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Group-based Training for General Practice in Norway: Making a New Model Work

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In operation since 1985, the Norwegian five-year postgraduate educational programme for general practitioners is based on one year's hospital training and four years of training in general practice. One of its main components is a two-year group-based educational programme. Since there was little previous experience to rely on when setting these groups to work, there has been some concern as to whether the system would work – and how. This paper summarizes the practical experience of the first 45 groups established, based on a questionnaire filled in by the group leaders during their third one-week trainer course. There had been few problems that were not solved by the groups themselves. All 45 groups, including 326 participants, fulfilled the 40 scheduled three-hour meetings within two and a half years. This group-based educational system is now an alternative to the traditional one-to-one trainer/trainee relationship established in many countries as a part of the postgraduate training for general practitioners.

Key words: general practice, specialist, vocational training, postgraduate training, medical education, group-based learning, evaluation, Norway.

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The Norwegian model of training for general practice, operational since 1985, has a strong emphasis on training in general practice (1). In the making of this model, a crucial question was how to construct a suitable system for teaching and learning outside the hospital setting. A proposal to adopt the British one-to-one trainer/trainee model (2) was turned down by the Norwegian Medical Association in 1983. As an alternative, a group-based model was suggested. The reasons are reported elsewhere (3), key words being economy, geography, and stability: it was thought to be cheaper to run, better suited to Norway's sparsely populated countryside, and less disruptive to the doctor-patient relationships.

Little experience was available on group-based education in primary health care. Therefore, questions of whether this new system would work gave rise to some concern (4). When the first 'class' of trainers attended their third one-week trainer course in May 1988, they were in a position to give the answers. While outcome in relation to educational objectives has been evaluated in other studies (5, 6), this paper focuses on the practical aspects of implementing the group-based training programme – number of groups, participants, travels, time, place, and costs.

METHODS

Structure of the programme

The group-based training programme should normally be attended during two of the four years allocated to training in general practice (3). Groups consisting of from two to ten general practitioners are established by group leaders, trainers, on a local

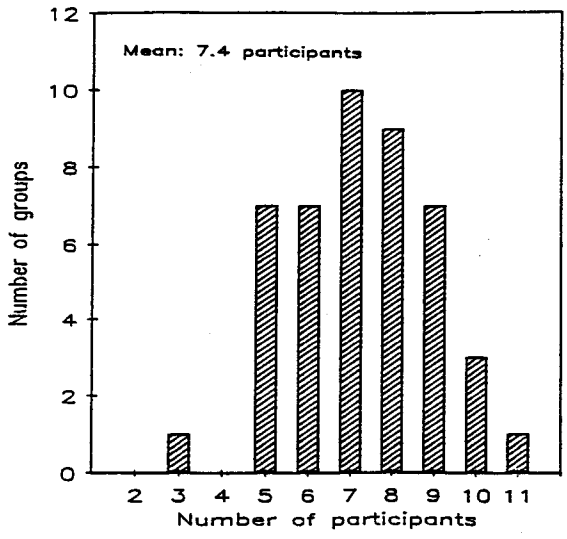

Figure 1. Distribution of educational groups according to number of participants (n = 45).*

*Two trainers shared one group.

basis. They should meet regularly every two weeks for three-hour sessions to study, present, and discuss a series of subjects relevant to general practice. 20 of these meetings are devoted to clinical subjects and case discussions, and another 20 to tutorials (1). Introductions to the tutorials are available in an educational handbook (7), in which it is also recommended that these meetings should be arranged alternatively; one meeting of each kind every month. Once the groups are established, new participants are not usually taken in, so that the group's progress and feeling of security among group members are not disrupted.

The trainers should be recognized specialists of general practice, but are otherwise selected according to criteria not very different from those applied by our British colleagues (8). Geography is also considered, in order to make the programme equally available to practitioners all over the country.

The Norwegian Medical Association* has taken the responsibility, and the cost, of educating these trainers by means of three consecutive one-week trainer courses (9). The introductory course is needed before the trainer is allowed to form an educational group. The second course is arranged within the first year of their group work, and the third one near the end of or after this two-year programme.

To join the group-based programme, the physicians in training have to pay a yearly fee of Nkr 3,000 (equals approximately US$ 450). They also cover their own travel expenses needed to attend the regular meetings. The trainers, on the other hand, are salaried according to the number of hours spent in group meetings, usually 60 hours per year, with Nkr 250 (US$ 40) per hour. The Medical Association will also cover their travel expenses, if meetings are not arranged close to their own practice location.

The third trainer course

During the third one-week course for the first group of trainers in May 1988, 41 of the 47 first selected trainers participated. The last three days of the course were devoted to writing reports on subjects relevant to the recent trainer experience. The present paper is based on one of the six reports produced on that occasion, its title being: "Did it work? Practical aspects of the group-based educational programme".

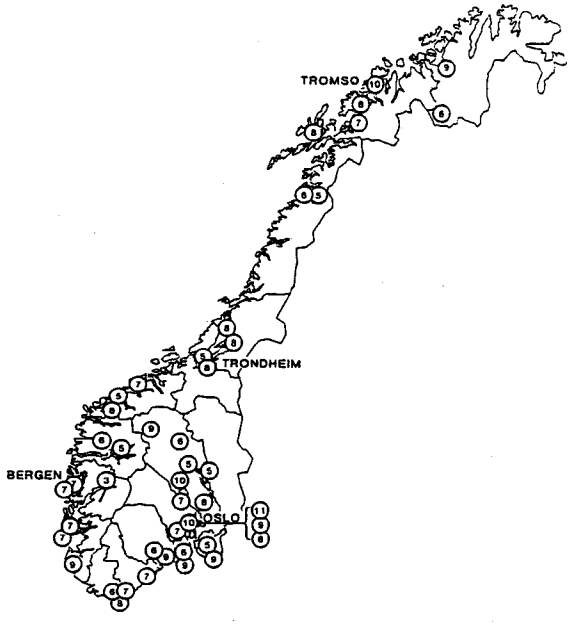

Figure 2. Location of the first 45 educational groups; number of participants, trainers not included, in circles.

*The programme is organized by a Committee on Postgraduate Education of General Practitioners within the Norwegian Medical Association (NMA), consisting since 1988 of Arne Ivar Østensen (chairman), Marit Eskeland, Jacob Prytz, Wenche Telstad, Steinar Westin, and Arne Lie (from the NMA administration).

Table I. *Travel distance one way from home to place of meetings for trainers (n = 46) and trainees (n = 326).*

	kilometers											
	0–10		11–50		51–100		101–150		151 +		Sum	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Trainers	22	(48)	19	(41)	3	(7)	1	(2)	1	(2)	46	(100)
Trainees	135	(41)	134	(41)	41	(13)	13	(4)	3	(1)	326	(100)

The questionnaire

A five-page questionnaire was distributed to all 41 trainers present at the course. The information asked for was limited to what one could expect them to memorize regarding their groups. They were given half an hour to complete the forms. The five trainers not present were interviewed by telephone, making the response rate 100%.

RESULTS

The trainers

Among the 47 ordinary participants at the introductory course, 43 had actually succeeded in forming groups and bringing them to completion within two and a half years. That also applied to three of the general practitioner members of the organizing committee*, making 46 the total number of trainers in this first class**.

The mean age of these 46 trainers was 42.8 years at the start of the programme, ranging from 33 to 62 years. Three were women.

The groups

45 groups had actually been formed, since two trainers had shared the responsibility for one group. All groups had completed the 40 scheduled meetings, but 3 were still running a few extra meetings to take care of participants with more than the allowed 10% absences from meetings.

The group size varied from 3 to 11, trainers not included. A total of 332 physicians joined the groups, making 7.4 the average number of participants per group. The distribution of group sizes is shown in Figure 1, while Figure 2 gives an outline of where they were located. These first 45 groups covered all 19 counties of Norway.

The trainees

During the groups' work, 26 of the 332 participants (7.8%) dropped out of the group they had originally joined. These reasons were reported for quitting: change of occupation (7), too far to travel (2), approved as specialist according to intermediate rules (2), moved (1), illness (1), old age pension (1), joined other educational groups (8), and unknown (4).

20 new trainees (6%) joined the groups after they had started, 6 of them from other groups.

A total of 326 participants had, or would have within one month, completed the educational programme. 290 of these were trainees not yet recognized as specialists of general practice. The remaining 36 (11% of those who completed) had already been approved as specialists, but wanted to attend the programme as part of their continuing education, recertification being required every five years (1).

Travel to the meetings

It was anticipated that the long distances to be travelled, at least in the rural areas, might be an obstacle to this educational programme. One trainer and three trainees had to travel more than 150 kilometers to reach the meetings (Table I). On the other hand, the distance was less than 50 km for 89% of the trainers and 82% of the trainees, and less than 10 kilometers for 40% of them.

** There are, by January 1989, three subsequent classes of trainers of approximately the same size (40) under education while running their groups. Some 900 of Norway's 3000 general practitioners have joined the group-based educational programme to date.

Table II. *How various tasks during the educational programme were taken care of, either by the trainer or shared among trainees (n = 45 groups).*

Task	By trainer		By trainees		Missing information	
	n	(%)	n	(%)	n	(%)
Making plans and schedules	12	(27)	33	(73)	0	
Searching for literature	3	(7)	42	(93)	0	
Copying literature	8	(18)	37	(82)	0	
Distributing papers etc.	11	(24)	31	(69)	3	(7)
Chairing meetings	10	(22)	35	(78)	0	
Writing meeting reports	22	(49)	14	(31)	9*	(20)

* Nine groups did not take regular minutes of the content of their meetings.

This pattern is reflected in the time used in the travel. 9% of the trainers and 14% of the trainees used more than one and a half hours to reach each meeting. A few of these 44 trainees had extremely long travel times; up to 12 hours by boat. Many of these had to stay overnight with friends, colleagues, or in hotels. However, the great majority, 80% of the trainers and 69% of the trainees, used less than half an hour.

The meetings

The recommended structure of organizing three-hour meetings every second week was adhered to by 36 of the 45 groups. Seven groups had two three-hour sessions (one tutorial and one case meeting) once a month as their main way of working, while the remaining 2 groups practiced a combination of 'single' and 'double meetings'. Double meetings were due to long travel distances.

30 groups (67%) had arranged week-end gatherings with overnight stay at least once, sometimes with their families. 11 groups had arranged such week-end meetings with other groups; 4 of their trainers reporting this to be a success, while 7 would not recommend it.

The trainers of 15 groups reported that their meetings were scheduled during working hours, with no objection from the employer, the municipalities. The rest (67%) had their meetings during evening hours, sometimes to avoid such anticipated conflicts.

31 groups had one single place for the meetings, while 14 practiced a rotation. Three of the groups met in private homes, 8 in private surgeries, 12 in public surgeries, 18 in public meeting rooms (owned by municipality, university, etc), 3 in hotels, and 1 unspecified. According to the trainers, 43 of the groups were satisfied with their meeting premises.

Organizing the meetings

All but one group made plans for future meetings, varying from 1 to 12 months ahead. 20 groups had arranged from 1 to 6 extra meetings to make up for absences. Only 6 groups reported problems with late attendance. 35 of the groups had practiced a 15 to 30 minutes' break during the meetings.

Table II shows how various tasks in the programme were distributed among trainers and trainees, while Table III gives an outline of the availability of educational aids.

Financing

When the groups were established, there was no agreement as to how any extra expenses, apart from

Table III. *Educational remedies available and used at least once during the two-year programme (n = 45 groups).*

Remedy	Number of groups	(%)
Photocopy machine	45	(100)
Overhead projector	40	(89)
Video recorder	36	(80)
Video camera	32	(71)
Blackboard	32	(71)
Flip-over	23	(51)
Tape recorder	18	(40)
Whiteboard	11	(24)
Slide projector	9	(20)
Light-case for X-rays	7	(16)

the annual fees, should be covered. Such expenses had not caused any major problems. 42 of the 45 groups had free meeting rooms; exceptions were the three groups that met in hotels. Approximately half of the trainers reported to have covered postage themselves, while literature, including photocopying, was usually paid by the participants. Only 9 groups had ever used the support of the pharmaceutical industry, 8 of them for the occasional week-end meetings.

DISCUSSION

This study gives the first account of how the group-based programme has been organized on the local level. In our experience, such concrete information is needed when educational programmes are to be evaluated. Completeness of data, with a 100% response rate, is one advantage of the study. Using the trainers as respondents should not introduced any major bias in this study, since the information asked for was simple facts and numbers rather than judgements and opinions.

The overall conclusion is that the programme has been organized according to its intentions (7), and that there were few problems which were not solved by the groups themselves.

Despite attempts to recruit women for the trainer courses, the great majority of the trainers were men, to some extent reflecting the sex distribution of general practitioners in this age group. From administrative data in the Norwegian Medical Association we know that a higher proportion (27%) of the trainees in these first 45 groups were women.

The drop-out rate of participants was low. Despite problems of long travel for some, the drop-out rate was not higher in rural groups than in towns. In 32 of the 45 groups no participant left before completion of the programme. Reports from some trainers and local health authorities indicate that the groups have had a stabilizing effect on doctors who would otherwise have considered moving (10). Whether this is a lasting effect remains to be seen.

Travel expenses were considerable for some, being dependent on cars, boats and ferries or planes to reach the meetings (3). A recent regulation will now limit this cost to Nkr 10,000 per year (US$ 1,500), any expenses above this limit being covered by the Medical Association.

Variations in time and place of the meetings and the need to arrange 'double meetings' at longer intervals primarily reflect local geographic conditions, roads for instance being sometimes closed by snow during the winter. A few groups had tried 'triple week-end meetings' for a while, but this proved to be a threat to the continuity of the group's work. When week-end meetings were occasionally arranged with family and with ample time for social life, they were experienced as positive. Spouses frequently attended the scheduled meeting on "Dedicated doctor – neglected family?" (7), often arranged during such week-ends. They apparently appreciated this as an opportunity to deal with frustrations so well known in doctors' families.

The importance of well equipped meeting rooms was emphasized by many trainers, 95% of them reporting that they had succeeded in finding satisfactory premises. As many as 32 of the 45 groups had used video cameras for consultation training, according to guidelines given by Pendleton et al. (11).

Another crucial element of the groups' work was related to delegation of tasks among group members. Several trainers reported having taken responsibility for too much, from providing literature to even taking responsibility for discussions ending with the 'correct' conclusions. Lack of experience in handling a leader role among colleagues, and insecurity as to what was expected of them, were parts of this initial problem. Most of them reported an improved ability to rely on the collective resources of the group as time passed by.

This study deals with structure and process of the programme, while outcome related to educational objectives has been evaluated in other studies carried out by an especially appointed Evaluation Committee within the Medical Association (5, 6). These studies, based on information from the participants, add to the overall impression that this educational model is an effective and highly motivating environment for learning and mutual feed-back. 'Developing a general practitioner identity' is a benefit often reported by the participants (6).

Postgraduate training programmes for general practice are now established in an increasing number of countries around the world. Within the European Community, all member states had committed themselves to start to establish training courses for intending general practitioners in 1988. By 1995, all general practitioners who want to work in the social security systems of the member countries will have to be trained (12).

The educational programmes that are in operation

at present differ greatly in structure and content, one main difference being to what extent the programmes are based on training in hospitals or in general practice (3). For the general practice part of the training, the one-to-one trainer/trainee concept in the British tradition has been the leading model (2). We think that this group-based model could be an alternative. It does work.

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