouping codes together (e.g. apply newly learned tools in assessments); iv) reviewing themes independently by the researchers, and grouping related themes together in domains that reflected the most prominent ideas. All discrepancies were resolved through discussion until consensus was researched as suggested by Clarke and Braun (2013)[24]; v) defining and naming of the themes and domains by considering their frequency, patterns and relevance[25] and finally vi) writing up the data by including examples from the PCSs.

Results

The results were based on the PCSs following a single workshop, without follow-up at e.g. three or six months to assess the actual changes implemented. A total of 71 text statements provided by the 32 participants were analyzed. Responses ranged from one to four statements per participant. The thematic analysis revealed three domains following the

CPD event: (1) Applying new knowledge in practice; (2) Increasing training-related content

knowledge; (3) Sharing information, skills and resources. Table 1 shows the theme

categories per domain as well as the codes that describe specific behaviours or intentions

(the what and how) with some examples.

TABLE 1: Thematic Analysis of Participants' PCSs

Theme category per domain	Codes	Examples from PCSs
DOMAIN 1: APPLY NEW KNOWLEDGE IN PRACTICE (44/71 comments = 61.97%)		

Incorporate others' perspectives in assessment (15 comments)	• Incorporate multiple perspectives in goal setting:
	  ○ Parents
	  ○ Teachers
	  ○ Friends
	• Be sensitive to the child's perspective, needs, goals, and preferences
	• Use "Talking Mats" in assessment to gain child's perspective
		• Include parents, teachers and children to gain valuable insight into their immediate needs and priorities (2.2)
		• Collaborate with the child, parents and teachers to formulate appropriate intervention goals (26.2)
		• I am enabled and can cooperate in a more structured way with parents and teachers (15.1)
		• Involve people who are important as well as the child (14.1b)
		• Be more sensitive to the child's goals (4.3)
		• Include the child more in choosing the therapy goals (8.3).
		• I will use the Talking Mat for goal setting – very valuable (3.2)
		• Get more insight into goal planning through using Talking Mats with the patient (15.3)

Apply newly learned tools in assessments (12 comments)	• Use in assessment:
	  ○ FOCUS
	  ○ ICS
	  ○ SPAA-C
	• Qualitative Assessments
		• Apply the new assessment tools in the next assessment that I will be doing and include the results in my assessment report and feedback session (3.1)
		• Use the FOCUS, ICS and SPAA-C to obtain objective outcomes of therapies provided (10.3)
		• Provide qualitative assessments on a child, which I can compare at different stages. Make use of supplementary tools in my assessment (17.1)

Make assessment and intervention more holistic (10 comments)	• See each client in a more holistic manner • Holistic approach to intervention	• Treat and assess the child holistically (6.1) • Be more aware of a holistic approach in dealing with current and prospective clients (8.1) • Use ICF-CY to have a more holistic view/approach in my therapy (10.1) • I am going to use it as a framework in my practice to get a better idea of the overall problem (14.1)

Implement new ideas in setting therapy goals (4 comments)	• Use ICF-CY to set dynamic therapy goals • Collaboration with others (parents, teachers) to formulate appropriate goals	• Set more dynamic goals (2.1b) • Use the information gained from SPAA-C to plan assessment goal setting and intervention (5.3a) • Collaborate with the child, parents and teachers in formulating appropriate intervention goals (26.2)
Implement ICF-CY (3 comments)	• Incorporate ICF-CY framework into report writing	• Incorporate the ICF-CY into report writing and interactions with clients and other professionals (13.4) • Very useful in report writing (14.2)
DOMAIN 2: INCREASING CONTENT KNOWLEDGE RELATED TO TRAINING (15/71 comments = (21.12%)		
Expand knowledge of ICF-CY (15 comments)	• Study ICF-CY framework further • Explore other ICF-CY material	• Further expand my knowledge about ICF-CY materials (1.1a) • Study the ICF-CY online (19.1) • Further explore and apply available ICF materials in practice, training and goal setting (4.1)
DOMAIN 3: SHARING INFORMATION, SKILLS AND RESOURCES (12/71 comments = 16.90%)		

Share new knowledge with others (12 comments)	• Share new knowledge with:
	    ○ Fellow therapists
	    ○ Teachers
	    ○ Students
	• Share knowledge about:
	    ○ New tools (FOCUS; ICS; SPAA-C)
	    ○ ICF-CY application to different fields of SLT
	    ○ Goal setting
		• Expand it to others (multi-disciplinary) working with the children in my work setting
		• I will present the content and tools at the Private Practitioners Meeting next Saturday (3.3)
		• I commit to incorporate my knowledge of this workshop into my teaching of students as well as sharing the concept of ICF-CY with other practicing therapists (21.1)
		• Share this framework and its applicability with audiologists via workshops and articles (22.1)
		• Share the new instruments with colleagues (19.2)
		• Inform my students on the application of ICF-CY to different fields in our profession – more practiced application – goal setting therapy planning (21.3)
		• I can and will be able to tell other teachers about this seminar (23.2)
		• Share the framework with the rest of MOT (members of team) at XX (school name) (28.3)

Applying new knowledge in practice

As expected, a large proportion (61.97%) of the PCSs related specifically to applying new knowledge in practice and included aspects related to assessment, intervention and report writing as the CPD event aimed at guiding participants in the application of the measures in clinical practice. Participants not only focused on the new tools to which they were exposed in training, but also considered aspects related to goal setting (i.e. incorporating multiple perspectives reflecting their own work context and

incorporating a framework such as the ICF-CY to set dynamic goals) and taking a holistic view of the child (rather than focusing on the communication disorder only). Participants increasingly reported including the child's own perspective in assessment and intervention by becoming more sensitive to the child's own preferences (essential for patient-centered care). They also reflected on the practicality of Talking Mats,[26] a visual representation system that can be used for goal setting, which indicated that they were integrating new knowledge with their existing knowledge.

Increasing training-related content knowledge

Of the participants, 21.12% stated that their ICF-CY knowledge had been expanded. They planned to further study the ICF-CY framework and explore other materials developed within it. They provided clear suggestions of how they intended to do this, e.g. "study the ICF-CY online", thus indicating that they would integrate their new knowledge with existing resources.

Sharing information, skills and resources

Following the CPD event, 16.9% of the participants intended to share with different individuals the new tools to which they had been exposed (FOCUS, ICS and SPAA-C), their new knowledge (the applicability of the ICF-CY framework), and their new clinical skills (using Talking Mats in goal setting). These individuals included colleagues, fellow therapists, teachers, and students they were mentoring. The tools that were included in the CPD event were open access tools, and facilitated the process of sharing them.

Discussion

Commitment-to-change statements have been applied highly successfully in physician CPD in high income countries to promote and assess CPD interventions.[10-12] As far as could be determined, this approach has not been applied in the evaluation of CPD events for other health practitioners such as speech-language therapy, occupational therapy, physiotherapy or audiology in LMICs. Our preliminary attempt at applying a PCS appeared successful and yielded promising results. The findings demonstrated that participants were more aware of the assessment tools and how they could be implemented in practice. They also intended to share information, skills and resources. Challenges to incorporate interventions into practice in less resourced contexts are, amongst others, limited financial and human resources in terms of expertise for intervention.[14] Research has shown that health professionals in LMICs acknowledge the importance of knowledge sharing practices as they regard information as the most valuable source to update their knowledge and deliver quality health services[27] to which they are committed. Without sharing, knowledge has no value – for its value to be fully recognized it has to be shared.[28] Given these findings it is likely that participants would have shared information regardless. However the qualitative analysis of the statements showed focused attention on the ICF-CY and the assessment tools that were introduced. It is postulated that the sharing would have been specifically directed to clinical practice, rather than just general feedback on a new framework. Therefore the PCS proved to be a tool to capture the intent of health practitioner to share specific knowledge gained with specific individuals following the CPD event.

The PCSs generated seven themes across three domains ranging from incorporating others' perspectives in assessment to sharing newly gained knowledge. Translation of the assessment tools into local languages was proposed as a practical solution to address the need for valid and sensitive assessment approaches for the South African context[29]. These results show that the participants reflected on their own clinical practice and how that corresponds to the knowledge imparted at the CPD event, in order to generate their PCSs. The latter contained no guiding statements, yet elicited responses regarding personal gains and implementation.

According to the existing literature on the use of CTC statements in CPD events, follow-up over time was required to enhance the percentage of physicians who actually made changes in their clinical practice. Unfortunately due to logistic reasons, a long-term involvement in which follow-up data could be captured was not feasible. According to Mazmanian et al.[9] physicians' behavior can be expected to change if the specified change is consistent with their beliefs and sense of what is important. The PCSs indicated a clear understanding of the importance of the ICF-CY[17] and it is postulated that the participants' practice was likely to change, even though there was no follow-up.

CPD events have an essential role in promoting evidence-based practice and using evidence-based information in their content. Evidence-based CPD sessions encourage participants to use new information to improve the practice in their clinical settings and to explore pertinent clinical questions that exist in their own practice.[30] Professional associations around the globe endorse the ICF-CY[17] and encourage researchers and clinicians to use it to help guide research, practice, and education. However, a decade after its inception, there is still limited application in clinical practice. The current findings

indicate a commitment by all participants to apply the ICF-CY[17] in a range of settings and variety of ways. Although no follow-up was conducted in the current study, the PCSs can be viewed as a first step in creating awareness of the ICF-CY[17] which advocates holistic, interprofessional intervention for children with communication disorders, which was the underlying theory of the CPD event.

Although participants in the study could have intended to apply new knowledge in practice and to share information, skills and resources irrespective of completing the PCS, the PCS proved to be a valuable tool for capturing this information. The current PCS made use of only one open-ended question. It is suggested that the PCS be refined and that the reflection can be more structured to include information on details of the change process to encourage deep reflection and change to practice. For example, i) how they intended to complete the change ii) what challenges or barriers they anticipated iii) what additional resources or supports they would require iv) how they would know if changed had occurred and v) the timeline for the envisioned change, would yield valuable results. These initial findings thus provide an important incentive for developing and piloting a specific reflection tool for health professionals in LMICs, modelled on that of Armson et al.[11] ("Personal Practice Reflections: Impact on Practice"), and aimed at stimulating transformative learning and enhancing changes in clinical practice. However, Mazmanian et al.[9] caution that more exploratory work needs to be done to better explain what triggers an intention and what enables health practitioners to follow their intentions through to successful implementation of change following CPD events.

Limitations were identified in this exploratory study. Firstly the majority of participants (78%) were speech-language therapists, limiting the generalizability of PCS

across all health care professions. The ICF-CY[17]framework is, however, adopted across

disciplines and the assessment tools introduced are not discipline specific. The results may

be skewed towards speech-language therapists but since the PCSs of the participating

occupational therapists, physiotherapists and audiologists were analyzed as a whole sample,

the outcomes are viewed to be interprofessional of nature.

Secondly, a single CPD event involving interprofessional health professionals was

used as a case study. Thirdly, since ethics permission was not initially requested to conduct

follow-up, it was not possible to determine whether the participants remained committed to

their statements and applied their new knowledge and skills in practice. Therefore further

investigation of the format of the PCS and the application of the actual commitment to

practice through follow-up at three and six months is recommended to determine if PCS

were applied and what changes were made in real practice.

Conclusion

The PCSs of the participants reflected their intention to make changes to their

clinical practice and in their workplace environments. This different manner of evaluating

the outcomes of CPD events for health practitioners such as audiologists, speech-language

therapists, occupational therapists and physiotherapists in LMICs is a promising first step in

exploring this approach and developing explicit practice reflection forms and follow-up

mechanisms to ensure that knowledge and skills are indeed converted from the CPD event

into clinical practice to the benefit of clients. CPD service providers in LMICs need to

critically evaluate CTC statements as a reflection tool and determine how they can best be used to enhance service delivery and the application of knowledge gained in CPD events.

Lessons for practice:

- PCSs have the potential to be a more effective measure of CPD outcomes for health professions in LMICs

- PCSs guide health practitioners to reflect on the implementation of change to their knowledge, skills or performance in practice.

- Structuring PCSs may guide reflection on both the direction and process of change including anticipated barriers and measures of success.

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Appendix 1: Example of a completed Personal Commitment Statement

YOU CAN MAKE A DIFFERENCE

MY PERSONAL COMMITMENT

After this workshop, I CAN and WILL do the following:

Further explore and apply materials available into practice, training and goal setting. Use similar approaches re drawing more frequently so as to enhance intervention. Be more sensetive to the child's goals.

Signature _____ 21 March, 2015 _____ SAAK. _____
                          Date   Place