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A survey of recently trained general practitioner anesthetists in Ontario. Part II: Does continuing medical education adequately meet their needs?

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There is an increasing demand for GPAs in rural Ontario communities. It has been estimated that GPAs administer 25% of the anesthesia care in Ontario. Currently there are no regulatory bodies to ensure that GPAs maintain adequate anesthesia skills. This is the second in a 2-part series on the results of a survey of general practitioner anesthetists (GPAs) who graduated from advanced skills training in anesthesia programs in Ontario between 1995 and 2000. The survey was conducted to evaluate the degree to which Ontario residency programs prepare GPAs for various aspects of practice, and to identify the activities and needs of GPAs for continuing medical education (CME). This article deals with the CME aspect of the survey. GPAs mostly employed journals, textbooks and Internet searches to maintain their skills and knowledge. The greatest barriers to CME participation were the availability of relevant CME resources and the difficulty in taking time away from professional and personal responsibilities. If these barriers to CME could be minimized, GPAs would mostly increase their use of conferences and small group discussions. We encourage the development of a national or provincial society to improve the quality and accessibility of CME resources, with an emphasis on the organization of conferences, journal articles, workshops and visiting anesthesia specialists.

Dans les communautés rurales de l'Ontario, il y a une demande croissante de services d'anesthésie dispensés par des omnipraticiens. Selon des estimations, en Ontario, les omnipraticiens anesthésistes (OPA) administreraient 25 % des soins en anesthésie. À l'heure actuelle, aucun organisme de réglementation ne veille à ce que les OPA maintiennent les compétences spécialisées nécessaires en anesthésie. Le présent document est le deuxième d'une série en deux parties sur les résultats d'une enquête menée auprès des OPA diplômés d'un programme de formation spécialisée poussée en anesthésie de l'Ontario entre 1995 et 2000. L'enquête a été réalisée pour déterminer dans quelle mesure les programmes de résidence en Ontario préparent les OPA aux divers aspects de la pratique, et pour établir quels sont les besoins et les activités des OPA au chapitre de l'éducation médicale continue

(EMC). Le présent article traite du volet de l'enquête portant sur l'EMC. Les OPA ont surtout recours aux journaux, aux manuels et aux recherches sur Internet pour maintenir leurs compétences et connaissances spécialisées. La disponibilité des ressources pertinentes d'EMC et la difficulté à s'absenter des responsabilités professionnelles et personnelles étaient les obstacles les plus difficiles à surmonter pour participer aux programmes d'EMC. S'il était possible de réduire ces obstacles au minimum, les OPA, pour la plupart, se serviraient davantage des conférences et des discussions en groupe restreint. Nous encourageons la mise sur pied d'une société nationale ou provinciale qui viserait à améliorer la qualité et l'accessibilité des ressources d'EMC en privilégiant l'organisation de conférences, les articles de journaux, les ateliers et les spécialistes visiteurs du domaine de l'anesthésie.

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Introduction

This is the second of a 2-part series on the activities and education of general practitioner anesthetists (GPAs) who completed their advanced skills training in Ontario between 1995 and 2000. This article examines the use of continuing medical education (CME) resources by GPAs.

As discussed in Part I (see page 263), GPAs are considered a valuable asset in providing rural communities with anesthetic, obstetrical and surgical services. It is estimated that GPAs administer 25% of anesthetic care in Ontario.[2] In 1995/96, 6.3% of fee-for-service anesthesia care took place in rural Canada; 498 GPAs submitted billing codes and were collectively responsible for 60.6% (151,168 cases) of this anesthesia care.[3] The demand for GPAs will likely continue to increase given the diminishing availability of rural anesthetists holding Royal College of Physicians and Surgeons of Canada (RCPSC) certification[4–6] A News article[7] in the Canadian Journal of Rural Medicine, reporting on a 1999 conference, stated that GPAs must deliver care as competently as an RCPSC-certified anesthetist. Others have also emphasized this point.[8] Rural populations should neither be denied anesthesia care, nor should they receive substandard anesthesia treatment. Isolated, nonacademic practices, however, potentially deprive GPAs of the opportunity to maintain their existing skills or to keep abreast of further developments in anesthetic care.

The SRPC Anesthesia Committee (Dr. Stuart Iglesias, committee member: personal communication, 2001) and others[8] have previously considered CME in anesthesia to be less accessible and not as relevant to GPAs in comparison with their RCPSC-certified colleagues. In the past, there have not been any organizations or regulatory bodies dedicated to the nation-wide delivery of adequate CME for GPAs. The SRPC, the College of Family Physicians of Canada (CFPC) and the Canadian Anesthesiologists' Society (CAS), however, have recently shown interest in supplying this unique practice group with appropriate and available CME resources (Dr. Hal Irvine, Chair, SRPC Anesthesia Committee: personal communication, 2001).

This article will identify the current use, desired use and barriers preventing participation in CME activities among Ontario-trained GPAs who continue to practise in Canada. The goal of the article is to provide encouragement and direction to those groups seeking to improve the delivery and quality of CME to GPAs in Ontario and across Canada.

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Methods

The survey population, questionnaire format and study design were as described in Part I.[1] Out of 41 physicians who had completed a 3rd postgraduate year (PGY3) of additional skills training in anesthesia in Ontario, 31 responded to the survey. Of these, only the 27 physicians who continued to practise as GPAs in Canada were included in the analyses of CME use and barriers. Data concerning general comments were gathered from all 31 respondents.

The survey contained 2 multiple-part questions relating to CME. As described below, the questions pertaining to CME barriers and desired use of CME resources employed Numeric Rating Scales (NRS) ranging from 1 to 5, with these corresponding, anchoring descriptors: "not," "mild," "moderate," "very" and "extremely." The questions were validated by a research group in the Family Medicine North: NWO (Northwestern Ontario) Family Medicine Residency Program.

With respect to the maintenance of their anesthesia abilities, the participants were questioned about their use and desired use of the following CME resources: conferences, journal articles or textbooks, small group discussions, audiovisual tapes, shadowing other anesthetists, formal courses, Internet searches, chat lines or teleconferences, dinner presentations, computerized learning tools, and "other" (Fig. 1). They indicated whether they used these resources 0, 1–2, 3–4 or 5+ times per year.

Study participants were also questioned as to what extent (on an NRS of 1–5) the following factors acted as barriers to participation in CME for GPAs: cost of CME fees, cost of travel, loss of generated income, loss of personal time, lack of practice coverage, lack of CME availability, lack of personal interest, and CME directed at RCPSC-trained anesthetists instead of GPAs (Fig. 2). They used the 5-point NRS to indicate their desired use of these resources (assuming all resources could be made readily accessible) (Fig. 3).

Statistical analysis was performed using the SPSS/PC+ computer software package. The ANOVA (analysis of variance) technique was used to investigate the influence of practice population size on current and desired use of CME activities.

Results

Figure 1 indicates the current use of various CME resources. The most frequently employed CME resource was "journals or textbooks," the mean use of which was between 3–4 and 5+ times per year. The second most frequently used resource was "Internet searches," the mean use of which fell between these same ranges. All other resources were associated with a mean use of less than 1–2 times per year.

Based on mean responses, most factors were considered "mildly" to "moderately" barriers to CME participation (Fig. 2). Only "lack of interest" (in CME) rated between "not" a barrier and "mildly" a barrier. There were no additional barriers suggested under the category "other."

Figure 3 depicts the desired use of the various CME resources provided all barriers to participation could be removed. The mean response for desired increase in the use of conferences was between "moderately" and "very." All other resources ranked between "mildly" and "moderately," except for audiovisual tapes and chat lines or teleconferences, which had mean responses between "not" and "mildly."

In all figures, wherever n equals less than the total subpopulation analyzed, respondents have neglected to answer the specific question.

Analyzing current and desired use of CME according to size of practice community did not produce any statistically significant differences.

The opinions of all survey respondents who left a general comment (61% of 31) were tabulated. Sixteen percent of the 31 respondents wanted the formation of an association of GPAs. They cited reasons such as a need to clarify the role of GPAs, to help decide what cases to undertake, to set national standards, to bring recognition to GPAs, and to provide CME and practice audits. A separate 16% reiterated their desire for increased CME availability. Some felt that CME should be targeted toward GPAs and that CME participation would increase confidence among GPAs. Six percent indicated that anesthesia skills were easily forgotten if not maintained in practice. One respondent commented on the potential benefit of having RCPSC-trained anesthetists and GPAs working in the same centres.

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Discussion

The survey results confirm that recent graduates of additional skills programs in anesthesia are using many CME resources to maintain their anesthesia skills. CME resources are relatively accessible to GPAs.

One can infer that although GPAs are mostly using journals, textbooks and Internet searches for CME, they would prefer to increase their participation in conferences and small group workshops. The factors potentially preventing GPAs from increasing their use of these CME resources are no more than moderate barriers. Even those physicians in practice communities smaller than 10 000 did not perceive these factors to be more than moderate barriers (no statistical differences relative to their colleagues in larger communities). Nevertheless, the results imply that GPAs want some changes in the delivery of their CME training and that several factors are at least mild barriers to the implementation of these changes. These barriers related mostly to the availability of relevant CME and difficulty in taking time away from professional and personal responsibilities.

We acknowledge that, by nature of the small study size, our conclusions are based on data trends rather than statistically significant observations. Out of the 41 physicians comprising the study population, 10 did not respond. At least 3 of these nonresponders received the survey but chose not to return it. The survey may be biased toward a more positive outlook assuming that the nonresponders were reticent to admit a lack of participation in CME. However, since the questionnaires were confidential and coded for mail tracking only, the introduction of this type of bias is rendered less likely.

Another source of potential bias is that the study polled only the recent graduates (1995–2000) of PGY3 programs. Those GPAs who received tertiary care training prior to 1995, and those who never received it, would most likely express a greater desire for CME access.

When asked for general comments, 16% of all respondents (26% of those who left a comment) expressed a need for the formation of an association to represent GPAs.[1]

With the above results in mind, we propose the following suggestions to improve the quality and accessibility of CME to GPAs.

1. A national or provincial association should be formed to represent GPAs. This group could organize conferences and workshops that meet the particular educational needs of GPAs, thereby delivering more relevant CME material to them. We wish to encourage the SRPC, CFPC and CAS to work together toward the formation of a representative body for GPAs.
2. The aforementioned body might distribute journal articles and textbooks that address the specific educational needs of GPAs, since these are the most commonly employed CME formats at present. The development of computerized learning tools, such as simulated anesthesia cases, could also be a worthwhile contribution.
3. GPAs should receive adequate financial compensation for taking time away from their practices to engage in CME activities such as conferences, workshops, visits to tertiary centres or peer discussion groups.

4. GPAs should be supplied with adequate funding to arrange for locum anesthetists to cover their practices so that they are available to participate in CME events.
5. RCPSC-certified anesthetists should be adequately funded to periodically visit the centres where GPAs practise. This would allow specialists to observe GPAs in their own practice setting and to provide practical, hands-on instruction. These visiting specialists could share their skills and knowledge by leading workshops, small group discussions and presentations.

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