GP selection of postgraduate education courses has implications for colleagues: messages for course providers and for those writing practice professional development plans

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SUMMARY

Background. The Department of Health’s review of continuing professional development in general practice advocates setting team and individual goals. Aim. To explore how general practitioners (GPs) share learning experiences with colleagues, focusing on how GPs choose courses as one factor influencing sharing.

Method. Interviews were conducted with 21 GPs using grounded theory methodology. The responses were coded by six researchers from psychology, education, and general practice.

Results. Much sharing with colleagues took place, though not always immediately following a course. GP explanations revealed four reasons for course selection that influenced the degree of sharing:
1. Attendance to meet group needs encouraged rapid sharing and could involve course attendance with colleagues.
2. Attendance to enhance ‘special interests’ could either encourage or inhibit sharing.
3. Attendance in pursuit of ‘personal interests’ peripheral to general practice did not result in sharing within the primary care team.
4. Attendance to meet personal learning needs did not involve sharing when needs were not currently shared with colleagues.

Conclusion. Course selection and subsequent sharing have implications for course providers and those writing personal and practice professional development plans.

Keywords: postgraduate education; general practitioners; professional development.

Introduction

The Department of Health’s review of continuing professional development in general practice recommends setting team and individual goals to improve practice performance. Personal development plans (PDPs) for the primary health care team would link with a practice professional development plan (PPDP). Training and education should improve practice performance and hence patient care. In this context, how professionals share learning within teams becomes important, yet a study of Dorset general practitioners (GPs) revealed that sharing occurred only if a piece of information was seen to be of vital importance.

This apparent paucity of sharing requires further exploration. The Dorset study focused upon immediate sharing of information from postgraduate education allowance (PGEA) accredited courses attended outside the practice. The present study used grounded theory methodology to explore how GPs share learning, both formally and informally, either immediately or later, and to discover which factors influenced sharing. This report focuses on how courses are selected, as one influential factor. Previous research has suggested that the course topic is not the only factor influencing choice. By exploring course selection within the context of sharing among colleagues, the researchers aimed to see whether mechanisms could be put into place to enhance the sharing process, thus enabling practices to gain ‘added value’ from course attendance.

Method

Confidential, semi-structured interviews were planned in one southern England health district. Within the grounded theory approach, data generation, analysis, and concept formation take place in parallel, each informing the others. Since the research topic spans general practice research, education, and psychology, the methodology was modified to incorporate coding and discussion by a multi-disciplinary team, allowing sensitivity to a wider range of issues. The health psychologist interviewer did not know the interviewees and, as a non-GP, was able to minimise bias in interviewing and interpretation.

Following a pilot study with one female GP, the interview schedule was finalised (Figure 1) and 21 GPs purposively selected. Using local GP lists, the interviewer identified GPs satisfying each combination of GP and practice characteristics from across the sampling frame then, using a pair of dice, selected each interviewee to achieve:

- an equal number of males and females;
- GPs from an equal number of training and non-training practices;
- practices across the range from one to eight or nine partners; and
two responders (male and female) from each of two practices as a validity check and to explore gender differences.

The GP tutor sent an introductory letter followed by a telephone call from the interviewer, who arranged a visit, confirming it in writing with a list of questions to prepare (Figure 2). A fee was paid for one hour and a PGEA point awarded for reflection on education.

Tape-recorded interviews, lasting 45 to 75 minutes, were conducted (July to September 1998) in a consulting room, quiet meeting room or, in one case, at home. Field notes listed overall impressions, key points, and hypotheses to pursue in subsequent interviews. Thus, the interview schedule evolved. Tapes, identified by code number, were transcribed and three research meetings helped clarify the conceptual framework and link codes together. All six researchers received the pilot and first four study transcripts; the remaining 17 were each read by the interviewer and one other. They used agreed headings for suggested categories and comments but could list additional areas and send a summary and relevant references to the interviewer, who coordinated analysis.

Results

Responders and their practices
Two GPs declined to participate and replacements were selected randomly from similar practices. Eleven males and 10 females were interviewed in 19 practices ranging in size (one to eight partners), spread geographically, and including rural, urban, and inner-city practices. Nine practices had more than one site, 16 were fundholding, and 10 were training practices, the trainer being the interviewee in five practices. Larger practices (more than three partners), training practices, and female GPs were over-represented compared with district prevalence. Thus, the purposive sample was not representative but included the intended range of practices and GPs. Where two from the same practice were interviewed independently, their accounts supported each other, providing evidence of validity of self-reports.

The emergent grounded theory
Sharing was described in terms of responders’ personal values and reasons for passing on or requesting information, as well as in terms of team systems, personalities, and the practice ethos. The study found that all GPs discuss patient cases with their partners. Individual GPs share what they know with their colleagues more fully if the organisation in which they work creates and recognises opportunities for sharing, in spite of more immediate demands upon time. This happens in a working environment in which individual GPs value the opinion of other GPs, and in which people are not afraid to ‘admit they don’t know’.

This climate provided the backdrop to the second grounded theory: GP reasons for selecting courses can have implications for sharing learning with their colleagues.

The evidence for this second theory is presented here.

Reasons for course selection
Most GPs favoured attending local courses in their own time, so
they could add their five days of study leave to annual leave. Among the reasons for course selection, the following four were described as influencing feedback to colleagues:

1. Meeting group needs — representing the practice.
2. Enhancing special interests — relevant to general practice.
3. Pursuit of a personal interest — considered of no interest to partners.
4. Meeting personal learning needs — filling gaps in knowledge or skills.

Each reason is described, with illustrative GP quotes, followed by sex, number of partners, and whether they were from a training (T) or non-training (NT) practice.

**Meeting group needs**
Attending courses to represent the practice led to rapid sharing, usually at a meeting (in practices that held meetings). This was commonly reported for courses dealing with organisational matters, such as primary care groups or service developments. Representing the practice on a clinically-focused course was often linked to protocol preparation, potentially influencing how the practice managed a condition:

‘I mean, with the asthma ones that was particularly important because we were setting up the asthma clinic then so a lot of that came straight back in … to a Monday meeting saying, “I’ve done this on the asthma course,” and that’s when we started setting up the asthma protocols for the practice.’ [Male; 6; NT.]

Another organisation might be the catalyst:

‘I had a piece of paper across the desk today from the Breast Clinic up in [city], who wanted a representative of the practice to go up and … one of us will have to go and then come back and educate the others.’ [Male; 6; T.]

Some GPs attended with nurses:

‘Certainly things like asthma courses and diabetes courses, we delegate a lot of that to our nurses and if we see … there is something new within the area, we would normally go with them.’ [Male; 3; T.]

Attendance with a colleague promoted discussion upon return. Although PGEA points might be available for dissemination, the process was perceived as lengthy and arduous:

‘…we actually fed back about 10 days, two weeks later, which I think you need to do it while it’s fresh in your mind … I just didn’t bother trying to seek PGEA approval really, because I think the effort involved in trying to get it all through and the forms through before the day, is, you know, it is an effort.’ [Female; 8; T.]

**Enhancing ‘special interests’**
Most GPs reported attending courses related to their ‘special interest’. Colleagues would seek them out to discuss particular cases and some learning took place:

‘…actually over the years, you do glean things from each other and quite a few of us have got different interests which, like Dr X … he’s also done a postgraduate dermatology degree so he’s our sort of resident dermatologist … And Dr Y does orthopaedics, particularly children’s orthopaedics … ’ [Male; 6; NT.]

Most responders in practices with three to eight partners recit-ed (unsolicited) a similar list. In teams where GPs all acted as generalists, particularly those with personal lists, advice-seeking was less focused, depending upon chance encounters at coffee break, prescription-signing, in reception or the corridor. Single-handed and two-partner practitioners were more likely to be self-reliant generalists:

‘Just books, magazines and if I’m aware of any shortcomings then I really do need to make sure that I am up to date, because I have to really rely on myself. If there’s a particular problem that I don’t find and I want to get an answer quickly, I pick up the phone, I ring the consultant with that specialty, and I ask the question from him and I get the answer …’ [Female; 1; NT.]

At the other extreme were practices with a clear division of labour:

‘…so instead of all of us knowing a bit, actually having super-specialists within the practice is beneficial … And that information is known at the desk, so the patients are directed to the appropriate doctor.’ [Female; 3; NT.]

In still other practices, GPs with certain responsibilities felt it nonetheless important to educate partners about new developments:

‘If it was included in my own area of interest and it meant I was going to change how I did the diabetes clinic, I would want to convey that to them, ’cause, if I was making changes, I would want to explain to them why I did that …’ [Male; 4; NT.]

Partners commonly trusted GPs with a ‘special interest’ to keep up to date, provide advice, and even see their patients but never required them to do any continuous updating. Whereas male doctors apparently chose areas of ‘special interest’, females acquired them:

‘…lots of ladies will go and see a female doctor for gynaec, so there are people who come along to see me for their management of their angina or their heart failure or their asthma and will automatically go and see [female partner] for their smear or for their HRT.’ [Male; 3; NT.]

Only one male mentioned routinely updating on gynaecology or family planning. Females felt it was their duty:

‘…and I think particularly being the only female doctor here, I think it’s important for me to be aware of up-to-date women’s problems and what’s going on, so I tend to do lots of things like that.’ [Female; 5; T.]

New information concerning women’s health, including particular psychological problems, was often shared between females across professions (assistants, registrars, nurses, and health visitors):

‘It may well be that I disseminate my information more to the registrar than I do to my partners, because, well, that’s partly because the last two registrars have been female … so they will tend to get the same type of patients as I will …’ [Female; 6; T.]

Male colleagues might be kept informed through notes, coffee-times or meetings but only for information rather than to teach them to provide a similar service.

**Pursuit of a personal interest**
For some, PGEA courses were an opportunity to follow personal
Meet the personal learning needs

Some GPs did an annual one-week general update, relying on course organisers to provide a balanced programme. Otherwise, GPs said they balanced ‘interests’ and general updating by spotting convenient courses from advertisements. Addressing ‘weaknesses’ or ‘knowledge gaps’ was a frequent reason given for course selection but GPs did not identify gaps before making their selection. Many acknowledged attending courses in areas of ‘interest’, rather than addressing weaknesses:

‘…one of the things is that of course you go on courses that you’re interested in. You don’t necessarily go on courses in areas where you feel deficient ... perhaps I should be honing up on orthopaedics or ENT or my weaker subjects.’ [Female; 6; T.]

‘Okay, you’re doing a course that you know roughly what it will be about and who it’ll be aimed at. You know it’s an add-on to a previous course. You know it’s the right standard for you, whereas I wouldn’t be particularly confident about learning about statistics or something.’ [Male; 3; NT.]

Practitioners were reluctant to discuss weaknesses or guide each other:

‘That would be very hard. I would never dream of suggesting, you know, they went on a course.’ [Male; 3; T.]

Formal assessment of genuine need was rare. Needs assessment computer packages, where available, were used primarily for training registrars, not continuing professional development. Rare discussions of partner inadequacies concerned business or clinical medicine:

‘She’ll come to us because she’s not terribly computer literate ... and in fact she realises that that’s one of her needs. It might not be her wants but it’s one of her needs, so she’s off on a Microsoft course …’ [Male; 3; T.]

Practice managers and sometimes GPs, in their role as employer, helped nurses and clerical staff to identify learning needs and appropriate courses:

‘If I felt that we needed to offer a particular service, I would talk to the team and say how do they feel about it? ... and if there is a particular person interested I’d say, “Well, if there is anything that comes up, would you like to go on it?”’ [Female; 1; NT.]

In only two practices, awarded ‘Investors in People’ by the Training and Enterprise Council, appraisal extended to GPs. The practice manager co-ordinated appraisals and PPDPs. However, in most practices, nobody had helped to plan a GP’s education, so nobody asked whether courses had met their undefined objectives. Following a local introductory session, some GPs thought mentoring might be a useful way forward but only one planned to take it up.

Discussion

This study explored the views of 21 GPs, varying in age, sex, seniority, team working arrangements, practice location, and team size. The method of sampling ensured greater diversity than recruiting only from active research or training practices. GPs with similar characteristics (sex, team size, and training status) gave similar accounts. We are confident that, although other GPs might have idiosyncratic views, the most common were identified. Implications for course providers and writers of practice professional development plans are considered below, based upon accounts of what already happens in sharing practices.

Meeting group needs

New information concerning management guidelines, diagnostic criteria or hospital services can be summarised and relayed quickly to colleagues through practice representatives.

Implications

Course organisers should emphasise to lecturers that participants may filter information for colleagues. To ensure that all of the main points are conveyed intact, the following are encouraged:

• An A4 sheet of main points, suitable for distribution to non-attenders or pinning on a noticeboard.
• Alternatively, time should be allocated during the course for participants to generate their own main points or an action plan to feed back to colleagues.
• Organisers can assist rapid cascade by speeding up accreditation for dissemination.
• Measuring the impact of continuing education upon services would be improved by recording education alongside team goals within the PPDP.

Enhancing special interests

Research into teamwork within practice teams has focused upon roles and responsibilities of different professions; however, this study recognised the roles of individuals in bringing expertise based on ‘special interests’. By taking a short term view of information relay (see above), we deny the complexity of what really happens. GPs seek advice from each other daily to meet patient needs. Fundamental to this delayed transfer of learning is the value placed upon the established, updated expertise of partners. While ‘opinion-leaders’ are important in cascading new information, existing informal cascade routes require recognition and formalisation.

Implications

General practice tutors could encourage practices to provide a list of GP ‘special interests’ so that they could target GPs explicitly for disseminating information to teams.

If practice teams acknowledged the expertise of individuals as...
a team resource within the PPDP, GPs could pursue ‘special interests’ as a valuable team responsibility, rather than a selfish indulgence. Identification of areas in which nobody has a ‘special interest’ may alert everyone to a practice need.

**Pursuit of a personal interest**

There is some uncertainty concerning government plans. Personal learning not linked to the PPDP may be allowed but may not include credit points towards payment. Our interviews suggest that this would displease some GPs.

**Implications**

Practices may wish to recommend that a certain number of study days are spent enhancing individual expertise with practice benefits, while some are used for general updating, etc. It will be necessary to define where a ‘personal interest’ ends and a ‘special interest’ begins so that guidelines can be agreed.

**Meeting personal learning needs**

Adult learning assumes that GPs can identify learning needs based upon experiences in their day-to-day work. GPs may not, however, be good at recognising their needs unassisted. **18-20** preferring to stay in their ‘comfort zone’ rather than covering topics that challenge them. **21** Investors in People, recognised throughout both private industry and the public sector, **22** requires a structure in which personal learning plans are based upon both the needs of the organisation and the personal development of the individual. Even where the ‘continuing learning culture’ **23** exists in general practice, however, it usually provides ‘impartial learning and career guidance’ **24** for ‘employees’ (nurses and clerical staff) but not for GPs.

**Implications**

General practitioners require information about the level of expertise expected for each course so they can choose appropriately from advertised courses. Mentoring may be threatening and must be handled sensitively, since it touches on the sensitive area of admitting ‘I don’t know’. **25** Discussion of learning needs within teams is likely to lead to admission of deficits only in non-clinical areas. It may be better to identify needs with a trusted mentor from outside the team, perhaps a non-GP, trained in learning needs identification. Computer programmes of knowledge tests, despite their limitations, **26** could aid this process.

**Learning plans: another burden?**

Besides patient demands, GPs have suffered many externally imposed requirements, perceived as a drain on time and resources and as encroaching on family time: health promotion clinics, fundholding, PGEA point-scoring, and, most recently, primary care groups. If practices are asked to impose one ideal framework for practice learning plans upon their diverse ways of learning and working together, the knee-jerk reaction is likely to be negative, with demands for ‘protected time’. Yet many GPs recognised how much they learn from each other as they prepared for the interview — a promising indication of the benefit of spending 15 minutes to reflect and document what already happens. Practices could gain further from discussing each other’s work and interests as a basis for practice learning plans. Practices with a positive sharing environment will do this naturally in response to demands for PPDPs. It remains to be seen whether external demands will encourage non-sharing practices to begin such reflection and discussion.

**Conclusion**

How GPs select courses influences how much they share. Accurate relay of information can be enhanced if course providers recognise that dissemination is better if planned. Much sharing is delayed and depends upon long-term ‘special interests’. PPDPs could give such internal expertise greater recognition and support, GPs may try to address learning needs with inadequate planning and limited information about courses offered. Mentoring systems must acknowledge that GPs are more likely to admit weaknesses in non-clinical than clinical areas and seek ways to overcome this.

**References**

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