Evidence-based medicine competences of general practice trainees and their learning styles: a survey study

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Abstract

Background: Evidence-based medicine (EBM) can be considered as a method for managing information in clinical practice and may be used in different ways in relation to the way persons acquire new information, as is their preferred learning style. To eventually adapt EBM education, in this study we aimed at giving an overview of the EBM competences (knowledge / skills, attitude and behaviour) of GP trainees and at assessing whether their idiosyncratic learning style and the above-mentioned EBM competences are related.

Methods: In 2008 we held a survey among 140 novice GP trainees in order to assess their EBM competences and their learning styles (Accommodator, Diverger, Assimilator, Converger; or a mixed learning styles group).

Results: The trainees’ EBM knowledge / skills (scale 0-15; mean 6.8±2.4) were adequate and their attitudes towards EBM (scale 0-100; mean 63±8.8) were positive. We found no relation with their learning styles (p=0.21; p=0.19). Of the trainees 40% used guidelines to answer clinical questions and 55% agreed that using guidelines is the best way to apply EBM in general practice. Trainees preferred evidence from summaries to evidence from single studies. There was no difference in medical decision-making or in EBM use (p=0.59) among the various learning styles.

Conclusions: We found no difference in EBM competences in the learning styles of GP trainees.
Background

Education in evidence-based medicine (EBM) has been adopted by all Dutch General Practice Training Institutes. EBM is the translation and application of results from clinical epidemiological studies into daily practice. A definition often used states that “EBM is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients, in combination with the physician’s clinical expertise, the patient’s condition and the preferences of the patient.”[1-4]

For the assessment of the actual behaviour of EBM no validated instruments are currently available.[5] Therefore -to assess the actual EBM behaviour- proxies are needed. Since both the concept of EBM and the learning style of an individual are methods for retrieving and using information, the learning style of an individual could be correlated to the EBM behaviour of that person.

For the teaching of EBM it is relevant to know whether there are differences between EBM competences of trainees (knowledge / skills, attitude and self-reported behaviour) and their idiosyncratic learning styles. There are four idiosyncratic learning styles and every one prefers one learning style in particular.[6] It is still unknown whether, in relation to information use, there is a relation between learning style and EBM. If so, the EBM competences could be predicted by the trainees’ learning styles, and education could be adapted accordingly. The potential relation between learning styles and EBM would explain how trainees use information and combine it with their own preferences and with the patients’ preferences in clinical decision-making. The aim of this study is to give an overview of the various EBM competences of GP trainees and to assess whether a relation exists between EBM competences and learning styles.
Methods

This is a cross-sectional survey study in 140 GP trainees who just started their Specialty Training. We collected data from September 2008 to May 2009.

Setting

In the Netherlands, the GP Specialty Training is a competency-based 3-year-course consisting of clinical practice training and educational tutorials, organised according to the CanMEDS competencies at training institutes.[7] EBM plays an important role and trainees are trained in the knowledge / skills required for translating evidence into clinical practice.[8,9]

Subjects

In this study we included first year GP trainees of GP training institutes of Leiden University, University of Groningen and AMC-University of Amsterdam within a month after the beginning of their Specialty Training and before the start of EBM education.

Study design

We simultaneously administered questionnaires regarding EBM competences within each training institute under exam conditions. We printed the definition of EBM (as given in the introduction) on top of each section of the questionnaire. The trainees filled in the learning style questionnaire at home. We notified the trainees that we would use the questionnaires for research purposes. All gave written informed consent. Trainees were free to refrain from participation. The study was approved by the heads of the training institutes and was performed in accordance with the Declaration of Helsinki.
**Questionnaires**

The trainees filled in five questionnaires:

*Personal Characteristics*: besides sex, age and year of graduation, we asked the trainees about the number of years of experience in research and practice.

*Learning Style*: learning style is measured on a bipolar perpendicular scale (Figure 1); Kolb et al. arranged the learning styles on two axes: active-theoretical (vertical), and reflective-pragmatic (horizontal).[6] Filling in a learning style questionnaire leads to a score on each axis (e.g. A5, R14, T19, P8). The triangles represent the four learning style quadrants: Accommodator, Diverger, Assimilator, and Converger. As the grey triangle has the largest surface (this is the quadrant of outcome), this person prefers an Assimilating style.[5,6,10] To determine the trainees’ learning styles, we used a Dutch translation of the Learning Style Questionnaire.[11] This questionnaire has been derived from Kolb’s learning theory and has been used in recent studies among GPs.[6,10] The questionnaire consists of 80 true/false questions.[11] We considered the quadrant of outcome as the preferred learning style of the trainee or – in case of multiple quadrants – we designated the trainee to a mixed group (if scores in ≥2 quadrants were equal).[6,11]

*Knowledge / skills*: to assess EBM knowledge / skills we used the two equivalent and interchangeable versions of the Berlin questionnaire.[12] Each version consists of 15 multiple-choice questions and is high in validity (content, discriminative and responsive) and reliability.[5] Each correct answer generates one point, with a minimum of 0 and a maximum of 15 points per questionnaire. Mean scores significantly differ between groups with varying EBM knowledge.[12] We translated and subsequently validated the Berlin questionnaire into Dutch using forward-backward
translation. In this study we used the Dutch translation. Results of the validation of the Dutch Berlin questionnaire are described elsewhere.[13]

**Attitude:** the attitude questionnaire, composed by McColl et al.[14], consists of 20 questions: seven with a visual analogue scale on general attitude towards EBM and 13 multiple-choice questions that assess understanding, attitude, alertness, the value of evidence in literature and EBM as a whole.[14] The questionnaire was translated into Dutch using forward-backward translation[15] and has been adjusted for Dutch GP trainees. As the McColl questionnaire was developed in 1998, we adapted the questions on databases to current standards (Clinical Evidence, Trip, Sumsearch, Cochrane Systematic Reviews, PubMed Systematic Reviews via Clinical Queries). The overall attitude score from the visual analogue scales was valued between 0-100. We inversed scales with opposite outcome measures (questions 6 and 7) for statistical comparison. We determined the mean attitude. Other questions focus on the current use of methods, motivating factors and barriers, use of databases, EBM education and knowledge of epidemiological terminology.[14]

**Self-reported behaviour:** the self-administered questionnaire on behaviour consists of five components, with a total of 2 open and 38 multiple-choice questions/statements about actual behaviour based on the “Conceptual Framework” of Straus et al.[16] and the five EBM steps as described by Dawes et al.[1] We asked trainees how often the EBM steps had been applied in the two weeks prior to the survey administration and to which extent EBM contributed to the trainees’ clinical decision-making. We asked: “How often have you translated a clinical problem into an answerable question during the last two weeks?” For the multiple-choice questions/statements we used a 5-point Likert scale so the trainees could indicate the intensity of their answer: 1=never, 2=seldom, 3=sometimes, 4=often, and 5=always.
**Statistical analysis**

For statistical analyses we used SPSS for Windows version 16.0. We described the characteristics of the participants and their overall scores on the questionnaires by means of proportions, means and standard deviations for continuous data that are normally distributed and medians and interquartile range (quartiles) for data that are not normally distributed. We analyzed all the questionnaires as described in the description of the original studies.[6,11,12,14] We compared differences in scores among subgroups for each learning style using the $\chi^2$ test for categorical data, ANOVA for continuous data that are normally distributed, and the Kruskal-Wallis test for data that are not normally distributed. We used a post hoc Bonferroni correction to deal with the bias of multiple testing.

We considered age,[17] sex, research experience and years since graduation[18] to be potential confounders in learning style as related to EBM knowledge / skills, and EBM attitude. The reason for assuming possible confounding relations between the above-mentioned variables has been drawn from research that states a relationship between sex, research experience and also time elapsed since graduation with knowledge[18] on the one hand and a relationship between learning style and knowledge in postgraduate education[19] on the other. More experienced persons (they graduated seven years earlier)[17] and women[19] were shown to have higher knowledge levels. Due to changes in EBM education, differences in trainees’ education may exist among trainees who graduated in different periods. We entered only factors with a p-value of $<$0.10 in the univariate analyses into the multivariate model. We considered a p-value of $<$0.05 statistically significant.
We performed multivariate linear regression analyses to assess factors influencing knowledge / skills, and attitude towards EBM. Only knowledge / skills, and attitude were taken into consideration because these two variables have one numeric measure of outcome. This does not apply to the self-reported clinical behaviour variable.
Results

Baseline characteristics

Of all 145 first year GP trainees, 140 trainees – response rate 97% – were present during the questionnaire administration: Amsterdam=73/75, Leiden=35/35 and Groningen=32/35. Of these, 138/140 filled in the learning style questionnaire. Reasons for not responding were either absence during the questionnaire administration[5] or not handing in the learning style questionnaire[2]. Questionnaires were matched using the respondent number. Table 1 illustrates the characteristics of the participants. Of the trainees, 83% had followed an additional course in evidence-based searching(EBS) and 38% had taken a course in critical appraisal. A complete EBM course had been taken by 12%. Course participation did not differ among groups with different preferred learning styles(Table 1). Of all GP trainees 34% were Assimilators, followed by Convergers(20%), Accommodators(19%), and Divergers(14%). Trainees with two or more learning styles fell within the mixed group(14%).

EBM knowledge / skills

During questionnaire administration, 52% filled in version A and 48% filled in version B of the Berlin Questionnaire. The mean knowledge / skills of GP trainees was 6.8±2.4. Divergers had the highest scores(7.7±2.1), respectively followed by Convergers(7.1±2.6), Accommodators(6.4±2.0) and Assimilators(6.4±2.4). ANCOVA corrected differences in levels of difficulty of the two versions of the knowledge / skills questionnaire(p=0.22). The results of the knowledge / skills were similar for the various learning styles.
**EBM attitude**

The overall attitude score, measured using the McColl questionnaire, points into a positive direction: the mean is 63±8.8 (0=very negative, 100=very positive). Trainees with idiosyncratic learning styles had identical mean scores regarding attitude towards EBM (p=0.19): Divergers scored a mean of 61±9.8, Accommodators 62±9.0, Assimilators 62±8.8, and Convergers 63±7.7.

**EBM self-reported behaviour: the EBM steps**

*Step 1: Ask*

Of the participants, 52% reported that they did not ask themselves answerable questions on clinical problems encountered in patient consultations in the two weeks prior to filling in the questionnaire. The remaining participants, however, did ask questions and subsequently answered those questions, although a majority of 67% did this in less than 50% of the clinical problems they encountered. The various learning styles show no difference in self-reported behaviour (p=0.45). (Data not shown)

*Step 2: Access*

Most trainees (99%) have Internet access at home or at work, although access to digital databases (not specified) is less common (90% at home and 93% at work). Table 2 shows where trainees seek information. Cochrane Systematic Reviews and/or PubMed Systematic Reviews were used by 52% in clinical decision-making. Synopses (Clinical Evidence, Trip Database and/or Sumsearch) were used by 3% in clinical decision-making. Of the trainees 73.5% often asked their GP trainers for advice. There is no difference in searching behaviour among trainees with their preferred learning style.
Trainees currently prefer to use guidelines (40%) but indicate that in the future they would prefer to use reviews plus guidelines (37%) or even prefer to learn how to fully apply EBM (38%). In practising EBM, all learning styles show comparable self-reported behaviour (p=0.59). For general practice in particular, 55% believes that the exclusive use of guidelines is the best way of working evidence-based. The assumption about the way in which EBM should be used in general practice differs among the learning styles (p=0.04): Divergers and Convergers feel that using guidelines plus systematic reviews is best for General Practice, while Accommodators and Assimilators think that using guidelines is sufficient.

Trainees generally do not necessarily record and file the answers they find when searching the literature: 14% regularly files questions and answers, 45% hardly ever does so and 41% never does. If questions and answers are to be filed, this is mostly done by writing down annotations and –sometimes- by using digital databases, saved files or printed results. No significant differences among the learning styles have been found (p=0.07).

Step 3: Appraise

When reading articles (Table 3), trainees focus on the abstract (on a 5-point Likert scale the median is 4; IQR 1-4), but hardly ever read the whole article (score 2;1-2). If the entire article is read, the Methods section or validity of the study is seldom appraised (score 1;1-3 and 1;1-2.75, respectively). Relevance is sometimes evaluated (score 3;1-4) and evidence from articles is applied to practice occasionally (score 2;1-4). Trainees with an Assimilating learning style score highest, though not significantly, in all appraisal sections.
**Step 4: Apply**

In making clinical decisions (Table 4), the evidence retrieved (score 4;3-4), the trainees’ clinical preferences (score 4;3-4), the trainers’ preferences (score 4;3-4), and the patient’s condition and prognosis (score 4;4-4 and 4;3-4) are taken into account. Patient’s preferences (score 3;3-4) are considered less often. Intuition frequently plays a role in decision-making (score 4;3-4). When outcomes are split according to learning styles, the use of intuition differs significantly (p=0.02): Accommodators and Convergers use their intuition in clinical decision-making more often. The evaluation of EBM performance was not assessed in this study.

**Multivariate analyses**

None of the possible confounders (age, sex, research experience and number of years since graduation) were significantly related to EBM knowledge / skills, and attitude towards EBM.
**Discussion**

In teaching EBM, it is necessary to have a clear idea of the EBM learners.[20] We hypothesized that the manner in which persons with their preferred learning styles acquire *new* knowledge / skills could be related to the retrieval and use of new evidence (i.e. evidence-based practice) by these persons as well, and therefore be used as a proxy for the assessment of EBM behaviour. Although we found some small differences in EBM competences among novice trainees with their own learning styles, the differences were not statistically significant. Learning style, as a way of obtaining knowledge / skills,[6,19] is not significantly related to the EBM competences of GP trainees and for this reason cannot be used to predict EBM behaviour of novice trainees. This does not imply that the learning style of trainees should not be taken into account when teaching the principles of EBM.

In measuring learning styles, some people suggest that differences in scores of both axes (active-theoretical score and reflective-pragmatic score) should be used to express learning style.[10] When using those numbers, however, the integration between the two dimensions is lost. That is why many studies on learning styles use a combination of these methods by subdividing the system into quadrants to express the learning style.[11,19] In doing so, both dimensions have been taken into account.

In this study we found that the use of EBM is limited to the application of practice guidelines. Knowledge / skills-levels of GP trainees are comparable to those of the course participants(postgraduate doctors) as described by Fritsche et al..[12] The attitude of GP trainees towards EBM is comparable to results found in other studies.[14,15] Attitude towards EBM is positive and therefore should function as a facilitator in teaching EBM. The knowledge / skills and attitude of GP trainees do not deviate from what we found in other studies.
Putting EBM into practice by trainees, however, is unsatisfying. Only half of the trainees ask questions during clinical practice. Moreover, answers to these questions are rarely sought and, if answers are sought, trainees most often look for GP guidelines or ask their trainers. Clinical trainers still seem to fulfil important roles as informants and the influence of their preferences is substantial.[21] There is a risk that the opinions of trainers are not evidence-based or based on outdated evidence. Preferences of the trainers may also discourage trainees to develop their own clinical preferences.

Negative influences of trainers could limit the use of EBM by trainees.[22] It is therefore important that clinical trainers are taught how to teach EBM in practice.

A point of interest is that the intuition of the trainees has a major influence on their decision-making. The frequent reliance on intuition when making clinical decisions is surprising, as solely relying on intuition is unlikely for novice physicians.[23] In experts who report to rely on their intuition, this intuition often involves applying internalised or integrated knowledge / skills,[24] but it is unclear in what way trainees rely on their intuition. It would therefore be interesting to investigate what trainees understand by ‘use of intuition’ and to find out whether decisions based on intuition are evidence-based.

There are some limitations to this study. The assessment of EBM could be discussed. We assessed EBM behaviour using a self-reported measure, which may have influenced the outcomes. Currently no valid measure is available for measuring the actual practice of EBM.[5] Because the trainees filled in the questionnaires anonymously, we created optimal conditions for the trainees to give reliable answers to the questions. The relations between learning style and EBM behaviour should be interpreted with caution until studies using the observation of actual clinical behaviour have been performed. Our choice for the Berlin Questionnaire was based on the fact
that this is the only multiple-choice test on EBM knowledge/skills which has been completely validated[5] and which measures the ability of applying knowledge in written clinical scenarios. Also, the trainees just started their training. However, all trainees have had earlier exposure to EBM in clinical practice and education.
Conclusions

Learning styles are not related to EBM competences of novice GP trainees. Among the trainees with idiosyncratic learning styles we observed no differences in levels of the EBM competences. Research in clinical practice needs to be done in order to understand how trainees handle information in practice and what kind of practical education could improve the actual EBM behaviour of GP trainees.
**Contributors (conform ICMJE)**

*S.E. Zwolsman* was the primary investigator of this study and 1) designed the study, acquired the data and analysed and interpreted the data 2) drafted the article and 3) approved the final version to be published.

*N. van Dijk* was the research supervisor of the study and 1) designed the study, assisted in data analysis and interpretation of the data; 2) revised the article critically for important intellectual content; and 3) approved the final version to be published.

*A.A.H. Verhoeven* 1) made substantial contributions to the acquisition of data; 2) revised the article critically for important intellectual content; and 3) approved the final version to be published.

*W. de Ruijter* 1) made substantial contributions to the acquisition of data; 2) revised the article critically for important intellectual content; and 3) approved the final version to be published.

*M. Wieringa-de Waard* was the clinical supervisor of the study and 1) designed the study and assisted in the acquisition and interpretation of data; 2) revised the article critically for important intellectual content; and 3) approved the final version to be published.

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EBM and learning style

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EBM and learning style

31.
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>All trainees</th>
<th>Accommodators</th>
<th>Divergers</th>
<th>Assimilators</th>
<th>Convergers</th>
<th>Mixed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of trainees</td>
<td>140</td>
<td>26</td>
<td>19</td>
<td>47</td>
<td>28</td>
<td>20</td>
</tr>
<tr>
<td>Women</td>
<td>% 71</td>
<td>69%</td>
<td>53%</td>
<td>77%</td>
<td>82%</td>
<td>60%</td>
</tr>
<tr>
<td>Men</td>
<td>% 29</td>
<td>31%</td>
<td>47%</td>
<td>23%</td>
<td>18%</td>
<td>40%</td>
</tr>
<tr>
<td>Age</td>
<td>mean ± SD</td>
<td>29.3 ± 3.3</td>
<td>28.8 ± 2.4</td>
<td>30.6 ± 4.1</td>
<td>29.6 ± 3.8</td>
<td>28.8 ± 2.2</td>
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<td>Years since graduation</td>
<td>median IQR</td>
<td>2 (1-3)</td>
<td>2 (2-3)</td>
<td>2 (1-3)</td>
<td>2 (1-3)</td>
<td>1 (0.25-2)</td>
</tr>
<tr>
<td>Research experience*</td>
<td>% 28</td>
<td>23%</td>
<td>16%</td>
<td>28%</td>
<td>33%</td>
<td>35%</td>
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<tr>
<td>Practice experience</td>
<td>% 90</td>
<td>92%</td>
<td>100%</td>
<td>92%</td>
<td>86%</td>
<td>80%</td>
</tr>
<tr>
<td>Course EBS*</td>
<td>% 83</td>
<td>77%</td>
<td>63%</td>
<td>89%</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>Course Critical Appraisal</td>
<td>% 38</td>
<td>24%</td>
<td>37%</td>
<td>41%</td>
<td>43%</td>
<td>40%</td>
</tr>
<tr>
<td>Course EBM*</td>
<td>% 12</td>
<td>4%</td>
<td>11%</td>
<td>20%</td>
<td>7%</td>
<td>10%</td>
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*Research experience and courses not included in Bachelor or Master Studies of Medical Science
**Table 2. Information-seeking behaviour of 140 Dutch GP trainees**

<table>
<thead>
<tr>
<th></th>
<th>Clinical Guidelines for GPs</th>
<th>Systematic Reviews</th>
<th>Medline/PubMed</th>
<th>Ask GP trainer</th>
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<tbody>
<tr>
<td>Never</td>
<td>-</td>
<td>40.9%</td>
<td>47.7%</td>
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<tr>
<td>Seldom</td>
<td>-</td>
<td>26.8%</td>
<td>29.2%</td>
<td>-</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2.2%</td>
<td>27.6%</td>
<td>16.9%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Often</td>
<td>51.4%</td>
<td>4.7%</td>
<td>6.2%</td>
<td>73.5%</td>
</tr>
<tr>
<td>Always</td>
<td>46.4%</td>
<td>-</td>
<td>-</td>
<td>11.0%</td>
</tr>
</tbody>
</table>
Table 3: Appraising articles* per learning style

<table>
<thead>
<tr>
<th></th>
<th>All trainees</th>
<th>Accommodators</th>
<th>Divergers</th>
<th>Assimilators</th>
<th>Convergers</th>
<th>Mixed</th>
<th>p-value</th>
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<td>Methodology</td>
<td>1 (1-3)</td>
<td>1 (1-3)</td>
<td>1 (1-2)</td>
<td>1 (1-3)</td>
<td>1 (1-2.25)</td>
<td>2 (1-3)</td>
<td>0.46</td>
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<tr>
<td>Validity</td>
<td>1 (1-2.75)</td>
<td>1 (1-2)</td>
<td>1 (1-2)</td>
<td>1 (1-3)</td>
<td>1 (1-2)</td>
<td>2 (1-3)</td>
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</tr>
<tr>
<td>Applicability</td>
<td>2 (1-4)</td>
<td>1 (1-3)</td>
<td>2 (1-3)</td>
<td>3 (1-4)</td>
<td>2 (1-3.25)</td>
<td>2 (1-4)</td>
<td>0.59</td>
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<td>Relevance</td>
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<td>3 (1-4)</td>
<td>2 (1-3)</td>
<td>3 (1-4)</td>
<td>2 (1-3.25)</td>
<td>2.5 (1-4)</td>
<td>0.91</td>
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*Median values and IQR for 1=never, 2=seldom, 3=sometimes, 4=often, 5=always
Table 4 Variables influencing the decision-making process in GP trainees per learning style

<table>
<thead>
<tr>
<th></th>
<th>All trainees</th>
<th>Accommodators</th>
<th>Divers</th>
<th>Assimilators</th>
<th>Convergers</th>
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<th>p-value</th>
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<tr>
<td>Evidence</td>
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<td>Trainees’ intuition</td>
<td>4 (3-4)</td>
<td>4 (3-4)</td>
<td>3 (3-4)</td>
<td>3 (3-4)</td>
<td>4 (4-4)</td>
<td>3 (3-4)</td>
<td>0.02</td>
</tr>
<tr>
<td>Trainees’ preferences</td>
<td>4 (3-4)</td>
<td>4 (4-4)</td>
<td>3.5 (3-4)</td>
<td>4 (3-4)</td>
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<td>3 (3-4)</td>
<td>0.49</td>
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<tr>
<td>Trainers’ preferences</td>
<td>4 (3-4)</td>
<td>4 (3.25-4)</td>
<td>4 (3.75-4)</td>
<td>4 (3-4)</td>
<td>4 (4-4)</td>
<td>4 (3-4)</td>
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<td>Patients’ preferences</td>
<td>3 (3-4)</td>
<td>3 (3-4)</td>
<td>3 (3-3.25)</td>
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<td>3 (2.25-4)</td>
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<td>Patients’ condition</td>
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<tr>
<td>Patients’ prognosis</td>
<td>4 (3-4)</td>
<td>4 (3-4)</td>
<td>4 (3-4)</td>
<td>4 (3-4)</td>
<td>4 (3-4)</td>
<td>4 (3-4)</td>
<td>0.87</td>
</tr>
</tbody>
</table>

*Median values and IQR for 1=never, 2=seldom, 3=sometimes, 4=often, 5=always
**Figure 1 Learning Style Quadrants**  
Freely adapted from Kolb & Kolb 2005

<table>
<thead>
<tr>
<th>Description per quadrant (Kolb &amp; Kolb 2005)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accommodator</strong></td>
<td>Learns by experience and relies more on people than on technical analyses for information. Has the tendency to act on intuition.</td>
</tr>
<tr>
<td><strong>Diverger</strong></td>
<td>Views situations from many angles and performs best in situations where ideas are generated. Likes to gather information.</td>
</tr>
<tr>
<td><strong>Assimilator</strong></td>
<td>Good at understanding (new) information and putting this into a framework. Interested in ideas and abstract concepts.</td>
</tr>
<tr>
<td><strong>Converger</strong></td>
<td>Good at finding and using practical solutions for ideas. Prefers to experiment.</td>
</tr>
</tbody>
</table>