2. GPs who are serious about micro-computers would readily inform Dr Potter that they see no value in storing 'sensitive' data onto storage media. Their concern is chiefly to compile highly sophisticated computerized morbidity and 'at risk' registers. In this way the grave handicaps of manual records in preventive work, monitoring, and increasing practice income are minimized by the simultaneous assistance which can readily accrue from the new technology.
3. A computerized morbidity/at risk register can firstly be in encrypted form. Further, intelligent use of encrypted passwords can prevent even a determined expert from extracting the data—data moreover which need not be of a sensitive nature. What manual system of records can afford similar protection from prying eyes? In any case, a breach of confidentiality would lay a GP open to the attentions of the GMC. Does Dr Potter know all this? If so, why does he not enlighten the victims of his own questionnaire?
4. I would not hesitate to submit that if the respondents had been informed in detail of the safeguards and the potential benefits they would have answered very differently.

Notwithstanding the above criticisms, it must be said in Dr Potter's favour that it is wonderful to see a new entrant into our profession who is sensitive to the feelings of his patients and the immense importance of respecting and preserving confidentiality. It would be a pleasure to show him how to use a micro-computer properly!

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OPINION

The general practitioner tutor

S. F. OLIVER, East Anglian Faculty

The East Anglian Faculty has a long tradition of educational activism, and Dr Stephen Oliver, the Faculty's representative, wrote the following paper for Council in September 1981. We reproduce it to stimulate discussion. It is one person's views, albeit based on wide discussion, particularly of the conference on continuing education held in Cambridge in March 1980 (*Journal* report, December, pp. 765-6), but we know that different views, and different policies based on these views, are held elsewhere.

The general practitioner tutor is a general practitioner, in active practice, responsible for the organization of postgraduate medical education for general practitioners in his district. He will have knowledge of the principles of adult education and the skill to apply them.

He will usually work from the local postgraduate centre where he should have office space and secretarial help. He will be responsible for planning postgraduate centre meetings for local general practitioners. He will work in the closest co-operation with the clinical tutor. The general practitioner tutor will be a member of the district postgraduate committee or its equivalent.

He will encourage and help his local colleagues to organise their own practice-based educational activities. He will have particular regard to the educational needs of the single-handed practitioner. He will have knowledge of simple research tools and improved record systems and encourage his local colleagues in their use. He will be prepared to advise on the provision of modern facilities for continuing education in new health centres, group practice premises and postgraduate centres.

While his primary responsibility is in the field of continuing medical education, he may advise on the placement of medical students in local practices. He will liaise, when necessary, with the local vocational training scheme course organizer or tutor over the effective use of resources and in programme planning.

Suggested Guidelines for GP Tutors

1. Identify learning needs. The district programme must be relevant to the educational needs of the local general practitioners as perceived by themselves and others—consultants, other health care workers, patients and so on. Methods must be developed to identify needs—personal contact, use of questionnaires etc.
2. Obtain feed-back about meetings. The successful planning of future meetings depends on feed-back from the participants at past meetings. Short questionnaires should be developed for use at the end of meetings. More detailed questionnaires at infrequent intervals, perhaps annually, should also be considered, as should an approach to non-attenders for information regarding subject matter and times of meetings preferred and reasons for non attendance.
3. Aim to involve the learner whenever possible.
4. Employ a wide variety of methods. If the district programme is to reflect the wide spectrum of motivation to learn among the doctors in the district, a similarly wide spectrum of educational activities must be available to them—from the passive, non threatening lecture to the highly participatory small group.
5. Co-operate with the clinical tutor. (Essential with respect to use of the postgraduate centre.) Meetings may be arranged with an appeal to both general practitioners and hospital doctors and require close co-operation with hospital colleagues, too, for success.
6. Co-operate with the local VTS organizer. This makes for better use of resources such as outside speakers; the PGME programme and half-day release programme should be planned to complement each other and therefore make postgraduate centre programmes more valuable to trainees. Trainees and training practices should act as valuable resources to the programme.
7. Plan regular meetings. Human beings are creatures of habit. Make attendance at meetings a good one.
8. Identify practice education secretaries. The GP tutor needs active support from his colleagues. Aim to identify one GP in each practice which might be expected to attend the postgraduate centre with whom you may liaise over educational matters. These practice education secretaries might meet once, twice or three times a year under the chairmanship of the GP tutor to discuss past and future programmes. Be prepared to delegate responsibility.
9. Don't forget the important social element. Much unrecognized learning takes place during the purely social part of a meeting. The better consultants and general practitioners know each other, the better the opportunity for improving the quality of their com-

bined care. A friendly atmosphere, good food and wine (and therefore discreet drug company sponsorship), are essential ingredients to a successful meeting. The postgraduate centre must work not only as an educational, but also as a social centre.

10. Sell it and see that doctors enjoy it! Educational activities need imaginative advertizing. Good publicity and gentle but firm pressure to attend may be exerted through the practice education secretaries. Don't be afraid to use a little showmanship. Learn and enjoy. Enjoy and learn!

ANNUAL REPORT

GMSC/RCGP Joint Computing Policy Group for General Practice, Report for 1981

Introduction

FOLLOWING the publication of two reports (RCGP, 1980; BMA, 1980), the Royal College of General Practitioners and the General Medical Services Committee of the British Medical Association established a Joint Computing Policy Group. This is an advisory body. It reports quarterly to the GMSC/RCGP Liaison Committee, and its remit is:

1. To act as a joint policy group.
2. To consider developments in computing and assess their relevance and value to general practice.
3. To promote ordered development of computing in general practice by making recommendations to the parent bodies through the Liaison Committee.

As an advisory body on policy it has no links with any commercial firm or activity.

The membership consisted initially of three members appointed by the GMSC and three by the RCGP. Two technical advisers and an observer from the Primary Care Division of the DHSS have been co-opted. Recently, the British Computer Society Primary Health Care Specialist Group has been invited to nominate a member.

The first meeting of the group was in January 1981.

Information and Education

In order to be able to make informed decisions concerning the introduction of a computer into his practice, it is clear that a general practitioner should be aware of what a computer can and cannot do, of the questions he should ask, of the possible problems as well as benefits. Most general practitioners have had no training in these matters. The group therefore recommended that undergraduate education, vocational training courses and postgraduate courses for general practitioners should contain information on computers and their application to medicine with particular reference to general practice.

Action: The GMC, Postgraduate Deans and Regional Advisers were informed of this recommendation in a joint letter from Dr Frank Wells and Dr John Hasler.

When a general practitioner considers buying a computer system he needs practical advice with, if possible, personal experience in handling a computer. The Central Information Service for General Medical Practice (CIS) and the GMSC Secretariat have a register of computer users. In addition, the CIS can advise practitioners as to the systems available, their cost, and user experience. Recommendation was made that the role of the Central Information Service as a resource for information about computers be publicized and that the policy group should negotiate a centre where practitioners could obtain 'hands-on' experience.

Action: The National Computer Centre (11 New Fetter Lane, London EC4) has installed a number of general practice computer systems. These are available for demonstration to general practitioners and their staff. At the Press Conference announcing this facility, and in subsequent statements, the advisory role of the CIS has been emphasized.

As a future development the group considered that the practitioner should have access to a non-commercial source of advice concerning the reliability, capability and efficiency of different computer systems. The recommendation was made that the policy group should consider the feasibility of establishing a centre which would evaluate machines and programs for general practice on a continuing basis.

Action: Various different options, of structure, management and finance are under active consideration.

Development

Promotion of ordered development entails taking action to ensure that when the majority of general practices are using computers they have access to efficient relevant programs and that information on a system in one practice can be transferred with minimum difficulty to another (subject to confidentiality codes). This argues either that programs should be transportable and systems compatible or that general practitioners should all use the same programs and systems. The policy group favoured the former and to this end recommended that specifications should be established which the GMSC and the RCGP would jointly approve.

Action: The group has set up a technical working party whose remit is to consider specification standards appropriate to general practice computing, and to make recommendations with particular regard to data transmission protocols, security of data during transmission and transportability of programs.

Research

The policy group has neither the time, the money nor the remit to itself carry out research. It does, however, believe that the advent of computerization will eventually lead to fundamental changes in the organization, delivery and quality of medical care. There are many aspects which need to be researched.