PRACTICE OBSERVED

The Course Organiser

Seven years of running a half-day release course

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For seven years I was responsible for running a half-day release course for trainees in their general practice year. As time went by certain principles acquired overriding importance and dictated the structure of the courses. The first was that the activity to be encouraged was learning, rather than teaching. This means that the trainee becomes actively concerned in the educational process, and that the role of the group leader is to monitor and supervise the learning rather than to do the teaching—which for too many means to do the talking.

The second principle, which stems directly from the active participation of the learner, is that the material to be learned or the topics covered must be relevant to the learner. Trainees differ enormously in their knowledge, experience, and attitudes, and no two groups are ever the same. This means that each year the programme will be different, although important areas will obviously recur.

The third self-evident, but neglected, principle is that small group learning should be used for those areas where it is most efficient—namely, for learning about attitudes and behaviour. Many day-release courses seem to consist of a series of lectures, which however competent sadly understate the potential for learning that is inherent in small groups. Such lectures also undermine the small group process and encourage a didactic, one-way relationship between lecturer and trainee.

The final, and probably most important, principle is that such learning should be fun; an activity that is enjoyed is looked forward to with relish, prepared for with eager anticipation, and looked back on with pleasure—all these reinforcing the learning process. Fun by itself, of course, is not enough; but I do not share the view common in some quarters that learning proceeds only through pain.

The actual organisation of the course begins with the notification of the trainers and the selection of the members.

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Trainers like to know the "style" of the course that their trainee will be on, and efficient communication at this stage prevents misunderstandings later on. A suitably worded questionnaire for the trainee was included with the covering letter, and both trainer and trainee were asked to indicate that attendance will be regular and punctual. Group meetings were always held in the afternoon, weekly during term time, and trainees were discouraged from rushing off before the end to an evening surgery. Ideally the group should have no more than about 12 trainees, and whenever possible preference was given to those trainees who were at roughly the same stage in their training year. After the course had been running a few weeks no new entrants were allowed, thus preserving the homogeneity of the group. On the whole these community-based day-release courses were not seen as strictly relevant to the experience of hospital-based trainees, who should indeed be (but often are not) attending their own course.

The first meeting is the most critical and the one that causes the most anxiety for the organiser. The trainees are welcomed and encouraged to be on first name terms. The general structure of the course is outlined and their participation—indeed their running of the course—emphasised. Each session begins with lunch provided by each trainee in turn (including the organiser). The purpose is to break down barriers and restraints quickly between the group members, to facilitate a prompt start, and to enjoy good food. This was very popular and undoubtedly promoted the development of the group process. The first term requires more structure from the organiser, and I tentatively suggest the following plan.

Each session can begin with a review of the previous session and of the lessons learnt. Trainees would be asked to give examples of how they applied such lessons in their day-to-day work. This would be followed by readings from the "green book," as it was in those days—the *British National Formulary*. Each week one trainee in turn would briefly discuss the use of drugs in one section of the *Formulary*. The rest of the time would be spent in discussing the selected topic of the week (presented by each trainee in turn), and after a break for tea problem cases or random case analysis would be discussed. Trainees were

week in turn. Similar (but differing) rotas were constructed for providing lunch and discussing the *National Formulary*. I offered to provide whatever resources I could in the preparation of their topic and encouraged them to discuss the topics with their trainer. Speakers from outside were generally discouraged in the first term, the overriding aim of which is to construct the teaching tool—namely, a functioning group of peers. The second and third terms consisted of a broadly similar format, but included more "outsiders" and visits to relevant institutions and practices. As the group matures the leader should withdraw more and more. In the third term some of my groups managed without a leader. A group of what are now seasoned general practice principals from one cohort still meets irregularly.

Looking back my overriding impression is of the strength of the small group both in providing support and in facilitating learning. Unfortunately, evaluation of such learning is a primitive art (and one that was often resisted by the trainees), but on several occasions I witnessed important changes in attitude. Above all, the trainees learned to work in a group and as a group, with all that that entails in terms of sensitivity to others and understanding of themselves. One of the organiser's tasks is to encourage interaction in the group—the knowledge of group behaviour gained in this way is of undoubted value to the future general practitioner whose daily work is with that most fundamental of social units, the family.

For the organiser, running groups in this way is both exciting and stressful. He has to remain flexible and be prepared for all kinds of hitches. He has to manage the intensity of feeling that is sometimes generated within the group and to cope with the curiosity, often amounting to hostility, from those outside. In the end, however, he is the main beneficiary, for he learns most of all.

Practising Prevention

Smoking

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Smoking is the single greatest cause of disease and early death in Britain, and the World Health Organisation has stated that control of tobacco smoking could do more good than any other single action in preventive medicine. At least 50 000 and possibly twice this number of deaths each year in Britain are attributable to it, with an average loss of life of about 10 years. It accounts for about 90% of deaths from lung cancer, 75% of deaths from chronic bronchitis, and 25% of those from coronary heart disease in men under the age of 65 years. But because coronary heart disease is much commoner than lung cancer the actual number of deaths from this cause attributable to smoking is greater than the number of deaths from lung cancer. Moreover, the risk of coronary heart disease attributable to smoking is greater in the younger age group, so that a man under 45 years who smokes 25

or more cigarettes a day may have a 15 times greater risk of dying from a heart attack than if he were a non-smoker.

Advice to stop smoking is the most important help the doctor can offer the patient who has bronchitis, ischaemic heart disease, or some intermittent claudication or peripheral vascular disease, on health may be summarised as follows:

—Smoking causes many diseases, notably lung cancer, chronic bronchitis and emphysema, coronary heart disease and peripheral arterial disease.

—Furthermore, in pregnant women it has harmful effects on the fetus.

—Children are harmed by parental smoking—directly and by encouragement to smoke themselves.

—Passive inhalation of tobacco smoke by non-smokers is harmful to them.

—The risk of harmful effects from smoking is reduced by stopping smoking, and the benefits occur remarkably quickly in the case of coronary heart disease.

—The switch from plain to filter cigarettes has reduced the risk of lung cancer but not the risk of heart disease (which it may even have increased).

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Prevalence of smoking

There have been big changes in smoking in Britain over the past 30 years, particularly during the past decade. In the early 1950s almost two-thirds of men (and two-fifths of women) were regular cigarette smokers, while now just over 40% of men and just under 40% of women smoke. This decline in smoking is largely due to changes in the social class pattern of the habit. In 1960 smoking in men was more or less equally common in all social classes, but by 1972 the proportion of social class V who smoked was almost double that of social class I and now it is almost treble. Translation of this behavioural change among professionals to the population as a whole is the most important challenge facing preventive medicine. Doctors have been particularly successful in stopping smoking, 80% now being non-smokers (and 40% ex-smokers), and this enhances their potential to help others to stop.

There have also been changes in the type of cigarettes smoked. Over 90% of cigarettes now sold are filtered, and there has been a substantial reduction in the tar yield of both plain and filter cigarettes. But while this has reduced the carcinogenic effect of smoking there is no evidence that filters reduce the risk of coronary heart disease and there is even some suggestion that they may be worse in this respect than plain cigarettes. It also appears that smokers adjust their smoking habits to compensate for "weaker" cigarettes—a change to lower tar cigarettes being accompanied by more intense inhalation.

Stopping smoking—the role of the GP

Surveys show that most smokers—at least 70%—want to stop smoking. Eighty per cent claim that they would stop if advised to do so by their doctors, but only 10% say that they have ever been advised to do so, despite the fact that most doctors feel this an important task.¹ Each general practitioner has on his list on average at least 600 patients who smoke, two-thirds of whom smoked him at least once a year. The scope for offering help is therefore considerable, especially as advice by the GP backed up with a leaflet and follow-up has been shown to help patients to stop smoking. In a controlled trial Russell *et al* showed that such advice as part of a routine consultation in general practice resulted in about 5% of smokers giving up—representing about 25 ex-smokers a year for the average GP (or over half a million for all 25 000 GPs) (figure).²

The role of the GP in helping patients to stop smoking is therefore to: (a) ask about and record patients' smoking habits; (b) offer advice when requested; (c) seek an opportunity to offer advice in any consultation; (d) advise on how to stop; (e) supplement advice with appropriate literature; (f) follow up patients' attempts to stop; (g) set a good example by not smoking—at least in front of patients.

The advice offered should be in the context of the presenting medical problem whenever possible and should include: (a) information about the health hazards of smoking; (b) emphasis on the benefits of stopping smoking; (c) a reminder that there

is no panacea and that motivation is important; (d) a plan to include a target date for stopping; (e) advice on ways to prepare for stopping; (f) advice on how to cope with difficulties after stopping; (g) a warning about the dangers of relapse; (h) explanation of the need for follow-up.

GUS Kit

The GUS Kit is a literature pack that has been specially designed for GPs to help their patients to give up smoking. Produced by Action on Smoking and Health (ASH) in conjunction with the Health Education Council (HEC) and the Scottish Health Education Group (SHEG), it has been circulated to all GPs. The kit consists of posters, a guide for GPs, notes for receptionists, and a patient booklet. The most important feature is the patient booklet, which is designed to look like and be used like a National Health Service prescription, so that, like the latter, it may be made personal to the particular patient.

Nicotine chewing gum

Nicotine chewing gum has recently become available on prescription only (but not on the NHS), and its usefulness is being evaluated. There are two ways in which it may help: by providing substitute oral activity and by relieving withdrawal symptoms owing to nicotine dependence. Careful attention needs to be paid to instructions on how to use the gum (a useful leaflet is available from the manufacturers of Nicorette) and its use probably needs to be continued for about three months. For most smokers the 2 mg (rather than the 4 mg) strength seems appropriate.

The results of early studies have suggested that it is more effective than other methods of helping people to stop smoking. It may be especially useful for those smokers who have tried other methods without success and who may be presumed to be dependent on nicotine. Use of the gum may enable such smokers to tackle smoking in two stages—first the habit and then the nicotine dependence.

Other methods

Many other techniques such as hypnosis, acupuncture, aversion therapy, rapid smoking, and group therapy have been tried.³ Some individuals benefit from such approaches, but there is no scientific evidence that any one of these methods is better than another—or than firm personal advice from the GP (backed up with a booklet).

Action required

Ask about smoking and record it in notes routinely. Inform smokers of the risk of continuing and the benefits of stopping. Offer advice on how to stop and help patients in doing so. Set a good example. Prohibit smoking on surgery or health centre premises.

Pathology of Partnerships

The new partner

TYRO

It is a cliché, nevertheless true, that the new partner in general practice experiences the same anxieties as the new partner in marriage. The commitment to a potentially life-long relationship should encourage both parties to minimise the element left to chance. In my case the final decision to enter partnership was based on nothing more than the mutual intuition that we could establish contented working relationships. I was therefore fortunate in finding partners who understood my needs. The difficulties that did arise were largely due to my lack of a sense of practice history and to the effects of the loss of a paternalistic trainer.

It was soon apparent that even for a group of six general practitioners we contain an extraordinary spectrum of personality and interest, ranging from the academic and research-minded to the earthy and pragmatic. To the astute the stability of the practice might therefore have been called into question. It was much later that I discovered that the practice has withstood several upheavals in which factions have formed and divided. Soon after my arrival I was gratified, if puzzled, to find my opinions a matter for serious consideration and my support for issues in the practice a matter for serious competition. The effects were twofold. Firstly, that I might easily have compounded any intrapersonal feuds had it not been for a facility to try to agree with everybody. Apart from an entirely personal confusion brought about by my inability to remember what I had agreed with whom, I flatter myself that this vacillation had the net effect of cementing some of the cracks in the partnership. Secondly, encouraged by these attentions I prematurely suggested some changes in the practice. It says much for the partners' tolerance that the less bizarre have been adopted and others have, fortunately, passed quietly into obscurity.

In particular, my naive enthusiasm had its effect on my patients. I did not have to take over a ready-made list on my arrival in the practice, so that those regulars who did appear in my surgeries had deserved (or were encouraged to desert?) my partners. In those heady days I invariably, and unfortunately openly, committed myself to a series of hopeless objectives

which two years later I am still trying to disentangle. In future I shall view "Volume Two" on the front of the notes in the same light as a warning not to reverse up the motorway.

The continuity of care that general practice offers is one of its great attractions. I have since learnt that it is a double-edged sword that is wielded with equal effectiveness by patient and doctor alike.

As a trainee I had been privileged and sheltered, able to share my anxieties with my trainer. I expected to assume greater responsibilities as a principal, nevertheless I was surprised by the degree of isolation that I experienced even in a group practice. We hold regular formal and informal meetings, and frequently refer patients and problems to each other. Despite this there is still a reluctance to confide in the colleague. A particularly intractable patient. I asked her why she kept coming back when, as she said, "Nobody do anything for me."

"You all seem so worried about me," she replied. Perhaps we should discuss our failures as well as our successes. Although a newcomer, I soon had to confront the problems brought by familiarity, not the sort that breeds contempt but the sort that can blunt even the critical faculties of a new partner who is still oscillating between enthusiasm and introspection. Simple fatigue at the end of a long day after a night on call does not help any of us to stay alert when seeing a succession of common problems. It is therefore all the more important that we should be open to and prepared to accept constructive criticism.

The senior partner will soon be leaving. Initially we looked nervously at several applicants who had heard about the post informally. As the supply became exhausted to our confidence in our performance as interviewers—to such an extent that we have now decided not to seek a replacement.

New partners soon become old partners; anxiety does not discriminate.