

Small group learning for specialists in general practice – structure, importance and potential

ORIGINAL ARTICLE

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Background

Participation in continuing medical education small group learning (CME-SGL) is one of several mandatory activities for the recertification of specialists in general practice. The aim of this study was to increase knowledge about the structure of the groups, doctors' experiences with participation and their attitudes to the CME groups as a setting for quality improvement initiatives.

Material and method

A digital questionnaire with 28 open-ended and closed-ended questions was sent to all members of the Norwegian College of General Practice (n = 8645) and all SGL secretaries (n = 1281). The questionnaire was also accessible on the Facebook group *Allmennlegeinitiativet* (> 5000 members). Quantitative results are presented descriptively. We analysed the free-text responses using thematic analysis.

Results

Among the 555 respondents, average participation in a CME group was 11.8 years (ranging from zero to 45 years). Of these, 508 (91.5 %) reported being very satisfied or extremely satisfied with their group. A total of 306 (55.1 %) strongly agreed that it is easy to discuss professional insecurities in the group, and 489 (88.1 %) always or almost always looked forward to the meetings. In the qualitative analysis, the importance of the CME groups in providing reassurance and support, as well as serving as a valuable setting for collegiality, emerged as recurring themes across the responses. Many respondents described SGL as crucial for being able to carry on working as a GP.

Interpretation

CME groups are a valuable setting for support and collegiality among GPs, and for discussing difficult experiences and professional insecurities.

Main findings

Over 90 % of the general practitioners (GPs) who responded to the questionnaire were very satisfied or extremely satisfied with their continuing medical education (CME) group.

Around half of the respondents considered CME groups to be a very important setting for discussing their most challenging patients.

In free-text responses, SGL was described as crucial for being able to remain in a demanding job and for fostering collegiality both within their medical practice and between different practices.

In terms of externally developed courses being used in SGL, respondents were positive if these courses awarded ECTS credits (90.5 %) and were based on data from their own medical practice (50.6 %).

Participation in continuing medical education small group learning (CME-SGL) (loosely organised peer groups, commonly referred to as small group (*smågruppe*) in the Norwegian medical community) has been one of several mandatory activities for recertification in general practice and to maintain eligibility for specialist fees since 2003 [\(1\)](#). Unlike the supervision groups for junior doctors, there is no predefined structure for the format, frequency or topics of the meetings, but there should be 3–12 participants and at least three meetings per year. The meetings should last between one and six hours. Participants must complete at least 20 group hours per five-year period. There is no formal group leader, but a secretary is responsible for recording attendance. The pharmaceutical industry is not allowed to be involved in SGL [\(2\)](#).

Despite SGL being a mandatory activity, and many GPs speaking warmly and enthusiastically about their CME groups, there is little formalised knowledge about these groups. The Norwegian Medical Association has contact details for

the group secretaries but no information about the composition, duration or other characteristics of the groups. In a 2005 study, half of nearly 900 respondents reported taking part in SGL, and 13 % had been in the same group for more than ten years (3). The authors concluded that there is reason to believe that mandatory SGL can lead to quality improvements in general practice in Norway. In a 2007 study of supervision groups for junior doctors, satisfaction levels of respondents were high (4), but there is no equivalent study for SGL in continuing medical education.

Rules for specialisation and recertification change over time. The transitional arrangement from the old to the new specialist regulation, under which continuing education and SGL currently fall, ends on 31 December 2026. It remains unclear what continuing education and recertification will involve after this date, or whether SGL will continue in its current form.

SGL has become a popular setting for engaging with GPs, both for researchers and as a platform for quality improvement work (5–8). However, it is not known whether doctors actually want SGL to serve this role, or whether SGL is a suitable setting for quality improvement work.

The aim of this questionnaire study was to gain more insight into the experiences of specialists in general practice with mandatory CME-SGL, and to explore participants' attitudes to SGL as a platform for quality improvement initiatives.

Material and method

We facilitated participation in the questionnaire study for all GPs in Norway ($N = 5100$ at the time of invitation) as well as general practice specialists working in other positions. The invitation was initially emailed to all 8645 members of the Norwegian College of General Practice, followed by a four-week and four-month reminder (delayed due to the summer months). Invitations were also sent directly to all SGL secretaries ($N = 1281$; one person can be a secretary for more than one group). The study invitation was additionally shared in the private Facebook group *Allmennlegeinitiativet* (which had over 5000 members at the time of inclusion), followed by a reminder after 14 days. Information about the study was also included in the consultants' newsletter distributed to GPs throughout Norway. Data were collected in the period March to October 2023. One of the authors (JØ) is employed by the Norwegian Medical Association and was informed that, at the time of invitation, there were 1563 active CME groups.

The questionnaire was developed by the authors of the article and piloted among 12 GPs with both clinical experience and research expertise. The questionnaire was amended based on their feedback (the questionnaire in the appendix is in Norwegian). Responses were collected online via Nettskjema, a web-based survey tool from the University of Oslo. Only respondents who confirmed that they participated in SGL completed the full questionnaire and were included in the analyses.

The questionnaire consisted of 22 closed-ended and six open-ended questions. There were six questions on the primary function of the group (rated on a 1–7 Likert scale), nine statements about meeting formats (with five predefined response options), three questions regarding the group's composition in terms of age, experience and background (1–7 Likert scale), and five questions on attitudes to structured courses for CME groups (five predefined response options). The questionnaire concluded with the question: 'All in all, how satisfied are you with your CME group?', rated on a five-point scale from 'extremely satisfied' to 'not at all'.

The data collected were directly recorded and stored in a password-protected service at the University of Oslo. The study did not fall under the Health Research Act, and no personally identifiable information was collected. The study did not therefore require approval from the Regional Committee for Medical and Health Research Ethics, nor was it subject to registration with Sikt – the Norwegian Agency for Shared Services in Education and Research. The invitation was sent to members of the Norwegian College of General Practice in line with the organisation's objectives and in accordance with the Norwegian Medical Association's privacy policy and data protection officer.

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Analyses

Descriptive results are presented as frequency distributions, percentages and averages. Percentages represent the proportion of respondents who answered the respective question.

For questions about the format of meetings and attitudes to courses (with five predefined response options), the two highest and two lowest response categories were combined. For questions answered on a Likert scale from 1 to 7, either the number and proportion of respondents who answered 7, or the sum of those who answered 5–7, are reported. For the question regarding group composition, a combined homogeneity variable was constructed. This is further described in the results section.

The relationship between satisfaction with CME group and demographic background variables was examined using one-way ANOVA and t-tests.

Free-text responses to the question 'Describe the importance of the CME group for you' were analysed using a simplified version of the template analysis described by Brooks et al. (9). In this analytical approach, a coding framework (template) is developed based on a subset of the data, which then serves as the basis for further coding. The analysis is hierarchical and allows for both descriptive and interpretive themes, as well as integrated themes across code groups. Two random samples of 20 % of the responses (43 out of 216 answers) were drawn. Two of the authors (TBE and SH) independently read and coded their respective samples, after which they agreed on a template to guide the

subsequent analysis. TBE then read through the entire dataset and coded it according to the template. TBE and SH completed the coding during a final coding meeting.

Results

A total of 579 doctors participated in the questionnaire survey, of whom 24 were excluded from further analyses because they were not members of a CME group. This left 555 responses as the basis for subsequent analyses.

Table 1 shows the respondents' gender, age, regional health authority, employment status and specialist status. Among the 486 respondents working in clinical practice as GPs or locums with their own patient list, the average number of patients was 1083 (minimum 203, maximum 2500). The national average for the same period was 986 (10).

A total of 157 of the respondents (28.3 %) were members of more than one group. These were asked to base their answers on their main group. A total of 334 (60.2 %) had experience as SGL secretaries.

On average, respondents had participated in the same CME group for 11.8 years (range 0–45). In terms of group size, 278 (50.1 %) reported that their group consisted of 2–6 participants, 247 (44.5 %) reported 7–11 participants, and 30 (5.4 %) indicated the group had 12 or more participants. Table 2 shows the reported meeting frequency, location and duration, as well as the basis for group membership. A total of 265 (47.7 %) reported that group meetings lasted 2.5–3 hours, and 407 (73.3 %) stated that the CME group met every two to three months. The most common meeting location was a medical practice (380 respondents, 68.5 %). The vast majority agreed that SGL was a setting where they could discuss their professional insecurities/sense of inadequacy: 516 (93 %) of respondents answered between 5 and 7 on the Likert scale, where 7 was 'strongly agree'. A total of 306 (55.1 %) respondents gave a score of 7.

We also asked respondents to rate the group's composition in terms of age, gender and background (e.g. university, country of birth) on a scale from 1 (very different) to 7 (very similar). On a combined homogeneity variable that included all three of these, the average score was 4.6.

Figure 1 provides more information about the format of meetings. A majority of 489 respondents (88.1 %) reported that they 'almost always' or 'always' looked forward to the meetings. A total of 446 (80.4 %) said that it was almost always or always possible to talk about emotionally difficult topics related to work, while 366 (65.9 %) indicated that meetings were never or almost never held during regular working hours, and 398 (71.7 %) said they never or almost never invited external speakers to their SGL meetings.

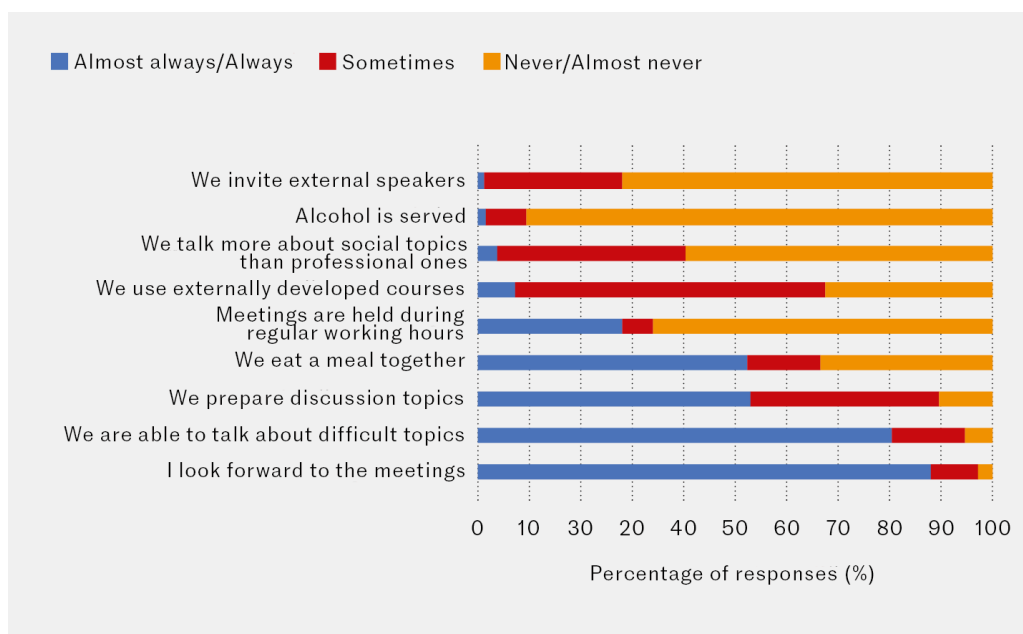


Figure 1 Structure and content of continuing education groups in general practice. Data from a survey in 2023 ($N = 555$). The figure shows the percentage of respondents who answered 'almost always/always', 'sometimes', or 'never/almost never' to various statements.

Figure 2 shows how the respondents rated the importance of CME groups (Likert scale; 1 = not important, 7 = very important). A total of 394 respondents (71 %) answered 6 or 7 regarding the group's importance for discussing challenging patients. A corresponding score of 6–7 was given by 362 (65.2 %) respondents for the importance of discussing experiences about practice management, and 340 (61.3 %) for the importance of the group as a social meeting place.

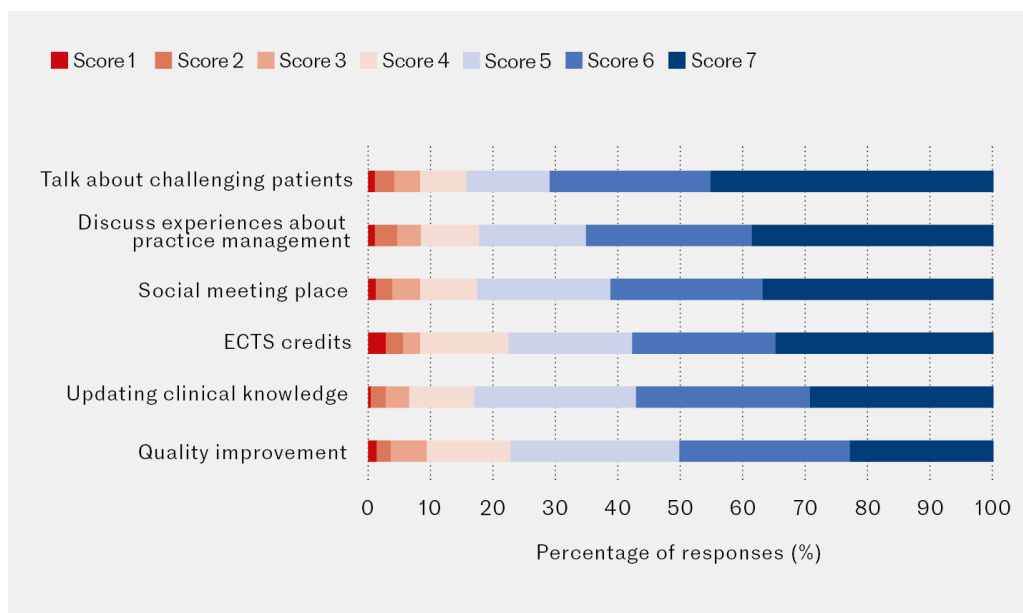


Figure 2 Reported importance of the continuing education groups in general practice. Data from a survey in 2023 ($N = 555$). Respondents were asked to rate the importance of CME groups according to predefined response options. The figure shows the percentage of respondents who rated the various categories on a Likert scale from 1 to 7, where 1 is 'not important' and 7 is 'very important'.

Among the respondents, 180 (32.4 %) stated that they never or almost never used externally developed courses, while 335 (60.4 %) answered 'sometimes' to this question (Figure 1). Table 3 shows the participants' emphasis on various factors when rating whether such courses might be relevant for their group. A total of 502 respondents (90.5 %) indicated that it was somewhat/very positive if the course awarded ECTS credits, and 281 (50.6 %) that it was somewhat/very positive if individual activity data could be extracted from their own medical practice (e.g. their own prescribing of various medications). A total of 259 respondents (46.7 %) stated that it was somewhat/very negative if the course required any preparation at home.

Most participants were satisfied with their CME group: 338 (60.9 %) were extremely satisfied and 170 (30.6 %) were very satisfied. Only 12 (2.2 %) were slightly satisfied or not satisfied at all.

There was little or no correlation between satisfaction with the CME group and demographic background variables, including age, gender and number of years as a specialist (data not shown).

Thematic analysis

We performed a template analysis (9) of the 216 free-text responses to the question about the importance of CME groups, which identified seven main themes, as detailed below. In these themes, respondents consistently emphasised the importance of SGL for fostering a sense of *collegiality* – something often missing from a hectic working day where they tend to work alone. *Reassurance* and *support* were also consistently emphasised as important aspects of SGL, both in emotionally and professionally difficult situations. These two themes were therefore perceived as integrated throughout the entire material.

The other seven main themes identified were:

Making the job manageable. Many expressed that SGL was very important to them, that it helped them continue their work as a GP and fostered collegiality, which was otherwise missing in their daily work.

Support in challenging situations. SGL was described as extremely important in relation to challenging situations, whether during patient consultations, in managing conflicts within their medical practice, and even in their private life.

Meeting place for colleagues. SGL was considered an important meeting place for colleagues, and many specifically expressed that it was a valuable opportunity to gain insights from other medical practices.

The importance of SGL changes as careers progress. Several respondents emphasised the value of meeting the same colleagues over many years. Over time, the main function of SGL could shift from a focus on updating clinical knowledge to a source of both professional and social support.

Freedom to structure SGL as desired. It was considered positive and important that there are no strict formal requirements for the content of SGL.

Professional benefits. SGL was considered useful for updating clinical knowledge, comparing medical practices and discussing specific clinical challenges.

It was also viewed in a positive light that SGL is mandatory, as this ensures that time is set aside for clinicians to update their clinical knowledge.

SGL is of little value. A few respondents perceived the requirement to participate in SGL as unnecessary and problematic due to time constraints both at work and in their personal lives.

A detailed coding framework (template), including main themes, subthemes and representative quotes, is provided in Table 4.

Discussion

We found that respondents had been part of the same CME group for an average of almost 12 years. Most reported that their groups met either monthly or every 2–3 months, and the majority said they met at their medical practices, although 32 % met in each other's homes. SGL was considered a setting where participants could discuss professional insecurities and the most difficult patients. A total of 91.5 % reported being very satisfied or extremely satisfied with their small group.

In the free-text responses, a large majority emphasised the importance of SGL, particularly for fostering collegiality and as a source of support in challenging situations. Many noted that SGL helped them endure the demands of a challenging job.

Implications

We know that continuity in the doctor–patient relationship is associated with reduced uptake of healthcare services and lower mortality (11). Achieving continuity requires GPs to remain in their positions long term. Our findings suggest that SGL is an important factor for remaining in the job.

Between 2010 and 2019, a significant increase was observed in harmful levels of stress among GPs (12), and measures to prevent burnout are crucial. We have shown that SGL is an important setting for discussing challenging situations, and as such can potentially help prevent burnout.

In a 2020 study, many doctors reported that the lack of a professional community was a key reason for leaving general practice (13). This aligns with our findings, where many respondents indicated that SGL is often the only setting where they have the opportunity for meaningful professional discussions with colleagues.

In previous studies, we have shown that GPs in Norway are positive about quality improvement and are motivated to provide high-quality clinical care, but that they encounter many structural barriers to quality improvement work (8, 14). The doctors in these studies had a positive attitude to externally developed quality improvement courses, provided they were relevant to clinical practice, manageable and preferably held within professional communities (8). GPs in Ireland have a SGL model similar to the one used in Norway, and a 2015 study found that SGL improved clinical knowledge while also fostering valuable peer support (15). SGL is somewhat more structured in Ireland than in Norway,

and is often led by trained course instructors. Well-designed courses for those leading group or individual supervision could, over time, also help build supervision competence in Norway.

Half of our respondents indicated that it was somewhat or very positive when courses were based on data from their own medical practice. Some such courses have already been developed by the Antibiotic Centre for Primary Care (ASP) and the Centre for Quality in Medical Practices (SKIL), and our findings suggest that continued emphasis should be placed on courses that offer easy access to individual practice data for use in SGL. Nearly half of respondents were not in favour of courses that required preparation at home in addition to SGL sessions, but many were open to courses extending over more than one group meeting. These results will be useful for planning future courses.

The study provides new insights into an under-researched area. This makes it a useful starting point for improving continuing medical education for GP specialists and developing quality improvement initiatives in general practice.

Strengths and limitations of the study

Recruiting busy doctors to participate in survey studies is challenging, as was the case in our study. This is consistent with previous studies we have conducted among GPs in Norway (16). Survey fatigue is a well-known phenomenon in international research (17, 18) that can make it difficult to achieve a sufficient response rate in questionnaire-based studies.

We aimed to invite all GPs in Norway to participate in the study, but we do not know what proportion actually received the information and therefore had the opportunity to take part. The Norwegian College of General Practice has around 9000 members and is assumed to include most GPs in Norway, but membership is optional. Our sample consists of 555 doctors. With 1563 active CME groups, each consisting of 3–12 members, this means we received responses from a relatively small proportion of all SGL participants. We do not have exact numbers on how many doctors take part in SGL, and it would be inaccurate to calculate a response rate based on the total number of GPs in the country, as the invitation was distributed more broadly than to just the GP population.

There is a potential risk of selection bias, as those who responded may be somewhat more positively disposed toward SGL than those who did not. Aspects highlighted in the survey invitation may play a role in whether someone responds, depending on how important these issues are to them (the leverage-saliency theory) (19). We invited specialists in general practice to participate in a study about the importance of SGL, and it is reasonable to assume that our respondents include a disproportionate number of doctors who feel that SGL is relatively important. If satisfaction with CME groups is high, the perceived importance of it is also likely to be higher. Such selection bias is not uncommon, but a recent Norwegian study showed that the effect was small (20). Overall, we conclude that the results are valid for those who responded, but that generalisability to all SGL participants is somewhat uncertain.

A total of 27.1 % of respondents were members of more than one CME group, and 60.2 % had experience as an SGL secretary. This supports the possibility of a selection bias and suggests that the most engaged – and potentially the most positive – participants may be overrepresented in our sample. We do not have information on whether any of the respondents belong to the same CME group or whether anyone may have completed the questionnaire more than once. We cannot, therefore, state with certainty that the reported percentages reflect group-level averages. A total of 3.4 % of respondents were retired, and it is therefore conceivable that their responses do not reflect current GPs' views on SGL. However, they likely have many years' experience with SGL and can thus offer valuable insights. Since they chose to continue with SGL after retiring, it is likely they have a positive view of it, and therefore may also represent a possible bias. A total of 8.4 % of respondents reported that they were not specialists, and it is possible that junior doctors also view SGL as a useful professional forum. The survey clearly stated that it was not studying supervision groups for specialty registrars, but we cannot entirely rule out the possibility that some respondents related their responses to their supervision group.

Conclusion

The respondents in our study were largely satisfied with their CME groups, which they viewed as a supportive forum for discussing professional insecurities and challenging situations in patient care. This was supported by the qualitative analysis, which showed that SGL is an important setting for collegiality and peer support. SGL was described as crucial for being able to remain in a demanding job. Although fewer than one-third of respondents considered updating clinical knowledge and quality improvement to be among the main functions of SGL, two-thirds sometimes used externally developed courses. Courses that are tailored to GPs, offer ECTS credits, and use data from the GPs' own medical practice are more likely to be positively received.

The article has been peer-reviewed.

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