General practitioners' views on continuing medical education

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SUMMARY

Background. *The 1990 contract for general practitioners altered the provision of continuing medical education.*

Aim. *This study set out to examine doctors' experiences of postgraduate education before and after the contract and their preferences for the provision of postgraduate education.*

Method. *In 1991 a structured questionnaire was sent to 1959 doctors registered on the database held by the west of Scotland postgraduate office.*

Results. *An 82% response rate was obtained. Eighty eight questionnaires had to be excluded. Of 1523 respondents, 74% were entitled to study leave under the terms of their practice agreement, an increase of 15% since the introduction of the contract. When attending courses 11% reported that they always employed a locum (32% occasionally). Those who did so were more likely to be general practitioners in rural areas than in urban or mixed areas. Almost all respondents (1485, 98%) had participated in postgraduate education since April 1990. Lectures remained popular (47% of respondents indicated it was their preferred or most preferred choice) while distance learning and practice based learning were least preferred. Evening meetings and afternoon meetings were the most popular, and Wednesday and Thursday were reported to be the most suitable days for educational meetings.*

Conclusion. *Organizing education for a large number of people is difficult, but individuals' preferences and difficulties have emerged which must be taken into account when doing so. In terms of attendance, postgraduate education seems to have been a success although its value in influencing quality of care is more doubtful. Perhaps the development of personal education plans may make learning more useful and relevant.*

Keywords: continuing education; learning techniques; doctors' attitude; doctors' motivation.

Introduction

THE major changes in medical education date back to the mid-1960s. Although postgraduate education has slowly evolved since then, little has been written about its effect and provision in general practice. One of the earliest papers was published in 1965, reporting Cartwright and Marshalls' survey of general practitioners' educational needs.[1] This was followed in 1969 by Byrne's postal survey of general practitioners in the north west region of England.[2] Subsequent papers which addressed doctors' views on education either had low response rates or only studied particular groups of general practitioners.[3-10]

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The introduction of the new general practitioner contract in April 1990 led to major changes in the provision of education for the family doctor. General practitioners can qualify for the postgraduate education allowance (£2150 per year) provided they attend 25 days of an approved and balanced educational programme in a five year period (National Health Service general medical services, statement of fees and allowances, 1990). This financial carrot has put continuing medical education in the market place and providers have emerged from within and outwith the profession. Concerns have been expressed that this could have harmful effects on the quality of education available.[11] The provision of education in this purchaser–provider environment must meet the needs of the consumers.

A postal questionnaire survey was therefore undertaken to examine general practitioners' experiences of postgraduate education before and after the 1990 contract, and their preferences for the provision of postgraduate education.

Method

A structured questionnaire, which had previously been piloted, was sent in 1991 to all general practitioners registered on the database held by the west of Scotland postgraduate office. This includes all general practitioners in the west of Scotland as well as other general practitioners who work outside the west of Scotland but have attended courses in the area. Questions were chosen by looking at issues which could affect and influence general practitioners' attendance and views of continuing medical education. A second questionnaire was sent to non-respondents six weeks later. The questionnaire was divided into five sections but only the areas dealing with perceived needs and preferences are reported here.

Completed questionnaires were coded by one researcher (M K), the data entered on to computer and checked by two operators, then verified and analysed by computer. No formal statistical analysis was undertaken.

Results

A total of 1959 questionnaires were sent and 1611 were returned, giving a response rate of 82.2%. Eighty eight questionnaires were excluded (for example because the respondent had retired), leaving 1523 suitable for analysis.

Thirteen respondents failed to complete the first question of the section on demographic details; of the 1510 who did 71.7% were men and 28.3% were women. Most respondents (1374, 90.2%) were working in the west of Scotland area. A total of 812 respondents were working in urban areas, 209 in rural areas and 470 were working in a practice in a mixed rural/urban area (data missing in 32 cases).

Practice arrangements for postgraduate education

Under the terms of the practice agreement, 73.5% of all doctors were entitled to study leave and in 891 cases (58.5%) this had been present before April 1990. Of these 1120 doctors who were entitled to study leave, 49.9% were working in an urban area, 14.5% in a rural area and 33.9% in a mixed setting (data missing in nine cases). These figures represent 68.8%, 77.5% and 80.9% of all doctors working in these areas, respectively.

The amount of study leave taken in one year varied considerably, from 1–5 days to more than four weeks. Just over half of all

respondents (829, 54.4%) took up to seven days. A total of 174 doctors out of all 1523 doctors (11.4%) reported that they always required a locum when going on a course, 31.5% occasionally did and 54.7% never did (2.4% did not reply). Of doctors working in rural practices 24.4% always employed a locum compared with 9.5% of doctors in urban practices and 8.3% of doctors in practices in a mixed setting. Of doctors in single handed practices 77 reported that they always employed locums (52.4%) and 42 did so occasionally (28.6%). The cost of a locum when needed for any reason was reported by 518 doctors (34.0%) to be borne by the practice and 214 doctors (14.1%) reported that they personally paid for locums. When a doctor attended an educational meeting, the cost of the locum to the practice per partner per year varied from less than £100 (estimated by 3.7% of doctors) to more than £4000 (estimated by 0.7% of doctors, two of whom were single handed general practitioners). Thirty seven doctors, 13 of whom were single handed, spent more than £2000 per year on locum cover. Of respondents 11.3% spontaneously expressed the view that education arrangements were poorly funded and that they were financially penalized by attending meetings.

Educational experience before the 1990 contract

The majority of all 1523 respondents (80.2%) had attended educational sessions before 1989, 70.9% of the 1221 reporting regular attendance and 29.1% reporting infrequent attendance. A total of 860 doctors (56.5%) reported attending 1–10 sessions per year and 361 (23.7%) reported attending more than 10. A total of 732 doctors preferred to attend both lectures and small group meetings before the new contract (Table 1). Ninety four doctors used distance learning in combination with other methods of learning, 17 of whom worked in rural areas. Nineteen doctors in rural areas used practice based learning in combination with other methods of learning. Before the new contract 647 doctors (42.5%) reported that they attended meetings only outwith surgery hours, 134 (8.8%) only used their study leave to attend meetings, 32 doctors used their half day only to attend meetings, 301 doctors (19.8%) were prepared to go to a meeting at any time of the day, 21 doctors only went to drugs company sponsored meetings while 207 doctors reported a combination of these (181 non-respondents).

The most frequently mentioned reasons for attendance at courses before 1989 was interest in the topic (506 doctors, 33.2%), a need to update knowledge (reported by 277 doctors), or a combination of the two (179 doctors). The social aspects of meetings were considered a main motivator by 37 doctors, 30 of whom worked in rural practice and 17 of whom were single handed.

Table 1. Method of learning reported to be favoured by general practitioners before the 1990 contract.

Method	% of 1523 GPs favouring learning method
Lecture only	*20.7*
Small group work only	*0.7*
Lecture/small group work	*48.1*
Practical work only	*0.2*
Practice based learning only	*0.2*
Distance learning only	*0*
Two of more of the above	*16.9*
Reading	*0.1*
No response	*13.1*

Educational preferences after the 1990 contract

Since 1990, 97.5% of all respondents had participated in postgraduate education. The most preferred type of learning was a combination of lecture and/or small group work and/or practical work (Table 2). The least preferred options were distance learning and practice based learning. There was no preference for distance learning shown by doctors working in rural areas compared with those working elsewhere. However, practice based learning was supported by 21.5% of doctors working in mixed rural/urban practices and 19.1% of doctors in rural areas compared with 15.5% of doctors working in urban areas (status of practice not known in six cases).

All respondents considered that the timing of the meeting was important; the most preferred option (rated on a scale of 1 = most suitable to 7 = least suitable), supported by 1016 doctors (66.7%), was an evening meeting. Afternoon meetings were the most preferred choice for 801 general practitioners (52.6%) and full day meetings for 752 doctors (49.4%). The least preferred meetings were morning meetings (least preferred by 884, 58.0%), then lunch time meetings (739, 48.5%), meetings of two to three days' duration (734, 48.2%) and weekend meetings (703, 46.2%). The most popular day of the week to hold a meeting was a Wednesday and the least popular a Monday (supported by 386 doctors, 25.3%). Thursday was the second most popular, followed by Friday then Tuesday.

Discussion

Continuing education provides general practitioners with an opportunity to maintain and improve their personal clinical skills with the ultimate aim of improving patient care. It is an essential part of a doctor's professional development and yet it is probably fair to say that the educational consequences in the 1990 contract for general practitioners have been lost among the concerns and anxieties for the implications for delivery of care. This is reflected in the dearth of literature on this topic. This large study achieved a high response rate and looked at a range of issues affecting general practitioners' needs and preferences for postgraduate education since the 1990 contract. Although the majority of respondents were based in the west of Scotland they came

Table 2. Preference for method of learning after the 1990 contract.[a]

Method	% of 1523 respondents expressing preference					% of non-respondents
	Least preferred	Not preferred	Equivocal	Preferred	Most preferred	
Lecture only	*7.4*	*13.5*	*27.4*	*25.1*	*21.6*	*4.9*
Small group work only	*7.7*	*13.1*	*26.0*	*31.3*	*15.7*	*6.2*
Practical work only	*6.6*	*12.9*	*31.5*	*28.5*	*10.4*	*10.1*
Lecture and/or small group work and/or practical work	*5.2*	*6.4*	*18.7*	*22.8*	*35.7*	*11.2*
Distance learning	*46.9*	*20.0*	*10.6*	*7.7*	*4.7*	*9.9*
Practice based learning	*24.4*	*23.6*	*23.6*	*13.5*	*4.5*	*10.4*

[a]Respondents asked to indicate preferred method of learning by grading each item.

from a range of practice types so should be representative of doctors in other areas of the United Kingdom.

The new educational arrangements seem to have formalized study leave provision within practices, with a further 15% having this facility at their disposal since the 1990 contract, especially those in rural areas (although a quarter of all doctors were still without leave provision). Despite 59% of all respondents reporting having had study leave before the 1990 contract, 42% of doctors attended meetings outwith surgery hours presumably because there was less pressure on them to obtain a certain number of educational sessions per year or because it was thought to be less disruptive to the practice.

When doctors were away on courses it would appear that their partners coped with the extra workload as only 11% of doctors reported that they always employed a locum (32% occasionally). Locums were more likely to be employed by doctors working in rural areas than in urban areas. Those 19% of single handed doctors who reported that they never employed a locum must have used their own time to go to courses or perhaps had assistants working in the practice. The low use of locums may be because it is often difficult to get a suitable locum or because the rising cost of locums may be greater than the financial benefit of the postgraduate education allowance.

The educational changes of 1990 have been heralded by the government as new and innovative but it appears that postgraduate education was well supported before the changes, 61% of general practitioners reporting that they regularly attended and 31% infrequently attended educational courses.

It is known that formal didactic teaching is an inefficient form of improving knowledge[12] and yet, as shown previously,[4] the lecture was popular among general practitioners. Only a small number of doctors favoured distance learning and practice based learning. Practice based learning was supported by 21% of doctors in practices in mixed areas, and 19% of doctors in rural practices compared with 16% of urban doctors. These numbers remain disappointingly small,[7] although practice based learning was better supported than distance learning. Both methods of learning have many advantages for the isolated doctor in that they do not disrupt the practice and no locum is needed. It is more solitary than attending meetings, but it does not appear that this is a deterrent as social contact was highlighted as important by only 9% of respondents. It may therefore be a conscious decision not to use these methods or lack of knowledge of these techniques.

Although it is impossible to create an educational programme to suit each individual, it is important to consult the consumer, and some valuable information on the timing of the meetings has emerged. For 67% of respondents, evening meetings were the most suitable. This is higher than in previous studies,[3] which may highlight doctors' attempts to avoid using practice time which now is a rare commodity. There has been a fall in the popularity of lunchtime meetings and meetings of two to three days' duration since previous studies.[3,4] The lunchtime meeting is worth one third of a postgraduate education session and this may not justify the effort involved in trying to attend. More than half of the doctors were unwilling to sacrifice their recreational time and for 46% weekend meetings were the least preferred option. As in a previous study,[10] Wednesdays and Thursdays were the most popular days for educational meetings, probably as they tend to be the quieter days of the working week and most likely to coincide with the doctor's half day when their absence from work will not leave the practice short-handed.

If success can be judged by attendance then postgraduate education has been successful, but it is necessary to look beyond this at the value to the individual doctor. This study has underlined the difficulty of producing an educational programme to suit such a large number of individuals. By listening to consumers, local courses can be provided at appropriate times and targeted to meet needs. Rural and single handed doctors have been shown to have particular problems such as difficulty in obtaining locums and the cost of obtaining such cover. The preference of doctors for lectures and the prevalence of these lectures[13] indicate that many educational lessons have not been learned. It is important that learning should be active rather than passive and this will require education of the course providers and a change in attitude of the general practitioner consumer. Perhaps the way forward is for the development of personal education plans for general practitioners which will give them ownership of their own personal and professional development and ensure that the learning will be relevant in timing and content. By so doing the quality of patient care may be improved which is the ultimate aim of the government contract.

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