Small group learning

A general practice program

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Background

Divisions of general practice have a major role in supporting continuing medical education for general practitioners. One option is small group learning (SGL), which requires GPs getting together to plan, organise their learning and to evaluate their learning outcomes.

Objective

This article describes the development and evaluation of an SGL program facilitated by the St George Division of General Practice in New South Wales.

Discussion

In 2009, 10 monthly SGL groups were running, involving a total of 130 GPs (59% of 2009 division membership) of whom 107 GPs completed the evaluation questionnaire. On the criterion of 'meeting learning needs' 82% rated SGL as very good and 18% as good; on the criterion of 'increase in knowledge' 90% confirmed specific new knowledge. On 'implementing a change in clinical practice' 66% of written responses directly attributed change of practice to the SGL sessions. The SGL program was well attended and rated positively. This may reflect that the groups were effectively organised, allowed GPs to decide their own learning needs, and that the group process engendered a culture of trust and collegiality that overcame reluctance to reveal knowledge gaps.

Keywords: education, medical, continuing; teaching; general practice; peer group

Continuing medical education is an expectation of general practitioners to maintain their vocational registration and clinical competence. The Royal Australian College of General Practitioners (RACGP) has promoted the idea of lifelong learning and there is a range of quality improvement and continuing professional development (QI&CPD) options available to GPs, including large group events. Divisions of general practice have a major role in supporting QI&CPD (known as QA&CPD until 2010) for GPs. The St George Division of General Practice (Sydney, New South Wales) noted that attendance at large group events had declined and feedback from the GPs was that such events did not necessarily meet their individual learning needs.

Small group learning (SGL) offers an alternative form of QI&CPD that may more effectively meet the learning needs of GPs. It requires GPs 'getting together' to plan, organise their learning and to evaluate their learning outcomes.

This article describes the development and evaluation of a SGL program in general practice.

Background

There appears to be little research on medical SGL and only one study specifically relates to the Australian general practice context. Searches in MEDLINE, EMBASE and Global Health databases revealed the following research.

De Villiers et al[1] in a 2002 South African study found evidence of self reported improvement in knowledge and skills – 91% of respondents indicated that SGL improved their knowledge and 61% indicated improvement in their clinical skills.

Gosh[2] in a Canadian meta-analysis on continuing medical education reported not only the size of groups but the interactivity and the multiplicity of methods of instruction as being important in learning.

Fryer-Edwards et al[3] found that 'small group teaching is particularly suited to complex skills such as communication' when researching medical oncology teaching.

Wilhelm et al[4] from the Sydney based Black Dog Institute, concluded that 'GPs found the small groups empowering, confidence increasing and useful for addressing psychological and interpersonal issues at work'.

A randomised controlled trial of problem

based versus didactic seminars by White et al[5] failed to show a difference in learning outcomes in evidence based guidelines on asthma management to primary care physicians in a small cohort of 23 participants.

Peloso and Stakiw[6] in an experience based report suggests that benefits included 'key concepts and practice changes are reinforced', the 'maturation of groups over time' and the 'opportunity to ascertain the standard of care of peers'. They also suggested SGL is sustainable over time.

We concluded from the literature that the group process is very important with interaction in the group, and over time is a key facilitator to learning.

The St George program

In 2003, the St George Division of General Practice started a SGL program; checking with the RACGP that its modus operandi met QI&CPD requirements.[7] A dedicated program officer was employed by the division to oversee and develop the program. The program officer took on the administrative burden; organised groups to meet temporal and geographic convenience; and made sure that the requirements/reflective diaries were completed. However, the GPs in small groups decided their own learning needs and met monthly under the guidance of local clinical specialists (relevant to the topic) from a pool of about 50 chosen by the GPs. They variously presented cases, discussed clinical problems and sought to understand best practice guidelines. Each session was self evaluated by the participant GPs regarding: learning needs having been met, knowledge gained and subsequently whether a change in clinical practice attributable to the SGLs had occurred.

Small group learning is an RACGP Category 1 activity that, if criteria are met, attracts 40 QI&CPD points. The criteria are: sessions totalling a minimum of 8 hours to include a planning session, 6 hours education sessions and a review session; GPs decide on their learning needs and what resources/specialists are needed; GPs fill out 'reflective diaries' at every session; GPs actively participate in the review session and program evaluation; and GPs acknowledge and sign the RACGP's 'Learning applications to practice or quality improvement'. The St George SGL sessions all exceeded these minimum requirements. (Special dispensation was given by the RACGP to exceed the maximum number of 10 GPs per group.)

The SGL program encourages GPs to decide their own learning needs and facilitates access to local medical specialists to provide expert input. Sessions chosen by the groups were diverse and tended to cover most of the speciality areas in which GPs need to demonstrate competence, currency and evidence based knowledge (although in any one year certain topics are 'fashionable').

Each of the 10 SGL groups was (and is) attended by the program officer who signs on attendees, reminds group members of the need to complete their reflective diaries, and introduces the specialist. The reflective diaries (which are added to a 'SGL kit' after each session) are kept as a resource by the GPs and include the GP's individual learning objective for the particular topic.

After the planning session the program officer sets up the programs for each group, organises the specialists' attendance and faxes a reminder to the GPs, a week before their next SGL session.

Evaluation

While the SGLs are evaluated annually in relation to meeting the learning needs and increasing the knowledge of the participants, in 2009 participants were also asked 'has your participation in your SGL group prompted a change in your clinical practice'?

At the 2009 last (evaluation) session, the evaluation forms (containing self report questions on satisfaction, increase in knowledge and change of practice) were collected and analysed. An analysis was made of whether the questions were answered and whether the answers appeared credible (to the GP author of this paper who had 35 years general practice experience and was overseeing the program).

Findings

A total of 107 (82%) of the 130 GPs enrolled in the St George program in 2009 submitted their evaluation forms. As there were six education sessions for each GP for the period of 2009, 642 individual evaluation forms were expected, but not every GP filled out every question on each form. There were 560 completed forms with all questions answered. The available data was analysed.

Table 1 summarises the findings relating to the level of satisfaction with the format and the organisational elements of the program. Most of the 107 GPs reported overall satisfaction with the SGL format with 85% reporting they were very satisfied. The program officer and the tasks they undertook in the administration of the group were seen to assist in the smooth functioning of sessions.

Table 2 provides the data on the self reported educational outcomes. It relates to the questions asked for each of the six educational sessions for each of the 107 GPs in the 10 groups. Of note, 90% of participants could identify a specific increase in knowledge after a session and 66% could identify a change in practice after the session.

Discussion

The GPs' responses to the question: 'satisfaction with SGL format for QI&CPD' revealed an overwhelming majority of positive responses. Being relieved of the purely organisational component of the SGL process, being assured of the regularity and location of the sessions and that the sessions were a start in establishing a relationship between the GPs and specialists, all appeared to be important.

Equally the acknowledgment of the dedication and organising work of the program officer was a repeated comment in the evaluation forms and given the some 400 individual sessions that the program officer ran over 5 years, it would seem reasonable to accept her observation that camaraderie, feeling of security and trust was evident in the participants after a period of 'belonging' to a group.

Like De Villiers,[1] we found evidence of self report improvement in knowledge and skills. The self report nature weakens the findings in that the GPs' perceptions may not be accurate and may not be translated into change in clinical practice. However, the evaluation forms were completed at the end of the year (ie. the final 'evaluation' session) and perusal of all the answers to this question by the author (KS), revealed them to be at least credible, especially given the time gap between topic and answer

(which could have been 6 months if the topic was presented early in the year). It should be kept in mind that SGL requires a reflective diary, the discipline of which probably reinforces learning and retention of learning.

The same limitation applies to the responses to the question about SGL prompting change in clinical practice and probably little can be read into the fact that, by self report, 'only' 66% of answers indicated that as a result of the SGL topic, a change of practice occurred.

This study is robust in its data collection and evaluation, but relies on self report; as practice audits were beyond the resources of our division and the patience of our GPs.

Conclusion

The evaluation of the St George Division of General Practice SGL program has confirmed its satisfaction to GPs and at least, by self report, increase in knowledge and to a lesser extent change of practice. This may reflect that the groups were effectively organised, allowed GPs to decide their own learning needs and that the group process engendered a culture of trust and collegiality that overcame reluctance to reveal knowledge gaps.

Table 1. Demographic and organisational information

Evaluation question	Responses	Typical comments
Number of years membership of St George division SGL?	Average 4 years (range 1–7)	
Are you satisfied with the SGL format and if so, what is it that makes it successful?	85% very satisfied 15% satisfied	Good interaction; plenty of Q&A; friendly; informal; relevant; 'enormous educational, social and debriefing benefit'
How important is a specialist speaker to the SGL?	72% very important 28% important	Specialist brings update, local practice and evidence based medicine in the topic
What benefit do you feel you have gained as a member of this group?		Getting to know colleagues and local specialists; update; support; collegiality; validating or changing my practice; 'has made learning a fun experience'
How important is the reminder fax before each meeting?	52% very important 44% important 4% unimportant	
Do you feel the organisation and presence of the division program officer (PO) helps the sessions run more smoothly. If yes how?	98% yes 2% no	The PO organises; coordinates; engages; structures; gives advance notices; keeps group focused and manages time; 'I feel more at home with the PO'; 'the endless paperwork was made 100% easier and everything runs on time'
How appropriate did you feel the locations of the meetings were?	61% highly appropriate 39% appropriate	Close to my surgery; on my way home

Table 2. Education outcomes reported

Evaluation question	Response	Explanation
Does SGL meet your learning needs?	Likert scale (1 = poor; 4 = very good) 82% for 4 18% for 3	
How would you evaluate the presentation of the session?	Likert scale (1 = poor; 5 = very good) 62% for 5 33% for 4 5% for 3	Each of the 10 groups had six education sessions over the year
Write down increased knowledge (if any) you have gained from the above session	90% of participants filled in one or more of the three spaces offered	GPs did not necessarily limit their answers and more than one was common. This question was completed at the year end evaluation session with the aid of reference to the GP's individual reflective diary from each of the six education sessions
Write down change of practice (if any) you have implemented as a result of the above SGL session	66% of participants filled in one or more of the three spaces offered	GPs did not necessarily limit their answers and more than one was common. This question was completed at the year end evaluation session with the aid of reference to the GP's individual reflective diary from each of the six education sessions

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