Online continuing medical education

Thepwongsa et al[1] (*AFP* October 2014) have presented a comprehensive report on the outcomes of a systematic review of online continuing medical education (CME) for GPs.[1] The results are helpful and clear – there are few high-quality studies and those that do exist show some evidence of impact on learner satisfaction, knowledge and practice change but little evidence of impact on patient outcomes. The authors call for more research and, specifically, more research on the characteristics of online CME that produces good outcomes, and more high-quality randomised controlled trials of online learning programs. The interested reader might be tempted to ask – is more research really justified and, if so, are these the types of research studies that are needed? The answers to these questions are not completely straightforward.

High-quality medical educational research should be underpinned by sound educational theory and should borrow, when necessary, from educational research outside of technology-enhanced learning (TEL) research and, indeed, from outside medicine.[2]

In terms of educational theory there are few reasons to regard online learning as anything different from any form of learning. An online text-based resource is no different from a print-based resource. An online multimedia resource is no different from a resource on terrestrial television. There is nothing magical about online learning. Indeed, future generations of learners will regard online learning in the same way that past generations regarded learning from books. Do we need research that tells us that books can be good and effective educational resources? Educational theory tells us that an interactive learning experience based on learners' needs and aimed to help them put their learning into practice will 'work'; this is surely true regardless of the medium. In terms of borrowing from educational resources from outside of TEL research and, indeed, from outside medicine, there is already a growing evidence base as to what works in online learning. There is no reason to believe that general practitioners or other doctors or other healthcare professionals learn in a different way from other people – their minds work in exactly the same way.

For these reasons it may be better to focus efforts on learning from learning outside of the boundaries of general practice and indeed healthcare more widely.

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Reply

We thank Dr Walsh for his insightful comments on our paper. In the hierarchy of study designs, randomised controlled trials (RCT) remain the gold standard.[1] Other experimental designs, such as the quasi-experimental designs, have their own set of potential threats to internal validity.[2] Therefore, causal inferences must be drawn with caution.[3,4] To answer the question 'Does online CME work?', the gold standard study design that can answer this kind of question is an RCT. However, we acknowledge limitations in undertaking RCTs in educational research. Other forms also have a place but are more limited in answering the question 'Does it work?'

Although the ways general practitioners learn may not be different from other healthcare professionals, there is no evidence that different learning media have an impact on different professions, using a wide range of outcome measures, compared to traditional forms of CME, which still remain more popular than online learning.[5] In addition, each method (IT versus print-based materials or IT versus face-to-face) seems to have its pros and cons, and the final outcome might depend on the context and a range of factors. This review highlights the limited evidence for the effect of CME programs in general practice. The authors simply suggest that more rigorous studies in this area are needed, particularly as online CME seems to be a growing area, attracting increasing resources, time and participation. There is, therefore, a need to ensure that all CME interventions are evaluated for their quality, effectiveness and cost-effectiveness.

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Family violence

Loved the article 'Family violence across the life cycle' (*AFP* November 2014).[1] Having worked in this area for over 20 years, running men's behaviour change groups, it is encouraging to see how this work and these ideas are becoming more and more mainstream and are starting to become incorporated into regular general practice.

Some thoughts:

- A stronger emphasis on the gender difference in domestic violence would have been good. In many medical articles the gender difference is mentioned early. For example, articles on systemic lupus erythmatosus state, 'The disease occurs nine times more often in women than in men'. There is a similar gender difference in domestic violence and this needs to be mentioned and stressed – women are subjected to domestic violence about nine times more often than men, and men are the perpetrators of domestic violence about nine times more often than woman.
- Language/words are crucial in this sort of delicate work. There were descriptions of 'abusive relationships' or 'the violence', which, to the reader, can imply that the violence/abuse occurs in a vacuum. Abuse/violence occurs because one person – usually the man – is violent or abusive to his partner and/or children. Thus, where it states '… returning to an abusive relationship' it could have read as '… returning to her partner who has been abusive'.
- The idea of 'listening and responding non-judgmentally'. When I meet with a woman who states her partner has subjected her to violence and abuse, the feedback from the woman is how important it was that I took a stance against the violence and abuse – that I said it was wrong, that it shouldn't have happened. Many times the woman will share how she has told her story and the person 'has listened and responded non-judgmentally', and how this for her has supported the dominant discourse – that it was her fault and her responsibility. We always take stances in medicine – that it is bad to smoke, good to exercise, good to eat healthily and have a normal body mass index – this is just another example of how we should take a stance against the violence that has been perpetrated against her by stating it was wrong and shouldn't have happened.

Hopefully, more and more doctors will become aware of the work of Kirsty Forsdike et al and others in the community, and through this there will be better recognition and responding to domestic violence by general practitioners.

Dr Ronald Schweitzer
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Reference

1. Forsdike K, Tarzia L, Hindmarsh E, Hegarty K. Family violence across the life cycle. Aust Fam Physician 2014;43:768–74.

Reply

We would like to thank Dr Schweitzer for his support of our article 'Family violence across the life cycle'. His thoughts are welcomed.

We agree with Dr Schweitzer on all points raised. In particular, it is important to emphasise that, although men can be victims of domestic violence and that violence does also occur in same-sex relationships, women are predominantly the victims. In Australia, over their lifetime, 17% of women will experience violence from a partner, compared with only 5.3% of men.[1]

We agree that language can be fraught in such a sensitive area. The recommendation to specify that it is the woman experiencing violence from an abusive partner rather than using the term 'abusive relationship' is particularly poignant and in future work we will more consistently consider this.

Regarding the third point, we apologise for any confusion in meaning. It was not our intention to suggest that GPs respond non-judgementally to the abuse the woman is disclosing. The Royal Australian College of General Practitioners' White Book[2] explains that when raising the issue of domestic violence with their patients, it is a good time for GPs to acknowledge that any violence is not acceptable. We do argue, however, that this disapproval should never extend to the woman herself or her actions, as this would give her the sense that she is being blamed for the violence.[2]

We hope that the conversation around this topic may continue so that GPs can be well supported in their work with patients experiencing family violence.

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1. Australian Bureau of Statistics. Personal Safety. Canberra: ABS, 2012.
2. Royal Australian College of General Practitioners. Abuse and violence: Working with our patients in general practice, 4th edn. Melbourne: RACGP, 2014.

Letters to the Editor

Letters to the Editor can be submitted via:
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Erratum

Henderson J, Pollack A, Gordon J, Miller G. Technology in practice – GP computer use by age. Aust Family Physician 2014;43:831.

The legend for *Figure 1* was incomplete and should include the following description of the red bars: GPs 50+ years. The correction has been made to the HTML version of this article.

We apologise for this error and any confusion this may have caused our readers.