THE NEW ZEALAND MEDICAL JOURNAL
Vol 116 No 1172 ISSN 1175 8716

Experiences and preferences of general practitioners regarding continuing medical education: a qualitative study

Felicity Goodyear-Smith, Melanie Whitehorn and Ross McCormick

Abstract

Aim To explore the experiences and preferences of general practitioners (GPs) regarding their continuing medical education (CME).

Methods Qualitative study using semi-structured interviews of twenty four GPs from Auckland and North Island rural areas assessing GPs' experiences and preferences.

Results The need for CME was emphasised. Primary themes identified were: the value of personal interaction; the perception that CME that did not involve personal interaction was adjunctive; an opportunistic rather than needs-based approach to learning; a preference for succinct, evidenced-based, GP-focused content; and lack of time as a major barrier to obtaining optimal CME.

Conclusions Interactive formats are generally preferred, but identification of which elements of interactive formats facilitate learning is not established. Most GPs do not direct their CME according to the adult learning model. The challenge for CME providers is to provide avenues to facilitate needs identification and self-directed learning.

New Zealand General Practitioners (GPs) undergo re-certification to maintain their vocational registration. This is usually achieved through the Royal New Zealand College of General Practitioners' (RNZCGP) Maintenance of Professional Standards Programme (MOPS). This is a credit-based system drawn from two primary sources: practice review activities and continuing medical education (CME). Credits are mostly obtained from attending registered courses or peer review groups, but reading and approved Internet activities can give credits. The system has strong similarities with the British Postgraduate Educational Allowance (PGEA) system.

Traditionally, GPs have obtained their CME through didactic lectures and written material. Although these mechanisms may increase their knowledge, there is no evidence that they change performance.[1] Recently, there has been a move, in the literature at least, towards application of the Kolb adult learning cycle: identifying learning needs, addressing those needs and evaluating the outcome, with reflection inherent in the process. CME is undergoing change in many countries, in part because of this move. Obtaining views regarding CME from GPs may facilitate this change. Proposed changes are most likely to succeed when compatible with existing beliefs.[2]

Within this context, the aim of this study was to explore GPs' current preferences and views regarding CME to help inform future provision of their professional development needs, including their continuing education.

Methods

Qualitative research methodology was used to explore the complexity of, and relations between, issues relating to GPs' experiences of and preferences regarding CME. The study was conducted in November and December 2001. Initially, GPs were randomly selected from a database of Auckland GPs to obtain a diverse range. Purposive sampling was used to deliberately include 'outliers' with respect to their gender, age, ethnicity and the socioeconomic nature of their practice.[3,4] GPs were also selected from a list of rural GPs practising in the central regional of the North Island, again choosing GPs who increased the diversity of our sample. This permitted a focus on 'cases that are rich in information because they are unusual or special'.[5]

Twenty four GPs were interviewed by telephone by a GP researcher. Only one of the GPs approached declined to be interviewed. The GPs were paid for their time. The interviews were scheduled at the GP's convenience and rescheduled if the GP was unavailable at the predetermined time. Interviews were typically of thirty minutes' duration and took place over a six-week period.

Semi-structured, open-ended questions were progressively focused to more structured questions using a topic guide. As well as demographic details, questions included assessment of CME needs, CME sources, format and content preferences and perceived barriers to obtaining optimal CME. An iterative sampling process was used in which earlier interviews informed the sampling and content of later interviews. Interviewing ceased once no new themes emerged. The conversations were tape-recorded and although the recordings were not transcribed hand-written responses were double-checked against them.

A general inductive approach to the data analysis was used. Interview responses were analysed for emerging categories. These were reduced to major themes through ongoing discussions between the researchers and re-reading of the transcripts until consensus was reached. The data were independently double-coded as a consistency check for inter-rater reliability (to reduce individual researcher bias) and discrepancies resolved by adjudication (discussion between all three researchers).[6]

The study was approved by the University of Auckland Ethics Committee.

Results

The subject group comprised sixteen urban GPs from the Auckland region and eight rural GPs from the central North Island area. There were sixteen males and eight females with an age range of 37 to 75 years and an average age in the mid-forties. The majority of doctors were trained in New Zealand and of European extraction, but the group included several overseas-trained immigrants and doctors of Maori and Asian ethnic groups. Their mean number of years in general practice was 16 years (range 2 to 39) and 18 were Fellows of the RNZCGP.

Overwhelmingly, a need for CME was expressed.

> 'It's essential, I cannot think of another word for it, otherwise I would become a fossil.'

Five primary themes emerged:

1. Need for personal interaction There was a strong feeling that personal interaction is important in the provision of CME and was overwhelmingly the preferred format of delivery. The need for interaction was expressed equally amongst urban and rural GPs.

> 'Nothing better than face to face.'

> 'Better face to face rather than through a magazine or Internet page. Can't beat in person – with a delivery of a topic and then discussion. I think that is the best.'

Within personally interactive formats there was significant diversity of preference. Formats ranged from the specialist lecture with questions, to leaderless small groups

equally sharing input, engaged in activities such as problem solving, journal club or critical event analysis. Many liked audience participation as part of a lecture presentation, particularly the facility to ask questions.

> ‘I like the ability to ask questions to someone who knows their subject well.’
>
> ‘If I could only have one thing I would like a short 15- to 20-minute presentation of formative, semi-dogmatic type followed by group discussion. That is the form I found most useful for the utilitarian purpose of picking up information and turning it into everyday practice.’
>
> ‘I would prefer to hear from an infectious disease expert about antibiotics rather than a group of GPs giving their opinions.’

Some recognised that preferring lectures could be construed as ‘being lazy’, as interaction was not essential, but each wanted the facility to be able to participate. Some favoured small groups where they felt less inhibited to ask questions. Adequate time (at least 15 minutes) for questions was important. A view was expressed that live presentations with interaction had more credence.

> ‘I think when it comes down to changing behaviour it is better to hear about it from someone who is already doing it, rather than reading about studies in Connecticut that have shown that…’

Others preferred leaderless small groups with shared input.

> ‘We talk about things like antibiotics for respiratory infections. These discussions are much more influential than someone telling us what we should do.’
>
> ‘Dogmatic teaching is exciting but doesn’t stick as much as something that has been discussed and thrashed out.’

Discussion was valued by many.

> ‘Discussion should be the main emphasis with some input from expertise, with short updates.’

For others, discussion groups were perceived as not innately beneficial.

> ‘Most people who practise medicine, particularly if they have been doing it for long enough, have fixed ideas. GPs like to have a natter, but still go away and do what they think. It is interesting to get another viewpoint, but I don’t think it actually changes the way you practise.’
>
> ‘Discussion does not always add, but it gets rid of our frustration.’

Many GPs belonged to peer groups and the benefit of these most often mentioned was the support they afforded. These are typically regular, small-group meetings of GPs to discuss problem cases or mutually agreed topics. Many peer groups had been operating for several years with a stable membership.

> ‘We share experiences, it is more informal...There are a lot of emotional gains from a peer group that you don’t gain from formal education.’
>
> ‘There is an atmosphere of trust and confidentiality, so you feel you can bring problems that might be sensitive or controversial.’

> ‘We know each other pretty well, as we have been going for a long time, if we do have any tricky cases or even sometimes any ethical dilemmas then it is a really good forum for discussing it. People can feel quite comfortable and be quite open and feel safe doing so in that environment.’

2. Perception of CME that did not involve personal interaction Many viewed CME that did not involve personal interaction as adjunctive. Reading did not feature highly as a preference. Most ‘flipped through’ what was sent to them, and few subscribed to journals.

> ‘I tend to cheat and read the summary. It is trying to find out what is relevant and important and getting to the gist of the matter quickly. You can spend hours reading how they have done the study. Often it is a waste of time.’

There was variable use of the Internet. This was due to a difference in interest, expertise and availability. Most used the medium to search for answers to specific questions. Many thought they would use it more in the future.

> ‘If you look at the sea and you are not quite sure if it is cold, you stay out of it in case it is too cold. That’s where I am at the moment, I need to try it.’

There was limited knowledge or interactive use of the Internet such as the Goodfellow Unit RNZCGP-endorsed CME Clubsite www.cmeclub.auckland.ac.nz (which provides interactive material earning CME credits). Some rural GPs liked the concept. There were a few enthusiasts who enjoyed using the Internet to read particular journals or for CME.

3. Opportunistic approach to learning GPs’ choice of CME depended on what was provided locally or at centres; what they were paid for attending; their personal interests; need for CME credits for the College; or, less commonly, what area of weakness had been identified. Some had a vague idea as to areas in which they were deficient or in which they perceived an opportunity for improvement.

> ‘Something you know yourself, something you have never been confident in.’

> ‘I basically go to what I can go to and have an idea of what I need to have a refresher in, because I have not been to something for sometime. I don’t do it in a very scientific way. You basically go to what you can go to or what might take your fancy.’

Some thought all GPs’ learning needs were the same and therefore would be addressed in what was provided. It was voiced that it was important for GPs to have input into provision of CME and therefore deficient areas could be addressed. This input was usually involvement in the construction of the programme. It was noted that, whatever the subject, something could always be learnt and that addressing all common areas of general practice would cover learning needs. Most, on discussion, reported that patient contact elicited areas of lack of knowledge. Two doctors kept a list.

> ‘When I identify a lack of knowledge when encountering patients, I make a list and look out for information.’

These needs were generally addressed by discussion with colleagues, contacting a specialist, consulting books, journals or the Internet, or in an informal way, although a few would also seek to address their deficiencies with courses.

> ‘Well, commonly I go to a text book or visit a site such as Clinical Evidence.’
>
> ‘May need to ring up the consultant on the spot.’
>
> ‘If it is something urgent I look it up in a textbook. If it is a general lack of knowledge such as a topic like Paget’s disease, that is not urgent, I would look out for a CME course that relates to that topic.’

Some did participate in learning activities that would identify educational needs such as problem solving, case discussion, quizzes etc, but most did not cite these as methods they used to identify needs. Therefore, whether or not these needs were addressed is unknown.

Some GPs perceived the most useful CME was that structured around learning needs, but few had a structured approach to their identification of needs, although there was a recognition of the issue.

> ‘I realise that my needs are from my likes.’
>
> ‘I think because it is something I don’t have to do, I don’t do it very well.’
>
> ‘Quality can be judged on quality of service provided, but often the best quality CME is how much you learn yourself, which depends on your needs.’

None mentioned a structured evaluation of the CME undertaken. Changes in practice that had taken place because of CME were often difficult to identify. Most GPs were happy with the current focus of CME.

4. GP-focused content The preference reported most commonly fitted the traditional model of CME and was for relevant, GP-orientated, succinct, evidenced-based material that dealt with common conditions and affected patient management.

> ‘I don’t want anything too academic. Practical, quick, easy, short and relevant…common everyday stuff, not minutiae. There is too much complicated stuff rather than the basics, for example glue ear, treatment of acute asthma, bronchiolitis. Concentrate on the sparrows not the canaries.’
>
> ‘Something that is not ‘airy fairy’. I need something practical. I need to know what to refer. It has got to be relevant to the average condition I see. It’s pointless going on about stuff that is high and mighty and rare. We have got to have common things and appropriate treatment for those common things. In other words – simple.’
>
> ‘Got to be relevant to general practice. A presentation with three good, take-home points – that’s all anyone can ever absorb.’

However, GPs also showed discrimination in weighing up the evidence that was presented.

> ‘I like to know the relevant effectiveness of various treatment strategies. Increasingly, I want to know the answers in a quantitative sense, not just knowing whether a treatment is effective, but how effective. So we can make intelligent decisions with our patients as to whether it is worth following that track or not.’

There was evidence that GPs enjoyed a wide range of content including debating ethical issues, problem solving and developing support networks.

5. Barriers to obtaining optimal CME Lack of time was seen as the biggest barrier to obtaining optimal CME. All CME was carried out in personal time. GPs were perceived as working hard and long hours. Personal time is precious.

> 'It means night-time or weekends. Has to fit in with on call and family. Being a rural GP is an all-encompassing job. It is important to have time when not at work. So the attraction of kayaking down a river appeals much more than going to a CME meeting.'

> 'I am a working mother, time is the essence.'

Time efficiency of meetings was seen as important. Ways of being more time efficient were mentioned, including the availability of good summaries of recent, relevant changes and efficient use of 'downtime' such as educational cassettes for use in the car. While the concept of providing CME in conjunction with other members of the primary healthcare team (such as practice nurses, managers or pharmacists) was supported in principle, concern was expressed that their time was not wasted attending presentations that were not GP-relevant.

> 'The nurse's angle is going to be different from the pharmacist's which is going to be different from mine. So if I'm going to take the time to do CME I would prefer it is tailored to me and my needs.'

Motivation and fatigue were other barriers to CME. Distance, availability and cost were seldom raised as issues for urban GPs. However, distance precluded attendance for many rural practitioners, as did difficulty obtaining locums, cover for single days, availability of CME and financial considerations. The perceived challenge was to increase the accessibility of personally-interactive CME.

Discussion

The GPs in this study valued CME and partook in a wide variety of CME activities. Their preference for personal interaction concurs with several studies reporting favoured formats.[7–11] Some studies have shown a preference amongst physicians for lectures[12] but this may include interaction. Others have found journals the most popular source of information[13,14] but interactive formats were still highly rated. Preference depends on the type and quality of personal experience of this type of format. Pendleton differentiated the academic and professional approach to CME.[15] He postulated that the academic prefers the written medium and the clinician prefers face-to-face.

Davis reviewed randomized controlled trials on CME interventions and found personal interaction to be central to effectiveness in change in practice.[16] Several studies have reported that physicians seek confirmation and validation of current and new medical practices through their peers.[17] Other studies have confirmed the importance of interaction in changing professional behaviour.[18–20]

However, it has not been established which elements of the interactive process enable learning. Interaction allows for clarification, personalisation of information, exploration, feedback, and reflection. It can also address other needs of doctors that may not be recognised or quantified – the need for support, recognition, motivation and fulfilment, and the 'need' to belong to a professional community.[19,21]

Interactive formats are not inherently beneficial[22] nor always produce change.[23] Some formats may be more conducive to specific changes in behaviour and some to support. Group dynamics, facilitation, personal agendas, and internal and external influences contribute to the complexity of the format.

In general, the focus was on choice of CME as opposed to other elements of the learning cycle. This approach has been documented previously and reflects the traditional approach to learning.[24] It is well established that CME should follow the principles of androgogy – adult, self-directed learning. The term 'androgogy' has been coined to describe the learning culture appropriate to adult education.[25] Whereas the term 'pedagogy' describes the teacher-centred approach to the education of children, androgogy 'recognises education to be a dynamic lifelong process' that 'is learner-orientated'.[25] This is grounded in experiential learning – identifying and addressing needs and applying learning with continuing reflection.

Although much has been written about the theory and benefits of this model,[26–28] GPs do not appear to adopt it. This is not unique to GPs – a study of physicians' CME found that 'unstructured ad hoc reading and postgraduate activities predominate over methods based on specific, individual needs or on current patient problems'.[29] Some GPs in our study did recognise that tailoring their CME to their identified, specific needs was better than the opportunistic approach, but few attempted this in any structured way. Discussions with colleagues one-to-one and in small groups may serve as an informal process of reflection, even though the benefits may not be easily quantifiable. The process of reflecting on issues, debating problem areas and formalising opinions may be helpful to the clinician, even where there has not been a specific updating of knowledge.

Lack of time may be one reason GPs have not embraced the adult learning model. Clinical experience is abundant in general practice, yet many may be too busy to learn from it.[30] Al-Shehri suggests that GPs should set aside time each day for reflection,[31] but most GPs are likely to view this as unfeasible. Lack of time has been well documented as a significant barrier to obtaining optimal CME,[13,32] a finding borne out strongly in this study. Perceived high workload and stress lead not only to lack of time, but also de-motivation. Motivation is a complex issue,[30] however one role of CME is to sustain motivation.[31]

GPs may not be very good at identifying their needs unassisted.[33] The current system of CME credits rewards application of the traditional model, one of updating knowledge and skills, with no focus on utilisation of the adult learning cycle. Without evaluation of CME undertaken, GPs are likely to be unaware of any failings of the current system. Few tools are available to facilitate this process of reflection and evaluation. Personal development plans and mentorship have been suggested but need to be evaluated. Practical, evidence-based, user-friendly ways of addressing this issue are awaited.

Pendleton argues that most doctors want to improve the quality of their action as painlessly as possible.[15] They wish to maximise the return on their investment of time and this becomes a matter of cost-benefit analysis based on the likely yield of the activity. Personally interactive formats are costly on time, especially when travelling is taken into consideration, yet most GPs prefer these formats. This was also true for rural GPs for whom the inaccessibility of these events was a significant problem.

Clearly GPs consider time spent in this way to be beneficial. They may find that the scheduled nature of these events ensures their participation, whereas spending the equivalent time on their own reading or accessing the Internet may require more personal discipline. One study looking at alternative sources of knowledge found internal medicine physicians have a greater preference for consulting the medical literature, while family physicians more often rely on colleagues and specialists as sources of information.[34]

A focus on factual content as a preference has been reported elsewhere[35] and agrees with the traditional model of CME. Again, the emphasis was on the best use of time – information presented in succinct form relevant to everyday patient management – and concurs with earlier research.[11] Uni-professional learning was considered more time effective and hence was generally preferred.

CME cannot be entirely focused on GP preference. However, it is clear from this study that interactive formats were generally preferred in accordance with evidence of what changes GP behaviour. More research is needed into which elements of interactive formats facilitate learning. Most GPs are not directing their CME according to the adult learning model. This situation needs to be addressed, bearing in mind the barriers of lack of time and motivation, in order to change the status quo.

In conclusion, GPs in this study displayed a strong preference for personally interactive formats and non-interactive formats were viewed as adjunctive. What this demonstrates is the value GPs place on personal contact with their colleagues, despite the added demand this places on their time. Their approach to learning was mainly opportunistic. This paper highlights the discrepancy between learning theory and GP practice. It emphasises that the challenge for CME providers is to provide avenues to facilitate needs identification and self-directed learning, taking GPs' views and preferences into consideration.

Author information: Felicity Goodyear-Smith, Senior Lecturer; Melanie Whitehorn, Honorary Research Assistant; Ross McCormick, Director, Goodfellow Unit, Department of General Practice and Primary Health Care, Faculty of Medical and Health Sciences, University of Auckland

Acknowledgements: We thank all the general practitioners who participated in this project. In addition, Dr Stephen Buetow, Senior Research Fellow, for his helpful editorial assistance.

Correspondence: Dr Felicity Goodyear-Smith, Department of General Practice and Primary Health Care, Faculty of Medical and Health Sciences, University of Auckland, Private Bag 92019, Auckland. Fax: (09) 373 7006; email: f.goodyear-smith@auckland.ac.nz

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