Why do students not complete a Masters in Family Medicine Degree?

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Abstract

Background: The Masters in Family Medicine Degree of the Medical University of Southern Africa is a distance, self-directed learning course that usually lasts between 3 and 5 years. Since starting in 1970-80, more students have failed to complete the course than have graduated. We wanted to understand the students' reasons for not completing the degree

Methods: A semi-structured postal questionnaire was sent to all 139 students who registered for the degree before 1995 and who had not completed their degree.

Results: The response rate was 38% excluding those no longer registered with the South African Medical and Dental Council. Five main themes were elicited for the reasons that students gave for failing to complete the course: student perceived internal and external pressures, philosophical differences between students and teachers, the difficulty of some tasks, communication difficulties between student and the university and students' problems with their teachers. In spite of these difficulties many of the students found considerable benefit from participating in the course

Conclusions: It is clearly necessary to keep obtaining feedback from those students who do not complete the degree. As the response rate was low and therefore probably not representative, we cannot generalise from these findings. They are useful to respond to, but are not sufficient to radically change the direction of the course. We remain convinced of the advantage of a learner-centred degree as a form of higher education for Family Medicine, but accept that it may not be suitable for every doctor.

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Introduction

The Masters in Family Medicine degree at the Medical University of Southern Africa (MEDUNSA) started in 1980, and soon became a distance, self-directed learning, part-time course in Family Medicine. The first university in South Africa to run a Masters course in Family Medicine was the University of Pretoria in 1971[1]. Nowadays many universities offer Masters in Family Medicine courses[2,3,4], but self-directed, distance learning courses in Family Medicine are rare. The educational philosophy behind such a course is based on the premise that the self-learner is more likely to continue with learning than one who is simply programme and examination driven, and that distance learning is more appropriate for a country where primary care doctors are scattered over vast areas.

The MEDUNSA Masters course is expected to be completed in between three and five years. It comprises eleven themes: foundations of family medicine, the doctor/patient relationship, whole person medicine/ human growth and development, the family, culture and community, ethics, therapeutics, research, learning, management and illness, disease and common health problems. Theme books consisting of relevant publications accompany each of these themes. The Department has developed a resource centre that contains an index and library of

relevant research articles and provides a literature search facility.

Students meet together on four occasions during the year to share their experiences and to receive feedback and help in such areas as making patient presentations, experiencing peer reviewed video consultations, journal clubs and various workshops. Each student has to complete a research-based Masters dissertation and 12 written patient studies. Evaluation consists of a clinical and practical examination, completion of the dissertation and the 12 patient studies together with self-evaluation at various times during the course with their programme co-ordinator.

Since 1980 MEDUNSA has granted about 100 Masters degrees in Family Medicine, but there have also been 139 students who have failed to complete the programme. We wondered whether the price of running a self-learning course, which requires a high degree of self-motivation, has been too high. It seemed appropriate to review the reasons for these failures before examining the future direction for the course.

Methods

All students who had paid their first year course fees up to and including students who registered in 1995 were included in the sample. An attempt was made to find their current address by searching the latest edition of the South African Medical and Dental Council (SAMDC) register. Thirty-eight doctors, though, could not be found in the register, but the questionnaire was sent to their last known address. The questionnaire was devised to determine the opinions of the doctors as to the perceived benefits, the problems and difficulties and any suggestions that might improve the course, together with some basic demographic questions (see Appendix). One reminder letter was sent. The replies to the open-ended questions were transcribed in full and the replies were analysed separately by the authors to determine themes for the reasons students gave for failing to complete the course. The final themes were agreed after discussion between the authors.

Results

We had 37 (26%) completed questionnaires returned, together with 15 stating that the address was wrong. Excluding the 38 who are not currently registered with the SAMDC, the response rate was 37%. One of the respondents had registered before 1985, 12 between 1986 and 1990 and 24 between 1991 and 1995. The corresponding numbers of non-responders were: 6, 33 and 63. Demographic details of the respondents are shown in Table 1. The majority of respondents (89%) agreed that they started the course to improve their knowledge of Family Medicine and 15 (40%) stated that they started the course in order to obtain a degree. Eighteen (49%) had withdrawn from the course by the end of the second year with four not withdrawing until year 6.

Table I: ***Demographic details of respondents***

		Number of Respondents (%)
Age on joining course	30-39 years	23 (62)
	40-49 years	9 (24)
	50-59 years	3 (8)
	60+ years	2 (5)
Gender	Male	22 (59)
		(sample = 96 (69))
	Female	15 (41)
		(sample = 43 (31))
Marital Status	Single	7 (19)
	Married	26 (70)
	Seperated/Divorced	2 (5)
	Widowed	2 (5)
South African Citizen?	Yes	29 (78)
Medical School	South African	24 (65)
	Other African	2 (5)
	European	7 (19)
	Other	4 (11)

Perceived benefits

In spite of not completing the course, most stated that they had gained something from the course. Many mentioned their increased knowledge of Family Medicine as a discipline and a

better understanding of patients' psychological problems. The common benefit though resulted from being challenged to re-think their approach to patient care and comments included: 'I began to listen more attentively to my patients' and 'I gained a better understanding of different dynamics in health care other than clinical judgement'.

Many also gained a lot from contact with peers 'I interacted with some amazing people and made some good friends'.

Problems and difficulties

The problems and difficulties for students embarking on a course that will take in excess of 3 years are inevitably varied. They were classified into the following themes:

External and internal pressures

The external pressures include family pressure, work pressure and financial considerations together with changes of job,

'no family support, I went through a difficult time, had to cope with work, studies, children etc' 'I had to ask for leave from the medical work; it was granted at last. I had to drive very far, not enough time to study in between lectures and to put into practice what I learnt', 'I had to travel and be away from home and work for the whole week when I had to attend the course'.

and internal forces are often put down to lack of self-discipline.

'I was not sufficiently disciplined about the course – re getting on with case studies and research project', 'because of laziness, honestly I did not cover all the syllabus'

Philosophical differences

These centre on the educational philosophy of the course and comments about the lack of direction, the need for deadlines, the lack of medical teaching and so on.

'I find it easier to learn and remember facts than write case histories'

'I felt that a structured programme would have been easier'. 'I am a poor adult learner, I felt not taken serious enough when asking direct questions'

The research project and patient studies

The main comments are about the difficulty in understanding what is needed.

'difficult patients at the hospital where I worked were not suitable for patient studies and my research project was not accepted'

'because of communication failure with X my research study was not accepted'

Communication over distance

Students were working in sites all over South Africa and there were a number of difficulties in communicating quickly with the department.

'difficulty in gaining access to resources from the resource centre and library'

Problems with the staff.

These inter-personal difficulties included the following statements: 'Had problem with one co-ordinator in the department, my research write up was never reviewed by the facilitators – even though submitted twice. Impression: already decided the candidate to have failed', 'the lecturers', and 'poor supervision'.

The reasons for giving up

These are based on many of the above comments and some students felt there was a limited benefit for continuing the course for their type of practice

'I lost interest in the course as it seemed to have limited application in my practice'

Five students decided on training for another speciality and one to help with the political campaign just before the 1994 election.

'I decided to specialise in ophthalmology – an interest I had had since my undergraduate days', 'my most important problem was that I got committed to the ANC Health Desk and felt I had more to contribute there than to complete and write my examination'.

Three students stopped because the University decided to close one of the groups and to amalgamate that group with another one. Three other students failed the examination.

Suggested improvements

These included fewer patient studies and an easier research option, the setting of targets and deadlines by the organisers and more clinical modules. One doctor suggested screening students before the start of the course in order to weed out those who were not well-motivated and disrupted group work and some wanted the teachers to be less critical and to end the self-directed approach.

Discussion

The low response rate in this study was disappointing but not unexpected as many of the students who enrolled on the course are now scattered throughout the world and are no longer registered with the South African Medical and Dental Council. However the results we have obtained are broadly similar to those obtained by Zahidi[5] who used a different methodology in his study. As the response rate was low and therefore probably not representative, we cannot generalise from these findings. They are useful to respond to, but we don't feel they are sufficient to radically change the direction of the course. A course that is designed to last between 3 and 5 years and is a distance-learning course is almost bound to have a high attrition rate, and the MEDUNSA course demonstrates this. Students' circumstances change

over time and we have examples of doctors changing their jobs from government employees to become private family doctors, moving to other countries and other parts of this country, deciding to become specialists, having a family and so on. We also had the example of the university deciding to close a group and amalgamate it with another. Many of which make it difficult to continue with the course.

Self-directed learning is not a skill that all doctors appear able or willing to develop. Whether students should be interviewed or tested before being allowed to start such a course is questionable, but there is no doubt that one of the common reasons for dropping out of the course is students' stated frustration with the lack of formal teaching. Another frustration for many students has been the lack of clinical teaching. This issue has been

Most Masters' students find the courses challenging but standards between universities vary. The MEDUNSA course, for instance, insists on the completion of 12 patient studies and a research project. This latter challenge includes the development of a formal protocol and submission to the University Ethics Committee for approval before proceeding with the research. Many of the students in our sample challenge the need for such rigour, but there is no doubt that those students who have survived the challenge have benefited considerably. These students, like those in London [2] 'have made, and continue to make, a significant contribution to their discipline'

Finally the communication problems experienced by many students were very great. Not only did students have to travel considerable distances, but also contact with supervisors was often difficult. Some students found the resource centre a problem to use, citing slow response as one of the common problems. The development of the Internet and E-mail over the last few years has inevitably reduced the dependence of students on the resource centre. Difficulties in the student/ staff relationship that we have found is perhaps not surprising, but it encourages us to consider instituting further training for our facilitators.

Even though this course has had a high attrition rate, we believe that the underlying course philosophy is right and worth persisting with and it certainly conforms to current approaches in medical education[6,7].

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