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Staying the distance

ANOTHER major initiative in distance learning is launched this month by the College. Management skills, which have always been important in general practice, are rapidly becoming essential. *If only I had the time* is a book based learning programme for management in general practice which complements the College's video package *Management in practice.* This new distance learning programme follows the successful CASE (clinical assessment for systematic education) programme which has been running now for five years. Some 10 000 general practitioners have participated in CASE and it is hoped that similar numbers of doctors will become involved in the new programme, especially if it is approved for the new postgraduate training allowance.

The topics covered in *If only I had the time* were identified by general practitioners themselves in a survey of their needs for help and advice in management: planning, the effective use of time, organizing and implementing change, monitoring and assessing performance, staff management and communication, teamwork and the management of conflict. A reference book covering these 10 areas will be sent to all participants and this will be followed over 18 months by a series of monthly diaries which participants will fill in and return. Each diary will present a problem in management with cross-references to the relevant sections of the core book. Thus the programme draws on theoretical aspects of management in a way which is tailored to show their relevance to the practical problems faced by general practitioners. The launch provides an opportunity to look at the contribution that this form of learning can play in continuing medical education and to speculate on the way in which it might develop.

What is distance learning? While books, journals, audio and videotapes are all forms of distance learning, the term implies some form of active participation by the individual enrolled in a programme. Frequently there will be some form of assessment as to whether learning has taken place and feedback will be given to the participant about his or her performance. The Open University is a massive and continuing success story in adult education which is based on this concept of distance learning. The large number of students and the wide range of subjects indicates both the versatility of the educational method and its popularity with people who are able to fit their learning around other work commitments. Medicine has been relatively slow in developing distance learning programmes. Stimulated by the geographical isolation of many of its members, the Royal Australian College of General Practitioners has for many years produced programmes which have allowed individual general practitioners to assess their own knowledge in a number of different clinical areas. In this country Professor Harden and his colleagues at the Centre for Medical Education in Dundee have been the pioneers in developing and evaluating the different approaches to distance learning. The CASE programme and *If only I had the time* are the result of close collaboration between the Royal College of General Practitioners and the Centre. Doctors from the West of Scotland faculty of the College have taken a leading role in the drafting of *If only I had the time,* while the skill and experience of the Centre for Medical Education have enabled this material to be presented to general practitioners in a form which is both attractive and easy to use.

An evaluation of the CASE programme has shown that it is a very acceptable form of continuing medical education for large numbers of general practitioners.

Participating doctors appreciate the flexibility of the method and the opportunity to compare their own responses with the previously gathered responses of others. This gives immediate feedback as a form of self-assessment. More elaborate assessments can be provided if there is a central support service to back up the distance learning programme. Combining different methods of communication provides the potential for exciting forms of continuing medical education, which not only present facts, cases and issues but can also be used to assess knowledge, problem solving skills and attitudes. The Centre for Medical Education will be using a computerized system to collate doctors' responses and thus participants in the new programme will receive personalized feedback about their responses and how they compare with other participants.

The advantages of distance learning in general practice seem clear. However, the way in which it is to be funded in the future is less obvious and, ultimately it is this that will determine the direction in which distance learning develops. ICI, Glaxo and the MSD Foundation generously provided the funds which enabled the College to create the three distance learning programmes mentioned above. The benefits of this form of continuing medical education have been acknowledged by the government and in Scotland, the Scottish Home and Health Department has been willing to support distance learning for general practitioners through the Scottish Council for Postgraduate Medical Education. In spite of this, there is no sign that the central funding necessary to create and sustain distance learning for general practitioners will be made available. In future general practitioners will be expected to pay for their continuing education from the postgraduate training allowance but setting up and publishing distance learning materials requires capital funds before income can be attracted from participating doctors. Unless some form of central fund can be created, the new arrangements for continuing medical education for general practitioners in this country will not encourage distance learning other than through material which is funded by advertising.

E.G. BUCKLEY
Editor of the Journal

Further information about *If only I had the time* can be obtained from: The Centre for Medical Education, Ninewells Hospital and Medical School, Dundee DD1 9SY. Applications to take part in the programme should be sent to the same address, enclosing a cheque for £20.00 made out to 'University of Dundee/RCGP'. Access and Visa cards are accepted.

The future role of mental illness hospitals

RECENT debate on the care of the elderly, the mentally ill and the mentally retarded has centred on the need to develop strategies of care in the community. The administrative framework for future developments in this area was laid out in the Griffiths report[1] and the government has now made a formal response to these proposals.[2]

The success of community based programmes in the management of some forms of mental illness has led to the belief, dubbed 'the new simplicity' by Finzen,[3] that given sufficient resources all mental illness can be managed in the community. However, there are many mentally disturbed patients who are either recurrently or permanently too ill to be managed in the community. An analogous statement could be made of any group of patients and it is difficult to see why recognition of this fact should be regarded as defamatory to sufferers by some pressure groups acting on their behalf.

Mental hospitals emerged in the late Victorian age as a humanitarian response to the need to provide asylum for the mentally ill as an alternative to vagrancy, prison or the poor house. The paucity of therapeutic regimens led to the emergence of a primarily custodial role, which in countries such as Italy persisted well into the twentieth century. Only in the 1950s and 1960s did drugs become available that were effective in the management of the mentally ill in the community. This development coincided with reform of the legal framework of admission and detention, with emerging concern over 'patients rights' and with the academic exposition of the detrimental psychological sequelae of institutionalization by workers such as Barton[4] and Goffman.[5]

The last two decades have seen the development of strategies of community care for the mentally ill not only in the UK but widely throughout the developed world. In some countries such as Italy and the USA campaigns for the closure of mental hospitals have assumed frank political overtones and have been backed by statutory force. However, the limits of community care are now beginning to be recognized. Public concern increasingly focuses on the fate of the mentally ill, deprived of any institutional asylum, who are forced to huddle among the homeless, to eke out an existence in seaside boarding houses or to be housed inappropriately in remand centres and prisons. A report by the Group for Advancement of Psychiatry[6] has catalogued the dismal outcome of the community mental health programme in the USA set up by President Kennedy. In the UK Abrahamson and Ezekiel[7] have studied the ability of severely disturbed people to form normal relationships in the community and concluded that such patients are as isolated outside hospitals as within. There is no doubt that in this country many of the problems have been caused by the inappropriate discharge of patients owing to closure of large institutions in situations where community care is inadequate. Nonetheless, attention is again beginning to focus on the need for psychiatric inpatient care.[8,9] Awareness of the evils of large institutions has to be balanced by an awareness of the evils of community care. Indeed, community care could become 'a euphemism for unavailable treatment and a policy of neglect'.[10]

Now that the administrative and financial basis of community care for the mentally ill has been clarified the role, scale and physical basis of inpatient care of the mentally ill needs to be defined. The types of mental illness which are most likely to respond only to inpatient care should be identified. It is clear that some people are chronically unwell and need the sheltered environment and asylum available in mental hospitals. The prevalence of dementia among the over 75 year olds is about 10%.[11] Half of these demented patients may be classified as 'severely affected' and yet at present specialist inpatient care is available for only about one in 10 of this group.

New therapies and new strategies of care, such as short term admission, also affect the size of the inpatient population, but in a complex way. Lithium therapy has been associated with a reduction in the risk of relapse in depression but recent work shows that hospitalization as a result of severe relapse is as common now as it was before the introduction of this drug.[12] Patients with depression receiving lithium therapy or patients suffering from schizophrenia receiving neuroleptics are now in