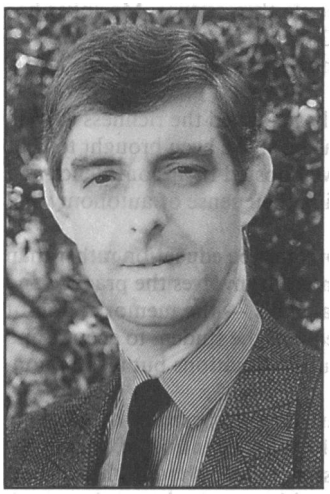
My brother's keeper

MICHAEL BOLAND



I WAS honoured and overawed by the invitation to deliver this lecture — overawed by the quality of my predecessors; honoured not just personally but for Irish general practice and the new Irish College of General Practitioners, the establishment and development of which owes so much to the Royal College of General Practitioners.

The family of general practitioners

'Then the Lord said to Cain, "Where is Abel, your brother?" He said, "I do not know; am I my brother's keeper?" '[1]

Families cannot be exchanged or denied. There is a sad futility about wishing our families were otherwise. So it is with the community of general practitioners to which we all belong. We share the same title, and will be judged collectively whether we like it or not. We may not want to account for some of our colleagues. We may try to surround ourselves with like-minded doctors and pretend that others do not exist. But they do and will continue to do so even after they have failed to pass our examinations, to respond to our initiatives, to meet our standards, or to join in our research. Our concern therefore must be for all general practitioners because we must live with them, their patients must live with them, and to some extent government must live with them.

Professional sanctions

What options are open to an aggrieved public? Whether they seek redress through the sanctions of the General Medical Council, civil actions for negligence or the complaints procedures of contracting authorities, all will leave the vast majority of questionable professional behaviour unchallenged.

It is that behaviour and how it may be influenced which concerns me. It is also a central concern of colleges such as the RCGP. And it is the part played by continuing medical education in that process which is the theme of this lecture.

M Boland, FRCGP, MICGP, national director of continuing education, Irish College of General Practitioners. This is an abridged version of the 1991 William Pickles lecture, which was delivered at the Spring meeting of the Royal College of General Practitioners in Newcastle upon Tyne on 14 April 1991.

William Pickles

In 1953 William Pickles was elected president of the RCGP and he was the obvious choice. Certainly his colleagues admired his painstaking gathering of data, the elegant simplicity of his observations, his widely acclaimed book and his fluency as a lecturer. But that was not the reason he was chosen.

Reading Pemberton's fond memories of his friend,[2] Pickles emerges as an idyllic country doctor. He epitomized all that was good about general practice. Audiences marvelled not at his research findings but at Pickles himself as a caring professional — in Norell's[3] terms a 'thoughtful' doctor. They saw him as an ordinary general practitioner driven not by greed or fear of litigation or by the requirements of any contract but by higher values — scientific curiosity, and the fulfilment of a vocation.

Responsibility and accountability

The Irish College of General Practitioners and the RCGP share a common aim — 'to encourage, foster, and maintain the highest possible standards in general medical practice'. This is not a burden of acountability but a challenge to be the active agents of change — architects and builders of the discipline. That implies a corporate vision of the future and a desire to assume some control of its shape and direction. However, only a small number of us are sufficiently committed to invest our time and energy as active members. In Ireland although 95% of general practitioners are members of the Irish college, only 15% are substantially involved.

As activists we are driven by our belief that the changes we seek are for the better. Such is our understanding of what is right and important that we want to share it with others. Not surprisingly some of our colleagues are sceptical. Yet it is precisely because they are our colleagues that we must continue our search for ways of directly influencing their behaviour without antagonizing them.

Control and accountability by contract

Meanwhile, in the name of the consumer, politicians are trying to make us more accountable. Unimpressed with our ineffectual self-regulation, our authority, on the basis of collective status, is being challenged. Increasingly, individual doctors are being asked to justify their own performance in terms of explicit criteria such as contracts.[4]

This 'control by contract' has now extended beyond issues of accountability and efficiency. The changes sought include the balance of care itself. This is 'social engineering' as applied to clinical medicine. Already concern has been expressed that as a result of the new National Health Service contract numbers of longer consultations may fall, adversely affecting quality of care.[5]

The quality initiative and standard setting

How have we reacted to 'control by contract'? One response was the quality initiative launched in 1983.[6] Irvine, reviewing its progress after seven years[7] identified five developing areas of standard setting: practice visiting, practice activity analysis, confidential case analysis, clinical standard setting and surveys of patient outcome satisfaction. These are encouraging innovations but how widely have they been applied? More recently he has suggested[8] that 'the habit of managing for quality' be made an integral part of every practice. Education is one of a number of strategies which can achieve this wider vision.

Another strategy — national standard setting — is currently being developed by the Dutch college.[9] Their standards are drawn up by small working parties, tested by 50 general practitioner colleagues, approved by the Dutch college and distributed to all their members with their journal. Grol reports that the concept has been well received by most Dutch general practitioners. But some had reservations about the details of the particular diabetic standard offered and many did not conform to it for a variety of reasons.

In an earlier study, Grol and colleagues[12] reported that peer review could change clinical practice in accordance with pre-agreed protocols but concluded that the real value of the study lay in the resulting positive attitudes to peer review.

We may conclude that there is still time for general practitioners to become self-regulating by assuming control of the rapidly growing system of quality assurance. But these developments are fraught with difficulties and dangers.

First, standards make objective statements about care. This favours traditional clinical method above the wider subjective 'patient centred method'[11] which explores the meaning of each patient's illness in it's personal and biographical context. A purely objective approach excludes much that is important in general practice.

Secondly, standards can be unduly prescriptive thereby diminishing professional autonomy and self esteem. Simon[12] describes two categories of management decisions: programmed, predominantly operational decisions which are routine, repetitive and almost automatic, and non-programmed, predominantly strategic decisions which are unexpected, with a high degree of uncertainty, and where usual routines and rules do not apply. Simon used the term 'satisficing' to describe those decisions which may not fully meet management objectives but which are sufficient to satisfy the needs of the situation. Here subjectivity, judgement and rules of thumb are used rather than explicit decision rules. Consultations may involved all these concepts. We need to distinguish those clinical decisions where standard setting really matters and to express our standards in terms which permit subjectivity and judgement.

The third difficulty centres on sheer complexity. Devising and implementing standards is not easy. They must be at once comprehensive enough to embrace all of general practice yet specific enough to be unequivocal. Such a system would need to be on an enormous scale and would require as much time, personnel and resources as the service itself.

Finally, standards should not have a distorting effect on the overall priorities of care. To avoid this, all important aspects of performance must be included and made explicit. If only a fraction of practice is addressed then the measurement process itself will upset the proper balance of clinical time and attention.

Jack Norell in a previous Pickles lecture[3] warned us not to become '...infatuated with educational theory'. The parallels between standard setting and writing specific educational objectives are striking. We cannot write detailed standards which accommodate all the variables of clinical decision making just as we cannot train doctors for every situation they are likely to meet. Furthermore as every teacher knows, whoever sets the examination controls the real curriculum.

What is important is not the standards but the establishment of a rigorous review process and a broader vision of good practice. McIntyre and Popper have written that '...efforts to improve performance must come from a desire for self-improvement, a desire based on an essentially ethical insight. Audit must not be part of a disciplinary instrument; it must be a tool for learning by feedback'[13]

Intentions of continuing medical education

Can formal continuing medical education become our chosen vehicle for rigorous review — the route to better standards? As with all education, continuing medical education strives to change behaviour; in this case so that doctors can better meet the health care needs of the people they service. Marinker has given us a broader vision: 'General practice is not only a biotechnical enterprise and a managerial challenge; it is also a moral endeavour.'[14]

Could continuing education have tapped the richness of Will Pickles? Could his positive influence have been brought to bear on his colleagues? Could it have boosted their confidence and commitment without diminishing their sense of autonomy and personal responsibility?

Continuing medical education must be education rather than training.[15] Training is task oriented. It involves the practice and perfection of practical technical skills — the memorization of cognitive routines. Education requires the student to acquire and use information not only in routine situations but also in non-routine applications.

Continuing education is part of the spectrum of life-long learning but that does not make it an extension of vocational training as some have suggested.[16] Nor should the role of course organizer and general practitioner tutor be amalgamated.

Principals in general practice are neither students nor trainees. Tutors and organizers must recognize that they are free, independent and fully matured adult learners. As such they will prefer to be self-directing and to learn using a problem oriented, patient centred approach for immediate application. They will want feedback and the chance to contribute to the learning of others. The focus must no longer be on what they will become but on what they are.

Current state of continuing medical education

Given these ideals what is the current state of formal continuing medical education in the UK? For convenience it may be divided into solitary activities, large audience methods and interpersonal activities.

Solitary activities

Personal reading is the most obvious solitary form of continuing medical education. Most general practitioners prefer to read newspapers and review journals.[17] Reading combines maximum flexibility with minimal curricular control. It can both create and satisfy learning needs. Reading in the practice has the special advantage of immediacy. Time spent on personal reading is difficult to quantify. The Canadian college will allow half their annual requirement of 50 hours continuing medical education activity to be claimed under the heading of 'planned reading' (Rainsberry P, personal communication).

Another solitary format is distance learning. It also offers flexibility in time and place but provides the added advantage of a definite curriculum including elements of self-assessment. Some limited interaction is possible but individual feedback is necessarily impersonal. A good example of this format is the RCGP CLIPP project.[18]

Large audience methods

Didactic lectures continue to occupy pride of place in continuing medical education. Teleconferencing means that there is now virtually no upper limit to the size of their audience. For participants they are undemanding and cheap. In the UK the advent of the postgraduate education allowance has strengthened the position of the lecture. The Keele survey[17] confirmed their

persistent popularity. Seven out of 10 respondents claimed to have attended lunchtime lectures occasionally or frequently. This compares with six out of 10 for all other section 63 activities such as small group meetings, evening meetings or half-day and full-day courses.

Most general practitioners still see their continuing medical education obligation in terms of their knowledge base and lectures can provide a simple and efficient means of conveying factual information. Our eventual aim must be to widen that obligation but in the meantime an approval system must ensure planned programmes, well briefed lecturers and relevant content.

Interpersonal activities

Between the privacy of solitary continuing medical education and the anonymity of a large audience lie interpersonal activities such as small group meetings within and outside the practice. They are distinguished by the fact that each learner must actively contribute thus adding feeling to learning.

No communication is devoid of affect. The doctor's confidence can be bolstered or shaken, values and beliefs reinforced or undermined, the balance between enthusiasm and caution, pride and shame can be tilted. The result can be a subtle shift in relative importance and priority which is central to clinical judgement.

The 'hidden curriculum' of undergraduate education[19] has been described as the 'vast latent content of [student] learning' by which 'the ethos of medicine'[20] is assimilated. The student learns it by 'modelling and identification' with 'his teachers, his patients, medical science, and the institution of the teaching hospital'. Equally in continuing medical education each of us can both influence, and be influenced by, the prevailing culture of our peer group. The balance of this 'mutual modelling' may not be equal. Members whose opinions are respected will carry more weight within the group. Nevertheless all doctors share in the hidden curriculum provided they participate in the activities where it is to be found.

This should make interpersonal activity, and small groups in particular, the centre-piece of formal continuing medical education. Yet in the Keele survey[17] three quarters of the respondents had not taken part in a section 63 small group meeting in the preceding four months and most had not attended more than two non- section 63 meetings in the same period. On average 82% of the practice-based meetings were drug-sponsored and almost all of these were based on videocassette or tape presentations. Of those meetings not drug-sponsored only one in five was devoted to audit or performance review.

In other surveys[21,22] 90% of respondents worked in practices that had held an educational meeting where the main content was supplied by a drug company and only 45% worked in practices where the doctors themselves provided the content. A majority of general practitioners, and particularly of younger general practitioners, regarded the content of meetings provided by drug companies as unsatisfactory.

This steady growth of practice based education should be a welcome development. It brings continuing medical education close to day-to-day service problems; it could be used for interprofessional learning; and it could turn mere data collection into real audit. Continuing medical education could become part of work, not leisure. Given such valuable potential it seems a pity that the organization and content of practice-based education should be so haphazard. The pharmaceutical industry has effectively filled this vacuum. The situation cries out for a well trained, adequately resourced general practitioner tutor in every district who would have the time and the expertise to provide quality small group education within practices and outside them.

One to one continuing medical education

There is another potential form of interpersonal continuing medical education — one to one counselling. Recently employing authorities have appointed doctors whose task will be to visit individual general practitioners for the purpose of discussing with them aspects of their clinical performance. In the UK they are known as independent medical advisers; in Ireland they will be known as practice support doctors. Irish general practitioners have viewed this development with some suspicion. They fear that the true intention is to form a corps of 'prescribing-cost police'. But looked at positively a truly independent adviser trusted by both sides would be a welcome innovation. One to one teaching and learning is notably absent from continuing medical education. There seems no good reason why this should be so.

Organization of continuing medical education

I will not attempt to summarize the byzantine bureaucracy which serves general practitioner postgraduate education in the UK. Wiser men have failed to unravel the roles of its personnel, reconcile the interests involved and allocate the responsibilities for approval, promotion, organization and tutoring the continuing medical education curriculum. To an outsider it appears unnecessarily complex. For effective continuing medical education the key appointment is still the general practitioner tutor — the rest is a matter of administrative convenience. As Grant and Gale have written[23] 'control of the curriculum ... rests wherever the teaching and learning are actually occurring.'

The Irish tutor network

The development of general practitioner tutors in the Republic of Ireland is worth describing, not as a model, but because it illustrates the complexities of implementing a national tutor network. Irish continuing medical education follows the traditional lecture-based pattern. Modest study leave allowances are payable for approved attendance. There are few postgraduate centres and because almost 70% of general practitioners are single handed, practice-based continuing medical education is virtually nonexistent. The pharmaceutical industry fulfils the same role as in the UK.

For the last 10 years the Irish college supported by a statutory body, the Postgraduate Medical and Dental Board, has been developing a complimentary programme of small group activity. The intention was to gradually build up a core of tutors and group leaders with the necessary skills to establish meaningful performance review.

The 2000 general practitioners in the Republic were divided into 28 areas including about 65 general practitioners each. If the local college faculty requested a general practitioner tutor and the post was approved, it was then advertised and a general practitioner from the area was appointed. So far 13 such tutors are in post. We expect to complete the network within three years.

Tutors are paid two sessions per week by the government together with half-time secretarial allowances and travelling expenses. Some funds are also available to enable them to attend courses relevant to their personal development. The tutors' job description includes the tasks of organizing, promoting and tutoring the continuing medical education programme. This includes forming the general practitioners in their areas into groups, and devising a curriculum in consultation with them.

Motivation is a specially important task for the tutor. Tutors therefore contact all their general practitioners personally, invite them to attend, and obtain their personal commitment. In

spite of this a third of the total general practitioner population still refuse to participate.

The 13 tutors now serve areas which include over 1000 general practitioners. Those who agreed to participate have been formed into 56 groups which last year held almost 400 meetings. Of those participating about 60% attend in any month, representing 37% of the total population of general practitioners. Our experience has shown that motivation is very much higher in rural areas. This is reflected in the percentages of non-participants (25% versus 53%). However, those city-based general practitioners who do participate show very comparable attendance levels.

Initially the tutor leads all the groups personally. In due course a suitable group leader is identified in each group. The leaders are formed into a planning group and provided with training in small group leadership skills. Tutors are expected to coordinate their schedules and programmes with other continuing medical education activities locally but they are not responsible for providing or approving lecture programmes. Tutors keep records of all their meetings and any discussion material prepared for them. These are returned to the college where a national 'material bank' has been established.

The general practitioner tutors come together for three extended weekend workshops per year. These meetings allow tutors to report progress in their own areas; to have their material critically reviewed by the tutor group; to practise and receive feedback on their leadership skills; and recently to explore methods of developing relevant curriculum content. The intention is to organize the general practitioner tutors into a 'school' — an organized educational community where curriculum innovation can be negotiated and discussed.

The tutor network is evaluated by a system of scheme visits. Four visitors spend half a day reviewing the programme in detail. Beginning with an extended interview with the tutor, they check the performance of the groups, the content and methods of every meeting and how it was received, and the tutor's plans for the future including his or her personal educational development. They observe a group meeting and later in the absence of the tutor listen to the impressions of group members. Finally in consultation with the tutor a report is compiled for the Irish college.

Lessons from the Irish experience

Any voluntary system of continuing medical education must compete with family and leisure activities. How are we to motivate our colleagues to participate? To begin with each one must be asked to join — not because they need us and what we have to offer, but because we need them. We must show that every contribution is valued. We must promise relevance in the programme and involve them in its preparation and planning using their experience, their problems and their cases. They must be convinced that the activities will be well organized, interesting, enjoyable, stimulating and convenient. This can only be achieved by actively promoting our programmes, by selling what we have to offer.

Target audience

Promotion of continuing medical education depends on a thorough knowledge of the target audience. Although continuing medical education is referred to as a single phase of learning this does not mean that the audience is uniform.

Young principals groups are a spontaneous response to the special needs of young doctors. A survey published in 1988 identified 167 such groups in the UK and found that only one out of four young principals are members.[24] The existence of these groups highlights the awkward transition between training and continuing medical education which ideally should be almost imperceptible. It follows that the MRCGP examination should be formative as well as summative — providing both the candidate and the continuing medical education tutor with a qualitative assessment of strengths and weaknesses upon which to go on building in the years that follow training.

The middle years of practice are often characterized by a need for some new challenge. Not surprisingly few of us can go on doing the same job with the same degree of interest indefinitely. These needs are largely ignored. Many of us have found a challenge in education at different levels. Our guilt is summed up in Shaw's scornful words: 'He who can, does. He who cannot, teaches'.[25] Others turn to practice management and organization, research or other interests unrelated to general practice. Contracts should provide for this 'flight' from service commitments. Our system of continuing medical education should also support these professional transitions.

Needs change again as retirement approaches. Older doctors fear their declining capacity to sustain their service workload and the reliability of their ageing knowledge base. Yet they feel that their experience should be valued and respected. Continuing medical education can be used to address these issues.

Curriculum planning

Satisfying the special needs of the target audience requires curriculum planning. For years continuing medical education has been no more than a random selection of current interest from which individuals may choose. Challenging this educational anarchy by suggesting a planned approach can offend deeply held beliefs. Yet there is already a curriculum. It may not be comprehensive, relevant, interesting or tailored to the needs of the participants but it does exist.

Perceived learning needs

Originally in Ireland we thought devising a curriculum was a simple matter of following certain basic principles: discover learning needs, derive specific objectives, choose appropriate methods, provide for evaluation, and give feedback, recognition and accreditation.[26] We tried to establish perceived learning needs by canvassing the participants' views. The results were curiously predictable. As a result tutors were separately and simultaneously choosing very similar topics. However, the exercise was not futile because it helped to confer on the participants ownership of the programme, and thus commitment to it.

Perceived learning needs seem to originate in the repeated publicity given to some topics in the specialist and general media. This once unintentional process has now become the subject of manipulation by pressure groups, commercial interests and ambitious individuals. The result is a rollercoaster of clinical fashions. Its importance lies in the fact that it determines the continuing medical education agenda and thus perhaps even the development of the discipline itself. We need to understand this process if only to use it to pursue our own agenda.

True learning needs

Ideally we should be guided by true learning needs. We must begin by showing doctors what they need to learn and why they need to change what they do. Audit should provide the necessary convincing evidence. Yet a survey in Leeds[27] showed that 47% of general practitioners were doing nothing with their collected data. Worthwhile nationwide audit will require a suitably led discussion group for every practice. Many may find the discipline of regular performance review unacceptable. Freeling reported

that a group of 16 London general practitioners could not be persuaded to repeat an audit after an interval to establish the outcome.[28]

We found that true learning needs, particularly those relating to qualitative and unmeasurable aspects of practice, only became apparent in the course of discussion. Fabb has suggested[29] that questioning is the central act of identifying knowledge deficits and learning needs. He describes the skills required to frame pertinent questions. These skills should be included in the training of group leaders.

Focusing discussion

Our tutors' workshop has tried to refine a method of responding to perceived learning needs using a menu of relevant discussion material. Using the 'brainstorming' technique we identify the issues of concern within any given area of the curriculum. We then arrange them in order of priority in terms of what is common, important and a problem. Finally we express the issues more precisely in terms of doctor behaviour to be changed. We then choose the most appropriate vehicle to focus discussion on the precise issues identified.

Window of opportunity

Each year each group member spends at most 20 hours at our meetings — a tiny window of opportunity when compared with the 1200 hours spent in face-to-face consultation with patients. To be effective continuing medical education must have relevance far beyond its specific content and enable learning to continue into everyday experience. Achieving this 'generalizability'[30] is a skill in itself. Knowledge acquired about one problem may be applicable to others but more often subtle changes in attitudes, values and beliefs will have the desired pervasive quality.

Stepwise approach to performance review

Whatever our chosen method, our intention is performance review. Thus we have attempted to adhere to the six steps outlined by the New Leeuwenhorst Group.[31]

1. Choose an area of performance.
2. Look at what we do — directly or indirectly.
3. Decide what we ought to do based on:
   - — individual knowledge and beliefs;
   - — the consensus of the peer group;
   - — the opinions of experts;
   - — the findings of research.
4. Reflect on the gap between the reality and the ideal and the barriers to change.
5. Agree on action to achieve change and a timetable for it.
6. Agree to review progress after an interval.

Needless to say reality often falls short of the ideal represented by this aspiration.

False consensus trap

George Bernard Shaw has written: 'Optimistic lies have such immense therapeutic value that a doctor who cannot tell them convincingly has mistaken his profession.'[32] However, honesty is a prerequisite for a sound group consensus. The desire to avoid the pain of confronting a colleague can tempt us into telling each other optimistic lies. Freeling has described how a led group 'joined in a kind of false consensus in order apparently to avoid disagreements in the group.'[28]

The role of the RCGP

Since the foundation of the RCGP its greatest achievements have been in education. The establishment of departments of general practice in almost every medical school, and the universal availability of vocational training are monuments to its pioneering efforts. Two other parallel activities were equally important: the development of educational expertise (the Balint seminars, the London teachers workshop, the Nuffield courses and publication of *The future general practitioner*[33]) and the search for suitable forms of assessment (the MRCGP examination,[34] the 'What sort of doctor?' working parties[35] and the fellowship by assessment criteria[36]).

These preoccupations may explain the apparent avoidance of the central challenge for any college — that of establishing a theory and practice of continuing education. That is not to say that continuing medical education has been neglected. Far from it. It has been the subject of several occasional papers,[17,26,37] and numerous editorials and articles. In a recent policy discussion document[38] the RCGP identifies '...as one of its highest priorities the appointment of a general practitioner tutor in every district.' However, it also mentions new proposals for higher professional training, higher university degrees for established principals, interprofessional and practice-based learning incorporating performance review, distance learning and practice visiting. There is a danger that this comprehensive list will dilute the emphasis on continuing medical education tutors and may provide opportunities to become once again embroiled in other less infuriating aspects of education.

Could it be that we are inhibited from wholehearted involvement in educational services for all general practitioners by the fact that full membership is not available to all. My own view is that the time has come to review that policy in both our colleges.

Furthermore by referring only to the need for general practitioner tutors to be appointed the implication is that whatever follows their appointment will not be the RCGP's concern. Does this mean that the definition of the role of the tutors, and the development of the theory and practice which surrounds this would be a matter for someone else? For the tutors themselves perhaps or for district and regional education committees? Already there are plans to form an association of general practitioner tutors. Some job descriptions have been drawn up, and some MSD Foundation tutorship courses have begun. I am privileged to be involved in some of these courses as a tutor. All these developments may be very appropriate and a more professional approach to the task of the continuing medical education tutor is overdue, but what part is the RCGP playing in all of this?

Teaching at undergraduate and vocational training levels has now moved to a professional level. While entirely desirable, this has nevertheless placed this teaching outside the realm of the RCGP and to some extent beyond its intellectual influence. The professionalization of continuing medical education may well do the same.

The virtual exclusion of the RCGP from a central role at any level of general practitioner education must have serious implications for its relevance and therefore its future. Some of that uncertainty about the future of the RCGP has already surfaced at the first meeting of its current Council.[39]

Conclusion

We have asserted our right to be a separate discipline in medicine. That means accepting the responsibility which accompanies that right — to be answerable for all general practitioners. I must indeed be my brother's keeper.

Governments have now made that accountability explicit through contracts in ways which distort practice. As an academic

body our response must be to devise mechanisms of self-regulation which are demonstrably better than the prescriptions of contract. Medical audit and national standard setting can greatly assist us in meeting that challenge by providing information about what we actually do and by defining acceptable levels of performance. But they are limited and fraught with danger. They can become too prescriptive; they can seek to impose uniformity where being uniform matters little; and they can spawn nightmarish bureaucracy.

The key to good practice is still going to be good practitioners. They must be not only competent but must want to perform well. In a discipline characterized by so much uncertainty and individuality, training doctors to make programmed decisions will have its limitations. What we need is a system of education which equips the learners for the changing task of medicine, which can provide for their evolving career needs, and which enables them to at once create and assimilate the hidden curriculum — the ethos of general practice.

Only interpersonal forms of continuing medical education — and specifically performance review groups — offer these wider opportunities but their development has been sadly neglected. At the administrative level general practitioner tutors are only beginning to find the support they need. In my view their job description is too wide and should be narrowed to allow them to concentrate their efforts on the central task of forming and resourcing performance review groups in their areas.

Administrative reform alone will not be enough. The theory and practice of continuing medical education also demands attention. Acceptable methods of defining learning needs must be developed as the basis for a rational continuing medical education curriculum. We must understand the origin of our perceived needs so that we can begin to control the development of our own discipline. We must learn to use the window of opportunity which formal continuing medical education provides; we must learn how to focus our discussions, how to avoid premature and superficial consensus, and how to draw lessons of more general use from the specific subjects discussed. This expertise must be widely disseminated through a formal system of group leadership and tutorship training.

This is surely the central challenge for the RCGP now. In meeting it we will be doing what we do best. We will secure for ourselves an important role for the future and with it some of the self-confidence and sense of purpose which we have lost.

Some will see in this suggestion an attempt to impose rigid structures on continuing medical education — a nightmare of inflexible red tape. Others will regard it as the naive musing of a dreamer. I can only reply in the words of William Butler Yeats:

> 'But I being poor, have only my dreams;
> I have spread my dreams under your feet;
> Tread softly because you tread on my dreams.'[40]

References

1. Genesis 4: 9. *The Holy Bible.* Revised standard version. New York: William Collins, 1959.
2. Pemberton J. *Will Pickles of Wensleydale. The life of a country doctor.* London: Royal College of General Practitioners, 1984.
3. Norell JS. What every doctor knows. *J R Coll Gen Pract* 1984; **34:** 417-424.
4. Klein R. From status to contract: the transformation of the British medical profession? In: L'Etang H (ed). *Health care provision under financial constraint: a decade of change. International congress and symposium series no. 171.* London: Royal Society of Medicine, 1990.
5. Howie JGR, Porter AMD, Heaney DJ, Hopton JL. Long to short consultation ratio: a proxy measure of quality of care for general practice. *Br J Gen Pract* 1991; **41:** 48-54.
6. Summary of council meeting. *J R Coll Gen Pract* 1983; **33:** 523-525.
7. Irvine DH. Standards in general practice: the quality initiative revisited. *Br J Gen Pract* 1990; **40:** 75-77.
8. Irvine DH. *Managing for quality in general practice. Medical audit series no. 2.* London: King's Fund Centre 1990.
9. Grol R. National standard setting for quality of care in general practice: attitudes of general practitioners and response to a set of standards. *Br J Gen Pract* 1990; **40:** 361-364.
10. Grol R, Mokkink H, Schellevis F. The effects of peer review in general practice. *J R Coll Gen Pract* 1988; **38:** 10-13.
11. McWhinney IR. Through clinical method to a more humane medicine. In: White K (ed). *The task of medicine. Dialogue at Wickenburg.* Menlo Park, California: Henry J Kaiser Family Foundation, 1988.
12. Simon HA. *The new science of management decision.* London: Harper and Row, 1965.
13. McIntyre N, Popper K. The critical attitude in medicine: the need for a new ethics. *BMJ* 1983; **287:** 1919-1923.
14. Marinker M. Principles. In: Marinker M (ed). *Medical audit and general practice.* London: British Medical Journal, 1990.
15. Walton HJ. The balance between education and training. *Med Educ* 1988; **22:** 240-244.
16. Ruscoe MNJ. Thoughts of a general practice clinical tutor. *BMJ* 1987; **295:** 1175-1176.
17. Branthwaite A, Ross A, Henshaw A, Davie C. *Continuing education for general practitioners. Occasional paper 38.* London: Royal College of General Practitioners, 1988.
18. Harden RM, Mulholland H, Baker KL. *Distance learning and the continuing education of general practitioners: summary.* Dundee: Centre for Medical Education, 1990.
19. Marinker M. Medical education and human values. *J R Coll Gen Pract* 1974; **24:** 445-462.
20. Royal Commission on Medical education. *The Todd report.* London: HMSO, 1968.
21. Owen P, Allery L, Harding K, Hayes T. General practitioners continuing medical education within and outside their practice. *BMJ* 1989; **299:** 238-240.
22. Hayes T, Allery L, Harding K, Owen P. Continuing education for general practice and the role of the pharmaceutical industry. *Br J Gen Pract* 1990; **40:** 510-512.
23. Grant J, Gale R. Changing medical education. *Med Educ* 1989; **23:** 252-257.
24. Edwards P, O'Toole O, Pharoah C. Survey of young principal groups in the United Kingdom. *J R Coll Gen Pract* 1988; **38:** 61-63.
25. Shaw GB. *Man and superman.* London: Penguin, 1988.
26. Wood J, Byrne PS. *Section 63 activities. Occasional paper 11.* London: Royal College of General Practitioners, 1980.
27. Webb S, Dowell A, Heywood P. Survey of general practice audit in Leeds. *BMJ* 1991; **302:** 390-392.
28. Freeling P, Burton R. General practitioners and learning by audit. *J R Coll Gen Pract* 1982; **32:** 231-237.
29. Fabb WE. Continuing education — identifying our needs. *J R Coll Gen Pract* 1981; **31:** 395-400.
30. Champion A. The contribution of an adult educationalist to a trainers' group. *J R Coll Gen Pract* 1977; **27:** 135-136.
31. New Leeuwenhorst Group. *Quality improvement by quality assessment in general practice.* Leeuwenhorst, The Netherlands: NLG, 1986.
32. Shaw GB. *Misalliance.* London: Penguin, 1984.
33. Royal College of General Practitioners. *The future general practitioner.* London: British Medical Journal for the RCGP, 1972.
34. Lockie C. *Examination for membership of the Royal College of General Practitioners (MRCGP). Occasional paper 46.* London: RCGP, 1990.
35. Royal College of General Practitioners. *What sort of doctor? Report from general practice 23.* London: RCGP, 1985.
36. Baker R. *Practice assessment and quality of care. Occasional paper 39.* London: RCGP, 1988.
37. Reedy BLEC, Gregson BA, Williams M. *General practitioners and postgraduate education in the northern region. Occasional paper 9.* London: Journal of the Royal College of General Practitioners, 1979.
38. Royal College of General Practitioners. *A College plan — priorities for the future. Occasional paper 49.* London: RCGP, 1990.
39. Responding to members' needs. *RCGP Connection* 1991; February: 2-3.
40. Yeats WB. He wishes for the cloths of heaven. In: Webb T (ed). *WB Yeats. Selected poetry.* London: Penguin, 1991.

Address for correspondence

Dr M Boland, Lurriga, Skibbereen, County Cork, Republic of Ireland.