Rapid Retooling, Acquiring New Skills, and Competencies in the Pandemic Era: Implications and Expectations for Physician Continuing Professional Development

David W. Price, MD; Craig M. Campbell, MD

Abstract: The SARS-CoV-2 (COVID-19) pandemic has necessitated changes in health care delivery, including increases in delivery of care through asynchronous or virtual means, and deployment of clinicians in different teams and settings. Physical distancing and redeployment of clinicians has also necessitated changes in health care continuing professional development (CPD). Health care delivery and CPD is unlikely to fully return (in the near term, if at all) to pre-pandemic status. The authors raise questions and opportunities for development and provision of CPD during and after the pandemic.

Keywords: continuing professional development, CPD, technology-enabled CPD, re-imagining CPD, retooling, new skills and competencies

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Undergraduate health profession training starts with the development of foundational competencies (eg, history taking, physical examination, critical appraisal, clinical reasoning, evidence-informed decision making, and communication) acquired through a broad array of learning activities and supervised clinical experiences. Learning and training begin to focus in graduate training based on specialty choice. Further differentiation, throughout years of professional practice is influenced by a clinicians practice setting (inpatient versus outpatient, urban versus suburban versus rural), practice arrangement (individual versus small group versus large group, single versus multispecialty practice, interprofessional practice arrangements), evolving scientific evidence and procedural developments in the field, employer needs and expectations, teaching responsibilities, professional career plans, personal interests, and patient and population demographics and health needs. These factors contribute to shaping an individual’s scope of practice, which often evolves over time and may narrow later in physician careers.1

Although “scope of practice care” continues, the SARS-CoV-2 (COVID-19) pandemic has necessitated rapid and dramatic changes in health care delivery and staffing in many nations to deal with issues such as mass screening (to the extent testing is available), triage of symptomatic individuals, and redeployment of individuals to hospital settings (including emergency departments and intensive care) to deliver care to thousands of patients seriously affected by the virus. In addition to being asked to function in new teams, many physicians are being asked to reactivate knowledge, skills, and competencies that may have been dormant for lengthy periods. Clinicians are also being asked to diagnose and manage subacute and chronic medical conditions by telephone, interactive videoconferencing, or answering questions posed in electronic health records or email. Although communicating with patients by phone or email has been a staple of practice in many specialties for some patients, to minimize risk of asymptomatic viral spread, many clinicians are switching from face to face to virtual patient visits on a much larger scale, using different modalities (chat, video visits, and virtual/electronic consults) for conditions that would typically have been performed in person.

In many cases, clinicians are likely learning new skills or reactivating old ones in real time. Continuing Professional Development (CPD) providers have a unique opportunity to apply educational theory (eg, situated learning, reflective practice, and social cognitive theory), behavior change theory (eg, the Theory of Planned Behavior4), and evidence of effective continuing medical education (sequenced, longitudinal, and interactive),4 and successful practices from past pandemics (eg, SARS) to assist clinicians and the health systems in which they work to rapidly retool and develop new skills the health workforce requires during this (and other) time(s) of crisis. In the immediate term, creativity will be required to deliver effective CPD virtually, as needs for physical distancing limits in-person education and use of traditional classroom or conference settings. Although things may resume some semblance of the past as the peak of the pandemic passes, there will likely be enduring changes in health care delivery and the delivery of education across the entire medical education continuum. This raises a number of questions and opportunities for the CPD profession to explore, such as the following:

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Dr. Price: Professor, Department of Family Medicine, University of Colorado Anschutz School of Medicine, Denver, CO, and Senior Advisor to the President, American Board of Family Medicine, Lexington, KY. Dr. Campbell: Associate Professor of Medicine, Faculty of Medicine, and Director, Curriculum UGME Program, Faculty of Medicine, University of Ottawa, Ottawa, Ontario, Canada.

Correspondence: David W. Price, MD; Department of Family Medicine, University of Colorado Anschutz School of Medicine, 375 Birch St, Broomfield, CO 80020. e-mail: david.price@cuanschutz.edu.

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• Retooling:
  o How can CPD providers effectively (and to scale) help retool clinicians to re activates previous skills in response to public health (or other health system) emergencies?
• New competencies:
  o How can CPD providers effectively (and to scale) help clinicians learn new skills (eg, telemedicine) in response to public health (or other system) emergencies?
  o How can CPD expand its traditional focus on specialty-specific knowledge, skills, and practice gaps to enhancing physician knowledge and skills in public health, ethical decision-making, health advocacy, leadership, and professionalism?
• Technology:
  o How can CPD providers use distance learning to enable acquisition of skills development as well as knowledge development?
  o What are the opportunities for CPD, faculty development, and quality improvement leaders to partner on using technology to facilitate learning and practice improvement?
  o How can technology be used to promote CPD that is interactive, multimodal, sequenced, longitudinal, and spiraled to facilitate longitudinal learning and improvement in communities of practice of clinicians with similar scopes of practice distributed over regional or geographic areas? How can these activities supplement and reinforce in-person learning experiences?
• Teams:
  o How can CPD work with other health professions to foster team-based learning and practice improvement strategies applicable to individual practice settings and help new (and often temporary) interprofessional teams work together more effectively?
• Patient-centeredness:
  o What can CPD providers learn from patient and family experiences to enable educational experiences aimed at improving communication, team collaboration, shared decision-making, and patient-defined health care goals?

Winston Churchill said, “Never let a good crisis go to waste”. As society navigates through the pandemic to the new normal, we in CPD should consider ways in which we can reconceptualize the role of and the methods we use in CPD to meet the needs of patients, health care delivery systems, interprofessional health teams, and individual clinicians. We should explore questions and interventions, guided by theory and linked to evidence of effectiveness that considers the practice context, educational process, the learners, and the health system, so that we can identify the larger lessons from case examples that may be generalizable to other settings.

REFERENCES