The educational value of peer groups from a general practitioner perspective

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ABSTRACT

INTRODUCTION: Peer review groups are compulsory for New Zealand (NZ) general practitioners (GPs) but little is known about how they function. This study aimed to understand the educational value of peer group meetings to general practitioners and explore methods of increasing value.

METHODS: A qualitative study was undertaken comprising a single meeting involving 22 NZ GPs with an interest in education and subsequent thematic analysis on the raw data.

FINDINGS: Respondents indicated a strong belief in the educational value of peer groups. Pastoral care was also perceived as a valuable outcome of peer groups that was somewhat separate from the educational value. It would appear that the majority of peer groups work on the basis of internally driven contemporaneous learning needs based on difficult work experiences. There was limited concern over the wide interpretation of what constitutes acceptable topics for discussion as well as the informal nature of training and structuring the meetings.

DISCUSSION: The interactive nature of peer group learning with subject matter of 'real life' problems would suggest peer groups have the potential to make significant change in the performance of doctors. A broad and differing range of experience in the group is more likely to generate an educationally valuable environment. It would appear that there may be a limited role for assisting peer groups with methods of structuring content and increasing effectiveness.

KEYWORDS: Education, medical, continuing; peer group; peer review, research

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Introduction

Peer review is considered a compulsory part of continuing professional development. The Medical Council of New Zealand (MCNZ) requires doctors to undertake 10 hours of peer review per year as part of a suite of activities, and defines peer review as "...evaluation of the performance of individuals or groups of doctors by members of the same profession or team. It may be formal or informal and can include any time when doctors are learning about their practice with colleagues".[1] This excludes discussions on practice management or systems and non–clinical research or education. The Royal New Zealand College of General Practitioners (RNZCGP) is the organisation with the responsibility of assisting general practitioners meet this requirement and has produced guidelines that state: "Case review should be the cornerstone of peer review".[2] Over 800 peer groups are registered with the RNZCGP.

A literature search using MeSH terms "Education, Medical, Continuing" AND "Peer Group" revealed 36 articles. Of these, the only evaluative paper on peer groups was a qualitative Canadian study using a trained facilitator in a structured case review process.[3] The authors reported the process was highly valued, but hindered on occasion by the formality. The remainder of papers were concerned with the educational effect of teaching specific topics in a small group environment such as prescribing,[4] mental health[5] or peer groups with an expert specialist.[6] Balint groups[7] or similarly structured meetings[8] have found a place as a method of reflection on practice.

The aim of this research was to better understand the educational value of peer groups from New Zealand practitioners' perspective and identify potential methods of increasing their educational value. The Kirkpatrick hierarchy of educational

evaluation provides a framework for understanding value in education and describes four levels: reaction to education, assessment of newly learned material, assessment of change in physician behaviour and, finally, change in quality of health care.[9] The method of assessing value for this research is the reaction to education.

Method

At the RNZCGP's 2010 education convention, a workshop was held with 22 general practitioners with interest and experience in medical education. A qualitative structure to the research was chosen as it was desired to understand what broad issues existed and opinions on these from the participants' perspective. The methodology was grounded theory; the generation of theory from data. The method was a single semi-structured focus group with allowance for a larger group size than would normally be associated with this method.[10] The purpose of the workshop was explained as an early investigation aimed at increasing the educational value of peer groups. Four broad issues were discussed openly:

1. What makes a peer group learning unique?
2. What learning occurs?
3. Is the learning beneficial?
4. Do peer group activities need to be more formally structured?

Notes were kept of the meeting and a basic thematic analysis undertaken by the author according to the principles described by Thomas with the description of categories and coding of data within these categories.[11] Participants were informed that their comments would be recorded, analysed and potentially published, and gave verbal consent.

Results

Learning within a peer group

Participants indicated that learning is not always the main focus of peer group meetings. Providing and seeking support was considered complementary to and, at times, conceptually different from education, yet important as a function of the group dynamic. Peer groups offered an opportunity to understand personal learning needs. There was a need for peer groups to provide an environment where a practitioner could feel both safe and vulnerable at the same time. Honesty and confidentiality within the group were critical to this.

The question arose in the group concerning the nature of learning in general practice. Ideas put forward were of social interaction being a form of learning, peer groups representing a solution to the isolation inherent in day-to-day practice and peer groups providing a method of self-reflection on variability in practice with feedback as to where an individual sits within the range of variability. Such variability can represent either a positive or negative affirmation of standards. Learning of some form is inevitable in peer groups due to the social interaction. A supportive peer group makes it acceptable not to know and therefore the ambiance of a peer group will shape what is learned and how. A negative learning environment can occur with dominant controlling members. Rules of engagement or facilitation may solve some of the dysfunction that can occur in a peer group.

Composition of peer groups

Some peer groups have grown over many years so that members bring recognised areas of expertise to the peer group, such as research, political awareness, education etc. New members present specific challenges to peer groups. A group dynamic can present a barrier to those unfamiliar with it, with subsequent difficulties over integration. A successful dynamic can also be upset by new members. A problem to those exiting General Practice Education Programme (GPEP) 1 and entering GPEP2 is that many will form a peer group with those in the same level of training. This narrows considerably the depth and breadth

WHAT GAP THIS FILLS

What we already know: Participation in a peer group is a required activity for continuing professional development. Little is known about how general practice peer groups in New Zealand function as educational opportunities.

What this study adds: This research found that peer groups are well regarded educational initiatives and their autonomous nature is valued. However, some groups may depart from what is educationally or pastorally useful and better infrastructure may prevent this.

of knowledge available to the group and the opinion was expressed that these doctors should be accepted into groups with some experienced general practitioners. Rural practitioners drew attention to specific problems for peer groups in geographically isolated areas as there may be little choice over which group to join and scarcity of other groups should the dynamic in an existing group prove disadvantageous to learning.

Structuring peer group learning

There was some concern regarding the wide scope that peer groups have, coupled with a lack of external feedback to the group and the very informal nature of peer group guidelines. Participants knew of peer groups that predominantly discussed business problems, others that were clearly more concerned with social issues affecting participants, and yet others that dealt with difficult clinical problems. Suggestions were made regarding the usefulness of training for peer group leaders as a solution to some of these difficulties. There was general consensus that the informal nature of peer group discussions allowed a degree of flexibility that was of considerable value. Some groups actively plan what topics will be covered in the forthcoming year and discuss those aspects of the peer group that were of particular benefit in the preceding year. There was general consensus that the ability of a peer group to choose the material that will be discussed was very valuable.

Discussion

Continuing professional development should be primarily concerned with improved patient outcomes or, as a surrogate endpoint, improved physician performance. There is also a clear pastoral need concerning self-care, maintaining a community of practice, and developing intellectual interests. Peer groups can achieve both an educational and pastoral function, but this research revealed some confusion as to which of these agendas is being met or how much emphasis is placed on each in peer group meetings. The respondents in this meeting clearly articulated that both functions are considered important but, in general, had no formal mechanisms of identifying, prioritising or allocating time to address both issues. A more holistic view to separating education from pastoral care is that pastoral care may be perceived as an extension of education in that it is also a necessary component to improving patient outcomes or physician performance.

The format of peer group meetings has the potential to encapsulate powerful mechanisms known to achieve change in clinician performance or enhanced patient outcomes. Interactive programmes between practitioners and educators and being able to compare personal performance against optimal care have been shown to positively influence practitioner performance.[12,13,14,15,16] In the circumstance of a peer group, the question is immediately raised as to who the educators are. The 'zone of proximal development', as described by Vygotsky, divides learning that can occur autonomously from that which requires the social mediation of someone who either knows more or knows differently.[17,18,19] If peers are the educators, by implication they should either know more or know differently. Thus, the concern expressed by one of the participants over peer groups composed exclusively of those exiting GPEP2 has good grounding in educational research; such a group is unlikely to positively influence professional performance. Similar limitations on learning can also occur in peer groups with dysfunctional members.

Comparing optimal with actual care is also an effective method of influencing physician performance. Audit can achieve this for aggregated quantitative clinical data and peer groups can facilitate such comparison by reflection on unique complex cases. The variability in practice discussed by the participants is part of this reflection. Clearly, when dealing with complex problems, the simplicity of a single correct solution associated with quantitative data is not applicable as many potential solutions may vie for ascendancy, each being correct depending on the viewpoint. Such cases are the 'swampy lowlands' described by Shon where problems are messy, confusing and incapable of technical solution.[20] The discussion on such cases does provide an opportunity to review and revisit decisions, usual practice or opinions in the light of other perspectives and experiences.

Structuring the content of peer group learning is a complex issue. On one hand, the independence of a group to decide the content of a meeting allows the content to reflect deep learning; assistance to manage the most challenging of contemporary issues where conventional modes of education are inadequate to meaningfully contribute. Previous research with final year medical students undertaking a general practice run revealed that self-selected topics for group reflection were characterised by ambiguity of problem definition, the lack of an apparent solution and discrepancy between theory and practice.[21] It is likely that experienced practitioners would choose cases with similar characteristics to discuss. Also, the peer group may represent the only professionally based forum available for general practitioners to debrief from emotionally charged work experiences. Conversely, lack of structure can result in discussions that are of interest to the participants, but are of little pastoral or educational value in a professional sense.

Care must be taken before transferring the results of this research to others. The participants were a self-selected population with strong educational interest. It is intended to check the generalisability of the research by a survey.

Conclusion

The participants clearly indicated that peer groups are of value and are well regarded. There are two perceived areas of value; educational and pastoral. Peer groups can be anchored into educational literature and there is evidence that the underlying principles can create change in physician behaviour. The relatively autonomous nature of the topics discussed and managed was both a strength and a weakness in that the discussions could have high fidelity to learning needs, but could also become somewhat peripheral to professional practice. There was limited support for more formal structuring of peer groups, but the ability of a group to manage potentially dysfunctional members and maintain focus on relevant pastoral or educational initiatives would appear to justify some form of structuring. There remains a relative vacuum regarding how peer groups function across New Zealand and what value the participants place upon them.

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COMPETING INTERESTS
The author acknowledges as potential conflicts of interest his being the medical adviser to the Medical Council of New Zealand and his position as Chair of the Education Advisory Committee for the RNZCGP.