CHAPTER 1

Quick reference guide

The portfolio

- The successful portfolio is a developmental tool that builds a collection of evidence of experience, assessments of competence, self-reflection and personal development planning over time.
- Trainees should 'own' the portfolio by managing their own learning, using the portfolio as an iterative tool.
- Portfolio evidence of competence must demonstrate trainees' performance in reality rather than their factual knowledge or abilities in controlled examinations.
- Evidence of achievement of competencies occurs by combining different forms of evidence and assessments in various contexts and with multiple assessors.
- The more often the portfolio is used, the better, using formal points of appraisal as landmarks.
- True evidence in the portfolio is clear, transparent and demonstrable proof of competence.
- The evidence should not be overstretched.
- Attending a training course is not in itself evidence of competence.
- The portfolio supports the General Medical Council (GMC) revalidation process (General Medical Council, 2013).

Organising the portfolio

- Organisation and reference to clearly indexed, triangulated evidence at the start of the portfolio sets the tone.
- Make it user-friendly; summarise evidence and clearly state the competency, giving clear and specific locations of evidence.
- How much is enough evidence? Two sources at least and three where possible.
- Plan your educational objectives early with reference to competencies.
- Remember that 'if it is not documented, it did not happen'.

- Do not breach confidentiality within the portfolio. Never use patient-identifiable material. If letters about patients are included, remove all identifiers.
- Do not leave portions of the curriculum uncovered, especially if they are hard to evidence. Consider mapping the gaps.

Workplace-based assessments (WPBAs)

- The need to evidence a particular competence should drive which WPBA is chosen, not the other way round. Workplace-based assessment should occur regularly throughout a period in training. Do an Assessment of Clinical Expertise (ACE) early on as a benchmark.
- Present WPBAs in a logical sequence with a clear description of the experience and associated competencies.
- Link WPBA to reflective practice and show how this informs your professional development.
- Capitalise on opportunities in routine work – if you are discussing a case as a part of daily work, use it as a case-based discussion (CbD) WPBA.
- Patient feedback can be a powerful driver for learning. It comes in many forms and should be used even when it is challenging (e.g. complaints, thank-you letters, cards as well as formal feedback tools).

Reflective practice

- Reflective practice is a process of learning and development through focusing on thoughts and feelings.
- The successful portfolio must contain a good amount of reflective practice relating to both clinical and non-clinical experience.
- Reflective notes should cover the nature of the experience, any feedback, lessons learned and how these inform professional development.
- Trainees must decide how to make reflective notes more informative, by either filing them in a separate section of the portfolio or filing them where relevant, or a combination of these approaches.

Audit and research

- As a starting point, check early on exactly what competencies you need to evidence – planning is key.
- Not everybody will do a full-blown research project, but you must make sure you meet the requirements of your curriculum.
- For trainees with projects, present these in brief and then in detail if appropriate, making it clear what your skills are and what your involvement in the project was.

- If you have been involved in research, some academic skills can be evidenced in a variety of ways including simple approaches such as journal clubs.

Teaching

- Presentation of teaching experience should describe the task, topics, teaching methods, skills as well as audience evaluations and assessment.
- Teaching experience should be planned according to curriculum competencies appropriate to the stage in training.

Psychotherapy experience

- Give details of each area of psychotherapy experience in a standardised format that clearly communicates timescales, skills and techniques.
- Use the appropriate psychotherapy WPBAs.
- Use some method of linking your experience to reflective practice.

Management and leadership

- Provide a brief description of the experience, what skills were needed and what was learned.
- Bear in mind that experience and skills need to relate to competencies in the curriculum.

Reports, planning meetings and educational objectives

- There a number of reports that are required such as the induction meeting, personal development plan (PDP), mid-point review and educational supervisor's report.
- Use other records – such as records of supervision, on-call, PDPs – to further evidence competencies.
- There are a number of additional documents or achievements that can be valuable in the portfolio but remember that the curriculum is competency based, therefore explain anything you present. What exactly did you do? What are your skills? What feedback did you get?

Reference

General Medical Council (2013) *Ready for Revalidation: The Good Medical Practice Framework for Appraisal and Revalidation*. GMC.

CHAPTER 2

What is a portfolio?

What is a portfolio?

The concept of what a portfolio actually is has evolved over time (McMullan *et al*, 2003). Earlier definitions described the portfolio in more simple terms of a record of what someone has done (Redman, 1994). The definition has been extended to include giving regard to the dynamic process of learning, including a collection of different types of work that demonstrate achievement, learning and progress over time (Wenzel *et al*, 1998; Karlowicz, 2000). The portfolio can therefore be seen as a means of both assessment and recognition of learning (Knapp, 1975). Contemporary learning theory extends the portfolio's role as not only a document providing evidence of an individual's competence but also the record of professional development and how this has been achieved (Price, 1994). The developmental portfolio can therefore be seen as:

> 'A private collection of evidence, which demonstrates the continuing acquisition of skills, knowledge, attitudes, understanding and achievements. It is both retrospective and prospective, as well as reflecting the current stage of development and activity of the individual.' (Brown, 1995)

The portfolio should contain evidence from a number of sources chosen at the discretion of trainees, which should demonstrate particular competencies in different ways as well as recording personal reflections on the learning process and developmental needs. Put another way, the portfolio collects evidence by recording the process of development through experience, assessment and critical self-analysis or reflection.

The approach to the developmental portfolio

The theoretical approach to the developmental portfolio assumes that the individual is able to develop as an adult learner. As a part of this assumption trainees should (Knowles, 1975):

- be able to be self-directed

- have previous experience from which to learn
- be ready to learn, developing from experience
- be curious and motivated to develop.

Therefore, portfolio-based development is not passive learning facilitated and led by an expert but is informed by the process of reflecting on experience, so-called experiential learning. The dynamic interaction between theory, practice and experience is continuous and is demonstrated in Kolb's experiential learning cycle (Fig. 2.1).

In this way, Kolb's learning cycle is an attractive model for understanding the process of development as it explains the relationship between theory, such as concepts, and reflection on practice, such as experience and the testing of concepts. It is important to note that there is not a large body of empirical data to support this theoretical model (Quinn, 1998) and not all learning situations necessarily require the activation of all four stages of the cycle. An individual's motivation, interest and degree of innate curiosity will negatively or positively affect the degree to which the cycle is engaged.

The developmental portfolio is used increasingly in clinical training. The fact that the approach addresses the classic gap between theory and practice makes it desirable. There is evidence that portfolios can bring theory and practice closer together, as well as achieving subsequent improvements in practice and allowing the learner to take ownership of their development (Murrel *et al*, 1998) and gain a sense of responsibility (Wenzel *et al*, 1998). An additional benefit of this approach is that due to the continuous nature and structure of the portfolio, learners are encouraged to develop their skills in reflective practice, which then in turn enhances learning. However, this accountability, ownership and responsibility can be anxiety provoking. After a period in training, evidence of development will grow and confidence will increase, which should help to reduce such anxiety.

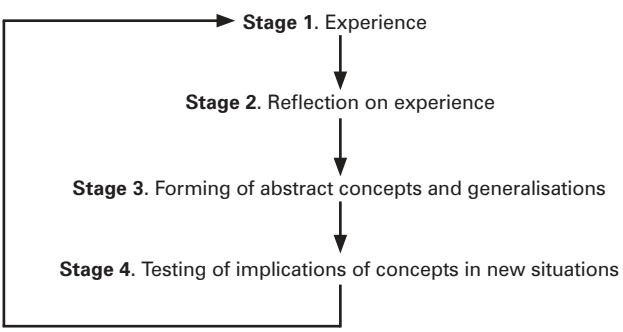

Fig. 2.1 Kolb's experiential learning cycle (Kolb, 1984).

Troubleshooting the portfolio

A recognised criticism of the portfolio is the time required to keep it up to date and acquiring sufficient evidence; indeed, trainees express anxiety about the nature and amount of evidence that should be collected (Mitchell, 1994). Such anxiety combined with the amount of time required negatively affects motivation (Mitchell, 1994). The best approach to counter this, which hopefully reduces anxiety, is integration and a change in learning culture. The portfolio is more useful as a learning tool if it is fully integrated into the training experience and always present, recording learning events, personal reflection and development plans as they occur. This may require trainees to timetable 'portfolio time' into their weekly plan and discuss the need for this with their supervisor in job planning. In this way the portfolio can be used to its potential and the workload needed for its upkeep is more evenly spread out. At the ARCP, the panel will be able to see that portfolios have been managed in this way and are more likely to result in a better outcome.

Too much information in the portfolio with numerous documents appended can be unwieldy and may only be meaningful to trainees, which may make the portfolios hard to interpret in the context of the ARCP and at other times of summative assessment. Equally, portfolios that have too little content may not effectively demonstrate the developmental process and thus become of limited value. It is impossible to be clear on 'how much is enough'. However, to be confident that sufficient evidence is gathered, the portfolio must be more than a collection or record of a range of work, experience and assessment, but must build on this by showing how the individual has reflected on these things, what has been learned and what still needs to be learned.

It is clear that reflective practice is key in adult learning and in the successful portfolio, where trainees identify gaps in their knowledge and competencies and take steps to address these needs. It is known that there can be a reluctance to engage in reflection on one's weaknesses and to some extent some see this process as intimidating and threatening (Snadden & Thomas, 1998). There is also uncertainty about how to reflect (Karlowicz, 2000) and some trainees may need guidance on this. For most trainees, reflection tends to occur through writing – writing ability varies between individuals (Snadden & Thomas, 1998) and there is a positive correlation between writing skills and positive reporting of the portfolio assessment by students (Mitchell, 1994). It is thought that, to a certain extent, the best way to overcome this is for trainees to focus on the developmental value of the portfolio, taking ownership of it and the process rather than seeing it as a tool for assessment. Hopefully, this approach will overcome the temptation not to fully disclose personal thoughts and feelings on experience. In this way the portfolio has a far greater developmental value and is more likely to be successful at the ARCP.

Learning theory suggests that the portfolio is a self-directed vehicle that promotes self-awareness, personal relfection, learning and accountability. For this to be possible the individual needs a degree of personal motivation and an adult learning style. The difficulty is that people have different learning styles (Snadden & Thomas, 1998) and therefore the developmental portfolio will not suit everybody. This difference in learning styles and the problem of some individuals finding the developmental portfolio approach difficult are to some extent unavoidable. However, one of the advantages of the developmental portfolio is that over time the use of this approach encourages and develops the very skills of self-relfection and personal development planning required for a successful portfolio.

The issue of ownership and self-direction is vital to the successful portfolio. Interestingly, it is known that trainees are less likely to engage with the portfolio if there is little or no pressure to be assessed (Harris *et al*, 2001). It is partly for this reason that the Royal College of Psychiatrists has concluded that there is a minimum number of WPBAs that should occur during a year in training (Bettison, 2010). These should occur throughout the year and not be left to the end, as it is impossible to use them to inform development if they do not address competence over time. The required minimum is exactly that; the more successful portfolios show that WPBAs occur in a range of situations, the number of which are related to trainees' developmental needs and should be fully integrated into reflective practice.

Educational theory

WPBA and competence

In assessing specialty training, one of the guiding principles is the recognition of the importance of reassuring the public about the safety and competence of doctors (Postgraduate Medical Education and Training Board, 2007). Workplace-based assessment provides a snapshot of what the doctor does in reality (i.e. it puts their performance into context), and it will therefore be conducted where trainees are currently working in the main (Postgraduate Medical Education and Training Board, 2007). So this is an assessment of trainees' actual performance as opposed to just their knowledge. Miller's pyramid helps to illustrate the progression from knowledge to competence as well as showing what level of performance common methods of assessment address in training (Fig. 2.2).

For a doctor to function competently, they need to acquire significant knowledge as well as a range of skills; these combine and contribute to competence. Therefore, as opposed to a known fact or skill, a specific competency may best be thought of as a constellation of abilities that include aspects of knowledge and skill as well as one's own experience and professional style. If portfolio evidence merely demonstrates the 'Knows' level of performance (e.g. a written examination result), it follows that it

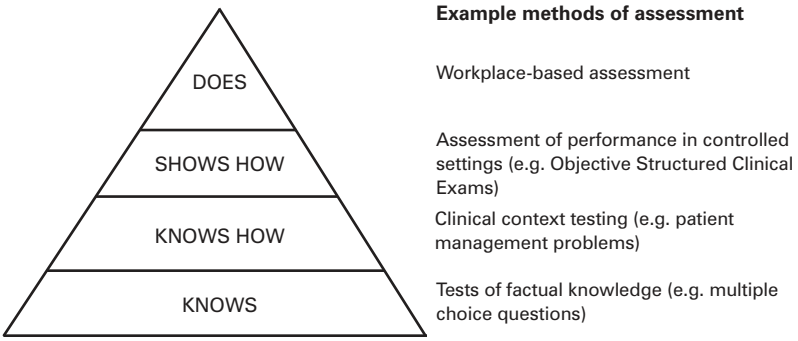

Fig. 2.2 Miller's pyramid (Miller, 1990).

falls short of demonstrating the 'Does' level, i.e. competence. One of the reasons that there is an important distinction between other aspects of performance and competence is that a doctor's performance in controlled settings, such as examinations, is a poor predictor of performance in practice (Rethans *et al*, 2002).

Objective structured clinical methods of medical assessment are reproducible but often offer little scope for developmental feedback. Workplace-based assessment, on the other hand, has the capacity to provide such feedback that informs trainees' understanding of their developmental needs, which in turn drives the content of the portfolio. If competence was something distinct and relatively stable, then reproducible assessments could be designed specifically to assess competence. However, competence is specific to particular situations and does not necessarily generalise. It is for this reason that assessments and other evidence should sample widely across the curriculum and are made more meaningful by evidence of developmental feedback and the individual's own reflections. The portfolio must show that assessment and reflection inform learning.

The competency-based curriculum and triangulation

Criticisms of the competency-based curriculum include being simplistic and narrow (Talbot, 2002). Competencies, although holistic and covering a variety of attributes and skills, potentially become case or situation specific. Gathering sufficient supporting evidence of competencies by way of WPBAs and other forms of evidence from a broad range of assessors and contextual situations overcomes the problem of case specificity. In contrast to traditional approaches, where single methods of assessment were used (e.g. certified examinations), a range of sources of evidence are required in the portfolio.

Triangulation refers to how a particular competency can be evidenced and judged, to be attained using various sources of evidence. In this way

over a training period, multiple assessors contribute to the portfolio evidence by using a variety of tools, as well as through judicious use of other forms of evidence. Information from one assessment can be compared with one or more forms of evidence relating to the same competency.

Bringing the evidence together – the portfolio

In medical training, the portfolio of competence can be defined as the 'dossier of evidence collected over a period in training that acts to demonstrate a doctor's education and skills in practice' (Wilkinson *et al*, 2002). Essentially, the portfolio shows the progression of trainees from novice to expert, driven by developmental assessment. The portfolio demonstrates competence in a number of ways:

- as a catalogue of WPBAs and other assessments
- as a developmental plan establishing developmental needs and how they have been addressed
- as a record of personal reflections regarding a wide range of clinical and non-clinical situations (these also inform development as well as being available to educational supervisors and the ARCP panel).

Interface with GMC revalidation

Revalidation started in 2012 and the GMC hopes to revalidate the majority of doctors by 2016. Revalidation of GMC-registered doctors is a single process with two potential outcomes: relicensing for all doctors and recertification for specialists.

Two key papers have driven the process forward: the White Paper *Trust, Assurance and Safety* (Hewitt, 2007) and *Medical Revalidation – Principles and Next Steps* (Department of Health, 2008). The principles forming the basis of the process include ensuring the safety and quality of care, sustaining confidence of the public, and identifying and addressing substandard practice. As such, doctors need to demonstrate that they are practising in accordance with the GMC's standards of good medical practice (General Medical Council, 2013) as well as standards appropriate to their specialty. These principles are strikingly similar to those set out by the GMC in their documents *The Trainee Doctor* (General Medical Council, 2011) and *Standards for Curricula and Assessment Systems* (General Medical Council, 2010).

The revalidation process will involve annual appraisal including formative and summative aspects, independent 360-degree feedback, resolution of any concerns, and positive affirmation of meeting of the standards of *Good Medical Practice* (General Medical Council, 2013) and those of the relevant college for specialists.

The annual appraisal will include the review of the portfolio presented by individual doctors, which is to be kept electronically in all likelihood. This is expected to bring together information from several sources,

including: multisource feedback, continuing professional development (CPD), participation in audit, evaluation of clinical skills with CbD assessment, test of knowledge possibly using online CPD modules rather than examination, the use of clinical outcome measures, as well as learning from complaints and adverse incidents. This process is similar to the structure and types of evidence considered at the ARCP.

The call for revalidation and how consultants should manage a portfolio share a common history with the specialty trainee portfolio, including the use of multisource feedback, WPBA, reflective practice and professional development planning. For those already engaged in specialty training, revalidation will not be at all unfamiliar and indeed the majority of the evidence required for portfolios will already be routinely collected by trainees.

Key points to remember

- A successful portfolio is a developmental tool that builds a collection of evidence of experience, assessment of competence, self-reflection and personal development planning over time.
- Trainees should 'own' the portfolio by managing their own learning using the portfolio as a tool.
- The public want to be assured of the safety and professional competence of doctors.
- Portfolio evidence of competence must demonstrate performance in reality rather than the doctor's factual knowledge or abilities in controlled examinations.
- Evidence of achievement of competencies occurs by combining a variety of forms of evidence and assessments in various contexts and with multiple assessors.

Further reading

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