From teaching to learning

Experiences of small CME group work in general practice in Sweden

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Scand J Prim Health Care 1999;17:196–200. ISSN 0281-3432

***Objective* – To describe the experiences of learning in small groups and the impact of small group continuing medical education (CME).**
***Design* – Literature review, personal communication and critical reflection.**
***Setting* – General practice in Sweden.**
***Subjects* – Small CME groups.**
***Main outcome measures* – Occurrence, themes and impact of small CME groups.**
***Results* – In 1998, there were approximately 230 small CME groups in Sweden, which means that nearly half of Swedish general practitioners (GPs) participated in such activities. Although widely used in Sweden, small CME groups are less practised than "traditional" CME activities, such as lectures. Group work might enhance knowledge development, enable the assessment of individual learning needs and facilitate the adoption of national guidelines and agreements between primary and secondary care. A competent group leader is crucial.**
***Conclusion* – A transition from passive to interactive learning in small groups is recommended.**

***Key words:* continuing medical education, small groups, peer groups, general practice, problem-based learning.**

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A qualified doctor is responsible for conducting his or her lifelong learning and physicians spend a large amount of time on continuing medical education (CME). According to Davis (1), CME is defined as "any and all ways by which doctors learn after the formal completion of their training". CME can take the form of reading journals, attending lectures and seminars, small group work, informal consultations with colleagues, interactive computer programs, audit, outreach visits, "academic detailing" and practice visiting (2).

Doctors learn best when they recognise the need for learning and when learning is self-directed (3). Although academic knowledge is important, the fundament for professional development is reflection of one's own practice or, as Schön (4) stated, "reflection-in-action". Until now, these aspects of learning have been mostly neglected, and teacher-led lectures along with journal reading continue to be the most common form of CME activities (2). "Traditional" education (often sponsored by the drug industry or other stakeholders) appears to attract general practitioners (GPs) as an easy way to get facts and new information. An increase in this type of CME is reported in the UK (5).

Motivation is a common denominator for many studies that have been able to show effects of CME. The desire to be more competent and "pride in performance" are other key forces for change, while regulatory measures have little impact (6).

Many studies on the effects of CME activities on quality of care suffer from methodological problems and there are few objective evaluations (7). Several reviews conclude that combinations of interventions are more effective than single ones and that no single CME activity is superior to others; thus, there are "no magic bullets" (8). More recent research supports the opinion that interactive CME can effect change in practice and, occasionally, even affect health care outcomes, while "traditional", didactic sessions do not appear to be effective at all (9).

CME in small groups, where colleagues meet on a regular basis, has been introduced in many countries. The theoretical basis for self-directed and problem-based learning in group sessions is well developed (10). Many studies have shown that small group sessions are one of the most popular and stimulating CME activities practised by doctors. However, hitherto only a few such studies have been able to show positive effects on quality of care, and if so, only for certain patient problems (11).

Small groups for CME and quality improvement have been running in Sweden since 1993. Sporadic questionnaire follow-ups of local activities have been carried out, but as yet no review or critical analysis of the contents and the impact of small groups on CME

and learning in Swedish general practice has been published.

AIM

The aim of this paper is to describe the experiences of learning in small groups in Sweden 1993–1998 and to analyse, compare and reflect critically on the impact of small group activities.

METHODS

This study began by reading and using the references in some well-known and generally accepted and discussed papers on CME (3,4,8). By reiterating this procedure we were able to ascertain those papers which are of real importance to small group CME. This enabled us to get an overview of the most relevant international literature on the CME topic.

In order to find information relating to Swedish CME small groups, one of the authors (GE) used his position as co-ordinator of the national CME programme and his membership of The Swedish Association of General Practitioners (SFAM) Quality Council to establish informal communication with GPs in different parts of Sweden, with colleagues in leading quarters and with pedagogic expertise. Both written information and personal communications have given rise to new questions being asked and new searches for additional information, in some cases leading to the rejection of earlier beliefs. This, in combination with partaking in international, national, regional and local CME conferences and seminars with opportunities to discuss scientific reports and divergent opinions, has given us a sufficient overview and comprehension of the CME topic in Sweden.

RESULTS AND DISCUSSION

In 1993, SFAM launched its CME programme, which was based on small group learning and individual learning plans (Appendix A) (12). The pedagogy of the groups was theoretically underpinned by the concept of problem-based, self-directed learning (10,13).

The idea of problem-based and self-directed learning from everyday practice, closely linked to quality improvement, seemed to appeal to many Swedish GPs and the CME programme was successively accepted by the majority of them. Decentralised responsibility and the use of networks were strategies that motivated Swedish GPs to embark on interactive CME in small groups without being exposed to any external pressure. The small groups were initiated and supported by SFAM through seminars, courses and printed material sent to group leaders and other key persons (Appendix B).

A set of printed study modules contributes to small group work. These modules contain short introductions and facts about a subject aimed at facilitating group discussions. They emanate from small groups or from authors with special insights into a subject (14). Presently, there are nine study modules available.

National follow-ups

A 1997 follow-up questionnaire to members of small groups in Stockholm showed that meeting frequency was once or twice a month, with an attendance rate of 70%. Eighty per cent of group members judged the educational value of the group sessions to be greater or equal in comparison with self-studies or activities sponsored by the drug industry (15). The role that small groups played in general practice was judged to be rather modest compared with "traditional" CME. In this study, small groups appeared to function fairly well as social support between colleagues but less well for knowledge development.

In a 1997 follow-up questionnaire in the county of Dalarna, 87 of 170 GPs were found to be members of small groups. The attendance frequency was 75% for meetings, which had a common duration of 1.5 hours (16).

In the county of Halland, a similar questionnaire study in 1997 showed that 78 of 112 GPs were involved and that their attendance rate was 60–80% (17).

A common denominator in these three investigations is that, although small group work is highly appreciated as CME, the majority of group members value it more as a complement to "traditional" CME than as a real fundament for CME. Another common finding is the importance of sufficient group leader competence. Regular meetings, courses and supervision for these persons are judged indispensable.

A national survey of small groups in Sweden was performed in 1998 by means of a questionnaire, which was sent to all known group leaders. The number of groups was reported to be 220 and the number of non-responding group leaders was estimated to about 5%. Less than half of the group leaders had undergone training courses. Case discussions were by far the most popular agendas in groups (Tables I and II) (18).

Strengths and weaknesses

In the following, the Swedish experiences with small group CME are analysed and commented upon in

Table I. Data from a national survey of small groups in Sweden 1998 (18).

Total number of GPs in Sweden	Approximately 4000
Total number of groups	222
Frequency of meetings	Once or twice per month
Number of participants in each group	5–12
Attendance frequency	50–90%
Number of group leaders with regular supervision	40
Number of group leaders who have undergone training course	100

relation to international experiences, focusing on the strengths and weaknesses.

The strengths of small CME groups are principally that learning is self-directed and based on relevant problems and "reflection-on-action", a pedagogic prerequisite for effective learning (4).

Table II. Subjects and themes reported from small groups in Sweden and number of groups who have used them (18).

	n
Improving consultation skill	
Case discussions, chosen at random	28
Sit-in	4
Video consultations	3
Examination	2
Doctor–patient relationship	1
GP competence	1
Rituals in practice	1
Management of chronic diseases	
Diabetes	9
Osteoporosis	8
Dementia	5
Heart failure	5
Allergy – asthma	5
Obesity	2
Hypertension	1
Management of "common problems"	
Chronic pain	7
Insurance medicine	6
Prescription of drugs	5
Laboratory tests	5
Parkinson's Disease	5
Driving licence matters	4
Lowering unnecessary use of antibiotics	4
Miscellaneous	
Performed practice visiting	6
Choosing the right diagnose	5
Organisation of care and improving working environment	5
Reports from journals and text books	4
Critical incidents and litigation	4
Audit[1]	3
Computers in practice	2
Individual learning plans	1

[1] Upper respiratory infections, lower urinary tract infections, prescribing of antibiotics.

Subjects, themes and cases discussed in groups come from daily work and are highly relevant to practice. The small group will meet the demands of developing the generalist knowledge as well as the expert role in general practice (19).

Many GPs regard the group as a place for social support, dialogue, growth in the professional role and for protection against burnout. Although the main purpose of small group work is the exchange and the development of knowledge, social aspects should not be neglected because they will increase the motivation to continue with meetings during less active periods.

In time, group members develop confidence and security in the group, rendering the disclosure of ignorance and "blind spots of knowledge" easier. Group members could either use the whole group or parts of it to assess their own learning needs.

Group work is built on sharing and improving "collective" knowledge and well functioning groups provide this in an atmosphere of joy and curiosity.

Some Swedish groups have been working on the local adaptation of national guidelines while others have started to improve the quality of primary–secondary interface. Communication between group leaders and GP liaison officers in Danish and Swedish hospitals is common (20). These efforts are interesting because they suggest a drift towards shared health care models.

Small groups will have opportunities to discuss the "art of medicine", founded upon context, anecdote, patient stories of illness and personal experiences (21). Accepting emotional responses being mirrored by other group members corresponds in some respects to the process in Balint groups. In addition, small group members have unique opportunities to discuss the way the individual patient experiences his or her illness through narratives, retold by the doctor. Thus, the "artistry" of medicine has a fair chance to be elucidated (22).

The weaknesses of small CME groups relate predominantly to their vulnerability. A dysfunctional group is constantly threatened by disintegration. Members have to prioritise group work, attend regularly, survive periods of stagnation and resist interpersonal incompatibilities.

The most crucial group member is the leader, who has to master group leadership. During 1999, there has been a noticeable downward trend in Sweden with regard to the interest in attending national seminars for group leaders. This could be because of an increasing number of well functioning groups but also because of a vanishing interest in CME, tiredness of group leaders or an increasing workload for GPs.

Participating in professional group sessions excludes nurses and other staff members. There seems, however, to be no way out of this problem. The group should act as a forum where its members can reflect freely upon all problems that bind them together in their profession.

Comments on methods and experiences

This study attempted a critical approach. An open mind and a proactive attitude to a phenomenon are searched for. Our method of retrieving references, literature, opinions and other information could be questioned as it entails a subjective viewpoint that would bring bias to the results. However, bias could also be looked upon as a resource, given that the position of the investigator renders him the ability of having insight and a unique understanding of the subject in focus (23). Our findings have been scrutinised and we have strived to hold the distance to the achieved information, trying not to reject those aspects of a phenomenon of which concepts for handling are not known (24).

It was not possible to find all group leaders in the national survey of small groups referred to earlier. However, the response rate was reported to be high, indicating a sufficient validity to the numbers in Tables I and II.

The Swedish experiences hitherto indicate that many GPs are still inclined to adhere to "traditional" teaching methods, such as attending lectures and predefined CME, and there is as yet no proven evidence on the effects on quality of care of small group CME. However, learning theory and the experiences from small group work in Sweden and also from other countries support the view that problem-based, self-directed learning in small groups is more effective than "traditional" educational events.

Even if small groups are highly appreciated and a widespread form for learning, most of today's GPs regard these groups as a complement to "traditional" learning. Shifting focus and allowing the small group to become the real basis for CME would imply a more peripheral role for the "traditional" teaching forms. Such a shift would favour learning occurring in a context close to the general practice setting.

The future role of small group CME will depend on expedient pedagogy. Therefore, the competence of group leaders is crucial. In addition, long-term maintenance of small groups implies a national support for CME in general practice with enough personnel and economic resources to assist all those GPs who have key roles in providing CME at the local level.

In addition to research on common multidisciplinary learning within an organisation, research into the impact of different CME activities on health care outcome and particularly of small group learning in general practice is urgently needed.

ACKNOWLEDGEMENT

Thanks to Henry Egidius, pedagogic consultant, University of Lund, for guidance and support.

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APPENDIX A: AIMS OF SWEDISH FQ-GROUPS, FORMULATED AT THE BEGINNING OF THE PROJECT

- Inspiration from individual learning processes.
- Exchange of knowledge between colleagues.
- Identifying needs and organising CME from these needs.
- Render professional support between colleagues.
- Be a part of quality improvement.

APPENDIX B: ITEMS FROM "A GUIDE FOR THE SWEDISH FQ-GROUP" (25)

- The group is intended to be the base for CME and quality improvement.
- The group itself should decide upon members, meeting-times, group leader etc.
- Ideally, a group will have 7–10 members and meet regularly: at least 1 hour once or twice a month.
- Members should preferably come from different practices.
- The group leader should help the group to abide by its decisions and provide for shared responsibility of group members.
- Different methods should be used, such as case discussions, themes, sit-in, video-recorded consultations, practice visiting, audit, invited experts etc.