Successful Self-Directed Lifelong Learning in Medicine: A Conceptual Model Derived From Qualitative Analysis of a National Survey of Pediatric Residents

Reference:

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Tags

Clinical domain Scholar
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Background

If “self-directed lifelong learning” is meant to be more than a “motherhood statement” in medicine. If SDLL is an essential ingredient in the acquisition and maintenance of the competence of 21st century physicians, further studies are needed to identify the abilities and barriers relevant to this aspect of medical education.

Purpose

This study aimed to characterize the barriers and successes of US pediatric residents in attempting to execute required “ILPs” (individualized learning plans). This data would then inform a model for SDLL.
Type of paper

- Research: **Observational- Survey**

**Key Points on the Methods**

The authors used a standard modified-Dillman web survey of US pediatrics programs in 2008. Program Directors were initially recruited to participate (46/196 programs). Residents were then sent multiple online contacts and asked two open-ended questions about barriers and strategies related to ILPs. Responses were extracted and coded qualitatively by two reviewers, with iterative discussion until consensus. A third investigator performed an external validation of the data and the themes identified.

**Key Outcomes**

The response rate was 57%.

The authors identified 5 major barriers with SDLL via ILPs:
1. Difficulty with self-assessment and personality traits (eg procrastination);
2. Environmental factors such as workload, fatigue, schedules;
3. Competing demands, such as balancing professional duties;
4. Difficulty generating appropriate goals;
5. Difficulty making a plan and implementing it.

Furthermore, the authors defined 6 elements of an effective strategy to incorporate SDLL into medical learning:
1. Selecting important or relevant goals;
2. Ensuring goals are specific;
3. Ensuring goals are measurable to track progress and completion;
4. Ensuring accountability to complete the goals;
5. Ensuring goals are realistic; and
6. Ensuring there is a timeline.

Together, these strategies make up the "ISMART" model.

**Key Conclusions**

*The authors conclude*...that the ISMART model is applicable to medical learning and could assist many physicians with acquiring this domain of competency.

This paper is an example of simple design that generates data of some utility in medical education. While there is a body of literature on SDLL in and outside medicine, this is a domain of competence that generates considerable angst among medical educators and front-line clinicians alike (eg the CanMEDS Scholar Role).
The results are tempered by the inherent threats to the validity of survey and qualitative methods. This is a select sample of a select population and the data are self-reported from a population who describe having insight into having little insight, which is ironic. The coding process was adequately described, but some critics may assert that the results reflect the inherent perspectives of the investigators. Overall though, I think these concerns should not be overemphasized.

There is nothing Earth-shattering in this paper, and "SMART goals" are all the rage at every business training workshop in many organizations around the world. We should use an approach like this in our curricula.

**Spare Keys – other take home points for clinician educators**

However, given the repeated claims by naysayers that this important domain of physician ability cannot be taught, this paper is a helpful tool for medical educators to turn to.