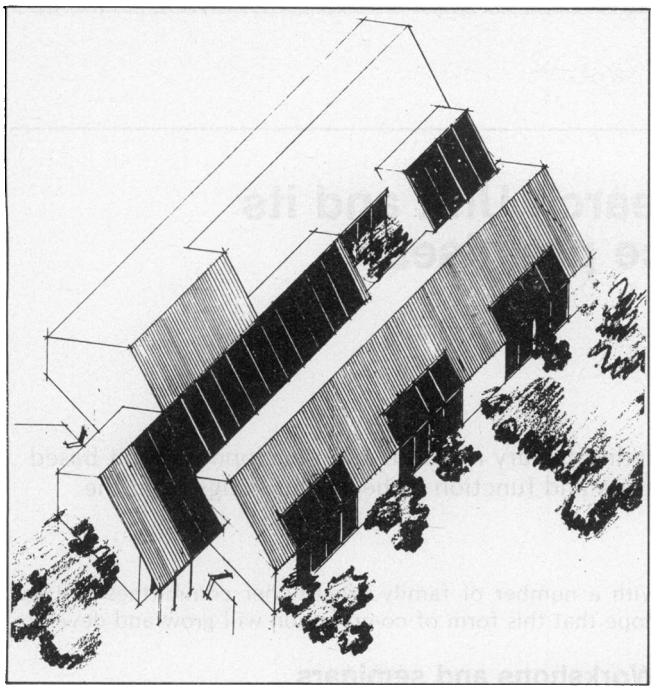

Figure 1. A low energy general practice surgery that is being designed by MARU.

It is disturbing to note that the basic rules of planning for confidentiality are still being broken. Figure 2 shows the two-door room. On the face of it a useful device for the doctor to lead his patient into the examination area; but to what result? He will be unable to use his consulting room for his next patient, as the consultation will be overheard by the patient in the adjoining examination room. Even if sealed acoustic doors are used, will not the patients in both rooms still think they are being overheard?

Drab interiors

When visiting newly built surgeries we have noted how interior design is still a sadly ignored and misunderstood feature of practice premises. Many seemingly drab and dull surgeries could be transformed overnight with more attention to the design of practice interiors. This appears to be particularly so in health centres. Drab and unimaginative colour schemes, inappropriate and unattractive lighting, utilitarian furniture and *ad hoc* hand written notices taped to the walls, unfortunately are common characteristics of many practice interiors in health centres.

It would be naive to consider the design of practice premises in isolation from the needs of improving the delivery of primary health care. However, the financial assistance now offered by the Red Book cost-rent scheme presents an ideal opportunity for general practitioners to provide their first class services from first class practice premises. At MARU our aim is to help general practitioners to make the best of that opportunity.

Further information about MARU and advice may be obtained by writing to Dr Raymond Moss MBE, PHD, DIP.ARCH. RIBA, Director, Medical Architecture Research Unit, the Polytechnic of North London, Holloway, London N7 8DB.

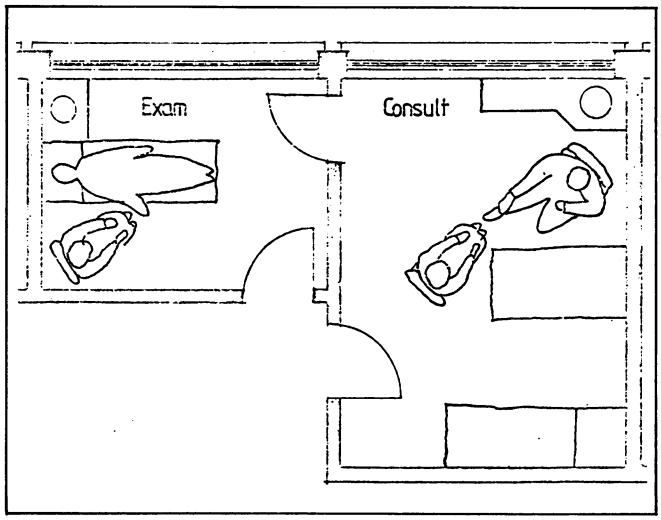

Figure 2. Rooms with more than one door are an unnecessary risk to privacy and confidentiality. Yet such basic planning errors are still being made by general practitioners and their architects.

CONTINUING EDUCATION

Continuing medical education

DAVID PENDLETON
Stuart Fellow

Eighteen months of working for the College as Stuart Fellow have now been completed. During this time I have been able to meet with numerous College and non-College groups and have attended approximately one hundred continuing education meetings. Inevitably, this experience has led to my forming several clear impressions of the College's involvement in continuing medical education. In this short article I should like to set out these thoughts and illustrate them with reference to several of the meetings in which I have taken part.

A large conference

At a large conference held at Cambridge University, the absorbing subject of motivation for learning was discussed. This conference was organized by the Association for Medical Education in Europe. The discussion group in which I took part considered the question of motivation for continuing medical education—a matter with which all of the College's faculties are concerned. The ideas that this group discussed were interesting:

Attitudes

Continuing medical education (CME) implies a continuum of education from day one of medical school through to the retirement of the doctor. For this reason, the attitudes and skills required to make use of all opportunities for CME should be learned in medical school. We know that attitudes and values are best learned from our teachers: we tend to take on the attitudes and values of those who guide our education. If our medical teachers in medical schools ridicule the continuing medical education efforts of general practitioners and other non-hospital doctors then these attitudes are likely to be taken on by the students. If, however, the message from the medical teachers is one of respect for non-hospital doctors, and for the importance of continuing medical education, then these values will also be learned.

Anxiety

It is also important to see the role of anxiety. Medical education provokes a lot of anxiety in medical students, and some medical teachers actually believe that this anxiety is a good thing. They believe somehow that it puts them on their mettle—makes them try hard, or helps them to concentrate. Most of the psychological evidence, however, would stand against this belief.

We are familiar with the relationship between anxiety and performance: it is curvilinear—that is, there comes a point beyond which increases in anxiety lead to deterioration of performance. The optimum level of anxiety is probably no higher than that which is inevitably created when students are educated together. Competition amongst peers, and the threat of passing or failing the final examinations is certainly enough for the student to become motivated, and any attempt by the medical teacher deliberately to raise anxiety in students will almost certainly lead to performance deteriorating.

Any parent who has nagged a child into doing homework will know that the child can get rid of the nagging in one of two ways: the child may choose to do the homework, and therefore earn the approval of his parents, but the child soon learns that if he goes out to play football, then the nagging stops as well. This is only a temporary measure, of course, but the point is well made that if anxiety is associated with a medical education of any kind then the student learns to avoid the anxiety-provoking stimulus—i.e. the education. During medical school he cannot learn to avoid it completely since he has to pass his examination, but once he has graduated, the medical student has learned that medical education is far from being a pleasurable activity—on the contrary, it provokes anxiety, so the medical student is reluctant to take part in continuing medical education.

Incentives

During the course of the group's discussion we started by trying to define possible incentives for doctors to take part in CME. The following were mentioned:

—money
—patient pressure—the threat of litigation
—publicity through the media
—peer group pressure
—pressure from professional organizations such as Royal Colleges
—the possibility of re-certification

As an afterthought, the following were mentioned:

—individual self-esteem
—boredom
—job satisfaction

You will see that all the topics that came to mind first were ways in which pressure could be brought upon a general practitioner, and that this pressure could form an incentive. This is the philosophy of one of my friends—he hopes to motivate his learners using the old stick and carrot method, but modified to suit himself: first he beats them with the stick, and if that doesn't work he beats them with the carrot.

When we started to analyse the personal motives of those members of the discussion group who were actively involved in continuing medical education, the list was very different:

—interest
—self-esteem
—the positive feedback of being asked to take part
—personal ideals

Assumptions

The assumptions we make about motivation for doctors to be involved in continuing medical education may be either pessimistic or optimistic. The pessimistic assumption is that people are not motivated, and we need to apply pressure to push the motivation into someone in whom it is lacking. One of the group suggested that this approach might be called the *suppository approach to motivation.* A more optimistic assumption, however, is that people are already motivated and that those organizing CME have merely to tap this motivation.

If we assume that people are already motivated, how can we account for poor attendance at CME activities? Surely the answer is that doctors are motivated to look after patients well, and this does not necessarily include any specific motivation to be involved in CME. Frequently, CME activities might be thought of as being irrelevant to continuing high standards of patient care, or it may be that there are so many CME activities that the doctor would feel the task of being involved in all of these daunting. And yet how is he to choose between them? Any CME will have to be seen, then, to be closely related to the task of looking after patients well, and should not heap upon the doctor more and more demands.

Conclusions

As the course went on, the agreed approach was seen to be as follows:

1. We should assume that people are motivated, and make a personal contact with all those being invited to take part in CME activities.
2. We should find out what they value in their professional lives, and make use of these values in the planning of the sessions.
3. We should work in groups of peers, to share ideas and values. In this way, the demands of CME will be kept within the bounds of practicality.

It is highly unlikely that peers will make life difficult for each other. It is also highly unlikely that peers will allow sloppy practice to continue where it is noted. CME could thus be centred around performance review, so that the strengths of an individual practitioner can be pointed out, and where there is a deficiency, encouraging, positive recommendations can be made. In this way, the group will provide positive feedback to its members, to build up trust and involvement, and this is a way of increasing motivation.

These methods had been tried and tested by one member of our group, Dr Michael Boland from West Cork, who described the attempts he has made to involve the 65 general practitioners in his area in CME. This approach was followed, and during the first 12 months of the pilot scheme

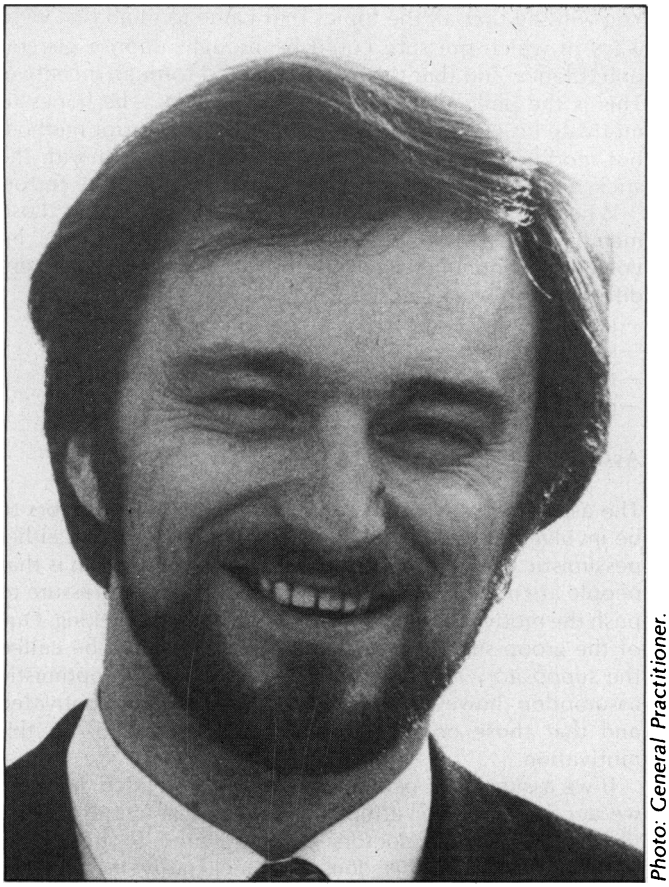

Photo: General Practitioner.

Dr David Pendleton

in that area 52 out of 65 general practitioners had been involved. In my capacity as Stuart Fellow I have had considerable contact with the West Cork Pilot Study and I am most impressed.

This is surely proof enough that a positive approach to CME can be taken, but we need to make sure that the crucial lessons are learned. Personal contacts need to be made, and peers should work together to assess each other's performance, providing positive feedback for group members.

A meeting of tutors

At a meeting of Midlands GP Tutors and College Tutors, the subject of continuing education and its organization was also discussed. In this group, the concerns were inevitably related to poor attendance at meetings. The tutors were impressive on several counts but especially for their work rate and the degree of insight they had into their difficulties as CME tutors. The problem was relatively simple to state—despite their very best endeavours, only between 10 and 15 per cent of those doctors circulated with details of their meetings actually attended. What is more, these tended to be the same doctors at each meeting. The format of these meetings was the usual pattern of invited speakers addressing audiences in postgraduate centres, occasionally with a sponsored meal as an added attraction.

It would certainly be hard to imagine a better motivated, harder working or more able group than these tutors so the disappointing attendances suggested to me a failure in the basic approach to CME which has become normal, rather than failures on the part of those responsible. This meeting went on to consider the limitations of the system as it has evolved and whether, if a greater proportion of people attending was desirable, a rather radical re-think of CME provision might be needed along the lines described above. The costs of this radical approach were also assessed. These were related largely to the time which would need to be devoted to it and the openness to scrutiny which would be required.

The group concluded that it would be difficult to change the existing pattern without considerable reorganization (reduction) of their existing commitments. Essentially, the tutors are asked to be responsible for too many doctors for the new format to be feasible.

A young principals group

There is a well known time lag between joining a practice and becoming involved in continuing education. Most young principals allegedly have too much to do in order to settle in to the practice and the neighbourhood for there to be time to be involved. Indeed, the slight increase in attendance after some time in practice would tend to support this view. But many young principals complain of the irrelevance of the fare which is frequently on offer.

Most of the young principals groups I have attended have been concerned with performance review and so have overcome any problems of irrelevance—they start with their own work. There is certainly an openness to the scrutiny of peers in these groups. One group I attended in Edinburgh was typical of this interest. We discussed how consultations might be analysed and how, to this end, video-recordings might be made and used. They are now involved in this activity.

The role of the College

The need for continuing medical education should be self-evident but who should provide it and what should it comprise? Clearly, my own advocacy of performance review reveals part of the answer for me. Continuing education based on performance review and peer evaluation overcomes the problems of relevance and is usually highly motivating. What is more, it is part of the coming of age of a discipline when it attempts to develop its standards by putting its efforts under scrutiny. Listening to lectures is the easy way out, and barely defensible educationally due to the inadequacies of memory.

But what is the College doing? Some faculties are certainly more active than others and some are trying to come to terms with dwindling attendances by re-thinking their approaches to the educational needs of members. But those faculties which are giving their thoughts to these matters are beginning to see the extent of the changes that may be necessary. Performance review requires small groups of doctors working together so that trust may be built up. It requires investment of no more time than regular attendance at postgraduate meetings but it might require that that time is invested in fewer, larger blocks. When a 'What Sort Of Doctor?' visit is carried out, the two or three visitors need to invest a day in each visit, for example. Thus, for such an activity to become widespread, the general practitioners involved would invest two days each in order to receive a visit which would produce a full report on the practice.

Time is not the problem. The difficulty is one of attitude since it is the wind of change of peer evaluation which chills the hearts of some 'independent contractors'. But the needs of the profession may dictate that independence be not used as a synonym for isolationism. One role for the College, therefore, must be to provide the expertise and the encouragement, maybe even the facilities, for such innovative continuing education to become the new norm.