Small group discussion in continuing education for general practitioners

J. P. TOBY, M.R.C.P.
A. M. G. BANTOCK, B.M., D.Obst.R.C.O.G.
J. D. CAMPLING, M.B., D.Obst.R.C.O.G.
N. M. HOW, M.B., D.Obst.R.C.O.G.
H. R. JONES, M.B., D.Obst.R.C.O.G., D.A.
T. A. RICHARDS, M.D., M.R.C.P.
E. D. SEVER, M.R.C.P., Area Clinical Tutor
Northampton

In educational circles great emphasis has been placed on learning by discussion in small groups. The value of such groups in a medical context has been emphasised by Graves (1964). At the same time Fry and Dillane (1964) suggested that general practitioners should form themselves into groups in their own localities to discuss the evolution of the health team. In Wales special interest groups have been formed under the auspices of the Royal College of General Practitioners (Llewellyn, 1968). Grene (1966) reported the start of a discussion group in Warwick which concentrated on problems of practice organisation. Reynell (1970) described the use at Bradford of the small discussion group as a learning technique for postgraduate medical education and he found the method far more successful with general practitioners than with junior hospital staff.

We present here an attempt to use small-group discussions on a wide scale in the continuing education of general practitioners based on a district general hospital.

Methods

General practitioners working in and around Northampton were asked if they would like to join a discussion group. Those wishing to do so were allocated to groups of about ten doctors. Half of these were composed of doctors of equivalent seniority (horizontal groups); the other half were made up of a representative cross section of each with doctors of varying seniority (vertical groups).

It was not possible to allocate doctors on a strictly random basis. The main factor preventing this was geographical and this led us to establish two peripheral groups. In all other groups we tried to ensure that doctors from the same practice were allocated to different groups.

Once the groups were formed each doctor was told the names of the doctors in his group and was asked to nominate a convener. In most groups the choice was clear cut and a meeting of conveners was arranged at which the future of the groups was discussed.

It was agreed that the activities of each group should be decided by its members and the value of some preparatory work was emphasised. It was also suggested that groups should meet approximately once a month. A record of attendance was kept and each convener recorded the activities of his group during the period of the study, which was from December 1969 to August 1971.

Results

Approximately 100 doctors live close enough to this centre for it to be regarded as their principal place for postgraduate education, but 150 doctors were circulated, including some who live at, or beyond, the periphery of our area.

Interest was expressed by 100 doctors and these were allocated to groups. Twenty-four doctors who work a long way from the centre were allocated to two peripheral groups, both of which were 'vertical' in structure. Another 26 were divided into three groups of this type

and the remaining 50 doctors were allocated to 'horizontal' groups. Figure 1 shows the age distribution of all the doctors with the shaded areas representing those allocated to 'horizontal' groups and the unshaded areas those in 'vertical' groups.

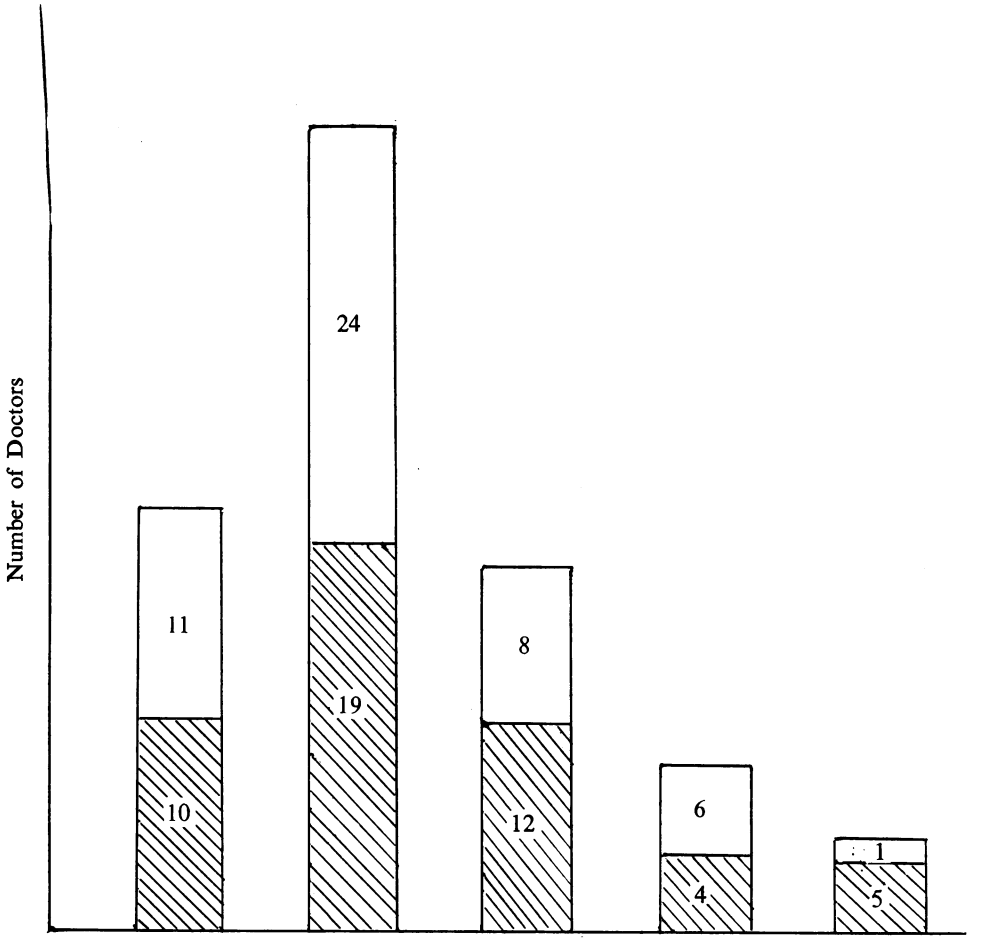

Figure 1

There were, therefore, ten groups containing 100 doctors, 38 of these did not attend any meetings. Each of the two peripheral groups lost about one third of its members in this way and the 'horizontal' group containing the most senior doctors did not meet at all. In the period under study one doctor died and one retired, while six doctors new to the area joined the groups. The first of our general-practitioner trainees was also attached to a group on completion of his hospital training.

Four groups no longer exist because of lack of support. Of these two were 'horizontal' and two 'vertical'. One of the latter was a peripheral group whose members were spread over a wide area. This left six groups which are still meeting regularly.

It is difficult to give accurate figures for attendance, since a number of doctors attended more than one group, either because their first group was not successful or because another group was more congenial or met at a better time. It was, however, possible to assess the attendance of those doctors who attended at least one meeting of a group which is still in existence (from the date of each member's first attendance). The relevant figures are set out in Table 1.

TABLE 1

Type of group	*Activity of group*	*Number of doctors attending*	*Total number of attendances*	*Total possible attendances*	*Attendance expressed as percentage*
Horizontal	Discussion of *Practitioner*	10	123	184	*61*
Horizontal	Miscellaneous	10	36	62	*58*
Horizontal	Discussion of *Update*	10	88	128	*69*
Vertical	Miscellaneous (usually *Practitioner*)	11	46	96	*48*
Vertical	Miscellaneous	9	113	145	*71*
Vertical	Tapes & slides	9	64	94	*68*
TOTAL	—	59	470	709	*66*

The groups whose activities were described as miscellaneous chose a wide variety of subjects for their meetings, such as 'The problems of prospective adopters', 'Physiotherapy', 'Immunisation' and 'The responsibilities and rights of the general practitioner'. At some meetings, for example one on 'Migraine', members brought clinical problems for discussion. The leadership of the discussion in the best-attended groups was shared by all members of the group in rotation. In the other groups the convener usually acted as chairman.

Sixteen of our doctors qualified before 1940. Half were allocated to a 'horizontal' group which never met at all. The remaining eight were allocated to 'vertical' groups and of these three are still attending, while a further two attended all meetings of their respective groups, but the groups themselves failed to survive.

During the period of study, meetings of the groups accounted for 247 out of 1,248 approved or recognised sessions.

Discussion

An important feature of the discussion group is the opportunity it gives to those participating, to talk about medical problems in their own words from their own point of view. Members find it easier to contribute if they have done some preparatory work and this is a pre-requisite of meetings based on a monthly journal. Previous study was often unnecessary in the other groups, but these offered more scope for varying the format of a meeting.

At the outset it was suggested that specialists might be invited to join the groups if their own special interests were being discussed. We felt, however, that their presence would inhibit discussion and no such invitations were issued. This meant that the meetings made no demand on hospital staff and that there could be no charge of hospital orientation.

We still cannot be certain whether 'horizontal' or 'vertical' groups are more successful, except in the case of senior doctors who are unlikely to attend unless they are in groups with younger doctors. On the other hand, several younger doctors have told us that they appreciate the opportunity of exchanging ideas with more experienced colleagues and there has been a general tendency for 'horizontal' groups to assume a more 'vertical' structure with the addition of new members. Whatever structure is adopted, we have little doubt that the best method of organising meetings is to have a permanent convener and to ask each member of the group to take the chair in turn.

We have found that these groups were established without difficulty and that they are

easy to run. If attendance is a valid criterion of success, then an overall figure of 66 per cent for all doctors who have attended one meeting is very encouraging. We suggest that it would be worthwhile establishing similar groups in other areas and we anticipate that meetings of these groups are likely to prove not only valuable, but also enjoyable.

Summary

The application of small-group discussion to postgraduate education for general practitioners is discussed. It is suggested that such groups may have an imporatnt role and the method used at a district general hospital is described. Meetings of this type now form nearly one fifth of all approved or recognised sessions held in the Northampton area.

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