Continuing medical education for isolated and rural practitioners*

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SUMMARY

Continuing one's education is a challenging task for anyone. It is even more so for the isolated practitioner.

How can doctors, even those in remote areas, be helped to effectively continue their medical education?

This paper attempts to answer this question using a problem-solving approach, using the following outline:

1. Definition, Aims and Objectives of Continuing Medical Education – are they appropriate?
2. The Problems – especially those encountered by the rural doctor.
3. Teaching and Learning Theory – some observations.
4. The Implications for Continuing Medical Education. The approach taken by the Department of Family Medicine at Medunsa is described. Five basic premises are stated and their implications discussed.

"The good learner is the one who has grasped the truth that the main source of his development as a physician lies not in some distant center of learning but in the day-to-day experience of his own practice."

I R McWhinney[1]

McWhinney's statement is particularly applicable to the isolated practitioner. Indeed, the opportunity for continuing one's medical education, using present CME programmes, decreases in almost direct proportion to one's distance from a university or hospital teaching centre.

The Medical University of Southern Africa and Ga-Rankuwa Hospital are located on the border of Bophuthatswana and the Republic of South Africa. The Department of Family Medicine is engaged in the coordination and teaching of undergraduate, graduate, and postgraduate programmes. The department has a substantial patient care commitment through the hospital's outpatient and casualty departments and through sixteen clinics scattered throughout the ODI district of Bophuthatswana and the neighbouring township, Soshanguve, in the RSA, serving approximately 800 000 urban and rural black South Africans. A significant proportion of the graduates will enter general practice in rural districts and the postgraduate programmes include educational opportunities for general practitioners in remote areas.

The problem addressed in the paper is that of how to enable doctors, even those in remote areas, to effectively continue their medical education.

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DEFINITION, AIMS, AND OBJECTIVES

It is difficult, if not impossible, to define continuing medical education meaningfully, except in terms of its aims and objectives.

The ultimate aim of continuing medical education is usually stated as being, "**to improve the quality of care given by physicians**"[2,3,4,5].

The main objective quoted as being necessary to fulfil this aim is that of 'improved professional competence'[6]. This is most often attempted by programmes designed 'to close the much discussed knowledge gap'[7].

True learning implies change.

The assumption is that 'closing the knowledge gap' will lead to 'greater physician competence', which, in turn, will lead to the provision of better quality health care. It is taken for granted that improved quality of health care will lead to healthier patients and thus to a healthier society. But there is no such straightforward connection. Parlette[8] points out that the evaluation of continuing medical education in terms of whether it exerts a positive influence on the health of a community is neither practical nor realistic. Ivan Illich[9] forcibly reminds us that doctors are not the only, nor necessarily the most important factor influencing people's health.

Malpractice suits repeatedly reinforce the fact that most patient-care deficits do not result from lack of physician competence, at least not in terms of lack of physician knowledge.

Patient competence is as important as physician competence.

Health care is far too doctor-centred each step of the way! It is the doctor's knowledge gap that is 'closed', in an effort to increase the doctor's competence, in the hope that the doctor will provide better care.

Such importance is attached to medical knowledge and technology that not only doctors, but also patients, have come to value doctors in terms of the investigations they can perform and the treatments they can prescribe. Those things that only people can offer to each other are neglected. When continuing education emphasises the things outside the doctor and his patient, rather than the things inside each of them that can be put to use in terms of health care, then its impact is limited.

True learning often begins without knowing the answer.

In addition to being defined in terms of its aims and objectives, continuing medical education is also defined in terms of when it occurs. Consider the following definition accepted by an expert committee of the World Health Organisation:

> *"...the training that an individual physician undertakes after the end of his basic medical education, and where applicable after the end of any additional education for a career as a generalist or a specialist – training to improve his competence as a practitioner (not with a view to gaining a new qualifying diploma or licence)".*[10]

This definition serves the purpose of being both explicit and understandable. However, it also contributes to the conceptual problem of continuing medical education as being something that starts after basic education is finished, rather than being an integral part of it. Indeed, no mention is made of continuing medical education in most undergraduate programmes, or even many postgraduate programmes.

Knowledge does not equal learning.

One further comment concerns the term 'isolated'. The physical isolation of the rural doctor is obvious. What may not be as obvious is the fact that, to some degree, all medical practitioners are isolated. They may be isolated from colleagues, from other members of the health care team, from patients, and most importantly, even from themselves.

PROBLEMS

Most of the problems encountered by the rural practitioner when attempting to continue his medical education are not unique to him, but his physical isolation is certainly an aggravating factor. Seven problems are highlighted below.

1. There is the problem of discontinuity, or fragmentation. Unfortunately, a statement made by the World Health Organisation in 1973 still applies today:

> *"In most countries, continuing education seemed to be a collection of unrelated courses offered by independent agencies and in conclusion it would appear that most of what is now available in the name of continuing education is neither continuing nor education; it might better be called episodic instruction".*[11]

Houle, a highly respected educator, comments that, "At present, the most startling and ironic characteristic of continuing education is its discontinuity in the experience of the professional himself"[12]. This is particularly true for rural practitioners as they so often depend on periodic courses, offered by different organisations.

2. There is the mammoth problem of one's previous experience of education. Brown gives a damning critique of undergraduate medical education when he states, "The student's reservoir of idealism and joy in learning is systematically destroyed by a teacher-centered, forced memorisation, innovation-inhibiting, infantilising style of medical education so long fostered by the faculties"[13].

Indeed, many doctors have had their motivation to learn long since eradicated by years of being taught. The reinforcement has been for concealment of ignorance rather than its identification. Another problem resulting from long years of authoritative-style teaching is that physicians often regard it as the only legitimate form of further education.

We are obsessed with the notion that exposure to the learned assures learning.

3. There are problems related to the commonly-used teaching methods for continuing medical education, which are not based on sound educational principles. The didactic orientation, with its emphasis on information-transfer, puts the student in a passive role, decreasing his likelihood of incorporating, remembering or using the given material. The information transfer model implies that the problem is one of knowledge deficit, but practice shows that it is more often one of performance deficit. To quote Miller, "We are obsessed with the notion that exposure to the learned assures learning", and "use methods that require the physician to do little more than bask in the learning of his teachers"[14].

"Adult learning is not most efficiently achieved through systematic subject instruction; it is accomplished by involving learners in identifying problems and seeking ways to solve them"[15]. In addition, forced compliance with method and structure runs a high risk of causing resentment towards both the material and the teacher.

There is no lack of criticism of the so-called 'traditional' teaching methods, but 'new' teaching methods, with the emphasis still on the function of teaching, will not solve the problem.

4. There is the problem of the irrelevance and the inappropriateness of many continuing education programmes. Present courses are often planned by academics far removed from the practice realities of rural doctors. This has been poignantly expressed by Ingle, in his article entitled *Country Cousins*[16], where he describes the gulf of experience that separated the learners from the teachers. He states with some feeling on behalf of his rural colleagues that the circumstances in which they are working are not just temporary, difficult, or unfortunate, but fact!

Irrelevance is not the only problem of inappropriate continuing medical education. Programmes geared towards highly technological medicine and dogmatic statements about the 'proper' way to do things, can lead to discontent, decreased self-confidence, and loss of self-esteem, sometimes with the tragic consequence of rural doctors leaving their practices behind for the city, or for a specialty.

5. The very nature of general practice, with its vast array of undifferentiated problems and its very wide spectrum of illness makes it more difficult for the generalist to 'keep up-to-date' than the specialist. Rural practitioners usually have an even broader scope of practice than their urban colleagues.

6. The nature of the learner group of general practitioners is heterogeneous – this may be even more true for rural doctors whose needs may differ markedly from one another, depending on the community in which they serve.

7. And lastly, inaccessibility to continuing medical education, as it is presently structured with the preponderance of courses being held at university centres some distance away, is a particular problem for rural doctors. Compounding this problem is the fact that there is often no one to take over their practices in their absence. This can greatly increase one's sense of isolation and of being 'out of touch'.

These problems pose a challenge if perceived as real, and can themselves be an inducement to learning. In fact, this is one of the key principles to emerge from present-day education theory.

TEACHING AND LEARNING

The principles of adult education have been stated by a number of authors[17, 18, 19, 20]. Nine observations of adult learners are listed below:

1. Adults, as they mature, move from being dependent towards self-direction.

2. They become increasingly interested in learning about things related to real-life problems; they must be faced with problems which are perceived as real for them.

3. They build upon previous knowledge; what they bring to a learning situation will greatly influence what they take from it.

4. They respond best to a non-threatening environment with a good teacher-learner relationship.

5. They desire to assess themselves against a relevant standard.

6. They wish to apply new knowledge and skills as soon as possible, and are likely to retain only what they can use.

7. They learn more readily from, and rely more increasingly on, their own experience.

8. They want to contribute from their own knowledge and experience to help others.

9. They seek value for their effort, time and money.

In addition, a number of interesting aspects have been discovered about the learning process itself[21]:

a. People learn what they want to learn.

b. Knowledge does not equal learning, and thus students should be helped to learn rather than to know.

c. True learning is an emotional experience.

d. True learning implies change.

e. True learning often begins without knowing the answer.

f. True learning requires freedom.

Carl Rogers, in his book, *Freedom to Learn*[22], cites exciting examples of what can happen when students, right from elementary school to doctorate programmes, are given the freedom to learn. He notes that when freedom is given, at first there is resistance and then the students seize the opportunity and the consequences usually exceed the expectations of both students and teacher. Rogers focuses on the facilitation of learning as opposed to teaching and states that one of the most important conditions for the facilitation of learning is the attitudinal quality of the relationship between the learner and the facilitator. He reports that the same three attributes found to be of such importance in the counsellor, namely, genuineness, trust and empathy, are also important for promoting learning. But, as Rogers himself is careful to point out, freedom can only be granted in as much as the facilitator is able in himself to grant it; that is, genuineness takes priority. A deep-seated trust in one's fellow human beings is essential.

IMPLICATIONS FOR CONTINUING MEDICAL EDUCATION

Thus far, some questions about the commonly stated definition, aims, and objectives of continuing medical education have been raised, problems have been discussed, and some of the present-day thinking about teaching and learning has been reviewed.

What are the immplications? This shall be tackled in as concrete a way as possible by describing the approach that has evolved at Medunsa during the past few years. Five basic premises follow:

1. The ultimate aim of continuing medical education should be 'the improvement of health of patients, their families and their community', rather than 'the improvement of care given by the physician'.

2. The main objective would be better stated in terms of the development of 'shared care', between physician and patient, rather than in terms of 'physician competence'. Patient competence is at least as important as physician competence.

3. For shared care to be put into practice, doctors must come to appreciate its value and they must become skilled in its facilitation.

4. To become skilled facilitators of patients' learning, doctors themselves must have experience and understanding of the learning process. Health care personnel teach as they have been taught and this underlies many of the past failures of attempted health-education.

5. Education is one continuing process. 'Continuing medical education' should start at the beginning of basic medical education, not at its end. Thus, the same approach to learning should be used, for both undergraduate and postgraduate learners.

At Medunsa, the main teaching-learning tool is the small group led by a facilitator, using a patient-centred, problem-solving approach. The facilitator's function is to help with the organisation of the group and to establish a climate conducive to learning. Patients are sometimes included as participants in group sessions.

Such an approach has been found to be well-suited for the facilitation of learning and for the application of sound educational principles. Moreover, such an approach goes a long way towards solving the problems mentioned earlier.

The application of the principles of adult education has, to a large extent, been dependent on the amount of freedom that the facilitator has been able to give to a particular group. The constructiveness of this freedom has, in turn, been dependent on the attitudes of the facilitator accompanying it. When the freedom given was genuine and was accompanied by trust and by empathic understanding, it was found, in accordance with Rogers'[23] experience, that wonderful things happened. One of the most exciting things that was witnessed was the increased sense of responsibility that learners came to feel towards their own learning.

Self-initiated, self-directed learning is readily stimulated by confrontation with real problems identified from daily practice. Group continuity fosters the development of a non-

threatening environment, which allows learners to share freely and to build upon their previous knowledge and experience. The influence that such give and take has on the development of attitudes, relationship skills, and self-understanding is often dramatic.

Physician-learners often present patients initially as 'interesting cases', list only well-defined organic diagnoses as problems and speak in terms of what they have done to and for the patient. Later, these same doctors start to present patients as people, with family and social contexts. The problem lists become much more complex and the patient's role in the decision-making process, (not only the doctor's), is discussed.

It is a treat to work with enthusiastic learners who are prepared to identify their own learning needs.

The impact that this approach to education has had on the problems discussed earlier has been directly proportional to the duration of its implementation. The most striking thing noticed is the difference in the graduate students who were introduced to this method while undergraduates. It is a treat to work with enthusiastic learners who are prepared to help identify their own learning needs and who take the same approach to their patients. Their past educational experience is a help, rather than a hindrance.

The broad scope of general practice ceases to be a problem to physician-learners as it comes to be perceived as the opportunity that it really is – the opportunity to come in contact with and to gradually understand more of the whole patient and his family.

Heterogeneity also, has been experienced, not as a problem, but as a source of tremendous mutual enrichment. One of the groups consisted of an Israeli Jew, an Afrikaner, an English-speaking South African, a Canadian, and a Zulu. The Zulu doctor presented a seventeen year old Tswana girl who gave a history of lower abdominal pain since childhood. The patient had been told by her mother that she had been bewitched when she was eight years old and that she had 'Idliso'. She had been taken to several Inyangas (traditional healers) in the hope that they would be able to make her vomit the 'Idliso' out, but to no avail. The mother had sent her to the hospital to have it removed by operation. This patient's previous encounters with hospital doctors had resulted only in treatment for 'salpingitis' – for which there was no evidence on the record, and which had refused to be cured!

It remains only to comment on the problem of discontinuity and inaccessibility. It is anticipated that both of these problems will become less as self-directed learning becomes more and more practice-centred. What should be more accessible than one's daily practice experience, and who could be more appropriate to meet with than one's neighbouring colleagues?

The small group sessions held in the local community are not intended to remain the focal point of the learning process but instead, they are meant to become the stimulus for ongoing self-education. It is hoped that the learner-practitioners will come to see the groups as their own and continuing medical education as part of their life style, not as something imposed from the outside.

CONCLUDING REMARKS

The role of providers of continuing medical education, has changed from that of supplying speakers and teachers to that of providing learning-facilitators and resources.

Teaching is relatively easy; helping someone to learn is exhausting.

The Medunsa experience has been in accord with that of Miller: "Teaching is relatively easy, helping someone to learn is exhausting"[24].

Finally, one last attempt at a definition of 'continuing medical education' is offered:

The ongoing process which facilitates the self-initiated self-directed learning of a physician, such that he becomes his own facilitator of learning, with a deeper understanding of himself and others, better able to use himself for the benefit of his patients, facilitating not only their healing – but also their learning.

REFERENCES

1. McWhinney IR. *An Introduction to Family Medicine.* New York: Oxford University Press, (1981) 193.
2. WHO Expert Committee. Continuing Education for Physicians. *WHO Tech Rep Ser* No 534. WHO, Geneva, (1973) 13.
3. Leeuwenhorst European Working Party. Continuing Education and General Practitioners. *J R Coll Gen Pract* (1980) 3(218) : 570.
4. Fabb W and Janssens H. Continuing Education. In : Fry J, ed. *Primary Care.* London : Heinemann Medical Books Ltd, (1980) 473.
5. Miller GE. Continuing Education for What? *J Med Educ* (1967) 42 : 320.
6. WHO, ibid, p 6.
7. Richards RK. Continuing Medical Education : *Perspective, Problems, Prognosis.* New York : Yale University Press, (1978) 141.
8. Parlette N. Evaluation of Continuing Education. *Am J Public health.* (1970) 60 : 316-21.
9. Illich I. *Medical Nemesis : The Expropriation of Health, Pantheon.* (1976).
10. WHO, ibid, p 5-6.
11. WHO, ibid, p 8-9.
12. Houle CO. To Learn the Future. *Med Clin North Am.* (1970) 54(1) : 8.
13. Brown Jr. RB and Henry SM. Mandatory Continuing Education. *JAMA.* (1970) 213(10) : 1661.
14. Miller GE. Medical Care : Its Social and Organisational Aspects – the Continuing Education for Physicians. *N Engl J Med.* (1963) 269 : 296.
15. Miller GE. Continuing Education for What? *J Med Educ.* (1967) 42 : 322.
16. Ingle RF. Country Cousins. *South African Family Practice* (1980) 1(2) : 26-13.
17. Knowles M. *The Modern Practice of Adult Education.* Association Press. (1970) 39.
18. Fabb WE, Hefferman MW, Phillips WA and Stone P. Focus on Learning in Family Practice. *Family Medicine Program,* RACGP, Melbourne (1976) 30-37.
19. Leeuwenhorst European Working Party. Continuing Education and General Practitioners. *J R Coll Gen Pract* (1980) 3(218) : 570.
20. Rogers CR. *Freedom to Learn.* Columbus, Ohio : Charles Merill Publishing Company, (1969) 130.
21. Miller GE. Adventure in Pedagogy, *JAMA* (1956) 162(16) : 1449.
22. Rogers CR. ibid,
23. Rogers CR. ibid, p130.
24. Miller GE. ibid, p1449.