The professionals

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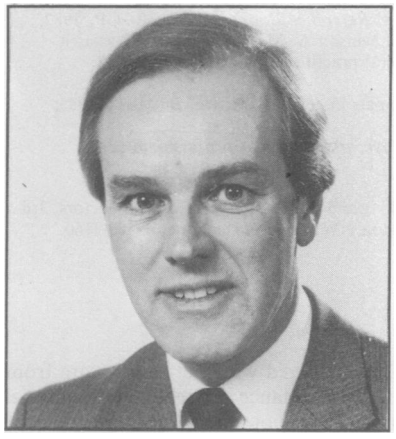

Michael McKendrick

It is my privilege to give the 1987 William Pickles lecture in honour of one of our most distinguished and respected colleagues and a pioneer of the discipline of general practice. The climate in medical care, in general practice and in our College is again turbulent and the excitements of a period of significant change are obvious. We may be approaching another watershed in our history. My theme is the education of the established general practitioner.

Introduction

THIS lecture is just one of the many contributions to the active debate surrounding the College's 'quality initiative'[1] and the Government's discussion document on primary health care.[2] I intend to put forward a point of view which may not yet have been advanced and to focus on the individual general practitioner in his practice, at his place of work — on the activities of that autonomous, independent professional in a branch of medicine which has a definable academic content and might be called a discipline. This approach will inevitably create a distortion of perspective, as does a wide-angled, short focus lens in close up; in the foreground the doctor appears in a dominant position with corresponding diminution in the scale of his surroundings.

I shall consider three aspects of the general practitioner and his work: (1) professionalism, aspects of the doctor's roles and responsibilities; (2) relationship with the state; and (3) individual and corporate professional health.

Professionalism, roles and responsibilities

Maintenance of knowledge and skills in a rapidly changing and increasingly technological age is not peculiar to medicine and certainly not to general practice. However, the pace of change is demanding and must be recognized and consciously taken into account. It affects the profession in the content and provision of its services; it affects our patients who require our services and may often be dependent on them; it teases politicians who debate and plan and must react appropriately to the views of their constituents. To the practising doctor such considerations may appear as abstractions if not distractions from his professional practice in which he sees himself as proficient, enthusiastic and hard-working.

Toffler[3] indicates how the survivor learns to use the process of change successfully and that those who do so best achieve the greatest rewards. But how? If the general practitioner is to survive he needs to be able to understand the necessity and desirability of change. Can we envisage the creation of personal career planning with guidance on professional development which is available to all general practitioners? Why should we not use our professionalism, enthusiasm and motivation to plan our professional development?

Clift[4] writes 'the soil is now in good condition for a great leap forward in primary health care but there could be dangers in complacency; how easy for a young doctor to sit back and enjoy a good and interesting life without injecting any new ideas into his newly chosen profession.' It may be that the dangers lie not only in complacency but in a lack of recognition of the need for change, in a lack of attention, in a lack of contact with like-minded doctors and in a shortage of time. The formative influences of undergraduate education and early days in hospital are strong conditioners; despite a few protestations to the contrary we have been mostly receivers of education, more often than not from doctors in disciplines other than our own.

The Mackenzie report[5] exposes the deficiency of undergraduate experience of general practice and proposes practical and achievable solutions. The pattern of vocational training for general practice provides for only one of its three years to be spent in general practice, compounding the mischief of lack of experience of general practice. Thus there is only one solitary year of general practice experience in 10 of the critical early years in medicine. The historical reasons for this imbalance are political rather than educational and are a compromise arrived at in negotiation with government. This short period in general practice underlines the need for trainees to have only the best of opportunities during their practice year. Shortage of time compels trainers to structure the experience which they provide and trainees have little incentive to learn to manage their own learning.

One outcome of this has been the emergence of young practitioner groups — young principals who feel the need to meet with their peers in order to provide mutual support during their early years in practice. The existence of these groups is to be welcomed but, when most doctors work closely with colleagues in partnerships, one wonders what the young doctor's experience is in his own practice-based working environment. Does he encounter a planned approach to the development of the practice; what is the relationship between the young partner and his seniors and what do more senior partners understand of their responsibility to their junior colleagues? Paternalism is dead, long live independence — or chaos? Dornhorst[6] begins an article on medical education with the aphoristic statement 'What matters in medicine is how patients are managed.' Perhaps this is equally true of professional practice.

The competition between graduates to enter general practice as a career is a comparatively new occurrence. It has been suggested that this is because general practice is seen as a 'soft-option' which does not require the time, training or intellectual and academic effort demanded in other disciplines to achieve a permanent career status. It has also been described as a vote

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of no confidence in hospital medicine. On the other hand some manpower researchers have shown evidence of positive motivation.[7] If general practice were seen as a rewarding but demanding branch of medicine, requiring exceptional and different qualities in its practitioners then we might cease looking to hospital based medical disciplines as role models. Importantly, general practice contains a cadre of teachers who are enthusiastic about their work, experienced in its practice and buoyant about its future. Do these teachers have the capacity to encourage learning and to excite a liberal approach to the development of the necessary qualities? As Parkhouse[8] writes 'There is a need to look at what individual specialties, including general practice, have to offer to patients through their expertise, how they can best be combined and what will give job satisfaction to all concerned.'

Learning during the preregistration year is essentially 'by doing' and sheer survival is all important. However, subsequent hospital posts in vocational training schemes for general practice provide a predictable and protected educational experience which encourages conformity and presents few intellectual or personal challenges. There is a danger that this regulated, conformist approach to education might also be encouraged by trainers in training practices and thus influence the whole of continuing medical education in general practice. The explicit recommendations contained in section 4 of the College's response[9] to the Government's discussion document[2] have a suggestion of this general move towards regulation and conformity and could lead to objective-led continuing education based on clinical audit, related to a contract with a monopoly employer.

Smith[10] writes of performance review 'It will take time and further efforts by regional advisers, trainers and enthusiasts to convince the profession of its value.' Note the use of the term enthusiasts by one of the greatest enthusiasts of general practice and a founder College member of Council. But is it enthusiasm for performance review, the quality initiative or general practice? This question points to the dilemma which is causing friction and potentially, fission in our profession. O'Donnell[11] writes that 'this pursuit of the academic ideal regardless of resources, may not be the best way to provide medical care (in a declining economy)'. He postulates two sorts of doctor: one to advance the ability to cure, the other the ability to care.

The profession and the state

The independence of general practitioners is signified by the nature of their contracts with the National Health Service. General practitioners are often seen as not only independent, but idiosyncratic and wilful. In the past, negotiation between the profession and government has achieved benefits for both doctors and patients but at the cost of the state's increased stake in and hence control of the provision of services. The family practitioner committee (or health authority) is responsible for the range and quality of services to its population and its contractors are bound by their terms and conditions of service. The identification and measurement of good standards of practice are seen to be important both to general practitioners and government but do the words mean the same to each? Can we feel secure in the future development of general practice being judged by its fulfilment of a contract?

Styles[12] writes that agreement over the availability of a basic range of services is 'an essential first step before going on to consider more difficult matters such as levels of performance and quality of service'. This may be so for the way general practice responds to the negotiation of a contract but is this a healthy approach for our discipline? Winkler, writing in *The Times*,[13] expresses doubts about the success of the managerial approach 'to clarify objectives, measure performance and reward achievement' because it may so easily be manipulated by a skilled administration. To argue to the contrary implies that the aims of the profession and the objectives of the government are not the same, need not be the same and are separable. In reality these aims and objectives should at least be linked and the ways in which they are related need to be scrutinized.

In considering the relationship between the profession and the state, the general practitioner's dependence on other NHS resources, both financial and manpower, need to be examined. As others in the primary health care team gain in professional strength supported by their managers, there is increasing pressure on general practice to conform to the expectations of other professional groups. A hierarchical structure with its explicit discipline and accountability is easier for people to understand than the self-regulatory approach of an independent profession. The juxtaposition of a managed and independent service has always been uncomfortable.

In general practice we seem to be edging towards a managed service characterized by regulation and adherence to collectively agreed objectives. Perhaps it is this move which is causing the tensions within our discipline? Donabedian in his visit to Britain[14] detected anxiety and ambivalence about the nature of general practice and whether academic consideration would damage the intuitive behaviour of the group; a further manifestation was distrust of a move towards criteria and standards. General practitioners are acknowledged to be lateral thinkers and this may be linked to the apparent anxieties which some general practitioners have experienced in their flirtations with educational and clinical approaches which emphasize objectives, protocols and measurements. As clinical audit is pursued in the chase towards better clinical standards, could it be that we have been paying insufficient attention to our own professional development?

The concept of professional responsibility includes the maintenance of standards of practice and pride in performance. The accountability of doctors to patients and the state is necessary and desirable but already exists through contracts of service, professional bodies, the General Medical Council and the courts. It is possible that the politicization of many of the College's activities has led to the encouragement of forms of accountability which may be counter-productive. Arbitrary externally created measures of performance may deter practitioners from developing their own feelings of responsibility and from contributing to the growth of their discipline.

Individual and corporate professional health

Continuing medical education has been a cooperative and collaborative effort between the profession, the universities and government. Its promotion through the postgraduate centre movement has been described in a collection of papers in *Update*.[15] The difficulty of reconciling individual responsibility for learning with a structure for continuing medical education is acknowledged and there is considerable uncertainty about the content of current programmes of continuing medical education.[16] McLachlan[17] argues the need for 'metaphysical speculation' on the future of continuing medical education and emphasizes the importance of a pluralist approach.

In the past, strategies in postgraduate education have tended to be centrally based. There is now a need for general practitioners to become more involved in the management of their own learning in their own locality. This change in direction implies a resurgence of some of the older values in medicine and may recapture the excitement and determination which characterized activities before any postgraduate education structure existed and which led to the establishment of our College.

Learning in general practice should be an everyday affair with the clearly stated aim of improved patient care. This should surely endear us to our patients and our political masters.

General practice has found it impossible to describe its domain except in the broadest terms.[18] Thus, areas of practice such as preventive care, care of chronic diseases and child development have become popular as readily measurable activities as well as being appropriate and effective in the practice setting. The danger is that they may distract general practitioners from their traditional strengths of responding directly to patients in consultations. This fundamental role for general practitioners is encapsulated in Spence's definition of the consultation[19] and emphasized in the statement on personal care in *General practice — the British success.*[20]

There is a danger that rationed educational resources may be disproportionately allocated to the support of measurable but possibly peripheral aspects of practice, to the relative neglect of learning about other more difficult aspects of our work. The content of the consultation, the ways in which a patient's problems are resolved and the maintenance of a continuing doctor–patient relationship are educationally still relatively uncharted waters.

I must re-emphasize that I am concerned with the balance between provided education and self learning as typified by Freeman[21] when he writes of 'combining a receptivity to individual patients' needs with a structural approach to the management of chronic conditions'. We have little information on the influence of our individual practice on patient care. We need to examine carefully what we do and above all to discuss with one another the performance of our daily work. When I have asked trainees on completion of their training how they see general practice in the future they have responded by discussing the provision of chronic and preventive care but few have displayed a vision of their own contribution to the future of the discipline and of their own professional development. Perhaps it is inopportune to pose the question at this time but the lack of conscious expression of ambition is concerning.

The College has actively expressed constructive policies on the content and arrangements of education for general practice, its regulation and most recently its service commitment. General practice literature and its research output have grown enormously. Vocational trainees have been encouraged to provide original material aided by imaginative projects such as the Syntex Award Scheme. However, formal continuing medical education is not well supported by practitioners. Postgraduate medical centres were intended to be for all doctors and clinical tutors were appointed to coordinate and facilitate their activities. However, most meetings at the centres became updating sessions for general practitioners and junior hospital doctors and this limited view of the purpose of meetings is still common. Nonetheless, the centres exist and at the least provide a place where neighbourhood general practitioners may meet.

Many doctors already meet in groups to further their own learning. Whether they do so as trainers, young practitioners, research enthusiasts or College members is immaterial. Yet, there are many doctors who do not attend any form of postgraduate educational meeting. They may be idle, even unprofessional, but they may be deterred by a rigid educational approach with overtones of regimentation.

If professional development is accepted to be an integral part of professional practice then continuing education is essential and financial support for it should have a high priority. Although government funds are available for our continuing education, an additional direct contribution by us towards our own learning would have enormous significance. It would symbolize our independence and offer each general practitioner a stake in his future development.

General practitioners are not isolationist — the very idea is inimical to our daily work which touches unselectively on all aspects of medical practice and care. A higher, more independent profile would encourage adult relationships with our specialist colleagues and could catalyse discussion on improvements in the delivery of care. It could lead to new relationships with university departments and with health service managers. Our very independence and key position in the health service enables us to take such a step. This is the very spirit of Pickles.

A move to promote independence and self-learning does not conflict with the interests of established bodies. Regulation and liberality are not mutually exclusive; it is the balance and dynamics between the two which matter. This emphasis on independence may be currently politically unpopular but may be the best way to ensure the survival of general practice in an increasingly hostile environment.

Conclusion

I am very much aware of the honour the College conferred on me by its invitation to give this lecture. I am particularly proud to have had the opportunity to do so in this distinguished and historic capital city with its university and colleges which have given so much to medical practice worldwide. Its general practitioners have made outstanding contributions to the establishment and promotion of our discipline and I have spoken in full acknowledgement of these achievements, not in ignorance. To some it may seem to be mere flag-waving and idealism. Certainly it contains the heart-felt belief in and enthusiasm for a proud profession but it also contains a challenge to espouse the causes of liberality and continued freedom in our professional development; something which demands a united approach, in which the undoubted talents of our youngest recruits, and the wisdom of our committed leaders combine to imbue all our colleagues with a belief in themselves. Surely a task for the professionals.

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