PRACTICE OBSERVED

Practice Research

Practice educational meetings: a new influence in general practice

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For many years medical clubs and societies provided forums for professional discussion and education.^{1,2} In this century, and particularly since the second world war, medicine has become more specialised. Each specialty gradually developed its own educational activities. General practice was neglected initially, but since the College (later Royal College) of General Practitioners (RCGP) started in 1952 there has been a striking increase in educational activity in general practice. To start with continuing education projects concentrated mainly on established practitioners. Meetings were held in hospitals and later in postgraduate centres. This type of "refresher course" has continued with the support of Section 63 funds and clinical tutors. Then vocational training developed and more medical students experienced some general practice in their undergraduate course.

In our work as regional advisers in the East Anglian Faculty of the RCGP we have become aware of a further development—the practice educational meeting. This represents a third development, and one which may have an important effect on general practice and postgraduate activities. The aim of our study was to determine the prevalence and characteristics of practice educational meetings in East Anglia; to identify successful features; and to consider their function in the future. We have defined a practice educational meeting as a group of general practitioners who meet on a regular basis for educational purposes.

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Method and results

In 1979 we sent all practices in East Anglia a questionnaire:
(1) Do you hold any purely educational meetings in your practice or jointly with other practices?
(2) How did they start?
(3) How long have they been running?
(4) What factors are useful in keeping them going?
Data were requested about partnership size; whether the practice was urban or rural; the type of practice premises; whether the GPs had a common room; and whether they taught trainees, or medical students, or both. Practices which gave negative replies were asked whether such meetings had been held in the past but had been abandoned.
A second questionnaire was sent in 1980 to all practices, which had said that they held meetings, asking for more detailed information about how the group functioned. We visited several practices and attended their meetings.

FIRST QUESTIONNAIRE

There were 858 unrestricted principals in East Anglia in 1979 in 285 practices—an average of three doctors per practice. From the 285 practices we received 120 replies from all parts of the region to the first questionnaire. Fifty-eight held practice educational meetings and 68 did not.

The positive answers fell into two distinct categories depending on whether intrapactice or interpractice meetings were held. In the former the GPs organised meetings solely for and within their own practices. Thirty-five practices, comprising 149 doctors, came under this heading—an average of 4.3 doctors a practice. In the second category GPs from several practices attended the same meetings. There were eight such groups and 67 doctors attended from 23 practices.

All of the 68 negative replies were from individual practices with 209 doctors—an average of 3.1 per practice. Random sampling of 30 from the remaining 159 practices from whom no reply was received showed that one in five were holding a regular intrapactice educational meeting. We estimated, therefore, that a further 31 practices

or at least 93 individual doctors must be added to those already identified by the first questionnaire.
Thus, about 399 GPs (or 36%) in East Anglia are meeting regularly for educational purposes at 74 separate group meetings. Table I shows some characteristics of the practices that replied to the first questionnaire.

TABLE I—Characteristics of practices

	Practices with PMAs	Practices without PMAs
No. (%)	No. (%)	No. (%)
Urban or suburban practices	29 (51)	32 (47)
Rural	28 (47)	31 (46)
Health centre practice	16 (27)	19 (28)
Private medical premises	10 (17)	10 (15)
Students attached	27 (46)	17 (25)
Total	55 (100)	68 (100)

The most striking feature is the strong association between teaching trainees, or medical students, or both, and the existence of practice educational meetings. Geographical location made little difference except that on further analysis most of the interpractice meetings were 10 miles or more from a postgraduate centre.

The most frequent reason given in 47 replies for starting meetings were teaching activities, especially the arrival of a trainee (28%), and a mutual need for professional discussion (30%). Our impression of the meetings as a recent development is confirmed by the survey and shown in the figure.

Five practices, which submitted negative replies, indicated that they had previously held meetings, but that these had been discontinued. Only one had ever been a training practice. Several practices not holding meetings expressed an interest in starting them.

SECOND QUESTIONNAIRE

We again divided the answers into intrapactice and interpractice educational meetings.

Intrapactice meetings—In the first category information was received from 23 groups (104 doctors). In virtually all the groups all the partners attended the meetings, and trainees attended 80% of them. Other staff and students attended some of the meetings regularly and most meetings occasionally. Sometimes hospital specialists attended—in one group regularly. Most groups were organised on a mutual basis, but sometimes an individual partner took responsibility. In only two cases was this the senior partner. Just under half had a chairman; this task was undertaken regularly in some cases, or in rotation. Occasionally a partner acted as secretary.

The 23 groups gave the following aims of their meetings: continuing education of partners (21); teaching trainees (19); support for participants (15); teaching students (14); education of employed staff (14); education of attached staff (12); liaison with other doctors and health professionals (12); and education of patients (five). Meetings were held weekly or more often in 95% of the practices, and most usually in the practice premises (table II). Table III shows the content of the meetings and table IV the variety of methods used. We found that one practice formally assessed meetings and 12 did so informally.

TABLE II—Process of practice educational meetings

	Frequency	Propagated
Weekly or more often	15	15
Weekly to monthly	6	6
Monthly to more than monthly	2	2
Site		
Practice premises	15	15
Health centre	6	6
Homes	2	2

TABLE III—Content of practice educational meetings

	Frequency	Regularly	Sometimes	Never
Clinical management of cases	15	10	0	0
Review of medical knowledge and skills	15	10	0	0
Advances in clinical medicine	15	10	0	0
Practice organisation	10	10	0	0
Explaining doctor-patient relationships	3	3	0	0
Developments in other subjects—for example, social work, physiotherapy, educational technology	3	14	0	14

TABLE IV—Methods used in practice educational meetings*

	Frequency	Regularly	Sometimes	Never
Clinical case discussion	15	10	0	0
Random case discussion	10	10	0	0
Talks or lectures	10	10	0	0
Audio, screening, research programme	4	0	0	0
Slides	10	10	0	0
Film, video	1	0	0	0
Journal review	0	0	0	0
Books	0	0	0	0

*No information was included in one questionnaire.

We wanted to find out what doctors thought were the important factors in keeping groups going and the features they considered particularly valuable. The replies reflected the enthusiasm and variety of activities associated with the meetings. They reinforced the information already recorded and some mentioned the use of projects and modified essay questions. The following factors were mentioned most frequently: regularity and organisation of meetings combined with informality; social contact; practice review including random case analysis; clinical discussion; and presence of a trainee.

There was one request for circulation of tapes and slides and one for help with speakers' travelling expenses. Some practices stated categorically that no help was needed. There was, however, an interest in an exchange of ideas between groups.

Interpractice meetings—From the eight groups (67 doctors) we obtained knowledge of three kinds of meeting.

(1) Groups similar in style to the "within practice" groups but attended by two or three practices.
(2) Young practitioners: three groups of young practitioners most of whom had recently completed their vocational training. These groups seemed to fill a void for younger doctors who had been accustomed to meet regularly with their peers. These doctors were mostly from practices where regular meetings were not held.
(3) Clinical societies: two small clinical societies had formed mainly because of distance from postgraduate centres. The usual format was

talks by consultants followed by discussion. Though carefully organised these meetings seemed to gain from informality and a free exchange of comment.

Examples of two practice educational meetings

One interpractice educational meeting took the form of a weekly working lunch. Sometimes this was a random case analysis as a starting point for clinical discussion. Every other week two doctors chose a project—for example, audit, quiz, discussion, consultation, or subject review.

The following is an extract from a report by IGT after he had visited a practice to discuss the project.

"The meetings are held twice a week and were started because of the trainee in the practice, but the main gainers from these meetings were the partners themselves. When the trainee left, the meetings stopped for a while but all the partners realised that this was a real loss for them. They have now been restarted as a permanent feature of the practice week. The organisation is informal, but one of the partners acts as a convenor and makes sure that a programme is decided on in advance. A variety of themes and educational methods are used at the meetings.

"An interesting experiment has just been completed in which the group used an outside group leader to help run meetings exploring the psychological aspects of general practice. These meetings started by an exploration of the doctors' relationships in which emotional problems arose. During the discussion a valuable exchange of views and knowledge occurred about the different partners' expectations of their work and of each other. All of them now feel that their future meetings are going to be much more rewarding because of the relationships that were established through this group work."

Discussion

General practice has suffered from isolation in the past unless the doctor has made efforts to meet and discuss his work with colleagues in general and hospital practice. Though there has been a growth in partnerships and group practices, arrangements have mostly been business ones and were little concerned with maintaining and improving the standard of practice. With the need to maintain good relations between partners and difference about criticising another's work the educational potential of group practice has not been fully realised.

The effectiveness of continuing education depends on the doctor accepting new information and relating it to his own practice. Any ways in which day-to-day work may be used as the basis for continuing education must help the process of change. The Alment Report stated, "The essence of continuing education is a critical approach to day-to-day work: the value of this is enhanced by the free discussion among colleagues of experience thus gained. . . . In our view it is a necessary part of the doctor's responsibility to assist his work regularly in association with his colleagues." Pickering said, "Much of the continuing learning process is derived from the doctor's own experience of practice. . . . The free exchange of ideas and experience among doctors at formal and informal discussion is a valuable medium for their continuing education."

Our survey shows that there has been a rapid growth of practice educational meetings during the past 10 years, and may seem to fulfil the criteria referred to above. Though the meetings have often been stimulated by the presence of a trainee, they have met a need for an exchange of views at a regular, often weekly, meeting—something more than the casual hurried chat over a cup of coffee. Regular attendance and the contribution of all participants to planning and leading the discussion adds to variety and sense of purpose. The meetings are supportive to their members while allowing critical discussion in a non-threatening environment. The groups could become too cosy, though regular regular medical audit, discussion of new material from lectures or journals, outside visitors, and regular or occasional meetings with other practices should help to prevent this danger. Moreover, trainees and students who have been brought up in an environment where criticism and

questioning is the accepted norm should spread the idea more widely.

The three young-practitioner groups in the region were formed largely to continue activities begun during vocational training. Anecdotal evidence suggests that when educational meetings are flourishing in a practice the needs of recently trained GPs are adequately met and there is less need for them to attend a young-practitioner group. The practice educational meeting thus provides a valuable link between the various stages of general practice education.

Meetings have started on the initiative of the practices concerned; help from outside would be regarded as interference. An exchange of ideas between educational groups is, however, likely to be acceptable. Ultimately, the effectiveness of any education depends on motivation and thus personal initiative is welcome and should be nurtured sensitively as possible. The relation of the practice educational meeting to meetings held at postgraduate centres is important. Both meetings have a common aim fulfilling different but complementary needs.

What positive steps could be taken to increase practice educational meetings? We hope that our findings will act as a stimulus. Some existing groups would probably be willing to act as "catalysts"; a list of groups could be held by the regional adviser in general practice and be available on request.

We foresee the practice educational meeting as becoming an integral part of the life of every practice—making a contribution to the education of students, staff, and trainees as well as to the continuing education of the partners.

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ONE HUNDRED YEARS AGO It has fallen to my lot during the past seven years to treat five cases of placenta previa, with three maternal deaths and three infantile deaths. The treatment in each case was the same—viz, manual dilatation and delivery by turning as soon as possible. All the cases were in multiparae. My first case recovered without a bad symptom. My second case, within an hour of delivery she was pulseless, and had anaemic convulsions; but, thanks to the subcutaneous injection of ether, application of hot water to the head, and injection of hot water per vaginam, she recovered. My fifth case died three hours and a half after confinement, apparently from shock, the pulse becoming excessively quick, and the patient dying within an hour.

My object in transmitting the above cases is to ventilate the subject of placenta previa, and, if possible, to obtain an expression of opinion as to treatment from those who make the study and the obstetric specialty. I remember, when a pupil, that my master had the same ill luck that I have had in the treatment of such cases. Nothing can be more distressing to a friend than to see a woman die, and to see a woman dying, and not be able to prevent her demise. Transfusion is not always practicable in the country. J. HENRY ASHWORTH, MRCP, Bourn. (*British Medical Journal*, 1981.)

Organising a Practice

Practitioners' progress

K G DICKINSON

Consultations, visits, and rotas

As "progress" has come our way over the years to the style and content of our consultations and visits have altered good general practice. The specific patterns of work that general practitioners do defy simple recording. Howie has noted over the years the fall in home visits and also the decrease in consultations in the consulting room. As he pointed out, there are wide variations between doctors. What is hard work for one would be regarded as easy by another. The family doctor image remains but is somewhat tarnished. We have lost some of our dedication, believing that we can revive it well at our patients. The division between on and off duty is now more clear-cut than ever before. (I write this on a wet Sunday morning off duty and "safe" almost from intrusion from the practice.) How different from the patterns of 30 years ago when doctors were mainly single-handed, or practised in small groups, and co-operation tended to be minimal because of the financial rivalry that then existed.

Percentage of general practitioners working alone or in groups (adapted from report of DHSS)

Groups of general practitioners	1951	1957	1963	1969	1976
Single-handed	43	34	25	21	17
2 partners	34	30	32	28	24
3 partners	10	10	10	10	10
4 partners	1	1	1	1	1
5 partners	1	1	1	1	1
6 partners	1	1	1	1	1
Total	100	100	100	100	100

By the 'sixties and certainly by 1970 most general practitioners who worked in reasonably close proximity with their neighbours had formed rota systems that initially covered some evenings, occasional weekends, and maybe a half-day a week. Depending on their friendship, co-operation, and need such rotas might also cover holidays, illness, and, later still, postgraduate study. Such a system obviously worked best with a group practising in the same building, and it was advantages such as these that tended to bring doctors together as they came to realise what could be gained by close working relationships. Single-handed practice has steadily declined in the large urban areas (table) and, I imagine, be a rarity indeed by the end of the century. A pity, for

the man or woman working alone can truly show an individuality unfettered by the view of more traditional colleagues. In such practices bonds between the patient and the doctor are necessarily stronger than in group practice, where constant attendance by the doctor has diminished. In its stead we find that a multi-purpose view of medicine has developed. Many doctors now have outside medical interests, which increase the practice income to a great extent.

There was a time when a general practitioner took it for granted and was expected by his patients to do morning and evening surgery each day except Sunday and possibly one-half day a week. The hours of surgery attendance were rigidly noted by the official paymaster, the Executive Council, and any request to change hours had to be submitted officially and would be rejected if thought by the appropriate committee to be jeopardising the interests of the community which the practice served. A change of evening surgery time from 5.30 pm-7.30 pm to 5.0 pm-7.0 pm was a matter for earnest discussion, therefore, at many levels. In those days it would have been a foolhardy doctor who tried to adopt a 4.0 pm-6.30 pm system once or twice a week. His family might welcome him home early, but he would lose popularity locally and would be penalised by a series of demands for evening visits. "It can't wait doctor." The chore of a long evening surgery at the end of a long day is still there at times, but at least the inevitability of it has now gone. Some general practitioners were, and still are, proud of their ability to get through large numbers of patients in a short time. The pattern of "instant diagnosis" may not be so frequent but the need to make a rapid decision exemplifies the good general practitioner under pressure.

Appointment systems were virtually unknown in the 'sixties but became increasingly popular so that by the 'seventies the casual "walk-in" surgery had become archaic. A survey¹ in 1951-2 showed that only 2% of the practices visited used an appointment system. In 1976 over 70% of practices were using the Lloyd Hamel Loose Leaf Appointment Diary,² and a further unknown percentage will be running appointments using different systems. The change has undoubtedly helped the doctor. He knows roughly what his work load is for any particular session and can extend or shorten it at will. He can decide the way that time is to be allocated per patient and make special arrangements for particular patients if he so wishes. A well-run, sympathetically-operated, flexible appointment system is also a definite gain for the patients. A rigid system that does not allow for late patients, the variability of the doctors' working habits, and the inevitable odd emergency is a disaster and has rightly led to attack by patients.

Doctors working in groups, in either self-owned or health centre premises, and using an appointment system has led to a less personalised service. No longer is "the" doctor always there. He may be playing golf, but more likely he is doing a session at the local hospital, attending an outpatients' home, visiting a factory, or regularly giving dental anaesthetics. The surgery sessions are covered by his colleagues whose outside interests will

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