Friday October 5, 2007
11:45 – 12:30: Workplace learning – Dr. John Parboosingh.

Slides 1 & 2:
As we mentioned earlier in the Conference, to be effective, CPD needs to take account of the realities of practice. First, there is an increase in the number and complexity of health problems and changes in practice, not only resulting from evidence-based research but also, new technologies, political pressures for change, new types of practitioners with which to work, an aging population, and so on.
Most health care leaders are convinced that traditional CME is not effective in this environment. Healthcare units, aspiring to be "learning organizations" will expect physicians and other health professionals to participate in team learning with the objective of achieving continuous self initiated continuous practice improvement.
In the second slide I list the topics that we will cover under the heading of workplace learning. But first, we must note the distance we have to travel from traditional classroom CME to get to a model of workplace learning.

Slide 3: Quotation from Sister Elizabeth Davis
We are fortunate in Canadian Health Care to have Sister Elizabeth Davis, who among the many hats she wears, is Chair of the Canadian Health Services Research Foundation. Responding to the cry for change, Sister Davis gives us this advice.
But we must remember that while we can have a vision of a new type of CPD in the workplace, the implementation of this has to be done one step at a time and fit into the culture that currently exists in hospitals and clinics today.

Slide 4: Industry is already focused on workplace learning
While we have a work force in health care that believes that learning takes place in the classroom away from practice, industry has learned over the last two decades that learning takes place in the workplace by workers interacting and exchanging information. This is the first concept we have to digest as we think about workplace learning.

Slide 5: Embedding learning in practice
I want to introduce the next concept that we have to work on in workplace learning, and that is what we mean by learning embedded in practice.
As you know, doctors are already overworked, and there is every indication that the workplace will become busier, shorter staffed, technology is driving us faster each year; and some are already saying we will have to do more CME/CPD and possibly be evaluated for maintenance of certification and licensure. The commonest reason for missing a CME event or being behind in our reading is that we are pressured at work.
Industry has learned that workers need more continuing education when they are requested to work faster and they need help to enhance performance. This cannot be left to the altruistic motivation of a few individuals - many of whom are in this room.
Embedding learning in practice means finding a mechanism or system that assists the healthcare team to identify and implement practice enhancements, a system that takes place without much time and conscious effort on the part of doctors and other health

workers. They must focus on high quality, safe patient care. My vision is to put in place in our clinics and departments a system that manages practice enhancements.
Finding a way of embedding learning in practice is vital to our future as the learned profession.

Slide 6: Built-in continuous improvement
Donald Berwick, President of the Institute for health care improvement, has echoed my vision in this statement.

Slide 7: how we learn in the workplace
The next concept for us to digest is that learning in the workplace results from interactions between practitioners rather than a process in which a teacher provides knowledge to a learner.

Slide 8: how we facilitate workplace Learning
Larry Prusak a senior member of IBM made this statement at the beginning of the era of recognizing workplace learning. He said we need to study the natural flow of information in a workplace if we want to understand how to improve it. Its not a matter of providing more education or in-service training.

Slide 9: natural flow of information
Health workers exchange information at three levels. First during practice, second when as a team they discuss how to improve practice such as in grand rounds; and there is a third level when healthcare workers meet informally say during lunch or outside of work. These are the communities of practice or groups of workers who share stories with each other. These are the workers who were noticed in industry two decades ago to be exchanging information and learning from each other. The communication is different when they function as a team compared with when they meet informally in CoPs. Here they tell stories and interact socially while still talking about their practice. It was noticed in industry that the discussions at this stage help team cohesiveness and improve the quality of the product more effectively than formal in-service training. These different levels of communication have now been studied in industry and are beginning to be studied in the healthcare workplace.

Slide 10: Communities of Practice
So we now come to the formal definition of communities of practice as defined by Dr. Etienne Wenger who is the world authority on workplace or situated learning. There are three characteristics of the community: first the domain or knowledge base; second the shared practice that CoP members talk about; and third, the community, namely a group of workers who want to improve their practice by sharing ideas and developing solutions and coping strategies.

Slide 11: Evidence and Stories
I want to mention yet another principle that is new to us, as it appears to conflict with our teaching. And that is evidence derived from studies and stories from practice are not competing with each other. In workplace learning, they are tools that are used for

different purposes. Solid objective evidence is best used to determine the direction for a team, for instance making a decision. In comparison, experience indicates that objective research-based evidence does not necessarily persuade people to change their values and behaviors, but stories do. So the best way to encourage doctors and other health professionals to change behavior is to provide them with stories of how their colleagues have achieved the change.

Slide 12: Evidence comes from four sources in Workplace Learning

Doctors understand that knowledge is more than research based protocols. In fact, there are four quite different sources of information that need to be taken into account. In workplace learning, we upgrade our use of the other 3 sources of information, which we currently use but in the traditional CME, they are not given much credence.

We use communities to validate and share practitioner experiences and to make sense of results from patient surveys and internal case reviews.

This approach to evidence leads us to the conclusion that to make sense of new information we need a discussion that involves more sources of evidence than just research studies, as important as these are. What we are learning is that "making sense' of new information means talking to each other.

Slide 13: Putting information to work

In addition to a new approach to evidence, we have also learned that new information from studies, for instance, are rarely ready for application to practice. The new information has to be viewed from many perspectives, barriers to adoption considered, improvisations suggested and validated before its translation into working knowledge. Communities of practice are being used increasingly because we are realizing that this way of interacting helps individuals and groups to take new information and make it applicable to their local conditions. This is called "making sense" of information. During this process where we modify information to put it to work, the information also changes us, a process known as co-evolution.

So, making sense of new information changes us and in doing so we are able to put it to work in our practice. This process, essential to knowledge translation, requires conversations between peers and mentors with a shared practice.

Slide 14: What is the evidence that relationships in the workplace are associated with high-quality care?

I refer you to this study by Dr Gittell and colleagues who studied relationships in nine hospital programs for hip replacement

Slide 15: elements of the relational coordination

Dr. Gittell developed a scoring system for these four components of good communication as well as for other behaviors expected of health workers including doctors.

Slide 16: predict a quality of care

The model counted for 74% of the variation between hospitals in the quality of care. This is convincing evidence of the value of relationships amongst healthcare workers to the quality of care they provide.

Slide 17: quotation from Dr. Cervero
You will recall that that we have become increasingly concerned of the funding of CME by Pharma industry and the reluctance of physicians to pay the full price. It has become increasingly obvious that when CPD becomes focused on practice enhancement, hospitals and other organizations including insurance companies are prepared to pay for workplace learning.

Slide 18:
Well its easy to talk about workplace learning, but how do you get started on a practical level. I want to mention three examples of projects that I can describe in the small group sessions this afternoon.

Slide 19: Moving a small group session to a CoP
Here is an example of how a CME provider or office can, after acquiring the skills, help a group of doctors who meet regularly to behave like a community of practice. The Royal College in Canada now gives credit towards MOC for this type of meeting.

Slide 20: The PACE model
This model is being developed by a national Ob program in Canada, called MORE(OB). Its goal is to help a birthing unit to establish a program of continuous practice enhancement while using the principles behind communities of practice.

Slide 21: The PEAK project
This model encourages care providers to identify opportunities for practice enhancement and a new position, called a knowledge broker, helps them to find answers to questions raised in practice. This project is running in a small rural hospital.

Slide 22:
This slide will act as a summary for my presentation. Traditional CME/CPD is gradually moving into a new era of workplace learning and improvement. Lets create a vision for the future:
In the past when asked what we do to keep current, we would describe the courses and education sessions we attend. In the future I predict we will describe a system we have in place to select, validate and introduce practice enhancements. We will talk, not about hours of CME for credit but practice enhancements we have introduced for credit towards maintenance of certification.
We will talk about CME as practice enhancements opportunities or PEOs.
We will of course participate in the same traditional CME activities listed here but aggressively hunt for PEOs and evaluate CME sessions by their ability to present PEOs that we can bring back to the department.
We will value and get credit for interacting with peers and identifying not just individual needs but practice needs as they relate to everyone in the department.

Slide 21: thank you for your attention and I look forward to discussing these issues this afternoon.