PRACTICE OBSERVED

Continuing Education

It's come a long way

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Continuing education in general practice as a formal programme of activities has only existed since the 1950s and, whatever the inadequacies now, has come an astonishingly long way since then. The academic and financial status of general practitioners was perhaps at its lowest ebb then.

In 1950 the BMA first supported the idea of a three year vocational training programme in the Cohen committee report. The College of General Practitioners was formed in 1952, but it was not until 1965 that the college published *Special Vocational Training for General Practice*, which was submitted to the Royal Commission on Medical Education and endorsed in 1968. Postgraduate training for general practitioners became a legal requirement in February 1981 for entry into practice. Gradual and systematic change led to vocational training becoming voluntarily enshrined in legislation. Certainly the impetus for continuing education for practitioners has had a more erratic and less universally accepted passage. Indeed, the mere suggestion of further requirements of postgraduate training would raise protests through the profession. In a society where consumers are increasingly aware, however, of the need for continuing education, the onus on the profession to disseminate higher standards and better accountability should be encouraging a greater provision for and uptake of continuing education.

Continuing education has existed through an organised programme of postgraduate activities since the late 1960s. The Nuffield conference of 1961 led to the proliferation of postgraduate medical centres in Britain.¹ It is interesting that the relative merits of a programme for postgraduate general practitioners was not thought to be sufficiently important to include in the programme of such a major symposium. When formal postgraduate sessions on general practice began to appear at

postgraduate medical centres it was therefore initially under the auspices of hospital clinicians. These clinical tutors were responsible for the content and format of luncheon meetings and courses that the centres ran for general practitioners. Since then, there has been a gradual increase in demand and uptake of courses, which have become more orientated towards primary care. Responsibility for running such programmes has largely devolved on general practitioners with the appointment of general practitioner tutors over the past 10 years.

This proliferation of activities has resulted in a bewildering choice of luncheon meetings, day release courses, and longer courses which are available to practitioners. The fact remains, however, that uptake of formal postgraduate education is haphazard and idiosyncratic. The findings of the excellent study by the Royal College of General Practitioners of the northern region of 1976 seem to be observed at most centres.² This study showed that only 4% of general practitioners had not attended a postgraduate event during a single year, and the remainder had attended on average eight sessions (equivalent to 24 luncheon meetings), six of which were at their local centre. Attendees fell into extremes, however, as occasional paper 11 showed, with one in four spending fewer than 15 hours (five sessions) a year and one in 10 spending 63 hours (21 sessions) a year.³

It is easy to ascribe reasons to why a percentage of general practitioners avoid formal postgraduate education. Perhaps they don't like formal courses, have more pressing commitments, organise their own further training, or just can't be bothered. What is irrefutable, however, is that a single measure is likely to change attitudes dramatically. Cynics might suggest that linking seniority payments to attendance at section 63 functions might improve attendance. Indeed, there were great rises in attendance (108%) at section 63 events between 1962 and 1977 when the seniority payments were linked to attendance.⁴ This rise, however, also roughly parallels the increase in the number of postgraduate medical centres and therefore the availability of courses. Besides, attendance at courses does not guarantee willingness to learn. There remains a small financial inducement to section 63 attendance with the postgraduate training grant.

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taking your performance for granted provides irrefutable data. Should there be inadequacies in your accessibility, therapeutics, prophylaxis, or records, for example, being aware of these deficiencies will inevitably tighten procedures. The question of a political stick to force audit on us is truly irrelevant, since external evaluation can be nothing more than superficial. Access to individual performance can only really work through the individual, since only self examination can ever be sufficiently relevant or reliable to spur self improvement. Self evaluation is thus educative in teaching us about ourselves and raising questions about the way we practice which we can only reasonably answer by improving performance.

In musing over future developments that might occur in postgraduate training my first thoughts were of greater use of video recorders and computers, but this is not so much imagination as inevitable. The technology already exists for rapid and comprehensive dissemination of information through microcomputers or videodata systems and their use is likely to increase in the next decade. The videodata system links a simple keyboard to a TV screen and to a Prestel line. This is a cheap system (roughly £400) and acts as a local terminal for the reservoir of information contained in any distant mainframe or microcomputer also connected to Prestel lines.

The microcomputer already has a place in a growing number of practices for improving recall of patients at risk, repeat prescribing, practice statistics for research, and practice administration. I mentioned that I think personal audit is educative and obviously a microcomputer makes this much easier. It is also technically feasible to connect your microcomputer to other microcomputers or even mainframes via Prestel or ordinary telephone lines. Recent developments have made this possible even if they use different languages. The advantage is that any central store of information is then available to all those connected to it. It is conceivable that there will be central stores of all medical literature. For example, as the journal or book is typeset for printing it might automatically be stored on a central reference computer. The *Times* is already typeset on a computer keyboard. Printed matter may eventually become redundant since diagrams and pictures may be stored as well. With one central reference centre, any practitioner with a microcomputer could call up the journal or book he wanted to read and review this at leisure at the practice, or even at home on a videodata system. Any article or passage where a permanent record was required could be obtained by a printer connected to the microcomputer.

I am sure that demand for more than purely administrative programmes would encourage the software manufacturers to develop drug formularies for cross referencing on interactions or

side effects and regular updating of new drugs. They might also update correspondence courses by making medical quizzes available. It would be easier to set up research groups where laborious procedures, like providing a matched control group, would become a simple task. Continued research in general practice is essential in view of the unique opportunity we have because of the structure of the Health Service to perform major studies on the morbidity and mortality of populations—providing education to us all.

I hope that postgraduate medical centres will eventually maintain selections of video tapes for lending alongside books. Particularly useful are consultation technique and clinical procedures, and as a highly portable form of tape-slide presentation they could be viewed at home or the centre. Many doctors have started receiving sponsored medical video programmes from the popular weekly journals and these videos seem to have created a popular niche for themselves.

I don't think that anything in the future could replace lectures, small groups, or symposiums, since they offer personal contact with other practitioners as well as education. What I would like to see is a more universal acceptance of their value, with a less polarised franchise of 10% high users and 25% virtual non-users.⁵ A thriving postgraduate education programme has existed in the United States since the 1960s. Perhaps this will only come about in the United Kingdom if there is a reduction in practice workload achieved with more general practitioners committing more of their spare time to postgraduate pursuits as well as recreation—something that is likely to occur only with the enthusiasm of the profession being equally matched by financial encouragement from the government.

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Diary of Urban Marks: 1880-1840

The complaints at Baldwin's went merrily on until at the end of 1912 I had serious thoughts of resigning the appointment. I could not go on as I had been doing. I was certainly getting an advertisement all around the town because, as I have said, the workmen lived at its four corners and naturally some of their friends came to me as private patients. The confinement cases were going up and I was building up a huge practice. I was sure to be able to see that I was bound to Baldwin's and my wife and I used to discuss the situation frequently. No doubt the fact that I had not had a holiday since I had settled down into practice accounts for my jaundiced view of the moment.

But suddenly everything changed. Mr Lloyd George presented his National Insurance Act to Parliament. All workmen were to be insured under that Act and this materially altered my view in regard to resigning from Baldwin's. I had been told that I was bound to benefit from the Act, as undoubtedly the vast majority of the workmen would come on my panel at the start. I therefore held on and well it was that I did so. On the night that the Act was brought into force, my wife and I were in separate rooms taking the names of

the insured people who wished to come on my panel. Each of them had been given a red card on which was the person's name, his name in his approved society, together with the name of the approved society. We had to fill in a paper with appropriate columns for the details of each person. Each paper had space for 15 to 20 names. For three weeks the house was crowded out. During surgery hours my wife and I attended to the actual patients. After surgery was over I joined her filling and docketing the papers and entering the names into an index book. It was all very exciting. In three weeks I had 3500 names on my list. The yearly fee for each possible patient was seven shillings, so that this meant an income of £1225 a year from the panel alone. Everything in the parlour was now looking rosy. As I had expected, people came to me from all over the town. I still had to work very hard because under the Act the populace at large were calling the doctors out for very small ailments and not troubling to come to the surgery. Soon all this settled down and life became bearable as regulations were framed for the conduct of the insured person as well as for the doctor.

There has been a small drop in both courses and rate of attendance since 1978, although it is likely that some doctors do not always register now.

Group workshop

Different types of meetings will attract their own supporters and critics, but since this is an appraisal of my favourite methods of education I suppose I might begin with my predilection for the group workshop. Small peer groups allow an intimacy and promote participation that is difficult to find in the large lecture. Small groups of doctors come together under many circumstances—like luncheon meetings or even meetings of partners—but the basis of a peer group is a commitment to attend regular meetings whose only function is educational and where the process is reciprocal. In a Balint model group this commitment is absolute and exclusive to further members and therefore promotes intense group dynamics. A more relaxed approach may be the participation of a few local general practitioners as illustrated in a paper from Sutton Coldfield.⁶ All trainers should have access and commitment to local trainers' groups, although the motivation for these is to improve training techniques.⁷ Trainers have compulsory group work based on their half day release schemes, which are usually well received.

Whatever the structure of peer groups, they all help to encourage doctors to share personal experience, and this makes them uniquely valuable. Of course they may adopt the format of lecture for clinical topics, but it is in the discussion of the modes of practice that doctors adopt that the group excels. The doctor-patient relationship and the consultation might occupy the energies of any group for many sessions. There are no right answers but a fairly broad common ground for practitioners to reflect upon. The individual experience is therefore peculiarly relevant and welcome. For this reason I personally prefer a group with a broad spectrum of doctors: from group practice and singlehanded, from affluent and inner city catchment areas.

Another advantage of groups is that the organisation may be democratic, with members taking turns in providing the initial introduction of topics for discussion, perhaps as suggested in a recent article in a journal club, or a short questionnaire on attitudes in the group. The format may therefore remain fresh and the sessions have some therapeutic benefit if members wish to discuss personal difficulties. Video tapes really work only in small groups, since people can see more easily and the video may be stopped or sections reviewed for comment. A variety of tapes is available now (most notably from the MSD Foundation) illustrating all areas of primary care from clinical management to business administration. Video recording is particularly useful for observing consultation technique in vivo. Tapes may also be gradually built up of procedures such as injection of joints or minor surgical operations. Video recording is by far the simplest way of seeing the gamut of clinical procedures being conducted.

It is interesting that all groups seem to have a finite life span and eventually discontinue meeting by mutual agreement. The likely life of a group is between three and five years. It is probably because workshops exist only because of the enthusiasm of the doctors who are not only prepared to establish the group but also give up their time to meet that makes them enjoyable for postgraduate review.

Lectures

According to attendance figures, the favourite method of formal education is the lecture. Most general practitioners have access to regular luncheon meetings. They are pleasantly habit forming and may easily be slipped into a working schedule. The lecture is usually based on recent developments or a review of common topics. They are more often delivered by general practitioners now rather than hospital consultants, and younger general practitioners apparently lay as much store by talks from

their general practitioner peers as by consultant opinions.⁸ I would certainly identify with this. It is particularly helpful to hear of the ways general practitioners have improved health care in their own practices. Practical example is a powerful motivator to stimulate change. I would further agree with the young doctors in the northern region in respecting the opinion of nationally recognised general practitioners more than that of consultant staff of equal repute. We are not generalists but specialists in primary care, and specialists always encourage imitators. It is useful for local general practitioners to meet local consultants—and only for this reason—I am sure hospital medicine will always feature equally in the programmes of general practitioners' meetings. It is also a good opportunity for local general practitioners to meet each other. I particularly like lectures on subjects where slide shows are hypnotic rather than narcotic—for example, dermatology or ophthalmology. I often leave such lectures feeling that my core knowledge of the subject has been doubled in 40 minutes, such being the paucity of my original information. Lectures, however, on subjects well entrenched in the mind, kept up to date through the journals (and the *Sunday Times* these days), provide a mere trickle of input. The biggest problem with a lecture programme is that it cannot be all things to all men and therefore may become repetitive or tiresome to some.

The lecture also figures prominently in the symposium, which is another popular educational format with general practitioners. Symposia have an enjoyable intimacy about them, reminding thoughts of university. They may run for one or a few days and therefore make a nice break from the routine of surgery. Undoubtedly, they are particularly popular when held in certain locations, such as London or Oxford. A pleasing development in group practices has been to provide study leave, perhaps one or two weeks a year, for partners to attend courses. Unfortunately, busy singlehanded practices or practices with two doctors have logistic problems in taking study leave. I think that it is ironic for locum costs to be reimbursed in these practices for extended study leave of more than 10 weeks but not for the shorter courses, which are more likely to help to improve general standards.

Publications and self evaluation

General practitioners' most accessible form of postgraduate education is obviously the printed word. It might be expected that private study would be the most popular form of continuing education, but too few studies have been done to consider incidence and trends. The sheer weight of regular publications constantly runs the mind. The mound of journals that crosses the doorstep at home or surgery, a fair percentage of which are never opened, is an awful waste. Regular reading of a few titles, however, is an appropriate method of continued learning. The *BMJ* always strikes me as a pleasing balance between primary care and other specialties, medical and paramedical, and is particularly valuable for its leaders that reflect on current issues of importance. The *Journal of the Royal College of General Practitioners* constantly promotes research in general practice and is particularly notable for the special reports and occasional papers which are published regularly.

The stalwart textbook has as much relevance in general practice as in any other specialty and there has been an exponential proliferation of specific publications for general practitioners over the past 10 years. I suppose that this is sparked off by the growing importance of vocational training, but we now have a choice so diverse that there ought to be some titles of interest to all general practitioners. All local postgraduate medical centres should have a representative library on general practice.

I think that self evaluation is perhaps the most constructive method of learning. It is a shame audit has become a term of abuse, largely through its unwarranted connection with the idea of compulsion. Examining the way that 'you practice rather than

Practice Research

Approval of trainers and training practices in the Oxford region: evaluation

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Abstract

This is the third paper on criteria and methods for approving trainers and training practices in the Oxford region. In this paper we discuss how they were evaluated.

Introduction

The criteria for the approval of trainers and training practices and the method of assessment that were proposed by a working party in the Oxford region have been described in two previous papers (18 February, p 538; 25 February, p 612). When these were introduced the regional postgraduate subcommittee for general practice agreed that there should be a six month period of evaluation, after which the arrangements should be reviewed.

Methods

All trainers in the region who had been approved for more than two years (n=76) were interviewers and to attend one of two study days, during which the new methods of assessment were described and discussed. Fifty trainers accepted and were included in a panel of visitors for the pilot period. Fifteen trainers and course organisers who had had experience of visiting practices for assessment were invited to act as team leaders.

These sources of information have been used in the evaluation. Firstly, after each visit each team leader was asked to complete a questionnaire about the methods of assessment used and any problems that were encountered. Secondly, each visitor who had been visited was asked to write his comments about the visit before the outcome was known. Thirdly, at the end of the trial period of six months each training group in the region was visited by one of us so that the views of all trainers might be obtained.

Results

In the pilot period nine prospective trainers and 16 existing trainers were seen for the purpose of approval and approval was given to 10 and 12 respectively. On two visits two doctors were seen, where prospective and existing trainers were partners. Of the nine prospective trainers, seven were approved and two were not. (One of the latter subse-

quently appealed against the decision and was successful.) Of the 16 existing trainers, 14 were reapproved, one was not, and one withdrew his application after the visit. During the 23 visits over 70 consultations were viewed on video tape and more than 1500 records examined.

Criteria

There were no major criticisms of the criteria or of the way that they had been applied. Some concern for the future was, however, expressed. Unless the criteria continued to be reviewed there was a danger that the system would become too rigid. It was important not to develop a stereotyped training practice to the exclusion of individuality. It was also thought that the gap between training and non-training practices might be widening and that this might make it more difficult for new practices to start training. The trainers' group therefore has a crucial role in supporting and helping the development of new training practices.

One major source of confusion was that the original proposal had used the word 'standard' in three separate ways: something to which we aspire, a current level of performance, or uniform. We have now tried to avoid this word and to use the term 'criteria' for each element of good practice, and the term 'level of performance' for the degree to which good practice is achieved.

The original proposals did not include any statement of acceptable levels of performance—for example, the proportion of patients' notes that should be summarised—nor was it clear whether visitors had to achieve some criteria—for example, the involvement of partners—would be an absolute bar to reapproval. This continues to be a difficult problem. The final decision depends on a judgement about the overall balance of strengths and weaknesses, the degree of movement that has been achieved in the past, and the potential for continued development. Because of the importance of development and movement the same performance level might be acceptable in one practice and not in another.

Visits

There was general support for continuing this method of assessment visits, though several specific problems were raised.

Visitors

The biggest problem was logistical. The visitors need to be absent from their own practices for a whole day, which restricts the number of visits that most trainers can make. On the other hand, visitors need to have a reasonable amount of experience for their judgement to be reliable. In future we estimate that team leaders will need to do approximately three or four visits a year and each trainer one or two visits a year.

Trainers found that being a member of a visiting team was a very valuable experience, and it was recommended that all trainers should be visiting assessors in future. Trainers new to visiting would be provided with notes on the methods of assessment and be included initially as a third member of a visiting team. All except six trainers in the region have now volunteered to participate.

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Discussion

One of the most controversial aspects of MAGPAS is that it operates a "blanket" callout system—that is, no assessment is made at the scene by the emergency services before a doctor is called. The reasons for adopting this policy are as follows:

(ii) The less often a callout system is used the greater the likelihood that it will not function efficiently in an emergency. The MAGPAS callout system is used on average four times a day and as a result the callouts are handled rapidly and smoothly. MAGPAS prefers not to define a set of criteria for call out nor to place additional pressure on the emergency services personnel at the scene by asking them to make the decision as to whether

(iii) The term "immediate care" implies that care is being provided "immediately" after the accident, as opposed to the term "prehospital emergency medical care," which specifies only that the care has been provided before the patient reaches hospital. MAGPAS is attempting to provide immediate care in the first few minutes after the accident has occurred.

(iv) Doctors are not trained in road accident rescue during their medical education and the practical skills required for this type of demanding work have to be acquired. The doctor learns practical first aid and rescue techniques from the emergency services personnel, while they, in turn, learn how to assist the doctor. All of the members of the "rescue team" need to learn how to work together at the roadside to avoid misconceptions and misunderstandings. The only way that a doctor can learn how to adapt his medical skills to this unfamiliar environment and acquire these practical rescue techniques is to attend an

many accidents

(b) The regular and predictable presence of a MAGPAS doctor at the roadside encourages the other emergency services to regard MAGPAS as the "fourth service" rather than a group of well intentioned volunteers who will turn out only if they can.

The performance of the MAGPAS callout system may be assessed from statistics compiled from the accident report sheets in the MAGPAS control room and from the doctors' report forms. During 1982, 1515 calls were passed to MAGPAS.

and in 97% of these cases a doctor was sent immediately. In the remaining 3% of cases, where a doctor was not immediately available, an attempt would have been made to contact one if the ambulance crew had confirmed that medical assistance was required when they reached the scene. Fifty five per cent of the

calls were passed to the doctor within one minute of the call being received in the MAGPAS control room and 81% within

two minutes. I thus the doctor arrived before the ambulance in 40% of the callouts (average seven minutes ahead, although in 40% of cases the doctor arrived more than 10 minutes ahead of the ambulance). In 60% of the callouts were the ambulance arrived ahead of the doctor the ambulance crew thought that medical assistance was not required in 42% of these calls and informed the doctor over the radiotelephone. Doctors living in the rural parts of the area always arrived well before the ambulance, whereas those practising in a town where an ambulance was based tended to arrive after the ambulance or were recalled en route if not required.

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MAGPAS communication system by their own patients and the doctors frequently use their MAGPAS resuscitation equipment on practice emergency calls. Furthermore, many of the accidents that occur in the doctor's locality concern his practice patients. The doctors are therefore able to use their MAGPAS equipment in their practice work in nearly 80% of the callouts. There is a considerable benefit, therefore, as far as the doctors' own patients are concerned. In the event of a major incident not only would the doctors be able to use their MAGPAS equipment, but they could also provide an incident medical officer, triage officers, and a large group of trained, equipped, and experienced doctors. Members of MAGPAS consider that their presence at the roadside is an important factor in the management of the accident scene, as well as with an obstructed airway or with major injuries, to ensure that the patient reaches hospital in the best possible condition, to alleviate the suffering of the patient in severe pain, and to provide medical, practical, and moral support for their colleagues.

I thank the members of MAGPAS and its staff in the control room, in particular Anne Gooch for assistance in collecting the statistics. I also thank Mr B B Milstein, consultant cardiothoracic surgeon, Papworth Hospital, Cambridge, for advice during the preparation of this paper.

¹ Silverston PP. Roadside medical care in Cambridgeshire. *Injury* 1979;11: 90-6.

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while wearing the brassard and with a revolver in his possession under the international rules he could be shot at dawn. His company was ordered to take a certain position and retain it at all costs. At the zero hour the company commander lost his nerve. He clubbed with the revolver and took command. The position was taken and retained. On reporting to the commanding officer what had occurred Evans was severely reprimanded by him and was told that he was guilty of striking a superior officer with its attendant penalty. But in the circumstances he would recommend Evans for the DSO instead of the Victoria Cross since in the case of the latter all details would have to come out. It was best for everyone that the actual occurrence should not leak out. Evans was granted leave and on his

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