WILLIAM PICKLES LECTURE

# A job half done

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IT is a great honour to be invited to give the William Pickles Lecture, and it is a great pleasure to give it in such delightful surroundings. I am sure that Will Pickles and Gertie would have approved for it was at Windermere that they spent their honeymoon in May 1917.

I saw Pickles on one occasion only. This was my 'short and only exposure'. It was at the opening ceremony and prize distribution at Birmingham Medical School on 3 October 1950. Pickles was giving the inaugural address and I was a very new undergraduate. I had forgotten completely until I saw a photograph of this occasion in Pemberton's (1970) fascinating biography.

I am very proud to claim at least some things in common with Pickles. He was a fellow Yorkshireman, and I too was born and bred in Leeds. We both failed finals. When I entered general practice I shared his aspirations for this College which made him its first President but rejected my first application for membership. I was rejected because I failed to demonstrate evidence of attendance at postgraduate activities.

When I was invited to give this lecture I was informed that it was "usual for it to be on an educational topic". And so, for the thirteenth William Pickles Lecture I am to speak about continuing education—not intrinsically exciting but important and topical.

I intend to review some of the developments in continuing education and to draw particularly upon my own experience as a general practitioner tutor. I will consider the relative influence of formal postgraduate education on what general practitioners actually do and draw some conclusions about what needs to be done in the future.

## Developments in continuing education

McKnight (1971), in the fourth Pickles Lecture, urged that continuing education should be equated with undergraduate education and vocational training. He saw formal continuing education as far less important than self-education based upon the 'need to know' and he stressed the need to inculcate the attitude of continuing education in trainees. He considered, as Byrne (1969) had two years before, that the way to improve formal continuing education lay through the activities of regional general practitioner sub-committees and departments of general practice influencing clinical tutors and devising courses. He concluded by appealing to practitioners to play their rightful part in teaching their fellows.

What, in fact, has been happening? We have a full quota of regional general practitioner sub-committees, regional advisers and associates, and an increasing number of university departments of general practice. The former have been preoccupied with vocational training and the latter with undergraduate education. Formal continuing education has come last and it probably had to. Nevertheless, there have been exciting developments and largely as a result of vocational training. Many in the audience have shared in these developments.

Vocational training has produced more than vocationally trained doctors; it has developed a body of teachers, course organizers and trainers with educational know-how and skills. It has produced in its vocationally trained doctors, practitioners with a different expectation of education, with a familiarity and preference for learning based on small-group activity, standard setting, and audit. Inevitably, continuing education has been influenced.

Some centres now have general practitioner tutors organizing continuing education in more relevant and interesting ways, providing focus and leadership.

In 1971 my experiences as course organizer for Doncaster Vocational Training Scheme encouraged me to challenge the established manner of providing postgraduate education locally. It was not that there was not considerable effort being made by a dedicated group of organizers, including clinical tutor, consultants and general practitioners, nor that there were not many enjoyable and well attended events, because all of this was true. The question was: were general practitioners changing what they were doing as a result? Was there any improvement in patient care? There was a need to decide what was to be learned first—a reversal of the tradition of inviting a 'good speaker' who would be expected to choose his own topic.

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It was agreed to have small working parties to organize individual events, speakers would be briefed about objectives to be achieved, the lecture would not be seen as the only instrument of instruction, and small-group activity would be introduced where relevant. A general practitioner tutor (honorary), myself, was appointed.

### *Midwifery*

I would like to illustrate my theme from some of my own experiences as a general practitioner tutor. In 1971 there were problems in our general practitioner maternity unit. Things were going wrong—there were delays in referring patients who developed complications in the antenatal period—toxaemia, primiparae with high heads at term—and unacceptable delays in labour, frequently requiring consultant involvement at a late stage, sometimes in unsociable hours, which were beneficial to neither doctor nor patient. The continued existence of the Unit was in danger. The main problem was the failure of general practitioners to keep up to date. The 'hands-off' expectant tradition had changed. The emphasis was now on early recognition of abnormality in pregnancy and labour. Failure to progress in labour had criteria for active management unfamiliar to general practitioner obstetricians.

Consultants were persuaded that an educational programme would be preferable to a feud and a detailed list of the knowledge, skills, and attitudes required by general practitioner obstetricians was constructed. Important deficiencies in performance were itemized and a programme of obstetric seminars was organized. Booking policy and indications for transfer to consultant care were restated and a flow chart introduced, its most important feature being the incorporation of an action line. Failure to progress in labour past a certain point was an indication for action, usually referral. This flow chart, known as a 'partogram', had originally been devised as a job aid for use by midwives managing primigravid labour outside hospital in Rhodesia; it had been found in practice to be useful not only in the bush but also in teaching hospitals—and so why not in general practitioner maternity units?

The results of the seminars and organizational changes resolved problems in the general practitioner maternity unit and transformed general practitioner obstetrics. It would be gratifying to record that we had measured the number of deliveries by forceps and caesarean section before and those after the educational programme, but we did not. However, no-one was in any doubt that things were better afterwards.

### *Therapeutics*

In 1975 the clinical tutor, a consultant geriatrician, proposed a study day on therapeutics relating to problems in the elderly. There were many distinct and common problems relating to side-effects, interactions and polypharmacy. Here were important educational needs, not only for local general practitioners but for others. The challenge was how to teach these complicated ideas in a way which people would understand and retain, and which would enable them to go away at the end of the day able to make some sense of their prescribing. A day of lectures would cover the ground but mainly with sleeping bodies and few residual effects. What we did was to have two lectures only. One was on 'drug treatment in the elderly', covering the more common drugs used and the more common problems, and the other was on 'drug interactions'. The other strategy for the day was to set groups of doctors to discuss a series of therapeutic problems, some of which were in the form of modified essay questions, and all illustrating differing and often multiple problems. Most of the problems used were found by the clinical tutor and myself from our own practice. Others were culled from such sources as prescribers' notes. The problems were chosen to match the lecture material. Each group had a resource leader and was allowed to use reference books. The answers to the problems were discussed further at a plenary session and a high level of discussion took place. The content was seen as relevant and was presented in a stimulating manner. Participants were able to relate their own previous knowledge and practice to the problems. The points made in the lectures were reinforced by the discussions in the groups.

What did we achieve? The response to a questionnaire seeking subjective opinion about the value of the day, its organization, and reaction to the teaching methods used was encouraging. As to a change in general practitioner behaviour, we had an unexpected indication that we might have achieved something unusual when pharmaceutical representatives asked what we had been up to—there was surprise at the level of questioning from general practitioners who had attended. Other than that we do not know.

### *Group work*

Sheffield Medical School has a tradition of week-long refresher courses for general practitioners. In the past these have consisted of a week of lectures and demonstrations, but in recent years we have introduced group activity aimed at setting criteria for the management of common conditions in practice. Groups have been provided with literature and specialist resources to assist them. It has been encouraging to see in members of such groups the acceptance of new ideas, particularly relating to continuing care and surveillance. This has been borne out by requests after courses for advice and material, such as simple morbidity indexes.

Last year we had a contrary experience: for several reasons the group activity was curtailed and on the final session of the course the reaction of members to concepts of continuing care and surveillance of such conditions as asthma and epilepsy were negative. There

**Table 1.** Management of epilepsy.

| *Performance deficiencies* | *New knowledge/skills* |
|---|---|
| Wrongly diagnosed | Drug level monitoring |
| Polypharmacy | Single drug effective |
| Failure to explain | Daily or twice daily dosage |
| Ignorance about blood level monitoring | |
| Poor records | |
| Poor supervision | |

were responses such as: "We can't be specialists in everything!" "Not paid to do it". This may have been a characteristic of course members, but my belief is that with carefully organized courses, attitudes can be shifted and enthusiasm generated.

## *Epilepsy*

In my final example I propose to go into more detail. If we consider epilepsy, a condition in which it is now possible to provide greatly improved care, as a topic for continuing education, we find that in order to identify standards of practice to aim for we need to know what is possible. In order to plan a programme which is relevant we need information about current performance and especially about deficiencies.

Recent literature gives us information about both possibilities and deficiencies. The British Epilepsy Association (S. McGovern, personal communication) has described problems encountered by patients with their general practitioners. Table 1 summarizes some of the main points. Jeavons (1975), reviewing 470 patients attending two epilepsy clinics in Birmingham, identified 20 per cent as not having epilepsy. Parsonage reports similar experience (personal communication). The most important reasons were found to be inadequate history taking and ignorance of the nature of epilepsy.

Amongst the many problems described by the British Epilepsy Association were: polypharmacy in response to repeat seizures, failure to explain about the disease or the purpose of medication, and ignorance about blood level monitoring.

That, in general, records are inadequate cannot in honesty be denied: it is a feature of British general practice and none of us can afford to be complacent. Long-term supervision depends upon good record keeping.

Drug level measurement has led to greater understanding of the pharmokinetics of anticonvulsants, especially phenytoin. It has been demonstrated (Cocks *et al.*, 1975) that this drug works effectively in a once-daily dosage and other anticonvulsants work in the majority of patients in a twice-daily dosage.

In hospital series it has been shown that 76 to 88 per cent of new patients may be controlled with a single drug (Shorvon *et al.*, 1978). It has also been shown (Shorvon and Reynolds, 1979) that polypharmacy may be reduced in chronic epilepsy with reduction to a single drug in 72 per cent of patients, with improvement in seizure control in 55 per cent, plus a striking improvement in mental function in 55 per cent. (It must be noted that a small number may become worse.)

Phenytoin dose adjustment is known to be particularly critical (Mawer *et al.*, 1974); above a certain serum level small increases in dose, as small as 25 to 50 mg, are needed to avoid toxicity. Conversely, to forget only the occasional dose brings the level below the therapeutic range. On the standard 300 mg per day dosage the majority of patients are likely to be under- or over-treated.

Improvement in care, however, will not result from the general practitioner improving his knowledge alone. Laboratory services must also be available, and available, I would like to stress, means specimen collection services—there is evidence that such a service can be cost-effective (G. E. Leyshon, personal communication).

Here then are educational needs to indicate learning objectives. What sort of learning situation is necessary to translate these into improved patient care? A lecture could be a start, but really the problem cries out for a standard-setting exercise carried out by groups of doctors with the emphasis on activity at practice level. The basic steps are familiar to many of you: first of all, preliminary meetings to set standards aided by discussion with experts and a search of the literature; secondly, identification of the patients and of deficiencies either by a review of the records, if adequate, or of the patients, or both; thirdly, action to remedy deficiencies; and finally, a further review to check the effectiveness of the exercise.

## *Audit of epilepsy*

I am aware that it is not wise to organize other people's standard-setting exercises and do nothing personally, and so, two weeks ago, I carried out an audit on the records of patients with epilepsy in my practice. This was neither research nor a model standard-setting exercise, rather a look at the state of affairs after several years in which we have gradually changed the management of epilepsy, but with increased activity in the past six to 12 months. Certain implicit criteria had been adopted, a requirement for:

1. As precise a diagnosis as possible, based on a description of any seizure; where a description was missing, one was sought.
2. A regular review, at least yearly.
3. Adequate records, especially of the incidence of seizures, side-effects of drugs and the problems patients were facing.
4. A policy of improving seizure control with a decreasing number of drugs, in simpler dosage, enquiring for and avoiding side-effects.

**Table 2.** Audit of epilepsy (from records). Practice population = 6,498, N = 37 (19 male, 18 female), (5.7 per 1,000).

| | Total | Percentage |
|---|---|---|
| Description of seizure | 29 | *78* |
| EEG | 26 | *70* |
| Seen in year | 34 | *92* |
| Seizure record | 32 | *86.5* |
| Seizure-free | 21 | *57* |
| Drug side-effects | 4 | *11* |
| Handicapped | 5 | *13.5* |
| Number of drugs | | |
| 3 | 2 | |
| 2 | 14 | |
| 1 | 17 | *46* |
| 0 | 4 | |
| Reduction from 3+ in two years | 9 | *24* |
| Blood levels | 13 | *35* |
| (Of value) | 8 | *21* |

**Table 3.** Audit of epilepsy—results.

| | | |
|---|---|---|
| Seizure control over two years | Improved in | 10 (6 male, 4 female) |
| | Worse in | 1 male |
| Drug levels | Critical in improving | 7 (mainly phenytoin) |
| General move to twice daily or daily dosage | | |

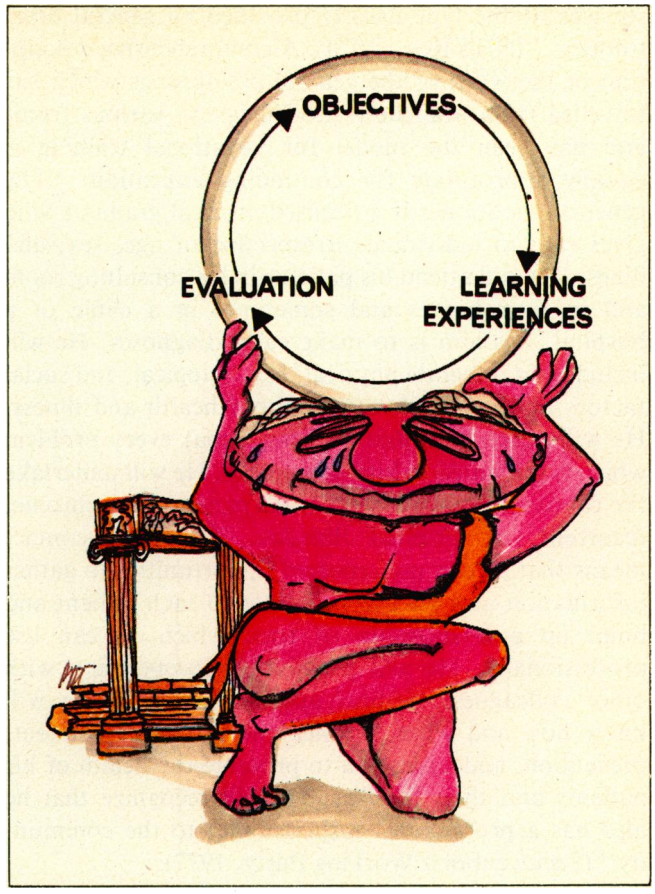


**Figure 1.** *The educational paradigm.*

The results are shown in Tables 2 and 3. Thirty-seven patients were identified in a practice population of 6,498, giving a prevalence of 5·7 per 1,000. This number included only three children under the age of 16. There was a description of seizures in 78 per cent and from this doubts about the certainty of the diagnosis in three, one of whom was an ex-barbiturate addict who had had seizures which appeared to be related to barbiturate withdrawal and who, in any case, was no longer on anticonvulsants. Three patients had not been reviewed in the past year and one of these had escaped for 18 months. Out of the five handicapped, improvement in control has made it possible for one to return to work and another to contemplate it. Another with previously apparently intractable epilepsy was noted to have very variable and often low serum levels of anticonvulsants and improved magically on the simplicity of a daily dose of phenytoin. Polypharmacy has been reduced in 24 per cent, and 46 per cent of patients are now on one drug.

Seizure control appears to be improved in 27 per cent. Improvement in general well-being in some patients has been dramatic.

These few examples demonstrate a range of educational activity. They are not unique—others in other places have done similar or better. I have presented them in order to show the need for thoughtful planning and skill; that there is a structure to the process of education which, if understood, can be of enormous assistance. I have to say something about this process.

## *Educational theory*

Unfortunately, educational theory is often seen as a burden (Figure 1) rather than something to ease progress. It is shown in a variety of forms fundamentally the same. The educational paradigm in its triangular form is familiar to you all (Pereira Gray, 1979). I personally prefer to think of it as a cybernetic cycle as described by Miller (1967), also known as Miller's carousel.

The pathway is common. We start with objectives through appropriate learning experiences to evaluation. Objectives indicate what we intend the learner to do as a result of the process.

What is the overall objective for continuing education? Byrne (1969) suggested that it should seek to initiate and promote change; I suggest that such change be towards improved patient care, and that it is necessary to work towards a model and that the model is fundamental. What models do we have?

The job description of our terms and conditions of service is as follows: "A doctor shall render to his patients all necessary and appropriate personal medical

services of the type usually provided by general practitioners" (NHS Reg., 1974). A comprehensive description of the work of the general practitioner which has travelled from Manchester to Europe in various forms and has been the model for vocational training is equally appropriate for continuing education: "The general practitioner is a licensed medical graduate who gives care to individuals irrespective of age, sex, and illness. He will attend his patients in his consulting room and in their homes and sometimes in a clinic or a hospital. His aim is to make early diagnoses. He will include and integrate physical, psychological, and social factors in his considerations about health and illness. He will make an initial decision about every problem which is presented to him as a doctor. He will undertake the continuing management of his patients with chronic, recurrent, or terminal illnesses. Prolonged contact means that he can use repeated opportunities to gather information at a pace appropriate to each patient and build up a relationship of trust which he can use professionally. He will practise in co-operation with other colleagues, medical and non-medical. He will know how and when to intervene through treatment, prevention, and education to promote the health of his patients and their families. He will recognize that he also has a professional responsibility to the community" (Leeuwenhorst Working Party, 1977).

The lowest level to which general practitioners retreat is to provide an on-demand service which responds to wants. A fuller job description is: "Comprehensive continuing care which responds to needs." The latter does not yet in any true or complete sense exist in British primary care. Objectives for continuing education programmes should have this model in mind.

## Objectives

Objectives need to be derived from training needs and I suggest that training needs may be identified by looking for deficiencies in performance and those arising out of new medical knowledge and skills (Table 4). Care must be taken in reviewing performance since shortcomings may not be due to lack of knowledge or skill so much as failure in execution; this may be due to heavy workload, high morbidity, the certification burden, or common-or-garden laziness. Lack of resources, for example lack of access to contrast radiology or absence of specimen collection services and laboratory facilities, would negate increases in knowledge or skill gained from an educational programme.

From outside we can look at the use of hospital services; we can ask patient groups; we can look at prescribing data. The possibilities from new medical knowledge and skills should be forthcoming from the postgraduate organization, universities, and specialists (the latter in a general sense), and this College.

**Table 4.** Selecting learning objectives.

| | |
|---|---|
| *Performance deficiences* | |
| Knowledge/skill | |
| Execution | |
| *From practice* | *From outside* |
| Ask | Use of hospital services |
| Audit | Referrals |
| | Diagnostic services |
| | Prescribing data |
| *New medical knowledge and skills* | |
| Postgraduate organization | |

## Learning experiences

Learning experiences should be both appropriate to the objectives and optimal for older learners. As Miller (1967) has pointed out, there is no one superior method and individuals learn in different ways. However, different methods suit different objectives. Acquisition of knowledge comes by reading or listening; skills are acquired by demonstration, practice, and correction; attitudes are more readily influenced by peer interaction. In general, methods which actively involve learners are more effective and adult learners are no exception. Their main problem is difficulty in accepting new ideas, especially when this means discarding the security of established practice. Since attitudes about role, for example, concepts about continuing care, preventive health, health education, and the need for good records, are the major obstacles to change, we need courses designed to influence attitudes. These courses must enable older learners to discover alternative ways of practice for they cannot be told; this requires skilfully led group activity.

## Evaluation

Have objectives been achieved? Has learning taken place? Are participants changing what they do? Have any new objectives been identified? These are questions which should be asked of every activity, but rarely are. This is true of vocational training as well as continuing education. There have been very few validated studies (Evered and Williams, 1980). We generally assume from unstructured comment or uncontrolled observation the success or failure of our efforts. There is a need to conduct evaluation studies of educational programmes and it is long overdue. But despite this I believe that we can accept that well designed and executed activities can lead to changes in what doctors do.

Let me now pull the threads together:

*What can we say about formal continuing education?*

1. It is possible to provide more effective learning leading to improved patient care.
2. It is complicated and to do it properly requires skill.
3. It is most effective if it leads to self-learning.
4. However, it reaches only a small number.

*What is the case for formal continuing education?*

1. It gives direction and indicates standards.

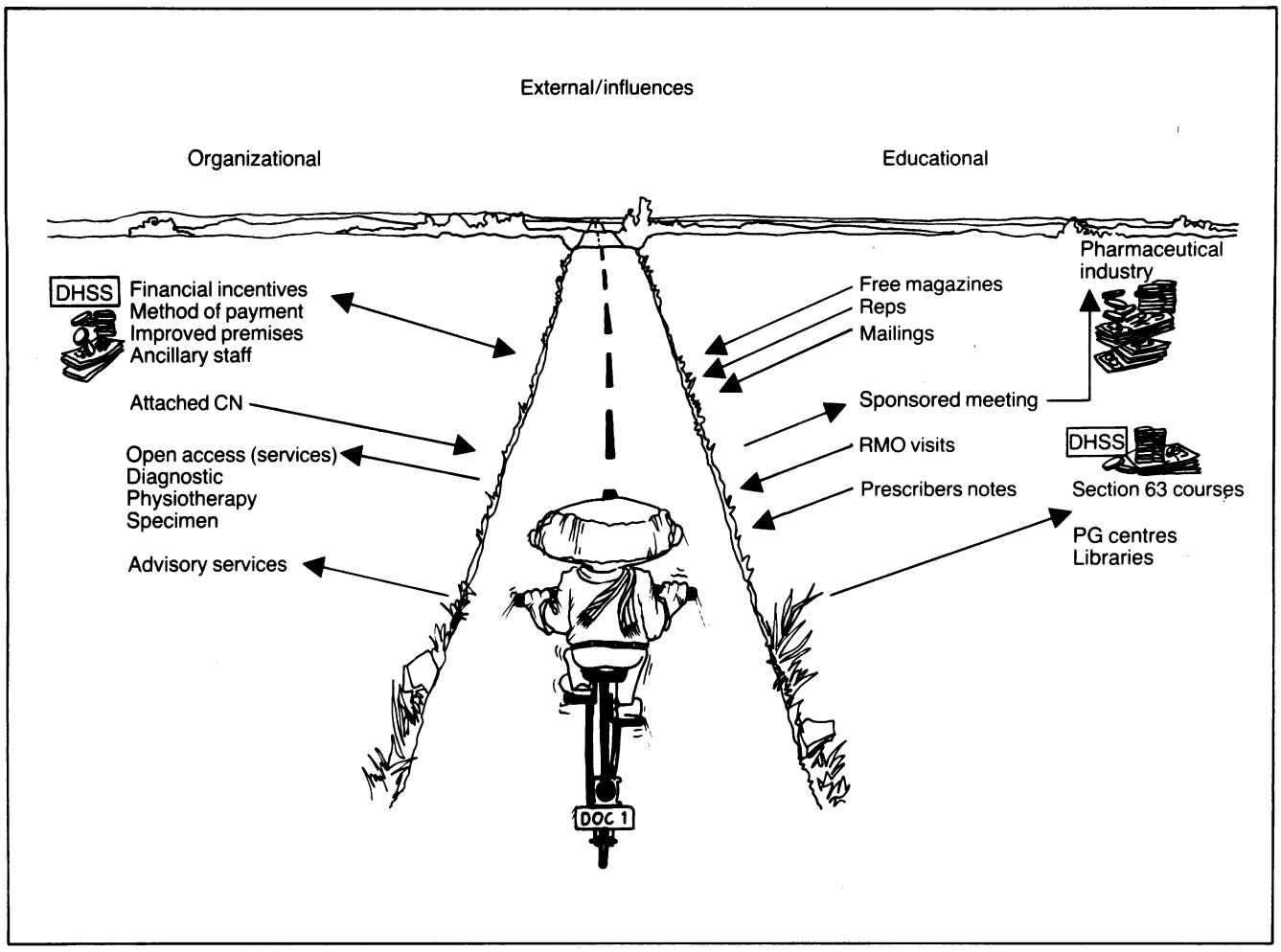


**Figure 2.** *External influences on a young doctor.*

2. It gives structure and support.
3. It reduces the effect of professional isolation.

Skill and leadership are required and my experience and that of others confirms my belief that this should be provided primarily by a general practitioner tutor at district postgraduate centre level—not to replace the clinical tutor, since his work is different and complementary. He should be paid and have secretarial support. Both he and the clinical tutor should have local budgets.

Secondly, at regional level, an improved postgraduate organization is needed which is able to provide resources—to link general practitioner tutors and provide more ambitious, long courses.

Pemberton (1970, pp 98-99) described and McKnight (1971) reminded us how Pickles, at the age of 40, comfortably settled in practice, was inspired by reading Mackenzie's (1916) classic *Principles of Diagnosis and Treatment in Heart Affections.* Soon afterwards in 1927 he undertook a correspondence course to bring himself up to date and, finding this inadequate, in 1929 he took a month's refresher course in hospital and continued to do so each year until 1939. Pickles, an exceptional man, took exceptional steps to keep himself up to date and he did this in early middle age onwards. So perhaps there is hope for many of us yet.

What about the young doctors entering general practice at present? Let us consider our young ex-trainee entering general practice. Has the desire to continue his education been inculcated in him? Are his attitudes 'tuned'? He will have many responsibilities including a wife and family. What if he settles in a busy under-resourced practice with high demand? Will he cope and maintain his standards? Will he experience difficulty in keeping up to date like 55 per cent of the practitioners responding to a recent survey on continuing education in Nottinghamshire (A. J. Pickup, personal communication)? Will it become harder as he becomes older? Will he, like the majority of Nottinghamshire general practitioners, find the job enjoyable or satisfactory despite over-demand and heavy workload? Will he be able to lead a balanced life essential to health and good practice, sharing in activities enjoyed by the rest of society, all very proper pursuits, or will it all prove too much and will his standards fall despite the early promise?

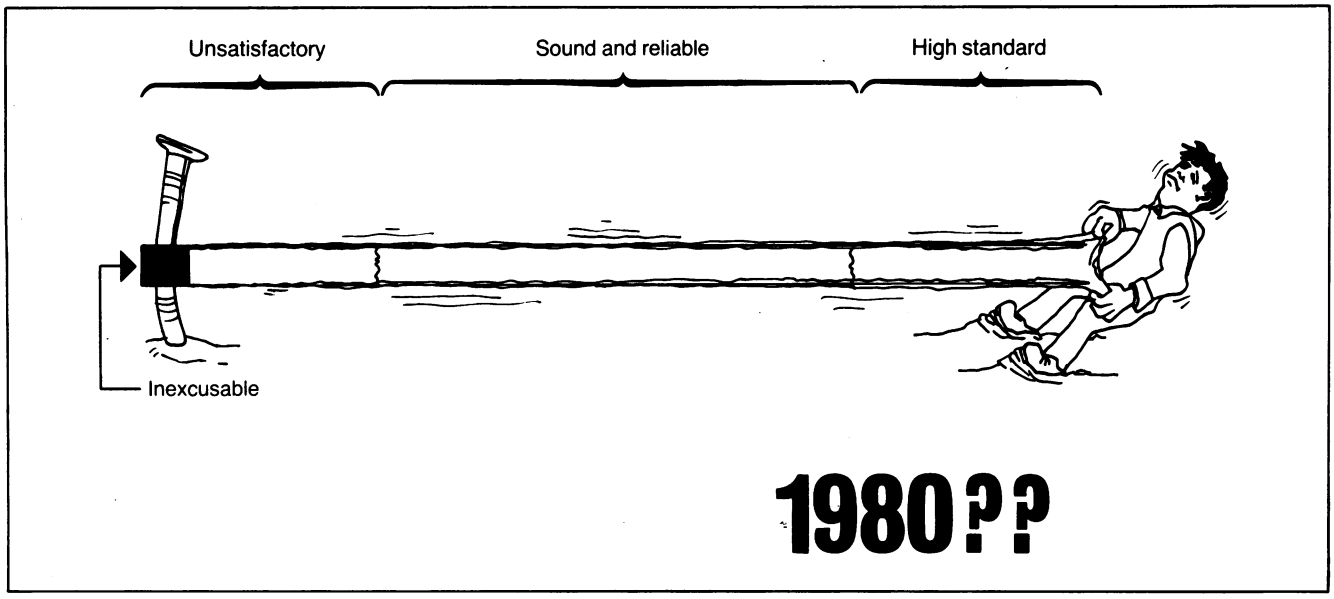


**Figure 3.** *Model of a general practitioner.*

Will he sink into professional obsolescence? Will he and colleagues, as Carr (1979) asks, face the challenge of our inner cities or opt out and leave it to the hospitals? Will they seek out vulnerable patients or leave it to community medical officers and community nurses? Will he become our ideal general practitioner providing comprehensive continuing care?

## The relative influence of continuing education

Apart from pressures of work, leisure, and the family, what external forces will be influencing the young doctor in the way he practises? Figure 2 shows the major influences and these are seen to be largely organizational or educational. Our colleague has, of course, views about where he is going: he has aspirations and attitudes. Changes in payment since the Charter have had a profound impact on general practice, in particular in providing improved premises and ancillary staff. Item-of-service payments influence a range of activity; the burden of certification will restrict it. Attached community nurses, open access services and specimen collection services expand what it is possible for him to do.

Of educational influences, the major contenders are the pharmaceutical industry and activities financed under Section 63. The former will reach the doctor whether he likes it or not and the latter only if he wishes. Over 40 free magazines will reach him, all financed by advertising. Numerous representatives will call and there will be the opportunity to attend sponsored meetings. Much of the information provided in this way is found helpful and informative, but many doctors complain about the sheer volume and variable quality of the material, described as 'overkill' (A. J. Pickup, personal communication). The pharmaceutical industry spends 10 per cent of its home sales on promotion, according to recent information from APBI, that is £80 million a year. About 80 per cent of prescriptions are written by general practitioners so, at a rough estimate if these sums are correct, something like £64 million is spent in influencing the prescriber. In contrast, the Department of Health and Social Security relies upon Regional Medical Officer visits, prescribers' notes, and funds postgraduate centres, postgraduate deans, clinical tutors, and regional advisers. The annual allocation for Section 63 courses, to cover both vocational training and continuing education, is £660,000. This is controlled at regional level and local centres have to request funds for specified activities from postgraduate deans well in advance. There are in addition, as you know, funds for travelling and subsistence which account for another £500,000.

## Who and what are we trying to change?

Taylor (1954) described general practice as consisting of a quarter which is of a high standard, a half sound and reliable, if unexciting, and a quarter unsatisfactory. Within that quarter was one-twentieth of the whole which was inexcusable. He considered that Collings (1950), in his damning description, was looking at the unsatisfactory quarter. He asked (p. 468): "Is it right for a doctor in a northern industrial town to have to do three times as much work for each of his patients as a doctor in a healthy London suburb, while receiving the same amount of remuneration?" He observed (p. 470): "The lowest standards of practice were seen more frequently in the large list industrial areas than elsewhere and appeared to result in part from excessive pressure of work on too few doctors." "Distribution of doctors should follow morbidity".

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What is the situation in 1980? I offer an image of general practice as a piece of elastic nailed down at one end and being pulled out at the other (Figure 3), the best getting better and better, the worst changing little if at all; the unsatisfactory portion limits the whole, its failure causing others to seek to fill the gap in primary care: hospitals, deputizing services, and a more recent and worrying arrival in London.

What is the nature of this nail? It is not just the weight of apathy. Good men as well as bad are pinned down by it. It is high morbidity, high workload, established patterns of practice. Taylor's (1954) statement is still applicable today. Vocational training and continuing education alone cannot change general practice, and the part of general practice pinned down is the most important part of general practice today: removing that nail is the most important single thing to be done. How this should be done is not for me to say, but suggestions such as those of the Greater Glasgow Local Medical Committee advocating special payments linked with accepted indices of social deprivation, which are themselves linked with high morbidity, deserve serious consideration. Remove that nail and away he goes.

Perhaps William Pickles' (1951) optimism in his inaugural address at that opening ceremony 30 years ago will be justified. "I have faith that even in general practice we have the makings of a first-class Health Service, if only some means can be devised to make it unnecessary for doctors to have enormous numbers of potential patients on their medical lists. The impossibility of giving adequate attention to patients is a source of great unhappiness to many of us, but I believe this can be remedied and we shall continue to have, as we always have had, the finest medical service in the world."

I have outlined what I believe needs to be done in continuing education. Although the practitioner of the future is likely to be greatly assisted by the microchip and improved information systems and self-assessment packages, the immediate problems relate to setting standards and shifting attitudes: this requires leadership, group activity, and general practitioner tutors.

General practitioners are busy people. It is nonsense to consign continuing education to lunchtimes, evenings, and Sundays and although surveys still find these times to be convenient (Reedy *et al.*, 1979), I submit that they are not truly desired. Rest, recreation, and family life are important and make for a better doctor. Time is the main obstacle and I believe that paid study leave is necessary and will provide the opportunities to lead to more satisfactory and effective continuing education.

I have an egg-cup. It is made of old English oak, five or six hundred years old. I turned it myself and I am rather pleased with it. I am pleased with it not just because of its appearance and feel, but because it is the first egg-cup that I have turned which will actually hold an egg. It does what it was intended to do.

So it is with this lecture in honour of William Pickles. It matters that it should lead to our doing something as a result of it.

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