Learners' experience of continuing medical education events: a qualitative study of GP principals in Dorset

CHARLES CAMPION-SMITH

HELEN SMITH

PETER WHITE

EMMA BAKER

ROGER BAKER

IMMY HOLLOWAY

SUMMARY

Background. *General practitioners' (GPs') attendance at continuing medical education (CME) events has increased since the introduction of the Post Graduate Educational Allowance (PGEA) in 1990. However, few studies have examined doctors' perceptions about their continuing education, and explored their views in depth.*

Aim. *To investigate general practitioners' experience of CME events, what personal impact they had, and how the GPs perceived the influence of CME in their professional practice and patient care.*

Method. *A qualitative study, with in-depth semi-structured interviews, of a purposive sample of 25 general practitioners in Dorset was conducted. Content analysis was used to identify major themes from the transcripts.*

Results. *GPs perceived CME events as beneficial. Confidence levels rose, and the events provided a break from practice that refreshed and relaxed, thus indirectly benefiting patients. The opportunities provided by formal events for informal learning and exchange of ideas, with both peers in general practice and consultant colleagues, were highly valued. The relevance of the subject to general practice, and the appropriateness of the educational format, were considered of paramount importance. Few responders identified major changes in their practice as a result of formal CME events, and information was seldom disseminated among practice colleagues.*

Conclusion. *The results of this study challenge GP educators to provide CME that is relevant, to recognize the value of peer contact, and to facilitate the incorporation of new information into practice.*

Keywords: continuing education; learning needs; postgraduate educational allowance.

C Campion-Smith, MB, ChB, MRCGP, DCH, GP tutor, Dorset Centre for General Practice; E Baker, BSc, research officer; R Baker, PhD, C Psychol, FBPsS, director; and I Holloway, BEd, MA, PhD reader, Research and Development Support Unit, Institute of Health and Community Studies, Bournemouth University, Bournemouth. H Smith, BMedSci, BM, BS, MSc, MFPHM, DM, Director, Wessex Primary Care Research Network, Aldermoor Health Centre, Southampton. P White, BSc, MB, ChB, MRCGP, GP tutor, The Nightingale Surgery, Romsey, Hampshire.
Submitted: 24 March 1997; accepted: 16 March 1998.

Introduction

IN 1990, the new Contract for General Practice[1] introduced the PGEA for reallocating money to GPs participating in accredited postgraduate education; the full allowance being paid to GPs completing an average of 30 hours per year. Prior to this change, the profession and the Government were concerned at the low attendance at educational activities; Government figures indicated that 'less than half of GPs attend any form of postgraduate education'.[2] After the introduction of the PGEA, surveys in the West of Scotland[3] and East Anglia[4] showed an increased GP attendance at CME events.

However, the authors of the West of Scotland study expressed concerns that the system should not only be judged by attendance, but also by the value of the learning to the individual doctor. It is not clear how effective CME is in producing change in doctors' professional practice,[5] and GPs' satisfaction with the PGEA system is not high.[6]

This study was conducted at the request of the Wessex GP Tutors Group, to examine the perceived value and impact of continuing medical education for GPs.

Methods

Our informants were 25 general practice principals in Dorset. A purposive sampling strategy was used to obtain a diversity of educational experience.[7] GPs were selected to represent a range of sex, age and practice size; of the initial 71 GPs invited, 25 accepted the invitation to participate and be interviewed. In preparation for the interview, GPs were asked to reflect on their CME activities over the preceding year, aided by a computer print-out of their accredited activity. The interviewer met with the GPs in their practice, to explore their experience of CME events and how they had impacted on them personally, on their professional practice and patient care. An interview guide was used to ensure that all the areas of interest were covered. This gave scope and direction to the conversation, and reminded the interviewer of possible probes to be used. It did not preclude exploration of unforeseen topics raised by the responder spontaneously during the interview.

Interviews were audio recorded and transcribed in full. The transcripts were then content-analysed, which involved reading through the data, identifying recurrent themes, and then categorizing the data.[8] The process of interviewing, data collection, and analysis occurred in an iterative manner.[9] The interviewer met with the research team to discuss emerging themes, and the interview guide was then amended to facilitate the exploration of these newly identified themes.

Responders' comments were plentiful, with discussion lasting about an hour and yielding over 400 pages of manuscript. Responders seemed comfortable with the interview format, and openly shared both positive and negative experiences of CME with the interviewer.

Results

Perceived benefits and problems of continuing education

GPs perceived CME, on the whole, positively; when successful it

refreshed and relaxed them and led to increased confidence.

'You come back very refreshed and reassured about what you are doing ... so I feel it is good for the patient.'

The break from routine of the general practice was seen as beneficial by the majority of participants, and as an antidote to the pressure of general practice that could become overwhelming.

'I really enjoy courses. I think it's quite a stimulating thing. It makes a break from the everyday sort of routine of surgeries.'

The opportunity to meet with colleagues was highlighted by all the responders. They felt that they gained much useful clinical information through informal discussion with GP and consultant colleagues. Equally important was the benefit of assessing common standards with which they could compare their own practice.

'I think it makes you feel more confident. You know that you are giving ... considered opinion rather than just a personal opinion. You've heard it from local specialists ... that they agree with the way you are managing something. I think it has to affect your confidence.'

'I mean the value of going on courses, and particularly these week-long courses, is that you meet a variety of other people and talk with them about what happens in their practice.'

It often seemed difficult to separate social and professional interaction; the two were frequently seen as being part of the same conversation.

'Often, you end up talking about patients, and you end up talking about difficult things. And "Oh yes, I've had something like that and this is what happened", which is very valuable.'

'Getting the feeling of how other people are reacting to the constant changes that we're all put under ... It's nice to find out where you are within everyone else's current experiences'.

However, GPs found some educational events a waste of valuable time. Lectures that failed to illuminate the GP perspective were particularly criticized.

'... sometimes you go somewhere, and you've been quite interested in the subject, and you think "This has been a complete waste of time." '

The problems of a build-up of work during absence from the practice was also noted.

'You come back to a mountain of paperwork, and so on ... it's all sitting there waiting for you!'

Importance of format and content

Lectures were felt by some to be undervalued, although they were disappointing if inappropriate. Poor presentation, a failure to relate the content to general practice, or inadequate time for discussion or questions led to low satisfaction.

'Sometimes the big, formal lectures are a bit frustrating because they might just hit the wrong aspect ... whereas a more formal sort of lecture style might present things very clearly but they might not be the things you want, and you don't really have any control over the information you are getting.'

Small groups were generally seen as a good way to learn, but the need for adequate structure was commented on. They were seen as a good format for interaction with consultants and specialists; participants found asking questions in smaller groups less intimidating.

' ... the small group basis is ideal if it is controlled ... it's the ideal thing in that you get the chance to be interactive and actually get the things discussed that you want.'

Multidisciplinary learning was also discussed. This was seen as very effective by some, but not all. The problem of setting the education at the right level for all the participants was mentioned. The GPs felt the benefits were greater if the topic was one of shared care; learning with practice nurses was noted to be especially useful.

'Very difficult to pitch so everybody understands ... everybody alternately ends up feeling patronized or baffled ... but it can be useful particularly in the feedback sessions, you get a line of view which the doctor wouldn't produce ...'

As in previous studies,[3] responders preferred topics relevant to their daily work. A favoured style of educational event was a combination of didactic presentation and group or practical work, with plenty of time for questions.

'I would like a mix of common standard management ... diabetes, hypertension, asthma ... and the more difficult end ... the patients that you'd be considering sending to hospital.'

'Some small group work, some patient contact, interesting patients, interesting problems ... Some lectures because it is a good way of getting information over, provided there is plenty of time and encouragement for it to be interactive, so that you can stop and ask questions and say "this isn't relevant".'

'With practical procedures, hands-on learning techniques are good ... Resuscitation for instance, and various operative techniques ... There is no substitute for doing it with somebody who knows how to do it well.'

The participants did not perceive formal educational events as the only or always the main source of learning. The responders felt they learnt from informal contacts in the course of their everyday work, particularly from direct, telephone, and written contact with consultant colleagues concerning management of specific patients.

'I might ... ring up if I had a particular problem and say "I don't know what the heck to do with Mrs Jones ... I have done all the tests I can think of ".'

Impact of continuing education on professional practice

Research by Drage *et al* suggests that CME is of limited effect in producing change in practice.[10] In this study, the spectrum of themes was large and not uniformly agreed. Some participants maintained that CME rarely affects patient care, while others suggested that what had been learnt had led to changes.

'Very rarely have I ever learned anything on a course that is actually changing the way I practise.'

'I can think of specific examples that other people have been on and have changed patient care for the whole practice.'

However, most participants, when questioned further, could think of something that had changed their everyday practice, although many of these changes were minor.

There was agreement that subject areas of relevance and common interest to general practice were more likely to lead to change, but that implementing change was not easy.

'I think you often hear "lovely in theory but not easy in practice" things ... Sometimes you try to implement them, but it is not as easy as it sounds ...'

Educational events are seen as useful and beneficial, mainly for the course participant; the information acquired is not often shared throughout the practice. Most participants believed that their practices should have a more formalized system for sharing information, but said that lack of time prevented them doing more.

'We ought to do that better, we often talk about that. We have endless business meetings ... and maybe patient problems. What we don't do well is feedback. You know, Dr X has been on a course, and this is a summary of the key points.'

In general, it seems that small bits of interesting information are shared in the practice only when the opportunity arises soon after the learning, or if there is something of particular and immediate interest.

'If there's something very interesting we tend to bring it up, but unless we bring it up in the first 24–48 hours it drifts into time.'

There were exceptions where practice members regularly discuss courses attended, and give a brief summary of the ideas presented. One GP reported that partners in his practice bring articles of interest to practice meetings. However, such sharing of information was unusual among the responders.

Attitudes to PGEA system and re-accreditation

Attitudes to PGEA were mixed, with some believing that it was necessary to encourage attendance, while others felt more negative about it; that it had added stress to their professional life. Some felt that professional development should be undertaken for its own sake, not monetary reward. Many responders felt the current PGEA system was unlikely to promote true learning in those who are not motivated to learn.

Re-accreditation was cautiously welcomed, but it was felt that it should be professionally-led. There was considerable support for the idea of regular meetings with an educational tutor/mentor to plan educational development.

Discussion

The GPs in this study showed themselves to be discriminating and demanding consumers of education. They showed a variety of preferred learning styles and were willing to use a mixture of learning formats. Much of their learning embodied the principles of adult learning;[11] they were self-directed and learnt in response to need. The finding that GPs gain much of their education in a variety of ways other than formal educational sessions agrees with Hayes's view.[12]

Nevertheless, the participants highly valued their educational time away from their practice, for professional stimulus and refreshment, and the chance to meet colleagues and review their own professional practice against those of others. Kelly and Murray reported that few responders valued the social contact; in this study it was the blend of social and informal professional contact that was highly valued.

The participants demanded that topics be relevant to the problems of general practice, and that they be dealt with from a general practice perspective. The GPs in this study had little patience for presentations they perceived as being irrelevant, or of poor quality. This is in accord with Salinsky's view.[13]

In more formal sessions, GPs wish to be able to influence the content to ensure its relevance to their work and learning needs. Time for interaction and negotiation with presenters was seen as a way of ensuring that the content of sessions met the learners' needs (or at least their wants), but didactic teaching was valued when used appropriately.

The perception was that formal educational sessions resulted in little change in practice, and this concurs with the earlier work of Davis.[14] However, one might speculate that professionals are not always aware of the internalization and application of what is learnt. Effects on patient care and professional practice are not always demonstrated in easily measurable health outcomes, but practice may be changed as described in Davis's later work.[15]

The majority of responders regretted that they had no system and insufficient time to share what was learnt with other practice members. This failure to share learning may be a reason why change in practice seldom seems to follow directly from educational sessions.

This study has not addressed the problem of helping GPs to identify their true learning needs, but we accept that there may be a conflict between learners' wants and needs.[16] Hayes's contention that performance review and clinical audit should be a starting point for educational planning[12] is interesting, and we are exploring this locally.

Because much valuable professional exchange occurs outside formal teaching sessions, it seems appropriate that this time should be recognized for PGEA purposes. As GP educators, we need to make the most of the potential for informal learning and exchange of ideas. Perhaps time for sharing the experience and wisdom of fellow GPs should be built into courses.

This in-depth exploration of GP learners' experience of CME was conducted in one county, but we believe that the findings are transferable to other parts of the UK and beyond. Our results challenge GP educators to provide or facilitate education that:

- is relevant and tailored to the learning needs of general practice,
- helps learners incorporate evidence and implement change in practice,
- recognizes the value of peer contact and professional discourse, and
- embodies principles of adult learning.

To achieve these objectives we recommend:

- building structured sessions into courses for experienced GPs, to encourage discussion of areas of professional concern and interest, and the sharing of successes and problems,
- instituting ways that allow the GPs' learning needs to influ-

ence the content of more formal presentations (e.g. by pre-course work or agenda-setting at the start),
- viewing work done in the practice, to share with colleagues what has been learnt as an integral part of an educational event. This work should be planned and accredited,
- allocating time, support and resources to identify individual learning needs, based on reflection on practice, with development of learning plans to meet these (e.g. by using mentorship, learning pairs and groups), and
- encouraging practice-based team learning with practice education and development plans and portfolios, where the aim is to plan and implement change.

We believe that these changes can ensure that GPs' education and professional development meet the differing needs in a variety of professional areas, and so contributes to improved patient care.

References

1. Health Departments of Great Britain. *General practice in the National Health Service: The 1990 Contract.* London: Department of Health, 1989.
2. Secretaries of State for Social Services. *Primary health care: an agenda for discussion.* London: HMSO, 1986.
3. Kelly MH, Murray TS. General practitioners' views on continuing medical education. *Br J Gen Pract* 1994; **44:** 469-471.
4. Perry J, Berrington B, Goss B. GPs' views of continuing medical education in the wake of the 1990 contract: an East Anglian perspective. *Educ Gen Pract* 1994; **5:** 283-287.
5. Fox RD, Mazmanian PE, Putnam RW. *Changing and learning in the lives of physicians.* New York: Praeger, 1989.
6. Al-Sheri A. The market and educational principles in continuing medical education for general practice. *Med Educ* 1992*;* **26:** 384-388.
7. Patton MG. *Qualitative evaluation and research methods.* 2nd ed. Newbury Park, CA: Sage Publications, 1990.
8. Burnard P. A method for analysing interview transcripts in qualitative research *Nurse Educ Today* 1991; **11:** 461-466.
9. Miller WL, Crabtree BF. In: Crabtree BF and Miller WL (eds). *Doing Qualitative Research*. Newbury Park, CA: Sage Publications,1992.
10. Drage M, Wakeford R, Wharton A. What do general practitioners think changes their clinical behaviour? *Educ Gen Pract* 1994; **5:** 48-53.
11. Knowles M. *The modern practice of adult education: from pedagogy to andragogy.* 2nd ed. New York: Cambridge Books, 1980.
12. Hayes TM. Continuing medical education: a personal view. *BMJ* 1995; **310**: 994-996.
13. Salinsky J. Confessions of a postgraduate consumer. *Postgrad Educ Gen Pract* 1994; **5:** 44-47.
14. Davis DA, Thomson MA, Oxman AD, Haynes RB. Evidence for the effectiveness of continuing medical education. *JAMA* 1992; **268:** 1111-1117.
15. Davis DA, Thomson MA, Oxman Ad, Haynes RB. Changing physician performance: a systematic review of the effect of continuing medical education strategies. *JAMA* 1995; **274:** 700-705.
16. Pitts J, White P. Learning objectives in general practice – identification of 'wants' and 'needs'. *Educ Gen Pract* 1994; **5:** 59-65.

Acknowledgements

The development of this research idea was facilitated by the Wessex Primary Care Research Network (WReN). This study was funded by the Wessex General Practice Educational Trust and the Wessex Regional Adviser for General Practice. We thank Professor Colin Coles and the Wessex GP Tutor Group for support and advice and the participating general practitioners for their time and co-operation.

Address for correspondence

Dr Charles Campion-Smith, 38 Prince of Wales Road, Dorchester, Dorset, DT1 1PW, UK; e-mail: ccampions@aol.com