General practitioners' reasons for not attending a higher professional education course

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SUMMARY

Background. *A proposal to run a higher professional education course attracted strong initial interest. However, only 12% of those 74 general practitioners expressing an interest subsequently enrolled on the course.*

Aim. *A study was undertaken to examine the factors that demotivated the remaining 88% from attending.*

Method. *A questionnaire was sent to the non-attenders, asking them to rank the impact of each of six factors on their decision not to attend.*

Results. *Major factors included time commitment, general practice workload and family pressures. Cost, attitudes of practice partners and structure of the course were much less important.*

Conclusion. *It seems that the conditions imposed by the current demands of working as a general practitioner, rather than the attitudes of the general practitioners themselves, inhibit this form of continuing professional development.*

Keywords: course attendance; doctors[1] compliance; continuing education.

Introduction

VOCATIONAL training was originally conceived as a five year programme, the first two years in hospital posts equating to general professional training, and the final three as higher professional training.[1] Mandatory vocational training subsequently modified this intention. Many trainees report finding themselves poorly prepared for practice, where standards and priorities may differ from those of their training practices (Koppel I and Pietroni R, unpublished report 1988). Furthermore, changes in the organization of the National Health Service have extended the role of the general practitioner to include responsibility for management and allocation of resources.

The need for a period of higher professional education which would follow the completion of vocational training and establishment as a principal in general practice has been recognized and promoted by the Royal College of General Practitioners.[2,3] Introduced in the Oxford region in 1986,[4] several regions now run similar schemes.

The educational subcommittee of the Wessex faculty board of the RCGP established a joint working party on higher professional education in 1991. As a result, the outline of a one-year course was proposed, using the structure of two small groups, each with about six participants and each working with a facilitator. Incorporating currently accepted principles of effective adult learning,[5,6] the course was to be learner-centred and learner-directed.

The aims of the course included the development of critical thinking skills, the application of basic research skills, use of the literature from general practice, development of management skills, and through development of the ability to define and negotiate learning objectives, the continuation and enhancement of the skill of self-directed learning.

The content of the course was to be dictated by the groups, and the process facilitated when necessary by the tutors. The intended structure allowed for three two-day residential sessions, 10 half-days of group meeting time, and unspecified individual study time during the year. The residential modules were to be held at a venue geographically central to the Wessex region. A portfolio of work done was to be developed and the course was accredited for the postgraduate education allowance.

Potential recruits were sought from general practitioners within their first 10 years of practice through the use, initially, of mailshots of course details to practices in four family health services authority regions (Dorset, Hampshire, Isle of Wight and Wiltshire), mailshots to the 462 RCGP members under the age of 40 years identified from the faculty database, and through the display of posters in postgraduate centres throughout the region.

It was hoped that focusing on this age group would build on the learning experiences of vocational training, and contribute to the emergence of future leaders within the profession. Some evidence that this may occur is derived from the experience of similar higher professional education courses,[4] and leadership courses run by the MSD Foundation, of which S V is a member.

It was also hoped that the course content would diverge from the conventional approach of keeping up to date, towards learning in the areas of unperceived learning needs. Often identified by groups outside mainstream general practice, such areas include audit, critical analysis, team working and resource utilization.[7]

The proposed course attracted interest throughout the region. In view of the discrepancy between the number expressing an initial interest and those subsequently joining the course, this study aimed to investigate the possible reasons for the decision not to attend the course.

Method

A questionnaire was sent by post to those principals who had originally expressed interest. A pre-paid return envelope was included. Six areas of possible difficulty, identified from widespread informal comment, were offered for consideration — time commitment, possible financial commitment, attitudes of partners, practice workload, family pressures and structure of the course — and other unspecified areas sought. Respondents were asked to rank the impact of each of the factors on their decision not to proceed, from one (not at all important) to five (extremely important). Respondents were also asked if they would be interested in such a course in the future.

Results

Interest in the course was expressed by 74 general practitioners,

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nine of whom subsequently started the course. The 65 who did not were the subjects of this survey. Completed questionnaires were received from 56 (86%).

Fifty respondents ranked the six factors on the questionnaire (Table 1). Major factors were time commitment, practice workload and family pressures. Six questionnaires included comments only in the 'other' category (Table 2). Three respondents mentioned difficulty with travel as being a factor in their decision not to attend the course.

Thirty seven respondents indicated they would be interested in the course in the future, and eight indicated they would not (11 non-respondents).

Discussion

Despite proposing an educational structure based firmly on currently-held principles of effective adult learning, this course failed to generate a commitment from the majority of those who originally were attracted enough to express an interest in writing. In the first higher professional education course in the Oxford region, 45 doctors expressed interest and 22 enrolled (49%), although five later dropped out; in their second course, 42 doctors expressed interest, 16 enrolled (38%) and three dropped out.[4]

Clearly, issues of motivation play a part in this discrepancy. Motivation represents the combination of forces, both intrinsic and extrinsic, that initiates and propels behaviour and determines its intensity.[8] The distinction can usefully be emphasized between internal and external motivation. The former relies upon perception of the relevance and value of the task, and may also relate to the satisfaction of an inner need, a need for achievement.[9] External motivation occurs when reward or punishment lies outside the task itself — the threat of examinations, or gain or loss of income or status. The concept of competence motivation, related to how achievement enhances and encourages further development, has been described.[10] Achieving self-confidence in learning lies within the aims of a higher professional education course.

From this study, it is clear that the principal areas of difficulty in participating in such a course lie in the external world — commitments of time and the demands of the practice and family. Given the intense nature of the proposed course, perhaps this may be expected. Financial commitment and the attitudes of practice partners, perceived or real (because of the effects of the absence of the participating partner on workload), assume a lower significance than might have been imagined.

Obstacles to change within the global context of medical education have been explored.[11] These may be directly translated to factors affecting individuals, such as overload, limited resources, isolation and division, poor management, and traditionalism.

Table 1. Respondents' ranking of impact of each of the factors on their decision not to attend the course.

Factor	% of 50 GPs ranking level of importance			
	Low[a]	Neither low nor high[b]	High[c]	% non-respondents
Time commitment	16	6	76	2
Possible financial commitment	60	20	10	10
Attitudes of partners	50	14	22	14
Practice workload	16	4	76	4
Family pressures	18	10	72	0
Structure of course	56	16	16	12

[a]Score of 1 or 2. [b]Score of 3. [c]Score of 4 or 5.

Table 2. Other factors mentioned by six respondents in the decision not to attend the course.

	No. of times mentioned
Difficulties with travel	3
Joined a new practice	2
Bureaucracy and stress	1
Lack of information	1
Moved house	1
Working as a locum	1

These findings are not new or confined to particular countries or health care systems. In a survey of general practitioners eligible for continuing education under section 63, 82% had encountered obstacles to attendance.[12] These were dominated by commitments to practice and family, although timing, distance and difficulties with locum cover were also mentioned. Obstacles to attendance at lunchtime lectures included lack of time and limitation because of practice arrangements.[13] A survey of Canadian physicians revealed that more courses and traineeships would be attended if resources permitted.[14] The authors state 'we presume that limiting factors include attitudes regarding the quality of courses offered, the expense of attending distant courses, the loss of income while away from work, and for solo practitioners, the difficulty of obtaining coverage for their practice'.[14] These assumptions have been supported by findings from the United States of America with conclusions that major impediments to participation in continuing medical education were time away from home and practice, expense, loss of income, and scheduling problems.[15]

How might demotivating factors be addressed? Apart from the issue of resources, the workload within general practice, together with family life, seem to dictate at an international level that continuing professional education is an add-on, often optional activity. Problems of geographical isolation and finding locum cover are being addressed in south Australia by a free locum provision service.[16] Several respondents in the present study made the unwarranted assumption that the residential sessions would take place at weekends. Professionalism ought to dictate an attitudinal shift towards a system where education is an integral and expected part of practice, built in to a reasonable and acceptable working week.

Despite a low uptake, the course is running successfully. It is gratifying to note that 66% of the initial respondents would be interested in a similar course in the future. Any such course requires full and detailed evaluation. If evaluation shows this course to have achieved its aims, then courses in the future must be supported by appropriate resources and attitudes. It must be hoped that those in a position of power and responsibility in the medical establishment will then make representations to those with power and responsibility in the government.

References

1. Royal Commission on Medical Education. *Report.* London: HMSO, 1968.
2. Royal College of General Practitioners. *Quality in general practice. Policy Statement 2.* London: RCGP, 1985.
3. Royal College of General Practitioners. An educational strategy for general practice in the 1990s. In: *A college plan — priorities for the future. Occasional paper 49.* London: RCGP, 1990.
4. Baillon BRF, Flew R, Hasler JC, *et al.* Higher training for general practice in the Oxford region. *Postgrad Educ Gen Pract* 1993; **4:** 29-36.

5. Knowles MS. *The adult learner: a neglected species.* Houston, TX: Gulf, 1984.
6. Brookfield S. *Understanding and facilitating adult learning.* Milton Keynes: Open University Press, 1986.
7. Pitts J, White P. Learning objectives in general practice: identification of 'wants' and 'needs'. *Educ Gen Pract* 1994; **5:** 59-65.
8. Cordes DL. Relationship of motivation to learning. In: Green JS, Grosswald SJ, Suter F, Walthall DB (eds). *Continuing education for the health professions.* San Francisco, CA: Jossey-Bass, 1984.
9. Wilson J. *Philosophy and educational research.* Slough: National Foundation for Educational Research, 1968.
10. White RW. Motivation reconsidered: the concept of competence. *Psychol Rev* 1959; **66:** 297-333.
11. Anderson PC. Obstacles to change in medical education. *J Med Educ* 1970; **45:** 139-143.
12. Pickup AJ, Mee LG, Hedley AJ. Obstacles to continuing education. *J R Coll Gen Pract* 1983; **33:** 799-801.
13. Branthwaite A, Ross A, Henshaw A, Davie C. *Continuing education for general practitioners. Occasional paper 38.* London: Royal College of General Practitioners, 1988.
14. Curry L, Putnam RW. Continuing medical education in maritime Canada: the methods physicians use, would prefer and find most effective. *Can Med Assoc J* 1981; **124:** 563-566.
15. Rothenberg E, Wolk M, Scheidt S, *et al.* Continuing medical education in New York county: physician attitudes and practices. *J Med Educ* 1982; **57:** 541-549.
16. Davies P. Continuing medical education for rural general practitioners in south Australia. *Postgrad Educ Gen Pract* 1991; **2:** 102-111.

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