The Thistle and the Maple Leaf: International Collaboration to enhance CPD

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Quality Education for a Healthier Scotland
Key elements of PBSGL

- The *process* - facilitated small group discussion
- Trained *peer facilitators*
- The *content* - evidence based educational modules
- The development and sustenance of a *community of practice*
Key elements of PBSGL

• The *process* - a facilitated small group discussion focused on:
  – Practice reflection
  – Identification of gaps between current practice and best practice
  – Strategies to enhance change in practice
  – Commitment to practice change
Key elements of PBSGL

• Trained *peer facilitators* who:
  – are chosen by their group
  – are trained in a one-day workshop conducted by experienced facilitator trainers
  – play a vital role in the enduring success of PBSGL
Key elements of PBSGL

• The **content** - evidence based educational modules that:
  – present specific representative patient cases that stimulate participants in the small groups to reflect on similar cases from their own practices
  – summarise relevant best available evidence relevant to primary care practice
  – promote application of scientific knowledge to the specific patient problems members encounter in their practices, resulting in improved patient care.
Key elements of PBSGL

• The development and sustenance of a *community of practice* that
  – is consistent with educational theory and
  – is borne out by the function and longevity of groups
• 1992 - Pilot project in Ontario, Canada involving 117 physicians in 16 groups
• 1994 - Program extended across Canada (English & French)
• 1997- Incorporated in Canada as
  • *The Foundation for Medical Practice Education*
• 2009 – 6150 family physicians organized in 720 groups
  - PBSGs in all 10 provinces & 3 national territories
  - outside of Canada (Scotland, USA, Hong Kong, Saudi Arabia, Kenya, Trinidad & Tobago...)
  - 2719 PBSG residents
  - PBSG-NP 557 (plus 180 NP students); PBIL 388
PBSG Membership Growth Chart
1992-93 to 2012-13

Quality Education for a Healthier Scotland
2003/04 pilot of 5 groups (>40 members) & roll-out from 2006
Memorandum of Agreement with the FMPE
Implemented in GP Specialty Training 2009
From Canadian modules through ‘tartanisation’ to UK ‘de-novo’ modules
By March 2014 approx 2100 members in over 200 groups (approximately a third of Scotland’s GPs)
Working with other professions to use PBSGL in their context; pharmacists, practice nurses
Uni-professional and inter-professional groups
Module production to meet members’ needs & wants as well as Government priorities
PBSGL Scotland growth

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PBSDG L Scotland membership

• End March 2014 – 2122 members
  – 1853 GPs (87%)
  – 91 Nurses (4%)
  – 140 pharmacists (7%)
  – 38 ‘other’/ unknown (2%)
  – ...plus up to 1000 GP Specialty Trainees

• More than 2/3 of the membership is female
• Planned detailed survey of membership
PBSGL Research

- Canada
  - (Premi, Academic Med 1994)
  - BPP (Herbert, Family Practice 2004) & CTC (JCEHP 2003)
  - Categorization of commitment-to-change statements
  - Role of practice tools in knowledge implementation
  - Impact of test enhanced learning, CTC & community

- Scotland
  - PBSGL in pharmacy
  - Inter-professional learning
  - PBSGL for Faculty Development
  - PBSGL in GPST
PBSGL opportunities

• Collaboration: modules, research, programme changes
• Potential to increase the pool of module authors
• Further development of inter-professional approaches to practice based learning (integration agenda in Scotland)
• Opportunities to incorporate successful components that are developed by the other programme e.g. Practice Reflection Tool, Newsletter, Facilitator training module
• Broadening the pool of people who are thinking, talking and researching various components of the programmes
• Further development of the PBSGL network (Wessex)
PBSGL challenges

• Effective collaboration
• Cultural differences in practice & language impact module development
• Ownership of the program and its transformation
  • Clarity around negotiable and non-negotiable aspects of the programme
  • Expansion vs dilution
• Consistency of peer-facilitator training
• Organisational size & structure- maintenance & expansion
  ▪ Canadian programme has been developed by a small group of physicians (directors of programs, facilitator training, module authors & editors) that is spread across the country and supported by a central office at McMaster University in Hamilton
  ▪ Scotland has a small, close knit team functioning in a much smaller, geographical area but that is stretched to the limit
• Funding for research & development
The Canada Thistle

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