

vices authority population register. The advantage would be that a patient would only need to be asked once about ethnic group, rather than at each contact with a different part of the NHS. However, the Department of Health has not offered general practitioners any guidance or help with the training of their staff to collect this data and, in the absence of these, it is unlikely that accepted good practice will be followed. There will be a temptation to define a patient's ethnic group by observation and the resulting data will be devalued. Many general practitioners will see the referral letter proposal as yet another case of the Department of Health attempting to offload work onto general practice which might be more appropriately done by health authority staff. The danger is that the precipitancy and insensitivity of the Department of Health proposal will detract from the clear potential benefits which ethnic monitoring has for general practitioners, primary health care teams and their patients.

Inner city practices, such as mine, may need to adopt the extended Tower Hamlets model to realize the most benefit. Also, practices, ideally in consultation with their local communities, may wish to elaborate the basic Commission for Racial Equality classification and choose ethnic categories which fit the local ethnic minority population and increase the usefulness of the data. My practice, for instance, might wish to differentiate the Irish and Greek Cypriot populations hidden within the white group. However, it is important that local categories can be neatly aggregated to the census categories. If a practice is in a position to know how many Gujarati-speaking smokers there are on the list, it will be able to assess the need for a Gujarati translation of the relevant health education material. If the census data, when it becomes available in 1993, shows that 10% of a local population are Chinese and yet only 1% of a particular practice's patients are Chinese, that practice would be in a position to argue for the employment of a Chinese-speaking linkworker. Differential rates of consultation, prescribing, referral or investigation between ethnic groups may indicate differential rates of morbidity, but may indicate problems of equity. Any such differential needs to be investigated and justified.⁶

City and east London family health services authority have

already appointed an ethnic minority services manager. Several linkworkers with language skills appropriate to the local practice population have been employed to work in health centres and general practice surgeries. In the first three years that a Turkish-speaking linkworker was in post at one surgery, the uptake of contraceptive services among Turkish-speaking patients increased from 3% to 75% and termination requests decreased in proportion.⁷

As with all audit, the circle needs to be completed and ethnic monitoring can only be justified if it can be shown to improve standards of patient care and equity of access to services. If evidence of this can be fed back to the local community and to the staff involved, it will validate the collection and use of the data. Only then will the role of ethnic monitoring in general practice be clear.

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Continuing education for general practice: a life long journey

POSTGRADUATE education in general practice in the United Kingdom is passing through turbulent times. Political changes have placed new emphasis on examinations, diplomas and qualifying for the postgraduate education allowance. This risks diverting attention away from professional development and personal growth. We have an urgent challenge to describe the nature of our specialty in order to preserve and develop its unique method of health care delivery, which is more than the sum of the elements of public health and specialty medicine.

The new entrant to general practice emerges from an educational system that teaches more and more about less and less.¹ Patient contact in general practice invites learning in many new areas. Experience produces an increasingly widening knowledge base. General practice education has to expand to include social, cultural, psychological and other areas in order to explore the way these areas interact with the biomedical model. New entrants to general practice often need less medical knowledge and more insight into other influences on patient health.

The majority of general practitioners do not occupy the academic 'high ground' of facts and abstract concepts and of deductive reasoning to produce single correct answers, but have to work in the 'swamp' of everyday reality² that consists of multiple possibilities, conflicting motives and emotions, competing priorities as well as difficulties in communication. This means that knowledge cannot remain unchanged in general practice. The idea that knowledge is 'provisional' is a threatening one but it allies itself more closely to what happens in the consultation where the picture changes as more pieces are added to the jigsaw of the patient's problem. Learning may modify understanding of existing knowledge or alter its significance or importance. One of the most difficult aspects of general practice is living with uncertainty, but this becomes less threatening if knowledge is no longer viewed as unassailable or unchanging. Uncertainty becomes legitimate if Popper's suggestion that nothing can be conclusively proved but can only be conclusively disproved is accepted.³

General practitioners need skills in assessing priorities and making compromises. Patient needs may conflict with the needs of those working in the practice. Ideal patient care may conflict with economic use of time and resources. Teaching and research may conflict with clinical workload. The imposed change of the new general practitioner contract may conflict with agreed work practices. Work commitment may conflict with personal, family and recreation needs. Ignoring these aspects belittles their importance.

General practitioners also need skills in interpersonal behaviour. Patients remember some doctors as special people because of the way they reacted to their problem and became involved with them. Doctors' humaneness and individuality are valued as well as their diagnostic skills. By developing better understanding of themselves,⁴ doctors might improve the service they offer patients and avoid the risks of overwork, depression, addiction or personal or health problems.⁵

I suggest that these skills should be incorporated in a revised definition of general practice. They embrace aspects of doctor behaviour that should be common to every specialty but that are uniquely important to general practice and are too often inadequately dealt with in educational programmes.

After medical school the responsibility of learning and personal development shifts from the syllabus and the teacher to the learner and this is the essence of adult learning as described by Knowles and Rogers.^{6,7} The most important influence on learning is what the learner already knows.⁸ By starting from the stage the learner has reached a personal syllabus can be defined and appropriate strategies chosen. Motivation to learn and the ability to define when adequate learning has taken place can be an individual responsibility or can be shared with trusted peers or a mentor.

Adults learn largely from personal experience.⁹ Past experience, personal knowledge of the patient and the illness, ability to apply heuristics, pattern recognition and collaboration with others are some of the many methods of problem solving that can be employed.^{10,11} The problem is deemed to be solved when both doctor and patient are satisfied that this has been achieved.

While most doctors have little difficulty identifying the mistakes of others, admitting their own may be more challenging. However, every mistake offers a chance to develop new skills and acquire new knowledge if the learner receives encouragement and support.^{12,13} This personal and individually controlled process fosters competence and confidence as well as providing the opportunity for self forgiveness. These qualities facilitate development of a less rigid approach to patients, for example by sharing knowledge and decisions and when appropriate, sharing uncertainty.

There are several ways in which doctors can monitor their personal development. Stretton¹⁴ sees accreditation as the small central hole in a 'doughnut' of learning that continues throughout life. Doctors spend most of their professional lives in the substance of the doughnut where more personally relevant methods of assessment are needed. A personal diary is a useful way of reflecting on feelings and problems encountered while working and can help monitor personal development. Small group activities can provide stimulus and support to explore areas of ignorance or mistakes that have been made. A portfolio of cases which might include research, audit, summaries of courses attended and other learning activities (not necessarily medical) chosen and critically analysed by an individual is a useful way of documenting educational activity and could contribute to self, peer or continuing assessment (Millard L, personal communication).¹⁵ It could also allow the description of different personal learning outcomes from a shared learning

experience. Learners need acknowledgement of their achievements and may hope to receive awards such as diplomas. Portfolios could contribute to summative assessments such as diplomas or could be incorporated into the fellowship by assessment of the Royal College of General Practitioners.

The consequence of the freedom to learn to solve problems one's own way when in the swamp of everyday practice is, Schon suggests, the development of professional artistry.² In a repetitive situation such as the consultation this involves use of knowledge that does not reach consciousness, described by Polanyi as 'tacit' knowledge.⁹ Schon suggests that our artistry can be studied through 'knowing in action', a process of reflecting on and describing our actions to reveal the tacit knowledge used. Schon also describes 'reflection in action', a process that addresses the surprise that new problems produce when they cannot be solved by the standard rules that govern the medical paradigm. On the spot experiments are conducted to test understanding or to attempt to solve the problem.² By developing a way of monitoring the unique approach and solutions we offer our patients we can avoid sloppy or inaccurate thought and become better able to understand and describe the process of our decision making.

Neighbour has described a way of monitoring the doctor's performance during the consultation.¹⁶ His practical checklist draws on many models appropriate to the consultation apart from the biomedical model and provides a useful framework which doctors can modify to suit their own needs. A framework or checklist is necessary if patient beliefs and other influences on health are to be explored in the consultation.

Doctors have the capacity to change during their professional lifetime but this is not an easy process. Measures of change such as indicators of adequate performance or quality assurance are needed to demonstrate our professionalism. Their creation needs to involve all concerned so that doctors feel responsible for the standards set. They must be sufficiently flexible to allow for individual as well as practice and geographical differences, in other words they must be seen as relevant and attainable. Discussion allows options to be explored and variations to be negotiated so that doctors will be less likely to erect barriers to change. Imposition of standards without discussion causes resentment and anger and militates against learning and development.¹⁷

Adult learning can encourage personal development and self value that helps guard against professional burn out. The trainee year is a crucial starting point and needs to be freed from the pressure of examinations to allow exploration of new approaches to learning and the acquisition of the necessary expertise and confidence to take charge of a life long journey of self education and renewal. This approach to education is already gaining ground in the south east Thames region. Many half day release courses are run as small groups and provide support and encouragement to explore individual learning needs. This safe environment allows identification of the many ways of tackling general practice problems from the unique perspective of the individual doctor. Many young practitioner groups have subsequently been formed to continue professional development. Mentors have been appointed to work with doctors to identify individual learning needs and to help plan and evaluate subsequent learning. The information gathered by mentors could influence the content and style of courses run in the future. At present, the foundation course, available to all principals and forming the first part of a learning package for those wishing to become trainers, is designed to incorporate adult learning principles.

Development and maintenance of standards set by our profession will be more creative and challenging than those

applied externally. The RCGP could seize the opportunity to become a focus and support for these exciting changes or risk being viewed as increasingly irrelevant in an area where it claims to foster excellence.

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