# Continuing medical education in family medicine: a report of eight years' experience

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**Summary: A practical method of providing continuing education for family physicians is described. Some of the problems and benefits of an eight-year experience are discussed. Changes in behaviour and activities in the group have led to some concrete achievements, including the foundation for a peer review program. It is suggested that this program could provide the basis for more comprehensive programs in continuing education in family medicine.**

**Résumé:** *Formation médicale continue du médecin de famille: rapport portant sur huit ans d'expérience*

**Nous exposons ici une méthode pratique de dispenser une formation continue aux omnipraticiens, et nous discutons des problèmes et des avantages que nous avons découverts après une expérience de huit ans. Les modifications de comportement et les activités des groupes d'études ont permis des réalisations concrètes, notamment la création d'un programme de révision, admis par les pairs. Nous estimons que ce programme pourrait servir de base à des programmes plus complets au formation médicale continue du médecin de famille.**

One of the most difficult problems now facing medical educators, as well as the medical profession as a whole, is that of maintaining currency of knowledge in physicians who have completed their formal training. The increasing volume of literature on the subject attests to the increasing interest and activity in this area. The wide variation in the themes and recommendations in this literature provides subtle evidence that a solution has not and probably will not be easily found.

It is of particular interest that the bulk of these activities seems to be directed at family physicians and family medicine. While one could speculate at length as to the reason, it is probably related to the vast breadth of family medicine and to the tardiness of establishing this specialty as a clinical discipline. It would also seem likely that, for the immediate future, family physicians will continue to depend heavily on contributions from their colleagues in other specialties and to improvise in the use of material and information that are not always readily incorporated into the clinical setting of community practice.

It was with these facts in mind that the program on which this paper is based was initiated. When the original discussions that led to the development of the program were held there did not seem to be any academic principles involved, only a vague and disquieting feeling that traditional refresher courses and clinical days were not necessarily the best or most efficient way of "keeping up to date". It seemed too often that while the content of many continuing education programs was excellent it was either not relevant to clinical family medicine, or the research on which the content was based had failed to take into consideration problems unique to community practice. As a result, while much information was provided to those attending a course, it was not always evident that this increased data base resulted in a change in practice habits.

This was the background that determined the climate in which a group of family physicians initiated weekly rounds at St. Joseph's Hospital in Hamilton. While the group does not feel that it has in any way solved the immense problems involved in the continuing education of the practising family physician, it has learned a considerable amount about the process. It also continues to modify the structure and content of the rounds in an attempt to make them more relevant and meaningful.

In the original format one member of the group would be called late the afternoon before the rounds to bring all his office charts from that day. The chairman would select several at random and would ask the designated physician to inform the group as to the nature of the patient's complaint and his management. Discussion would then be opened to the floor — and was usually lively. While the experience was very threatening to the presenting physician at the beginning, self-confidence grew as the group recognized common problems they had all faced without realizing others were having similar difficulties.

It was fascinating to watch the problem-solving process. Because case presentations were necessarily brief initially, many of the investigations and therapeutic interventions would seem very inappropriate at first glance. How-

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ever, as questions arose from the floor the presenting physician often supplied additional data from his knowledge of the patient, his family, work or social circumstances that cast an entirely different light on the problem and its management. Awareness of the tremendous importance of one's knowledge of the "whole" patient developed. One could also not help but become aware of the absence of important information from patients' charts. Lack of time and effort were not the only factors responsible for these gaps; it was often very difficult to formulate terminology to describe accurately the transactional processes between the physician and his patient that led to certain actions.

One very serious drawback to this type of rounds was the frequent inability of the group to resolve one or more problems arising in the discussion because no one had a sufficient academic base to provide a particular piece of information. This led to the identification of a second important problem, or rather to a conflict over the relative influence of "pragmatics" and "academics" in the educational process. This conflict is far from resolved and is certainly not unique to family medicine. To be too academic is to incur the risk that many practising physicians will be lost in what they consider irrelevancies and to be too pragmatic is to court the danger of irrational practices not based on sound scientific principles.

In an attempt to solve this problem two different avenues were explored. The first was to arrange a round to discuss the unresolved problem at a later date and to ask a consultant or expert in the field as a guest. The second approach was to designate an individual in the group to gather information from other resources and to report back to the group the following week. It was not infrequent that neither the expert nor the library could totally resolve the problem. We found that consultants frequently tried to transpose their hospital experience to an office situation and this was often not entirely appropriate or helpful. We often ended a session with more questions than answers, even after we had explored all the available resources — a situation most practising physicians would not find surprising.

With experience we found that it was sometimes worth while to preselect resource people and topics before the rounds. We would, for example, select intractable angina pectoris for discussion and start by presenting one or more case reports. Management would be discussed, then the resource person would summarize the results of his library search. A cardiologist and/or cardiovascular surgeon might be invited to act as a resource person and discuss the relative merits of surgical and medical management. We have found on several occasions that a mix of professionals tends to add to the rounds by giving different perspectives to the same problem.

A format that has proved particularly stimulating and enjoyable is one resembling the traditional clinicopathologic conference. All members of the department are now on the alert for an appropriate problem for such a presentation. The essential ingredients are either a rare disease with a common presenting symptom or, preferably, a common disease entity with an unusual clinical feature. The case is presented in stages, as it was seen in the physician's office. At each stage the group is asked for management suggestions and once these have been discussed the presenting physician details his own management, again in stages. This exercise is carried on until the diagnosis is reached. A resource person then fills in any details that might be missing in the overall management. This is a particularly valuable learning experience because analysis of the case proceeds in the same manner as did solution of the actual clinical problem.

While formal educational principles were applied at the outset, it has been found that our program is supported by sound academic rationale. The rapidly increasing body of knowledge on the conditions that provide good educational experience for adults suggests that at least two principles are involved:

1. Learning is the discovery of the personal meaning and relevance of ideas.
2. For learning, it is best to simulate conditions of application as closely as possible.

By having physicians who were facing similar problems we had arranged a forum for the exchange of ideas and views on clinical situations with which they could quickly identify. They could deal with very specific, relevant problem areas and compare methods of management. Even when there was no solution it was helpful to know that there was no answer and that others were frustrated by the same situation.

While the stimulus for initiating these rounds was vague and nondescript, the achievements to date are a little more tangible. It is tempting to say that the quality of practice has improved as a result of the rounds but at the moment we have no evidence for this. We do have evidence, however, that many health professionals find these rounds helpful and stimulating, for the attendance is good and continues to increase each year. The average attendance is approximately 30 but varies from 20 to 50. The rounds have created a certain *esprit de corps* and group cohesiveness in the department of family medicine at St. Joseph's Hospital that has stimulated other activities in the department.

One activity of particular interest is a research project that has been formulated and submitted to granting bodies for funding. The project relates to the incidence of pulmonary embolus in patients who present with lancinating chest pain. It arose from a round in which such a case was presented and from which we could find no direction from either the group or two experts as to the management of such a problem in the absence of other clinical signs and symptoms. The project was written up by a member of the department of family medicine with the assistance of a hematologist and an epidemiologist and serves as an example of the kind of problem identification that can occur in this setting.

Another and perhaps more important activity is the foundation for a peer review program. While this was not considered initially, the members of the department have, in fact, opened their charts to their peers for discussion and comment. In an era in which there is so much discussion about quality control and in which legislation has been passed in some areas to implement professional review programs it is gratifying to know that a group of physicians has taken the initiative. It is clear that much of the anxiety that arises when one entertains the thought of a peer review program has been dispelled in this group. We have not, as yet, a formal peer review program but when this was last discussed by the group a few months ago it seemed apparent that any obstacles would be related to administrative problems and not to lack of physician participation.

It will probably be some time before effective, formalized and reproducible programs of continuing education for family physicians are a reality. There seems to be no reason, however, for family physicians to wait idly and depend entirely on consultants to provide the basis for these programs. The content and process of family medicine are, and will remain, best known to family physicians. Such a program can be carried out by any group of family physicians even if consultant services are not readily available. More experience by more groups could lead to the refinement of such a program and make it an increasingly useful vehicle for continuing education. ■