PRACTICE OBSERVED

Practice Research

Role and responsibilities of general practitioner organisers of continuing medical education

R M BERRINGTON, MICHAEL VARNAM

Abstract

A total of 359 general practitioner organisers of continuing medical education in England and Wales were sent a questionnaire on their role and responsibilities in 1985; 206 with relevant duties replied. The results of the survey showed that they were playing an effective part in planning, organising, and evaluating educational activities at district level, that many were highly qualified and experienced general practitioners, and that many had previously been concerned in vocational training. Less than half had undergone formal training for their continuing education role.

Only 105 (51%) were appointed district general practitioner tutors. They were more active in postgraduate centres than in practice based education. Almost a quarter (49) spent three to five hours a week on their educational duties, but 111 (54%) spent fewer hours. Although well provided with educational resources, few had any control over district educational funds, and over half lacked office space. As to remuneration, 161 (78%) received £500 or less a year and almost two thirds received no reimbursement for expenses. Most had no job description.

Attention is drawn to the case for appointing general practitioner organisers of continuing medical education ("district general practice tutors") in all districts of England and Wales, to their role in improving the participation of general practitioners in continuing medical education, and to the urgent need for a national agreement on their job description, preparation, support, and remuneration.

Introduction

The value of primary care in improving standards of health has been emphasised by the World Health Organisation in the Alma Ata Declaration,¹ and continuing medical education can contribute towards achieving this aim.^{2,3} Continuing medical education for general practitioners in England and Wales has developed more slowly than vocational training. The reasons have to do with attitudes as well as organisation. Reedy *et al* in 1979 found that many general practitioners remained conservative in their perception of learning methods, although in 1981 Reiss and Berrington reported the development of practice education groups in East Anglia.^{4,5} In a wide ranging review of section 63 activities in 1980 Wood and Byrne reported that the systems for identifying learning needs, devising appropriate programmes, and evaluation were unsatisfactory.⁶

Until 1985 the Department of Health and Social Security continued to assign responsibility for regional funding to post-graduate deans. Local arrangements were in the hands of clinical tutors, most of whom were hospital specialists. Regional advisers in general practice pressed for alternative systems of budgetary control and for the appointment of general practice organisers of continuing medical education ("general practice tutors") in all districts of England and Wales. In 1982 a working party was established under the chairmanship of one of us (RMB) to examine the responsibilities, resources, and training of these organisers. A two stage survey was conducted using structured postal questionnaires.

Regional Postgraduate Office, Clinical School, Addenbrooke's Hospital, Cambridge CB2 2QQ

R M BERRINGTON, MB, FRCGP, regional adviser in general practice, East Anglia

Queen's Medical Centre, Nottingham NG7 2UH

MICHAEL VARNAM, MB, FRCGP, assistant regional adviser in general practice, Trent Region

Correspondence to: Dr Berrington.

Methods and results

In stage I an initial questionnaire was sent to 262 district clinical tutors in England and Wales during 1984 to discover how many districts had an active general practitioner organiser of continuing education. In stage II in 1985 a second questionnaire was distributed to all doctors who were identified by clinical tutors and to doctors similarly identified by regional advisers in general practice.

STAGE I

Of 262 district clinical tutors, 170 (65%) responded. (Percentages used throughout have been rounded to the nearest whole number.) According to 136 (80%) tutors, a general practitioner was active in organising district continuing medical education programmes, of which only 14 (10%) had a job description. In districts where no general practitioner was an organiser most clinical tutors thought that such an appointment was desirable.

STAGE II

The second postal questionnaire, distributed to the 359 general practitioner organisers of continuing medical education who had previously been identified, drew 265 replies—a crude response rate of 74%. Fifty nine, however, were concerned entirely with vocational training, thus reducing the number of usable replies to 206 (57%).

Respondents and their appointments—Of the 206 organisers, 105 (51%) held a recognised appointment as district general practice tutor or as general practice clinical tutor. Sometimes they held other appointments in postgraduate medical education simultaneously. Of those who were not recognised district general practice tutors, 41 (20%) were Royal College of General Practitioners tutors, 29 (14%) vocational training course organisers, and 31 (15%) held a variety of other posts such as university lectureships. Thus the highest number of replies came from district general practice tutors. Since the numbers in each category were small a differential analysis was not carried out. The results that follow therefore represent responses from all categories.

Appointing bodies—Altogether 132 (64%) said that their appointment was made by a district or regional education committee, the university, or the postgraduate dean, and in 93 (45%) cases the appointment was for a fixed term.

Responsibilities—Table I shows the numbers of organisers who carry

TABLE I—Responsibilities of general practice continuing medical education organisers (n=206)

	No	%
Organising meetings	160	78
Leading meetings	144	70
Planning meetings	142	69
Identifying needs for continuing medical education in general practice	120	58
Assessing educational activities	70	34
Organising self learning for general practitioners	60	29
Visiting practice to discuss continuing medical education	39	19
Missing replies	2	1

various district responsibilities and gives their role in the planning and execution of programmes. Table II shows the frequency with which certain education activities were organised for general practitioners in various settings. With the exception of audit, these organisers appeared to be more active in postgraduate centres than in education based in practices. Educational methods such as case discussion, audiovisual presentations, and patient management problems were often used in addition to traditional lectures and seminars. There was minimal participation with general practice self learning programmes. One hundred and twenty five (61%) had carried out informal assessments of these activities. Only 36 (17%) had done this formally, which may reflect lack of knowledge and skills as well as of time and resources.

Working relationships—There was strong evidence of the acceptance of these doctors into the local postgraduate structure: 153 (74%) said that they were members of a local education committee and that they worked closely with the clinical tutor.

Financial resources—Only 57 (28%) had any influence on the use of section 63 funds; 171 (83%) had no budgetary suballocation and only 41 (20%) saw applications for funding of individual programmes.

TABLE II—Educational activities arranged by continuing medical education organisers (n=206)

	In postgraduate centres		In practices		Self learning programmes	
	No	%	No	%	No	%
Seminars	119	58	50	24	—	—
Lecture demonstration	144	70	24	12	—	—
Group or case discussions	120	58	66	32	—	—
Audiovisual presentations	99	48	44	21	21	10
Audit and clinical review	70	34	71	35	20	10
Use of patient management problems	42	20	7	3	5	2
Quiz	33	16	12	6	12	6
Use of MEQs	41	20	16	8	11	5
Use of MCQs	66	32	29	14	8	4
Computerised learning programs	26	13	13	6	4	2
Journal club	29	14	14	7	9	4

MEQs= multiple essay questions; MCQs= multiple choice questions.

Educational resources and assistance—There was generous provision of educational materials and equipment: 193 (94%) had the use of slide projectors and 190 (92%) overhead projectors; 186 (90%) had access to video recording equipment and 151 (73%) to audiovisual learning materials. Only 44 (21%), however, had the services of a projectionist and seven (3%) the help of an educationalist.

Personal and professional characteristics—Eighty two (40%) doctors who had qualified between 1961 and 1970 made up the largest single age group. A high percentage of respondents had higher professional qualifications: 177 (86%) held the membership or fellowship of the Royal College of General Practitioners; 55 (27%) had either the membership of the Royal College of Physicians or the fellowship of the Royal College of Surgeons.

Practice characteristics—One hundred and forty six (71%) were in practices with four partners or more. Only 20 (10%) said that their partnerships were against the appointment because of the workload.

Preparation and training—One hundred and twenty (59%) said that they had never attended a course on organising continuing medical education. Many of the 206 doctors had relevant experience in other educational activities: 160 (78%) as general practice trainers; 78 (38%) as vocational training course organisers; 130 (63%) as members of the Royal College of General Practitioners Faculty Board; 99 (48%) as members of local medical committees; 39 (19%) as university lecturers, readers, or professors; and 16 (8%) as members of the Association for the Study of Medical Education.

Workload and financial implications—Table III shows the amount of time spent on responsibilities in continuing medical education. Given the wide range of educational and administrative tasks these organisers carried out, three to five hours a week seems to be the minimum needed. Approximately a quarter were meeting this presumed minimum requirement and another 30 (15%) did more. Nearly half (94) said that they had used study leave or holiday to carry out their responsibilities.

TABLE III—Hours spent a week on continuing medical education responsibilities and annual financial remuneration

	No	%
Hours per week:		
0-2	111	54
3-5	49	24
6-8	22	11
Over 8	8	4
Missing replies	16	8
Remuneration per year:		
Nil	107	52
Up to £500	54	26
£501-£1000	9	4
Over £1000	26	13
No response	10	5

Remuneration and reimbursement of expenses—Table III gives the remuneration of tutors per year to the nearest £500, showing that altogether 160 (78%) of the organisers of continuing medical education receive £500 or less. Although 33 (16%) doctors failed to answer a question on the expenses incurred in carrying out their educational duties, 110 (53%) said that they received no reimbursement.

Discussion

Until recently continuing medical education for general practitioners was almost entirely carried out in hospitals. When this survey was proposed only a few far sighted regions recognised the value of appointing general practice organisers of continuing education and the number of such appointments was unknown. Accurate identification and access to the organisers was therefore difficult to get. The 59 (16%) unusable replies from doctors whose only responsibilities were in vocational training illustrates the problem of sampling. Despite these difficulties the two postal questionnaires have shown that general practitioners are organising district continuing medical education programmes and are working well with the clinical tutors. Many of the doctors concerned have 15 to 20 years of general practice experience, higher professional qualifications, and previous involvement with vocational training, although many have no formal preparation for their role in continuing education.

We found them to be most effective in postgraduate centres, where they identify educational needs and arrange and evaluate a wide range of activities. In education based in practices, a topic of special importance given the numbers of general practitioners who fail to attend postgraduate meetings, their contribution to organisation was considerably less. Even so, a third said that they had arranged performance review exercises in the setting. There were few self learning programmes.

The results of the study suggest that there are major obstacles to further development of the organiser's role—for example, lack of control over educational funds, insufficient training, inadequate time, and poor remuneration. Although educational resources and administrative support are provided in postgraduate centres, many reported that they had to use secretarial help in the practice and few had office space in the postgraduate centre. Many comments were received on the impact that the appointment of general practitioner organisers of continuing medical education has made on programmes and activities and about the improvements that might result from providing adequate time and proper training for the job. Greater participation in district budget planning for postgraduate education would be logical, and cost effectiveness would surely be improved.

Although a quarter of respondents spent three to five hours a week on their educational duties, over a half spent fewer. This is hardly surprising since many of the respondents received little

financial recognition, most had no job description, and only a half were designated as district general practice tutors. Vocational training organisers often did the work in addition to their training responsibilities. Such factors are especially unfavourable to any extension of the influence of general practitioner organisers into the practices. Given the importance that the Department of Health and Social Security attaches to greater participation by general practitioners in continuing medical education, support for district general practitioner organisers or tutors should be a priority, and there is a need for a national agreement on their responsibilities.

The publication of the government's paper *Primary Health Care: An Agenda for Discussion*⁸ provides a clear opportunity for the profession, the universities, and the Department of Health to ensure that a general practitioner organiser of continuing medical education is appointed for all districts in England and Wales and to make constructive proposals on their preparation, support, and remuneration.

We thank Professor R Acheson and the staff of the department of community medicine, University of Cambridge, for help with the preparation of the questionnaire; Mr R Wakeford, Mrs Heather Wood, and Miss Lynn Allery for help with analysis; and Miss Rosemarie Davies for help with typing.

References

- 1 Director-General of the World Health Organisation and the Executive Director of the United Nations Children's Fund. *Primary health care: a joint report*. (International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.) Geneva: World Health Organisation, 1978.
- 2 Anonymous. The general practitioner in Europe. *Med Educ* 1976;10:235-6. (Report on second European Conference on the Teaching of General Practice, Leeuwenhorst, The Netherlands, 1974.)
- 3 Anonymous. *Quality in general practice, policy statement number 2*. London: Royal College of General Practitioners, November 1985.
- 4 Reedy BEC, Gregson BA, Williams M. *General practitioners and postgraduate education in the Northern Region*. London: Royal College of General Practitioners, 1979. (Occasional paper 9.)
- 5 Reiss BB, Berrington RM, Stuart DRM, Tait IG. Practice education meetings: a new influence in general practice. *Br Med J* 1981;283:1025-7.
- 6 Wood J, Byrne PS. *Section 63 activities*. London: Royal College of General Practitioners, 1980. (Occasional paper 11.)
- 7 Anonymous. Preliminary results of course organiser's worksheet. *Journal of the Association of Course Organisers* 1986;1(2) suppl.
- 8 Secretaries of State for Social Services, Wales, Northern Ireland, and Scotland. *Primary health care; an agenda for discussion*. London: HMSO, 1986. (Cmd 9771.)

(Accepted 18 December 1986)

100 YEARS AGO

We are now at the season of the year when busy men wisely resolve to shake off for a time the worries and anxieties of daily life. The hardworked practitioner, having handed over his practice, with more or less misgiving, to a stranger, wends his way with a sigh of relief to the seashore or mountain sides to recover from the depressing effects of his everyday work. The consultant and hospital physicians boldly adjourn to pleasant pastures for a period of time which their humbler coadjutors can only envy and not emulate. The columns of the medical journals no longer teem with the reports of societies which testify to the activity and enthusiasm of their members, and the schools of medicine, a month since thronged with students, now know their faces no more, at any rate for a time. The summer examinations are over, and the successful, together with the unsuccessful, candidates, have returned, with somewhat different feelings, to the bosom of their families. A holiday is a serious matter for most men in practice, for within that short span of varied activity they have to find health, courage, and energy for another year's work. An inappropriate choice or an ill-judged expedition may mar the pleasure and minimise the benefit to be derived from the change. Physical inactivity has charms for but few. What most require is a respite from the monotony and the responsibility of their lives, and this can be found, not in idleness, but in judiciously directed activity. This year many will turn their faces towards the sister isle, and will take advantage of a short leisure after the meeting of the British Medical Association at Dublin to visit the less well-known but picturesque sites which await the admiration of the tourist. Their journey will probably not be less interesting or enjoyable

than that of their *confrères* who have gone farther afield, and it will have had the advantage of being very much less expensive. This year, doubtless, many men who can spare the time will avail themselves of the opportunities of the American Congress to visit a country which cannot but be full of interest to the denizens of European cities. Such a trip will be replete with interest, and the fifteen or twenty days spent on the Atlantic will be a pleasant, novel experience. (*British Medical Journal* 1887;ii:369.)

The Parisian chemists' assistants are, it is reported, threatening to strike, or at least to take steps to protect themselves from "the rapacity of their masters." One ground of complaint is that they work seventeen or eighteen hours a day in summer, and sixteen hours in winter. One of their number gives the following melancholy description of the ordinary day's work of a Parisian chemist's assistant. He rises at seven o'clock, and serves the ordinary morning customers who come for castor-oil, sulphate of magnesia, and *tisanes*. At ten he goes to the laboratory, and makes up syrups, after which he returns to the shop, when he takes his lunch. After this, up to eleven o'clock at night, he is engaged in making up physicians' prescriptions. Even when in bed he is doomed to hear the frequent ring of a bell which summons him to the shop or laboratory in the small hours of the morning. These ill-fated *potards* are trying to form themselves into a syndicate, with a view of intimidating their employers. The success of such a step is said to be extremely doubtful. (*British Medical Journal* 1887;iii:521).