REPORT

# Continuing education and general practitioners

LEEUWENHORST EUROPEAN WORKING PARTY

## Introduction

This statement is written for all general practitioners, for all those responsible for organizing continuing education and those who create the conditions in which it can flourish.

We have already published reports on the contribution of the general practitioner to the basic education of all doctors and on the objectives for the special training of those who choose this career, based on an agreed definition of this role in medicine. These objectives include one which states that the established practitioner will continue to improve and refine his skills during his professional lifetime; he will need to add to his knowledge as new medical discoveries are made, and to adapt his attitudes in response to changes within society itself.

Medical education forms one developing process, of which continuing education is the longest part. Like the others, it needs to be planned. There are problems common to all our countries.

### *A new balance*

One intention dominates this document—to help to establish a new balance between the contribution of general practitioners to their own continuing education and the contribution of others—medical specialists, biological and social scientists, and workers in professions related to medicine.

We believe that general practitioners should have the basic responsibility at this stage for seeking their own education; for identifying their own deficiencies; for helping to plan, organize and contribute to the training of their fellows. General practice is developing as a research and teaching discipline, with its distinctive features of accessibility, breadth, synthesis, continuity and the use of the simplest appropriate methods in the care of patients. The increasing self-consciousness and self-criticism which result make it now capable of developing in certain ways its own continuing education.

But all clinicians have a responsibility for helping each other to discover what they see as needs in other clinicians' knowledge and practise in their own subject. In this way each can act as a resource for the others. We all need help in acquiring new knowledge and revising the old.

The planning and production of continuing education is a joint activity, in which the general practitioner's participation is crucial. This statement sets out the broad aims and discusses motivation, content, methods and organization. Evaluation will be considered separately.

## The aims of continuing education

Continuing education is concerned with the maintenance, development and improvement of the care which a doctor provides for people throughout his professional life. It starts for the general practitioner in most of our countries when he or she assumes professional responsibility.

This aim can only be promoted by continuing education if it is based on people's needs for care and on appropriate application of the biological, social and clinical sciences; and if it is related to the particular situation, personality and interests of the general practitioner. Success depends on the mutual understanding and respect of those who work in different parts of the health care system, since all have something to learn and something to teach.

Its purposes should be:

1. To review knowledge, skills, and attitudes already acquired in undergraduate and vocational training, eliminating those which are obsolete, while retaining those which are still valuable.

2. To help the doctor to discover his deficiencies and to deal with the difficulties which he already recognizes in his own work, by sharing experiences with his colleagues, both medical and non-medical.

3. To help the doctor to recognize and apply new evidence and ideas, using the experience of general practice as a basis for their evaluation and application. By giving as well as receiving training in this way, he will be enabled to develop new competences and learn new roles effectively.

4. To help the doctor's capacity to think creatively and to appraise his own work critically, by means of education and research activities.

## Motivation

If general practitioners are to assume such varied re-

sponsibilities for their own re-education, their motivation becomes a dominant issue. It will depend first on their basic education. If curiosity and self-criticism are to become habits of mind, they must be developed long before the doctor starts to practise. Basic university education should accustom students to regard knowledge as transient and replaceable, preparing them for a life-time of changing problems, changing solutions, and even changes which they themselves will initiate. In most countries it is no longer the intention to provide students at this stage with all the knowledge and skills which are thought to be essential for making them into safe general practitioners. A less crowded programme can result.

It is the period of specific training which has to ensure the competence of the general practitioner. But this period also has to foster the desire to continue learning. Not all countries yet provide specific training; its absence causes some doctors to search for it during the period of continuing education. Although this may be temporarily unavoidable, it is a wrong use of time intended for a different purpose. Continuing education cannot be a substitute for specific initial training.

Strong motivation can also stem from current experience. There is great satisfaction to be had by sharing in a science and art which is growing and offering increasing benefits to mankind. New challenges are stimulating. Without a constant stream of new problems for solution medicine would lose some of its fascination for the doctor. Difficult clinical problems, difficult patients—even failures—are challenges which immediately face him with the need to continue learning. But he does not always recognize the difficulty in a problem, for example, that it may be mainly in his relationship with a person; he may not see himself as others see him or be prepared to acknowledge his own failures. It is hard to become both self-critical and self-confident as a clinician; yet this is what is needed.

When general practitioners themselves contribute to continuing education, they come to recognize and discuss their successes and failures, so that they and others can learn from them. If some do this, it is easier for others to do the same, and easier still if they have acquired the habit as students. Discussion and interaction with peers tend in themselves to motivate.

The absence of a doctor from all organized forms of continuing education is no proof that motivation is lacking; there are hidden activities—from reading to research work.

Clearly, the best motivation lies in the satisfaction of daily work in a professional field which is developing; in the spirit of enquiry and self-criticism; and even in that sense of personal inadequacy which spurs to greater efforts. But these qualities can and must be supported by practical arrangements which will allow the doctor to participate. These are discussed later under the heading 'Organization'.

Some advocate that the doctor should be *compelled* to educate himself throughout his professional life. If this is understood literally, we believe that compulsion can diminish motivation to learn. If it is understood to mean, for example, the pressure of opinion of colleagues or patients, it is an acceptable incentive.

## The content and methods of continuing education

We said above that continuing education can improve the quality of health care only if it is based both on people's need for care and upon the appropriate application of the biological, social and clinical sciences. The general practitioner's role is also at the centre of the problem of selection and must act as a continuous focus for every contribution. In our first document we stated this as follows:

"The general practitioner is a licensed medical graduate who gives personal, primary and continuing care to individuals, families and a practice population, irrespective of age, sex and illness. It is the synthesis of these functions which is unique. 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. This will be expressed in the care of his patients. 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."

The educational aims which follow this statement in our first document apply as much to continuing education as to specific training.

## Content

The content must relate to the setting in which the general practitioner works, the range of problems he faces, the knowledge, skills and attitudes which he brings to their solution, and what he does and is as a person.

The field is vast—the actual content will vary from country to country and from year to year. We make no attempt even to outline it here, but only to indicate how we think it might best be selected if the aims described

above are to be achieved.

1. "Reviewing what was already acquired in the periods of undergraduate and specific training."

This will happen naturally in the process of discussing new knowledge.

2. "Helping the doctor to discover his needs and deficiencies and to deal with the difficulties which he already recognizes in his work."

The main responsibility lies on the doctor himself, but the extent to which each doctor discharges it will vary greatly. Daily experience in practice—particularly the requirements and reactions of patients—are unavoidable lessons. They alone give rise to a range of content far too extensive for description here.

The contact with colleagues and the mutually constructive criticism which play such an important part in raising the standards of medicine in hospital demand from the practitioner more initiative in making contact, particularly if he practises single-handed. A group practice offers one learning situation, but only if the members of the group meet regularly and talk freely. If it contains related disciplines, it is all the more stimulating. The daily working contact of a group practice provides an intimate and continuous setting in which successes and failures can be discussed, but it must not become an exclusive setting.

There are other ways of identifying needs and deficiencies. One example is the self-administered questionnaire. Another is created when a small group of doctors come together to define and agree their methods for managing a particular type of clinical problem, so that they can observe afterwards the degree to which their own performance differs from their standards.

Some doctors identify their own deficiencies by reading specialist reports on their cases, by reading books and papers, or by attending lectures in which specialists point them out.

Educational needs cannot necessarily be inferred either from the views of educators or from those of practitioners about what ought to be taught. The essential is to emphasize the systematic identification of personal and corporate needs, and the selection of priorities, and to respond by careful design of educational programmes.

The general practitioner's main concern is with the people for whom he cares. What he can extract in knowledge and skills from others must be constantly sifted and adjusted to their needs. It is this process which can ensure the practitioner's interest in his own education and the selection of content which is relevant.

3. "Helping the doctor to recognize new evidence and ideas."

This has hitherto been regarded as the sole responsibility of the specialist, who teaches while the general practitioner listens. We believe this to be wrong. It is the particular intention of this report to emphasize the integrated experience of general practice as an important source of continuing education. It is developing as a research and teaching discipline, already established within universities in many of our countries. Its distinctive features should be accessibility, breadth, synthesis, continuity, and the use of the simplest appropriate methods. It can link prevention with care and cure, concern for the individual with concern for the community, the physical with the psychological and social; it is the putting together of these elements which we mean by 'synthesis'.

But it would be a serious mistake to suggest that we want to manage on our own. There must be a balance. We still need new information from outside our discipline. Help from others is as necessary as ever to bring new knowledge, to revise and modify old knowledge and to help us to discover valuable ideas of which we could be unaware.

Specialists are increasingly trying to ensure that their contributions are relevant to doctors who deal with a different range of problems, work in a different setting, and have responsibilities and resources which are not precisely the same as their own.

4. "Helping the doctor to think critically about his own work."

This can be achieved if the previous aims are pursued. It is achieved more rigorously when a practitioner undertakes formal research which will be subject to the scrutiny of colleagues. Both research and teaching are excellent methods of continuing to learn.

## Methods

The choice of methods should depend as much as possible on the content, but geography or lack of resource may in fact have an important influence; it should certainly not depend merely on the preference or habits of teachers.

Traditionally, continuing education has been associated with lectures by experts to large groups. We believe that this method should be used rarely, because it places adult learners, who have much to give, in the passive role of receivers. Active methods of learning are known to be the most effective. Moreover, listening to a sequence of experts, general practitioners have been led to feel that expertise lies in every branch of medicine except their own. Continuing education is meant to increase, not to decrease, the confidence of the doctor in his role and his skills.

Like others, doctors see, hear and build upon mainly what they know already and can already do; what they bring to a learning situation, therefore, will largely determine what they take from it. Because of this and because they are likely to retain only what they can use, it is crucial that continuing education should be as relevant as possible to their work; teaching has to help them to widen, enrich and sometimes change knowledge, skills and attitudes which are already within them. Totally new concepts or knowledge will be intro-

duced most successfully if the doctor can see that it relates to those which he already possesses.

We see the small group as the most appropriate method for most of the established practitioner's learning needs. It is an active method which allows a responsible experienced adult to give as well as to receive. It provides a way for discovering deficiencies and dealing with recognized difficulties. It is one way in which continuing education can answer the individual needs of a particular doctor. It can help him to think creatively and to examine his own work critically, notably by sharing opinions about the clinical or organizational methods most likely to achieve improvement in health ('peer-review'). It has a profound influence on the development of attitudes, social and interpersonal skills and self-understanding. It can deal with the overconfident doctor or help one who lacks confidence and fears to expose himself, since within the group ignorance can be admitted without penalty or humiliation.

Small group learning lends itself as well to topic teaching as to the discussion of particular patients. It can start from a short presentation, or from questions, as often as possible by members of the group. It should end with 'feedback', in two senses—was it a good session? What will each member take from it that he can use? How useful the session proved for practice can be checked later if the group meets regularly.

In the small group a specialist has a most important part to play, but this depends on his capacity to imagine himself in the general practitioner's situation and to apply his own expertise to the general practitioner's problems. He is there as a resource, not as a leader. For most people this role is more demanding than that of lecturer.

### Planning and organization

The general practitioner should have the basic responsibility for seeking his own continuing education, for identifying his deficiencies, and for helping to plan, organize, and contribute to the education of his fellows. Trust in a doctor and the assurance that he will do his best for his patients are traditional. The responsibility of individual doctors to demonstrate their own continuing competence is therefore heavy. It is nevertheless prudent for patients, whether through local, regional, or national arrangements, to make sure that the doctor is able to fulfil this responsibility. Clearly the community has an interest in supporting this means both to the improvement of health status and to the containment of costs.

Whoever undertakes it—doctors or others—some degree of planning and organization is essential if continuing education is to be undertaken by all general practitioners, as the development of society and medicine in our countries so clearly demands.

As examples, there is a need for central and local sources of literature review; for encouragement to gen-

eral practitioners to contribute material from their own work and for support in their own more active involvement in teaching. The range of content needed is now so large that systematic review of the material for inclusion needs to be organized. Group 'leaders' need to be trained. Meetings of many sorts need to be arranged and co-ordinated.

The extent to which responsibility for these tasks is shared by the general practitioner, as consumer, with the other providers varies greatly even among our countries. So does the extent to which professional bodies, social security organizations or the state intervene by paying expenses, compensating for loss of earnings, organizing replacements or exerting pressure towards regular, or even compulsory, attendance at courses in relation to the right to practise.

Unquestionably in all our countries continuing education must be recognized as essential and given its proper priority for time otherwise devoted to patient care, by whatever means this can be achieved.

For the selection of content, teachers and teaching methods, general practitioners should have the dominant, but not the only, voice. Universities have both educational expertise and administrative machinery, without which planning, organization and evaluation would be far less effective than it can be through co-operative effort. Where universities include a department of general practice, this is an obvious focal point at which co-operative planning and organization can occur, but it will need to relate to other more widely distributed centres, whether in hospitals or group practices, where the actual work of education takes place continuously.

**Addendum**

Members of the working party are as follows: N. Bentzen (Denmark), R. B. Boelaert (Belgium), P. S. Byrne (United Kingdom), S. Häussler (Federal Republic of Germany), G. Heller (Austria), J. P. Horder (United Kingdom), S. Humerfelt (Norway), Z. Jaksic (Yugoslavia), J. D. E. Knox (United Kingdom), B. S. Polak (Netherlands), A. M. Reynolds (France), M. Simunic (Yugoslavia), M. Szatmari (Hungary) and J. C. van Es (Netherlands). I. Hügel (German Democratic Republic) remains a member, but was unable to contribute to this part of the work. K. M. Parry (United Kingdom) has helped in the drafting of all our reports.

The terms used in each country represented in the working party, equivalent to the English term 'general practitioner' are as follows: Austria, *Praktischer Arzt;* Belgium, *Médecin de Famille/Huisarts;* Denmark, *Alment Praktiserende Laege;* France, *Médecin Généraliste;* Federal Republic of Germany, *Arzt für Allgemeinmedizin;* German Democratic Republic, *Facharzt für Allgemeinmedizin;* Hungary, *Általános Orvos;* Netherlands, *Huisarts;* Norway, *Almenpraktiker;* Yugoslavia, *Liječnik Opće Medicine.*

# Training in the psychiatric aspects of general practice

INVITED representatives from the Royal College of Psychiatrists and the Royal College of General Practitioners met at 14 Princes Gate on 28 May 1980 to discuss how general practice trainees might best obtain suitable training for the psychiatric aspects of their work. The discussion ranged over a number of issues and by the end of the day the participants were questioning some of their fundamental assumptions.

The conference was chaired by Dr J. P. Horder, President of the Royal College of General Practitioners, who recalled that it was over 20 years since the College had first embarked on an attempt to define the content of psychiatric training for general practitioners, culminating in a document issued jointly by the two Colleges in 1975 which listed desirable learning objectives. This had recently been supplemented, not replaced, by another document prepared by the Liaison Committee of the two Colleges (1980) and which was introduced at the conference. These guidelines were essentially a set of learning opportunities considered desirable for any psychiatric post occupied by a general practice trainee at senior house officer level.

The guidelines met with a generally favourable reception from the Conference but the point was made that hospital training could not provide all that was relevant to this aspect of a trainee's preparation and that the hospital contribution had to be seen in the total training context. There were other things the trainee had to know which would allow him to relate his specialty teaching, in the words of the guidelines, "to the wider perspectives of general practice". As one contributor remarked, perhaps the real question for the general practitioner is not what proportion of his patients have psychiatric problems, but "what proportion of each and every one of my patient's problem is psychiatric?"

The question was asked, since the guidelines were thought suitable for general practice trainees, why not adopt them for trainee psychiatrists at senior house officer level? This might overcome one problem voiced by a very senior psychiatrist—an academic—namely, a reluctance to divert limited resources (and perhaps teaching libido) to train those who were not intent on a career in psychiatry. That warning, and the plain fact that there were not and never would be sufficient psychiatric posts at senior house officer level to give every general practice trainee an opportunity to work in one, created keen interest in the description by a postgraduate adviser in general practice of his region's