Editorials

CONTINUING EDUCATION AND PRACTICE AUDIT

THE great effort required to launch vocational training successfully and to secure teaching in the setting of general practice for medical students has left little time for improving continuing education, at least by practitioners themselves. There have been helpful developments nevertheless; for example, the past decade has seen a substantial increase in postgraduate medical centres; the Medical Recording Service Foundation of the College has extended the range of its services; the presentation and scope of postgraduate reading material has improved; and the Health Departments have provided for the travelling and subsistence of general practitioners attending approved courses.

However, it is still true that most continuing education for general practice is geared to the outmoded concept that general practice comprises only the sum of a number of specialties practised at a fairly superficial level; thus, not surprisingly, it is largely organised and delivered by hospital specialists using traditional methods which now must be regarded as limited in their effectiveness.

There are several indicators of change. First, research workers in general practice have made solid progress in studies into the content of our discipline, from which a working syllabus has been derived. Secondly, experience of learning-teaching methods more appropriate to general practice, gained with medical students and vocational trainees, is now available to be applied in continuing education. Thirdly, teachers in general practice especially in integrated training, where they meet and work together regularly, are beginning to look more openly and critically at their individual standards of clinical diagnosis and management and at practice organisation. Taken separately these developments may excite academic interest only; in combination they hold the potential of adding a whole new dimension to continuing education by relating it more positively to the quality of care.

We are beginning to realise that sophisticated measures of quality of care will be complicated and expensive; methods are in embryo and it is unlikely that validated criteria will appear within the next decade. Meanwhile, there is much that the providers of medical care can do themselves within the framework of existing knowledge. Effective provision of health care is partly a matter of Health Service management, but each clinician has his own responsibility, to ensure as far as possible that the professional services he renders accord with the standard generally accepted within his own discipline. To achieve this the practitioner has two tasks: he must be able both to maintain his knowledge and skill especially in areas critically relevant to the content of his branch of medicine, and to show to himself and to his colleagues that he applies such knowledge every day in practice.

Maintaining knowledge is an educational problem which is especially difficult in a broadly based discipline like general practice because of the vast amount of new in-

formation that is becoming available. Fortunately, small group methods can help by being used, for instance, to determine priorities and to distinguish optimum patterns of management and care, at least as they are perceived by health professionals themselves.

Demonstrating the use of acquired knowledge in individual practices presupposes, among other things, the presence of well-kept records and easy access to other practice statistics such as basic demography, mortality rates and data on prescribing.

It is right that these new methods of learning and of audit should take their place alongside the more traditional ways used in continuing education for general practice today and indeed they should be applied on a wider scale than is the case at the moment. Why should the teaching practices have all the exciting action?

Finally, mention must be made that some authorities are beginning formally to link continuing education and audit with competence to practise. The main step has been taken in the United States but in Britain the British Medical Association has taken the lead to bring together bodies interested in postgraduate medical education and professional standards, so that they might examine competence to practise in greater detail. There is now a Joint Committee on Competence to Practise and presumably it will eventually produce a report.

Meanwhile, the available evidence suggests that we should proceed apace to experiment with and to evaluate the new methods in an informal way, suspending judgment on the need for legislation on re-accreditation until the effects of informal processes, which are far less threatening to doctors themselves, can be seen more clearly in perspective.