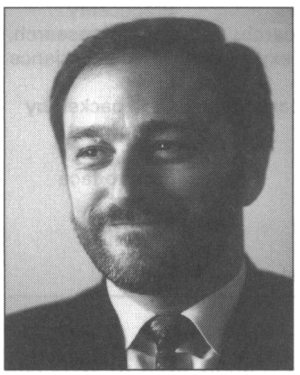
Professional development in general practice: problems, puzzles and paradigms

DAVID PENDLETON



Introduction

I DID not know William Pickles personally but I value enormously those who, like him, have been able to reflect on the specifics of practice and to generate broad principles from which all may learn. His professional effectiveness is justly commemorated by this lecture. The history of the Royal College of General Practitioners is hallmarked by such men and women.

Setting the scene

The scene is set by a story of everyday practice.

> Dr Mary James has received an invitation from her local postgraduate centre to attend a lecture on paediatric oncology. Two years ago she cared for a child dying from cancer. She found this episode in her professional life distressing, and wants to attend the lecture. She feels that there are complex matters to be discussed — the clinical nature of the disease and its treatment, dealing with the parents and family, the effect of caring on the carers including the doctors and nurses, and dealing with dying and grief.
>
> Unfortunately, Mary James cannot attend the lecture as there is a partners' meeting on the same day to discuss out-of-hours work. Three of the partners want to appoint a deputizing service and two do not. She is the sixth partner and has not fully decided on the matter. Although Mary James is a young doctor, she is an influential member of the group and her role is critical. The real problem is that the partners want to practise in different ways. One group wants to practise to pay the bills and then become involved in a range of medicopolitical work. They believe that clinical freedom is under threat and must be safeguarded by the active involvement of committed doctors. The other group wants to focus on the practice and turn it into the finest primary care facility in the area. Both groups have laudable aims, but they are incompatible.

D Pendleton, DPhil, CPsychol, AFBPsS, director, Opus Consulting Ltd, United Kingdom and Hong Kong. This is an abridged version of the 1995 William Pickles lecture which was delivered at the spring meeting of the Royal College of General Practitioners in Blackpool on 30 April 1995.

This case is fictitious but its elements are real. In professional life, choices have to be made. Many of the clinical choices such as diagnostic or therapeutic decisions have been the subject of extensive education in medical school. These may be highly complex and intellectually challenging but essentially are puzzles — there is an optimal answer and the answer can be found. Other choices are much more difficult, such as those which have to be made when confronted by ethical dilemmas, differences between people's values, and subjects which give rise to intense feelings. These are problems that require sensitivity, courage, the willingness to accept the consequences of one's actions and the fortitude to resist pressure. They are difficult emotionally and there is no optimal answer, merely a management plan.

The dilemmas facing Mary James are problems: she does not know where her career is going. She has to choose between dealing with her own needs and those of the practice; between one group and another; between two approaches to work in the practice; ultimately between two professional lifestyles. Certainly the practice will be profoundly affected by the choices made.

What is Mary James to do? She senses a potential split in the group and has mixed feelings on this. A split may be better, allowing each group to establish the kind of practice it wants to create. Yet the analogy has always been made between a practice partnership and marriage, implying failure if a split occurs. On balance, she wants to avoid such an outcome. The practice has pressing developmental needs. The partners need first to decide on the kind of practice they want to create and work systematically towards it. The practice as a whole could be involved in this discussion, turning a crisis into an opportunity for healing and growth.

For Mary James, there is a small, nagging doubt that she may have diagnosed the child's cancer later than she should. If she had made an earlier diagnosis perhaps the outcome would have been different, but she is a good clinician and knows this is unlikely. She simply wants to know the latest thinking on the subject so that she can do the best for her patients. However, she knows that she is unlikely to face many similar cases as most of her practice population are elderly. She also knows that her needs will not be fully met by the lecture.

As she surveys the possible sources of help, she sees the panoply of continuing medical education, audit and local young principals groups. Each is excellent, but not quite what she needs. The continuing medical education and audit activities are essentially episodic in nature and the young principals group offers support but at a distance. Mary James needs help that is relevant, indeed specific, to her practice and herself but it will have to come from an outsider, someone without a personal stake. She needs diagnostic help (an exploration of the problems) and therapeutic help (an exploration of how to solve them).

This lecture considers the continuing help available to practices and practitioners, analyses the approaches required and those offered, and considers the possibility of a mismatch between need and provision. The reasons for any mismatch and what could be done about them are explored. I want to conclude that there may be a further role for the RCGP which is a natural evolution of its roles since its birth. In all of this I speak as a distant but not at all dispassionate observer. On the contrary, I am passionate both about general practice and the RCGP.

Concept of professional development

Doctors emerge from medical school into the professional world of general practice with a great deal of knowledge yet they still have so much to learn. To adapt to the new world of practice they have to become comfortable with their role and they have to learn about dealing with practice partners and patients, how to manage rather than cure most problems and how to share decision making with their patients. Yet medicine changes, society changes and health services change, so doctors must be able to change, and that change must be growth.

In her current situation, Mary James cannot grow, and acquiring more knowledge will not help. The young doctor needs to acquire the skills to work with ethical and other dilemmas, the fortitude to live with uncertainty and the judgement to manage the competing demands of the health authority, community, patients, practice partners and family.

This is the challenge of professional development. It is concerned with helping the practice to change and to grow and the doctor to cope and ultimately to thrive in the practice environment. Such development is not to be confused with continuing medical education.

Table 1. Differences between academic and professional approaches to continuing medical education.

	Academic	Professional
Major aim	Insight and knowledge	Action to solve a problem
Urgency	Low	High
Cost–benefit analysis	Irrelevant	Crucial
Principal quality criterion	Elegance	Practicality
Usual source of insight	Own research, others' experience	Others' research, own experience
Level of complexity	High	Low
Means of persuasion	Theory backed by data	Data backed by argument
Preferred medium of presentation	Written	Face to face
Personality type most valued	Introvert	Extrovert
Method for dealing with uncertainty	Statistical	Personal

Problems of continuing medical education

Perhaps the best evidence of the mismatch between continuing medical education and doctors' needs comes from its relatively poor attendances. These have led the government to include an element of inducement in the 1990 contract for general practitioners. But why are attendances low?

Principally concerned with professional matters, most doctors want to improve the quality of their actions (their practice) as painlessly as possible. They wish to maximize the return on their investment of time and this becomes a matter of cost–benefit analysis based on the likely yield of an activity.

The lowest yield comes from the most common media for continuing medical education — journal articles and postgraduate lectures. These are usually so narrow in focus that it takes much time and effort to cover important areas of a doctor's work. Thus, postgraduate lectures are poorly attended and most journals are poorly read. This is not a lack of motivation on the part of doctors but a lack of insight on the part of the providers of continuing medical education. Much is taught by specialists and oriented towards the treatment of clinical conditions. It focuses on clinical puzzles rather than the problems of practice. Often the learners are passive recipients of subject matter chosen by a third party. Also of narrow benefit, but of lower time cost, are journal review articles or update lectures. Broad benefit (but at high time cost) comes from, for example, Balint training while broad benefit at low time cost comes from, for example, video-based skills training.

Differences between academic and professional approaches

Continuing medical education is based on knowledge acquisition and comes from the academic/educational paradigm. The needs it attempts to meet come from professional practice, but these needs change constantly. Some of the important differences between academic and professional approaches to education are shown in Table 1 and are described fully elsewhere.[1] The most important difference lies in their aims. The academic is seeking insight to understand the nature and cause of things, irrespective of the use to which that insight may be put. The professional is interested most in the subset of understanding that is relevant to the problem which he or she is seeking to solve or manage.

Persuasiveness is a property of the theory and data of the academic. Ideas persuade, not the individual. This has not always been so. The Oxford examination schools used to associate astronomy with rhetoric when astronomical measurement was crude. Professionals are frequently in the same position as the early astronomers. They have to offer the findings of others' research and a keen argument to support their recommendations with worried or sceptical patients. Indeed, professionals can be so persuasive with their patients that their skill becomes a weapon and the skill can easily be abused. It is not surprising, therefore, that the professional's preferred medium of presentation is face to face, where the full power of argument can be experienced. The academic publishes, hoping that those whom he or she wishes to influence read the journals. The professional, having to compete with other pressing demands on a patient's time, has to deal with objections as they arise so that a solution may be implemented quickly.

I stress that I do not wish to criticize academic endeavour. We all depend upon sound research and will always value the academic world for its high standards, its emphasis on scholarship and its meticulous attention to detail. We need the finest academic standards to be maintained. My argument is that the academic paradigm may not be the most appropriate basis for continuing medical education, as it does not aim to meet the needs of practitioners. Academic departments of general practice, on the other hand, provide bridges which academics and professionals can cross.

Mary James does not need to attend the lecture on paediatric oncology to address her problems. It is relevant but tangential to her professional dilemmas concerning her care of the child two years ago. Indeed, it may be difficult for her to concentrate on the lecture at all given her immediate preoccupation with the problems in her practice. She needs to resolve the practice problems before she can attend to any further individual development needs.

Establishing professional development

Doctors like Mary James seek development activities that are broad in their impact on practice and take effect quickly. They prefer help in dealing with the problems of practice, rather than the puzzles. Such approaches ideally start with the practice's development needs and then deal with the doctors' needs in this context.

Techniques for practice development

Strategic planning workshops. These workshops are opportunities for practices to raise their eyes from the present day to focus on the future. The key questions are what kind of practice do we want to become and how are we going to achieve this? Workshops may be confined to practice partners or may involve everyone. Pendleton first proposed these workshops (paper presented at a Bristol–Myers Squibb conference on continuing medical education in general practice in Dublin, Republic of Ireland, February 1990) and King and Flew describe how these work.[2] Workshops identify the aims, values, strengths and limitations of the practice and pinpoint its development needs.

Team building. Team building is a deliberate and systematic attempt to provide for the team's needs. The involvement of team members in planning and in making decisions that affect them tends to increase their commitment to the decisions made. This is a general principle of decision making.[3] Strategic planning workshops have team building as a by-product. Other shared activities will serve a similar purpose but involvement in structured activities with opportunities for supportive feedback and reflection seem to work best.

Techniques for individual development

Peer review. Initiatives such as the RCGP's *What sort of doctor?*[4] are both ambitious and in the best traditions of professional development. Doctors have found that carrying out and receiving peer reviews are both beneficial activities.

Focused audit. Focused audit first establishes a standard and then seeks to understand what caused the standard to be achieved or what conspired to frustrate that achievement.

Action learning. Action learning is a means of developing expertise in a field that is new to all those taking part.[5] Typically a group of professionals decide to tackle a new area of work, for example computerization, and agree on how to structure their activities and reflect on their experiences in a way which ensures that there is maximum learning as quickly as possible.

Video-based feedback on consultations. This technique brings fast results when it is based on real consultations and when evaluation takes place against clear and mutually agreed criteria. It is becoming widely used in vocational training and is one of the most potentially helpful means of continuing professional development.[6]

Joint working. The opportunity to learn from others is a feature of partnerships and yet it is infrequently used. Similar opportunities present themselves to learn from specialists. Ben Pomryn was an unusual psychiatrist who conducted pioneering work of this kind in the 1970s and 1980s, visiting general practitioners to conduct joint surgeries. Thus, he developed their expertise in dealing with the psychological aspects of practice, both the patients' needs and those of doctors.

Establishing the agenda for professional development

Typically, practices function reactively: they develop in response to a problem they encounter or to an externally imposed change. In order for practitioners and practices to develop, more is required than simply the introduction of those techniques outlined above. However, general practitioners lack guidance on how to identify and meet development needs.

Regular strategic planning sets an agenda for the future of a practice and seeks to anticipate real or potential obstacles (Figure 1). However, few practices have an overall practice strategic plan.

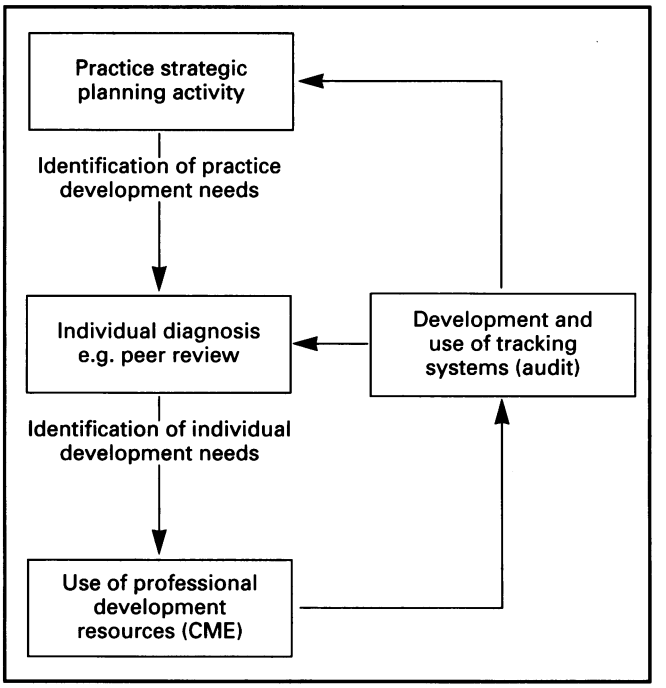


Figure 1. *The professional development cycle (CME = continuing medical education).*

In the professional development cycle, methods such as peer review help individuals to pinpoint those professional development activities most relevant to their needs. Thus, busy practitioners can specify precisely what they need from continuing medical education.

If Mary James' practice were to work through a strategic planning exercise, they would be faced with a stark choice: to find common ground and to build a practice on a shared vision, or to re-form as two practices, each with its own vision. Despite the potential seriousness of the situation for Mary and her colleagues, the advantages of this approach to professional development are obvious.

General practitioner tutors are often unsure about what activities to offer. Regular strategic planning identifies learning needs which can then be taken to the general practitioner tutor. The use of audit as a means of tracking progress towards agreed aims is a powerful tool. In the proposed model, continuing medical education and audit become more than mere adjuncts to practice; they become integrated into the cycle of professional development.

Turmoil

In the last 50 years there have been three important periods of turmoil for general practice: the establishment of the National Health Service in the 1940s, the general practice charter in the 1960s and the new contract for general practitioners in the 1990s. The last of these is still creating distress several years after its introduction. Predictably, some doctors have tried to ignore the changes, some have resisted them and others have embraced them with enthusiasm.

During this time, the RCGP was born out of a mix of turmoil and idealism — the classic preconditions for leadership. It has sought to influence, to support and to promote the highest standards of primary care and has recognized the importance of colleagues in a potentially isolating world.

Whereas specific changes are hard to predict, the process of change follows certain predictable patterns. One of these is the movement between simplicity and complexity. Naisbitt describes

us as living currently in the 'time of the parenthesis' in which we have neither left behind the past nor yet embraced the future.[7] We cling to the known past for fear of the unknown future. In his essay on the leading edge of change, Bennis[8] quotes Ibsen's play *Ghosts:* 'We're controlled by ideas and norms that have outlived their usefulness, that are only ghosts but have as much influence on our behaviours as they would if they were alive.'

General practice may be living in a time of parenthesis, as may be professional development for general practitioners. Yet there are changes occurring, in care, in the funding of general practice and in its role.

Changes in care

As information becomes more readily accessible, traditional medical professional boundaries are beginning to erode. Increasingly, general practitioners are spreading their functions into the province of specialists. Nurses are taking over some aspects of the general practitioner's role. The flow does not end there, however, as patients increasingly have access to the same information as health professionals. In this way the first boundaries to erode are interprofessional boundaries. Ultimately, the boundary between patients and health care providers becomes more blurred. This change, which has already started, will accelerate.

That patients are now increasingly expecting to share the decision making process with doctors heralds the end of medical paternalism. The doctor does not know best but, between them, the doctor and the patient can come to a mutually acceptable decision. This style of consulting produces real improvements in the subsequent adherence of the patient to the recommendations made.

In the 21st century, patients will still consult doctors as healers when in need, as they have done down the ages, investing them with the power to heal. However, general practitioners will not act primarily as repositories of knowledge but as advisers, helping their patients make choices concerning health, illness and treatment.

Changes in funding and role

Most doctors have traditionally considered the needs of patients as individuals. Now, the purchaser–provider split has made general practitioners themselves ration care on the basis of need. As the patient's advocate doctors have a clear and positive ethical position. However, current funding arrangements give rise to ethical dilemmas and cause patients to be less trusting. This situation threatens the doctor–patient relationship. Doctors will have to adapt to radical changes in their relationships with their patients and their colleagues. If general practitioners are to cope with these changes, they will need support.

There are additional changes possible for those general practitioners who are willing and able to redefine their role and rethink their involvement with their patients. The local health centre could offer more varied health services, some of which are not far removed from the doctor's current role. There are already health centres offering such services as dentistry, physiotherapy and counselling. The days when meals on wheels, home help and slimming clinics are available through the health centre may be closer than many imagine. The really entrepreneurial may introduce a fitness centre, health cookery classes, a healthy-eating restaurant and a beautician. Naturally these would all be offered on a paying basis.

The threat of ill health can be lifted from everyone so long as the diagnosis and treatment of serious illness is free at the point of contact. For this reason, Bevan ought not to turn in his grave at these thoughts on the expansion of health centre services, which cannot be ruled out as the basis of funding shifts. They will be resisted by some health professionals, however, who may find them trivial or exploitative. Yet a health centre may generate sufficient funds to use in many ways, to enhance partners' income or to provide additional funds to invest in patient care.

Professional development consultancy service

Professional development starts with the needs of practices and practitioners. It is logical that the development cycle should start here as these are the people who are closest to the patients — they are the frontline service providers. Help is required for a wide range of needs — the formulation of a practice strategy, the identification of development needs, the development of supplementary practice services, the introduction of new technology, the examination of new ethical dilemmas, and so on.

A local professional development consultancy service has considerable potential to fulfil these needs. Continuing medical education and audit activities would be part of a broader service to a practice. Professional development consultancy would offer help that is outside and separate from the practice but is intimately involved with it. In this way the service would ensure that the help offered was relevant and yet the service would have no hidden agendas of its own.

The service would take on many roles. The first would be in helping practices with strategic planning. Emerging from these strategic planning exercises would be practice and individual development needs which must be met. Audit would thrive in such a system of professional development. It would become a fundamental guide to the effectiveness of clinical care, or of any other change being monitored as the practice develops.

Other roles for a professional development consultancy service may be anticipated. It could serve as a resource investigator, networker and facilitator, bringing together people with needs and those who may be able to help them meet their needs. The service could be a disseminator of new findings, a communicator.

The service would be staffed by a range of professionals — academic and practising doctors and nurses, psychologists, educationalists and researchers. They would have access to an even greater range of help through their own professional networks. In this way, they would be able to meet a broad range of needs from technical (architecture, finance, technology) to interpersonal and clinical. However, all would share a common goal or mission, namely, to provide consultancy services to health care providers which maximize the impact of primary care on the health of the community.

Specific consultants might be expected to work with a portfolio of practices and seek to develop long-term relationships with them. They would regard their role as bringing the academic world and the world of practice closer together. They would address the problems of information overload and retrieval, and bridge the gap between new information and behaviour change. They would help to ensure that where evidence for a course of action was clear, the professionals would adopt it. The service would draw on the best that academic research has to offer, helping disseminate it into practice, and also help medical practice set the agenda for some of the research in the universities.

Leadership and the RCGP

At present, there are four principal groups involved in professional development: vocational training schemes, audit facilitators, RCGP tutors and university departments of general practice. They need to come together if the idea of professional development is to be realized. Each has a contribution to make.

If it chose to take on such a role, who better than the RCGP to influence such an initiative? The RCGP has the tradition of lead-

ership, advocacy of the highest standards of primary care, and a national network of contacts. Perhaps more importantly, professional development is the primary need of RCGP members.

The future of general practice requires new approaches and new skills, new institutions and new attitudes. According to Rogers there will be some who will naturally find themselves drawn to the innovations emerging, and others who are horrified at the thought.[9] Yet the future will require the same values as medical care in the past — the value of health and healing, of expertise and rigour, and of respect and care for individuals. It is a future that is to be embraced with enthusiasm and influenced creatively.

The RCGP has always understood the problems faced by the fictitious Mary James; it is made up of people just like her. It has always been concerned with the problems of practice more than its puzzles. It has been unashamed about promoting excellence, while understanding the human frailties that hinder the achievement of excellence. It understands the current and future turmoil that will affect those who seek to provide primary care in a changing world. It has the potential to provide much needed leadership now. May the RCGP do so with vision and courage.

References

1. Pendleton D. Professional development in general practice. In: Pendleton D, Hasler J (eds). *Professional development in general practice.* Oxford University Press, 1995 (in press).
2. King J, Flew R. Practice development through strategic planning. In: Pendleton D, Hasler J (eds). *Professional development in general practice.* Oxford University Press, 1995 (in press).
3. Janis I, Mann L. *Decision making: a psychological analysis of conflict, choice and commitment.* New York, NY: Free Press, 1977.
4. Royal College of General Practitioners. *What sort of doctor? Report from general practice 23.* London: RCGP, 1985.
5. Revans R. *The origins and growth of action learning.* London: Chartwell Bratt, 1982.
6. Pendleton D, Schofield T, Tate P, Havelock P. *The consultation: an approach to learning and teaching.* Oxford University Press, 1984.
7. Naisbitt J. *Megatrends.* New York, NY: Warner, 1982.
8. Bennis W. *An invented life: reflections on leadership and change.* Reading, MA: Addison-Wesley, 1993.
9. Rogers E. *Diffusion of innovations.* New York, NY: Free Press, 1983.

Acknowledgements

This lecture has benefited enormously from the input and feedback of three colleagues — Professor David Metcalfe, Dr John Hasler and my wife Dr Jennifer King. I owe them my thanks.

Address for correspondence

Dr D Pendleton, 10 Beaconsfield Road, Clifton, Bristol BS8 2TS.

Food for thought...

'If a death occurs in circumstances which ultimately require referral to the coroner then there is a clear duty for the general practitioner to report the case without delay. Decisions not to refer cases because of potential distress to relatives, embarrassment to colleagues or a failure to see any consequence by referral are misguided... General practitioners are advised to report all deaths about which they are uncertain, remembering that the referral of a case does not automatically result in an autopsy or an inquest.'

Start RD, Usherwood TP, Carter N, *et al.* General practitioners' knowledge of when to refer deaths to a coroner. April *Journal,* p. 191.