

Self directed learning and continuing medical education



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Self directed learning (SDL) for continuing medical education (CME) is the most effective approach for improving physician performance and patient care outcomes. Self directed learning is an essential basis for CME. However, instructor directed programs – particularly on-site conferences – remain the most popular method for acquiring CME. This article briefly examines the evolution of SDL and its importance in lifelong learning for general practice. The challenge for CME providers is to facilitate SDL while taking general practitioners' views and preferences into consideration.

The roots of self directed learning (SDL) lie in the work of Knowles¹ who explored adult learning principles and found that adult learning is optimal when it is self directed. Knowles defines the SDL process as one in which: 'Individuals take the initiative, with or without the help of others, in diagnosing their learning needs, formulating learning goals, identifying human and material resources for learning, choosing and implementing appropriate learning strategies, and evaluating learning outcomes'.¹

Brookfield² defines SDL as a process 'whereby we learn how to change our perspectives, shift our paradigms, and replace one way of interpreting the world by another'. One of Brookfield's criticisms of earlier concepts of SDL was that social and political aspects of self direction tended to be ignored. Brookfield's perspective on self directed learning is based on 'the occurrence and scrutiny of critical incidents', the purpose of the scrutiny being to provide the impetus for re-evaluation of our assumptions through reflection.

According to Brockett and Hiemstra,³ the concept of self direction in adult learning should be part of a broader concept; they

thought of it both as an instructional strategy and as a desired personality characteristic. Both are identified in the statements: 'A process in which a learner assumes primary responsibility for planning, implementing, and evaluating the learning process' and 'a learner's desire or preference for assuming responsibility for learning'.

Candy⁴ makes the distinction between SDL as an outcome of education as opposed to being a method of education. Self management and personal autonomy are seen as outcomes.

Effectiveness of SDL

Knowles¹ provides three major reasons why SDL is an important skill:

- individuals who take initiative in learning are more likely to retain what is learned than the passive learner
- taking initiative in learning is more in tune with our natural processes of psychological development, and
- many recent educational developments actually place the responsibility for learning right on the shoulders of learners.

Research into the effectiveness of SDL as a learning modality has focussed on

quantitative measures such as participation rates and the outcomes of learning tasks such as the development of skills, cognitive retention of information, and the application of knowledge to practice.⁵⁻⁹ These studies indicate that, compared to traditional modes of learning, students engaging in SDL retain information (over time) equally as well; have higher participation rates due to increased flexibility of program delivery; and are significantly more motivated because of their greater engagement in, and therefore commitment to, their learning.

While SDL appears to be beneficial, it is dependent on learners possessing necessary skills (possibly as measured by readiness scales¹⁰) and their preferences for, as well as prior experiences of, this learning modality. The use of standardised instruments may not be sensitive to learners' actual level of self direction or their satisfaction with this learning approach.¹¹ The experiences and preferences of education providers, and how these compare with those of learners, must also be considered. Obtaining these perspectives helps to identify any barriers to the implementation of SDL and potential strategies to overcome them.

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Promoting SDL in CME

A number of tools and skills have been identified as key facilitators of SDL¹²⁻¹⁶ including:

- self assessment
- evaluation
- reflection/monitoring
- management/planning
- critical thinking
- critical appraisal
- journals/diaries
- discussion groups
- peer reviews.

Patterson et al¹⁵ suggested that '... these skills are not mutually exclusive but are interrelated in such a way that students use all or a combination of them simultaneously to direct and control their learning'.

Conclusion

Optimal continuing medical education (CME) is highly self directed with content, learning methods, and learning resources selected specifically for the purpose of improving the knowledge, skills, and attitudes that physicians require in their daily professional lives to lead to improved patient outcomes.¹⁷ The medical literature shows that educational programs often ignore the self learner¹⁸ and that traditional lectures for the most part should be replaced by self directed and interactive discussion through informal workshops and problem based learning. However, this requires teaching skills and a culture change to be inculcated into educators.¹⁸ The challenge for CME providers is to facilitate SDL while taking general practitioners' views and preferences into consideration.

Conflict of interest: none declared.

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