areas, to provide a standard of medical care not far removed from that which could be obtained anywhere in the land.

In a town like Brecon, with no railway link before 1863 nearer than Merthyr Tydfil, a visit to a specialist in London must have been rare indeed. There were no large towns in Wales, and probably the nearest centre where specialist medical opinion could be found would be Bath or Cheltenham. Even after the railway came, such a journey must have been a formidable undertaking with several changes of train and one beyond the means of most of a country population. In the present days of hospital-based medicine, this would be an intolerable social injustice. But in those days the situation was saved by the brilliant 'local boy' who came home and provided without fuss a standard of local medical care relatively much higher than could be found anywhere now.

EDUCATION

Continuing education for general practice

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DURING THE PAST TEN YEARS general practice has escaped from the medical doldrums and should now look forward to an increasingly vigorous, productive and rewarding, and increasingly important rôle in the field of community medicine. This rôle must be based on close co-operation between the general practitioner and his health team, and allied social and medical services, for the general practitioner cannot continue to provide the best possible care of his patients if he remains aloof, and scorns to work closely with these colleagues. He must be able continuously to provide a high standard of clinical care within the expanding syllabus of medical knowledge. "A wide range of current knowledge and skills will be required, and will have to be obtained without the superficiality which would impose limitations in the practice of medicine".[1]

We must accept the growing burden of major and minor psychiatric disability in the community—a part of the work-load often shirked, and if not able or inclined to deal with it ourselves, must learn to recognize it and make use of our colleagues, whether health visitor, probation officer, psychiatric social worker, or psychiatrist. We must take some part in preventive work in this, as in all other fields of medicine. We must contribute to health education; not only face to face with our patients, but through our health team, and, if possible, in groups of one kind or another, or in schools etc. In other words, general practitioners, who sometimes look on themselves with the jaundiced eye of self-pity because of their burden of overwork, must anticipate a continuing, if changing burden, until the required increase in medical manpower becomes more than a faint prayer, and until preventive medicine, and health education begin to pay real dividends.

To be able to cope with this burden, we must learn to make best use of ourselves and our team, especially to make best use of our time.[2] And one of the uses we must make of our time is to continue to train ourselves so that we possess that "wide range of current knowledge and skill" that will ensure that *all* our time, on whatever of our diverse activities it is spent, is indeed best used.

Facilities for continuing training for general practitioners are increasing and improving. There are a wide variety of sources of information, and techniques for purveying it to us. Regrettably we make relatively little use of them. Around Manchester a 48 per cent response (762 replies) to a questionnaire on the subject indicated that 57 per cent regularly read *The Practitioner*, 17 per cent never buy new textbooks, 50 per cent of those with Journal Club facilities don't take part, only 23 per cent have clinical assistantships, 79 per cent do not watch

BBC-TV programmes for doctors. Over 50 per cent were dissatisfied with their local facilities. Of these 15 per cent had not attended courses anyway, only 47 per cent had attended more than one course (the period of time is not given).[3] In the Canterbury area 15 of the 90 doctors notified applied for the first two-year course for general practitioners recently settled in the area.[4] In the Southampton area, 90 replies were received to 400 requests for comments at the end of the first year's activities of the Postgraduate Centre.

These figures beg many questions, and take no account of the quality of the facilities actually offered, but they emphasize that those who take advantage of existing programmes of education are relatively few, and do so sporadically.

Individuals will give many reasons for this, lack of time and opportunity will probably be the commonest. The validity of these reasons will vary, but there are two which apply collectively, and involve criticism of ourselves and our undergraduate training, as well as of the programmes of education that already exist. One is a lack of initiative, which is to some extent innate in almost every one, whatever their profession, once student days are over, and which was to a lamentable extent bred into us by the neglectful, and often contemptuous treatment of general practice in our undergraduate curriculum. The second is the lack of stimulus in the programmes that exist. They are often adequate, but seldom really excellent. They are seldom based on any *detailed* survey of what general practitioners want and how they want it provided; and scant use is made of general practitioners themselves in providing it, though many are well qualified to contribute.[3] Teaching content and techniques are drearily and wastefully used. The programmes do not adequately " . . . engender an attitude, an appetite . . . a habit of mind that, given opportunity, bring steadily increasing knowledge, awareness and discrimination to its possessor" nor do they "achieve an atmosphere of liveliness, curiosity and enquiry".[5]

In short, the content of available programmes, be it printed, spoken or photographed, is not arranged well enough to encourage general practitioners to develop initiative, make sacrifices—if sacrifices are really required, and overcome difficulties, in order to continue training.

This can all be remedied. A remedy for the first complaint is already at hand. For some years the provincial medical schools have shown an enlightened attitude to the treatment of general practice, social medicine and community medicine in their curriculum. The London schools are beginning to see the light, and the changes proposed by the Royal Commission will further illuminate the medical mind. This means, however, that in future years the quality of continuing education will have to meet even more exacting demands than we might make of it now, and we must plan accordingly.

We must find out by specific and detailed enquiry what are the attitudes, needs and wishes of general practitioners in this field. At the same time we must try to anticipate the needs of future generations emerging from the new curriculum.

A proposal for an integrated scheme of continuing education

Finally we must ensure that programmes are good enough to attract the majority most of the time, rather than the minority some of the time, and to stimulate continuing interest and enthusiasm. This can be done by making the best use of all available teaching and learning techniques, and by planning the content so as to achieve maximum enjoyment and productivity.

The simple premise is that the combined influence of different sources and techniques will exceed the sum of their separate contributions. This could be achieved by a scheme which involves the participation of the broadcasting media, the medical schools, certain medical publications, regional postgraduate centres, and the 'prospective pupils'—not necessarily in that order of importance, and embraces all forms of teaching from videotape to discussion group.

The specific aims would be the usual ones of keeping abreast of advances, and consolidating and augmenting knowledge of the wide variety of subjects, clinical and otherwise, which are of value in general practice. The scheme would not imply total co-ordination and control of programmes, which would be impossible anyway. It implies the co-ordination and integration of part of the content of existing programmes. The optimum degree of this would have to be worked out and adjusted as the scheme progressed. It would be most important that no one should feel that they were being told what to teach, learn or do in a dogmatic way. The participation of all parties in the discussion and planning would be necessary to achieve this. Such a scheme might best be organized, and could well be tried out, on a regional basis, and existing regional facilities offer a basis for the scheme. Some degree of central planning would be

necessary and valuable, to aid communication between regions, to help share and distribute resources and "material"—e.g. certain 'programmes' might be 'networked' and involve journals and other contributors who have no regional organization.

A regional basis for the scheme would be congenial and would permit more intimate co-operation between the parties involved, and would probably lead to more productive planning and less conflict between sectional interests. The regional centres would be the hub of the scheme. They would assist in planning programmes, contribute to them and produce them. They would be an open channel of communication between 'school' and 'pupils', and the level at which the 'pupils' are represented on the 'governing body'—and comprehensively represented; not by the volunteered opinions of a few, but by the solicited opinions of all. They would be the level at which hospital specialist services are co-opted into the scheme. They would have to be a good multiple synapse. At this level postgraduate programmes should converge and diverge, and achieve the optimum blend of local variety with central and regional integration. Regional broadcasting, if it survives and develops might be used, as should national networks.

Some journals such as *The Practitioner* and *Update*, specifically designed for the general practitioner, are already organized in the form of symposia, or according to some plan of continuity of content, and so would lend themselves to this sort of integration.

The elements of such a scheme already exist, and to pull them together would, I am sure, reap rewards.

The form of such a scheme might be based on an approach to learning given by Graves.[6] To somewhat paraphrase and adapt, this is:

1. Basic principles—often most easily purveyed by sound (or sound and vision—T.V.)
2. Supplementary material—practical, written, visual, programmed
3. Discussion—perhaps guided by an informed member or teacher (could possibly be Journal Club type)
4. Individual exploration. Return to texts, references, personal discussion with experts etc.
5. Discussion—unguided; no teacher dominance

On this basis I would envisage something like this:

1. Subject to occupy certain specified period of time (=the "course")
2. Choice of subject based on discussion at regional level
3. Course to start with basic principles—broadcast
4. Follow up with supplementary material—journals, lectures, demonstrations, more specific auditory and visual aids, "programmed" teaching, machines, what have you
5. Discussion—? with expert present, ? without
   ? interdepartmental
   ? linked with other centres
6. Individual exploration—texts, references etc.
7. Final discussion

All this would be difficult to arrange, but it might be worth it.

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