

## Chapter 8

# Self-Directed Learning in Family Medicine

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### ABSTRACT

*Self-directed learners are able to recognize their learning needs, set their learning goals, identify the resources necessary to accomplish those goals, implement learning strategies, and evaluate the results of their efforts (Brockett & Hiemstra, 1991). Self-directedness is a skill that many adult learners possess. In an age when biomedical knowledge is increasing at a pace never before seen in human history, being a self-directed learner is not just a necessary skill, it is a critical one for family physicians. This chapter provides a brief overview of several self-directed learning models and the characteristics of self-directed learners, discusses self-directed learning in the context of continuing medical education, and provides an assessment of family physicians as self-directed learners.*

### INTRODUCTION

Perhaps more than in any other profession, being a lifelong learner is a vital part of being a family physician. Family physicians are specialty-trained primary care physicians (American Academy of Family Physicians, 2014). They are usually the first physician a person contacts when they have health concerns. Family physicians are required to demonstrate competence in professionalism, self-assessment and lifelong learning, cognitive expertise, and performance in clinical practice (American Board of Family Medicine, 2014). They must be able to synthesize and apply new clinical information to ensure that they are providing the most current evidence-based quality care to their patients (American Board of Family Medicine, 2014; Institute of Medicine, 2001).

Keeping current with clinical advances is not an easy endeavor. No other time in medical history has been filled with such overwhelming scientific and technological advances, with the greatest forces for change coming from the Internet and the field of medical informatics (Wentz, Jackson, Raichle, & Davis, 2003). The exponential rise in the discovery of new medical and scientific knowledge has created a staggering challenge for physicians: how to incorporate new data into clinical practice (Gillam et al., 2009).

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Patients expect their physicians to deliver the best care possible based upon the most current scientific evidence and they expect not to be injured by the care designed to help them (Committee on Quality of Health Care in America, 2001; Institute of Medicine, 2009). To provide quality care to their patients, physicians must commit to lifelong learning throughout their professional careers (ABIM Foundation, ACP–ASIM Foundation, & European Federation of Internal Medicine, 2002). Physicians must become the designers and executors of their own learning; they are the only ones who really know where there are gaps in their knowledge (Zaslove, 2004).

## **FRAMEWORK FOR LEARNING**

Constructivism asserts that learning is an active process that facilitates the construction of learning through personal experiences, dialogue, and social interactions (Merriam, Caffarella, & Baumgartner, 2007). Cognitive change and learning occur when a situation or an action does not produce the expected result and causes perturbation, that is, disturbance or disequilibrium, which then leads to a change that will eliminate the perturbation and create a new equilibrium (von Glasersfeld, 1989).

Constructivism had its origin in two philosophical roots; ontology, the nature of being, and epistemology, the origin, limits, foundation, and validity of knowledge (Oxford, 1997). The central elements linking these philosophies is the assumption that because no two people can have the same understanding of an experience, each actively constructs a personal version of reality and knowledge of the world (Cobb, 2000; Owen, 2002).

The idea of constructivism was first presented by the 18<sup>th</sup>-century Italian philosopher Vico (Cobb, 2000), whose central argument was that in order to know something, an individual had to build knowledge of it through experience. This argument was advanced by Kant, an 18<sup>th</sup>-century German idealist who put forth the notion that the world exists only in people's perceptions of it (as cited in Oxford, 1997). Kant laid the groundwork for Piaget, the most significant contributor to the theory of constructivism (as cited in Cobb, 2000).

Piaget used a systematic series of studies, not philosophical speculation, to understand how children think (as cited in Cobb, 2000). His characterization of intellectual development as an adaptive process of self-organization led to the theory that contradictions in reasoning lead children to reorganize their reasoning process in order to eliminate contradictions (as cited in Cobb, 2000). Constructivism interweaves assumptions about human nature, knowledge, and the meaning of learning, and it presents a view of how people, especially adults, make sense of their own reality (Candy, 1991; Merriam et al., 2007).

Candy (1991) cited Smock and von Glasersfeld's (1974) assertion that "a constructivist's epistemology... leads to the specific proposition that knowledge cannot be taught only learned (that is, construed), and therefore the constructivist view of learning – based on the principle that people construct their own reality – is congruent with the concept of self-direction" (p. 270).

Constructivism provides the foundation for the construction of knowledge as a constant activity focused on change and based upon a common, socially constructed understanding of the world (Candy, 1991). Physician learning is constant. Change in clinical practice depends on social interactions with colleagues. Through constructivism we can begin to understand self-directed learning (SDL) (Candy, 1991) and the need for family physicians to be self-directed.

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