Continuing medical education in mental illness: a paradox for general practitioners

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SUMMARY

Background. *In 1992, the Royal College of General Practitioners instituted its fellowship in mental health education, which aimed to provide general practitioner tutors with the skills they need to help general practitioners manage mental illness in general practice. However, the emphasis of the fellowship on pedagogic education may discourage educators wishing to introduce andragogic teaching, a paradox which general practitioners must resolve if the aims are to be realized.*

Aim. *This study set out to follow the difficulties encountered by the regional fellows in managing the fellowship and to understand how the scheme has evolved.*

Method. *Data collected for interim evaluation of the fellowship was studied and interviews undertaken with the senior fellow and the regional fellows participating in the scheme.*

Results. *From its beginnings, the project encountered difficulties involving acceptance among general practitioner tutors. In response to the objections raised, the project metamorphosed through three stages, from a (perceived) pedagogic approach to a much more overtly learner-centred one.*

Conclusion. *Learner-centred education requires trust and belief in the ability of general practitioners to teach general practitioners; over-protection of the audience from 'non-expert' educators merely perpetuates the* status quo. *If education in mental health care is to become truly learner-centred, general practitioners must address this paradox.*

Keywords: continuing medical education; mental illness; qualitative research.

Introduction

THE prevalence of mental illness in primary care is high,[1-5] and treatment of mental illness is high on the government's priorities.[6,7] The Department of Health is funding a senior general practitioner educational fellow at the RCGP, with the Mental Health Foundation and the Gatsby Charitable Trust, to take a national lead on continuing general practitioner education in treatment of mental illness.[7] The fellowship commenced in April 1992 with the aim of providing '... GP tutors with the knowledge and skills they need to help GPs improve their detection and management of mental illness in general practice.' The introduction of this fellowship has highlighted a paradox in the structure of continuing medical education.[8,9] Its emphasis on teacher-based (pedagogic) education through didactic teaching may discourage potential general practitioner educators wishing to introduce learner-centred (andragogic[10]) teaching.

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Method

This report is based on data collected for an interim evaluation of the fellowship:[11] annual reports, job descriptions, minutes of the steering committee and notes of meetings organized by the senior fellow. The senior fellow and 11 regional fellows were interviewed, using a semi-structured approach, to explore their reasons for joining the project, their recruitment and their relationships with regional advisers, general practitioner tutors and other fellows. All interviews were transcribed and supplemented with field notes. The proceedings of three meetings with all informants, each held over a 24-h period, were recorded.

Data were analysed using content analysis and interpretations confirmed through regular conversations with informants.[12]

Results

From the beginning, the project faced difficulties which necessitated its metamorphosis. The project developed in three stages.

Stage I: pedagogy in andragogic clothing

The fellowship was designed to be an educational programme based on research evidence, which general practitioner tutors would disseminate to general practitioners. The designers of the project assumed that learner-based teaching would be achieved by engaging the tutors to tailor centrally derived knowledge into courses that served local needs. Unfortunately, the design was interpreted as a teacher-centred initiative, generating resistance as one regional adviser indicated:

> '... he was also very careful to tell me at the very beginning of my interview with him that he saw his job as being to protect his Tutors and his people from people like me that come from the centre with top-down initiatives.'

Suspicion about teacher-centred education permeates the continuing medical education network:

> 'If you talk to the grass root GPs, they have a great suspicion of anything that comes out of the academics.... He [the associate adviser] is completely opposed to anything being imposed on his GPs.'

Resistance to this approach prompted redesign of the intervention; the education programme was to be undertaken by locally well known general practitioners. Accordingly, the 11 regional advisers able to support the project each appointed a regional fellow to act as intermediary between the senior fellow and the local tutors.

Stage II: andragogy in pedagogic clothing

The task of the regional fellows was to elicit the assistance of local tutors in constructing local educational interventions. They did this by undertaking a survey of mental health education in each district to identify areas of unmet need and relaying the findings to the tutors. However, success in engaging tutors depended on a fellow's previous experience of continuing medical education and proven ability to teach. All of the regional fellows had to counter suspicion from local tutors, but seven were

able to gain the tutors' interest fairly easily:

> 'A GP tutor came up afterwards and said: "That was great, we never have anything about the actual process of consultation.... I will tell them all about it at the next GP tutors meetings".'

However, the four fellows who were inexperienced in teaching and continuing medical education found access very difficult. Early overtures were often ignored and some took 12 months to establish contact with all tutors. Three central issues emerged from these experiences.

Authority of teacher. Some tutors place heavy emphasis on the authority of the teacher, and dismiss input from anyone whose status within the educational hierarchy is apparently low. One of the regional fellows remarked:

> 'I introduce who I am, and half the time I get a letter back saying: "Miss". People don't even realise I am a doctor, they think I am an administrator or something.'

Audience size. One of the consequences of providing continuing medical education in 'the market' is that large audiences are preferred.[13] Learner-centred education, with its emphasis on small groups, is less competitive than didactic lectures, reinforcing the notion that the operation of the Postgraduate Education Allowance (PGEA) may well militate against the desired principles of continuing medical education. Some fellows found that their proposals for small group work were considered unattractive to tutors, who were also wary of unsolicited help:

> '... the tutors all wrote very polite letters back, saying "we don't do things like this", "we know what we're doing", "we don't have any set agendas" and "we don't need any help"....'

Parochial suspicion. Local tutors were very suspicious of a centrally designed educational programme. One fellow summed up the attitudes encountered:

> 'I went to a tutor's meeting ... that's when I came under extremely heavy fire from the tutors. They saw me as somebody being manipulated by London.'

Analysis of the delivery of the Fellows' educational intervention highlighted the dominant influence that teaching authority had on tutors. Fellows with reputations as good speakers and an ability to address large audiences were better received by the tutors. However, engaging tutors also depended on how appropriate they perceived the educational material to be, and still tutors were reluctant to sanction a centrally driven initiative.

In response to these issues, the focus of the intervention was altered to emphasize application of knowledge rather than dissemination of knowledge.

Stage III: action research

Shifting the focus of the educational intervention from dissemination of knowledge to enhancing application of knowledge required the development of jointly negotiated regional initiatives, and involved each fellow learning what to 'teach'. A support network for the fellows was established, involving bimonthly meetings to provide experiential learning, formative assessment, specialist knowledge, peer review and mutual support. The original educational programme has been divided into separate educational packages covering treatment of depression, anxiety, suicide, alcoholism and schizophrenia, and contains training exercises in problem-based interviewing and interaction skills.

This support network increased the regional fellows' morale and confidence, as voiced by one regional fellow:

> 'When you are struggling and you know that other people have struggled there as well, I think that's helpful. Its nice to know that you are not the only one. I could feel terribly isolated and think "I am just really not doing this well, I shouldn't be here".'

Fellows pool their experiences and using nominal group techniques devise strategies to guide regional responses. Flexibility is paramount; new ideas are tested locally, assessed in the bimonthly meetings and modified in the light of feedback. Each fellow then tests their updated interventions in the 'field'. Using these techniques, interventions have developed into 11 projects, providing initiatives such as jointly derived local curricula, yearly educational programmes, consultation skills, video clubs for trainees and practice-based educational programmes.

Discussion

The notion that general practitioners learn best when education is directed at their own work following negotiation between teacher and student pervades modern views on general practitioner education.[15–21] However, identification of a concept does not automatically generate change, and the introduction of andragogy into thinking about continuing medical education does not automatically herald comprehensive learner-centred education: general practitioners still rely on secondary care teachers giving didactic lectures.[22–24]

This study exposed some of the complexities of learner-based teaching and the difficulties of delivering a national programme. The designers of the project believed that a national educational strategy could be used to disseminate knowledge if it was packaged in a range of forms that reflected the experiences of general practitioners. The success of the project relied on instructing general practitioner tutors to use the different forms of knowledge to assist their local general practitioners in delivering mental health care. The existence of tutors who are able and willing to teach in a learner-centred way was central to the strategy.

During the project, it became clear that the intended target audience, the newly emerging general practitioner postgraduate tutors, was inappropriate because most had neither teaching skills nor the desire to teach.[25,26] The absence of a body of andragogic teachers exposed the fellowship's pedagogic content. Recruitment of regional fellows as a means of addressing the problems of delivery failed to diminish resistance to what was still seen as a teacher-based intervention. The development in stage III of an action research approach, in which interventions are inductively derived, encapsulated an increasingly andragogic approach. In so doing, the project has moved away from national coverage as each fellow concentrated on tutors eager to develop initiatives; from such 'coalitions of interest',[27] a number of different strategies resulted.

The lack of general practitioner teachers limited the penetration of this learner-based initiative. Considerable time and effort was spent in identifying potential teachers (at the expense of providing education), compounded by the insensitivity of the current structure to the fledgling teacher. When tutors provided opportunities to Fellows to teach, they often required platform speaking:

> '... the difficulty comes when you are asked to present something and you have got the package and everything but

actually your knowledge is not necessarily greater than a lot of your other contemporaries.... I may not have the specialized reading background that a consultant psychiatrist might have.'

A system promoting learner-based teaching apparently excludes competent and enthusiastic teachers because they are not eminent in teaching or charismatic speakers (both pedagogic qualities).[27] Predominance of the expert in traditional medical education and emphasis on knowledge as the determinant of teaching authority militates against the new teacher:

'I can remember as a young GP thinking I have got nothing that I can teach anybody because everything that I know comes from some higher speciality. You know: everything about children, paediatricians know more than I do; everything about surgery, surgeons know more than I do; etc. You could take anything and somebody knows more because they specialize in it. Therefore, the only people that have anything to teach are specialists and not GPs.'

The project described here addressed this dilemma by shifting the teaching focus away from knowledge to application. Unfortunately, only a minority of tutors supported it.

Conclusion

This paper reflects the understanding of the context of continuing medical education in general practice from the perspective of the regional fellows within the orientation of mental illness. It must also be noted that the data collected are retrospective, and therefore, are reliant on fellow's recollections and interpretations of events, which may well have been influenced by more recent events. As a consequence, this paper is written only as a contribution to the debate on how postgraduate education of general practitioners is to develop: the findings cannot be generalized.

The fellowship in mental health education provides practical support to an evolving educational structure with a deep pedagogic pedigree. It has become moulded to its task by exposure to the needs of general practitioners through the sensitivity and imagination of the regional fellows, and has highlighted the unpreparedness of general practice to accommodate new learner-based teachers. This raises the question of who is to develop continuing medical education if the tutors have to spend their limited resources on managing bureaucracy. In this fellowship, the task was undertaken by the participants, but ironically, because they were from 'outside', local tutors rejected the regional fellows because they considered them anti-andragogic. Resourcing of continuing medical education using a structure that advocates andragogy has paradoxically made that structure more inaccessible to the non-pedagogic educator upon whom the development of the learner-centred approach depends, with the result that the pedagogic approach persists. Learner-centred education requires trust and belief in the ability of general practitioners to teach general practitioners; over-protection of the audience from 'non-expert' educators merely perpetuates the *status quo*. If education in mental health care is to become truly learner-centred, general practitioners must address this paradox.

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