What is the role of doctors? The medical profession has been in the vanguard of the struggle against smoking for 50 years. Doctors have, however, mainly concentrated on identifying the diseases caused by smoking and educating patients about the dangers of smoking. They now need to recognise that nicotine addiction is the central problem. In helping smokers they are seeking to help nicotine addicts. Treating nicotine addiction should be a core activity and responsibility, and all doctors should be familiar with the benefits of nicotine replacement therapy.

Doctors should demand comprehensive smoking cessation facilities for their patients affected by nicotine addiction, including nicotine replacement therapy on prescription in the NHS. On the wider political stage, doctors should demand a level playing field. The industry that promotes nicotine addiction should be regulated and the therapies that treat it not disadvantaged in relation to smoking. All doctors, on behalf of their many current and future patients who smoke, will want to help the Royal College of Physicians achieve its goal of persuading the government to set up a Nicotine Regulatory Authority embracing tobacco products and nicotine therapies.

John Moxham *professor of respiratory medicine*

Guy's, King's, and St Thomas's School of Medicine, King's College Hospital, London SE5 9PJ

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Voluntary organisations: from Cinderella to white knight?

We need evidence of effectiveness of those that deliver care directly

For much of our history medical care was delivered by religious organisations or philanthropic individuals and institutions.[1] Immediately before the second world war the prestigious forerunners of Britain's present day teaching hospitals were financed by charitable contributions. The advent of the NHS displaced voluntary organisations from organised health care. Such organisations have not withered, however, but have prospered: half of the current national organisations have been started over the past 20 years.[2] Now, after many years in official wilderness, voluntary organisations are back on the political agenda, their potential contribution having been highlighted in recent white papers on the future of health care.[3 4] The cynic might quibble that there is no formal strategy to increase the role of voluntary organisations and that no financial support has been earmarked to achieve this. But this does not deflect attention away from the real question: why should voluntary organisations be attracting this level of interest now?

The answer may lie in the growing pressure on NHS resources and the consequent need to find ways to augment the delivery of care without increased cost. The voluntary sector has a substantial income of £12bn ($19bn) a year,[5] and within health care it can provide an abundance of volunteers with the time to devote to individual patients. Further, given the immense numbers of voluntary organisations, there is likely to be at least one which could provide help for every type of patient presenting to the NHS. The major disease groups such as cancer, stroke, and heart disease have their well known champions, but there are also many support organisations for patients with rarer conditions such as neuroblastoma and Behçet's and Sjøgren's syndromes.[6]

But, although use of voluntary organisations by the statutory sector may be expedient, it would not be wise to rush headlong into their incorporation into the NHS. Especially in this age of evidence based medicine, we need some reassurance that the involvement of these bodies in health care will result in the hoped for health gains. Thus the paper by Grant et al in this issue helps provide reassurance (p 419).[7] It shows in a randomised controlled trial that referral of patients with psychosocial problems to the voluntary sector significantly improved wellbeing compared to usual management by general practitioners.[7] Not only is this a particularly difficult group of patients to study; they also make substantial demands on healthcare resources.

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However, this paper does raise the question of when we need evidence for effectiveness. Given the diversity of voluntary organisations, it would not be practical to require evidence for every one: this would effectively debar their use. Clearly for some we need no evidence: the provision of tea by the Women's Royal Voluntary Service, for example, or of drivers of minibuses for patient transport. But we do need evidence for the type of care provided in Grant et al's study. The distinction lies in whether volunteers provide care directly or whether they merely support the delivery of conventional care. The more voluntary organisations act as an alternative to the NHS, the greater the need for evidence. Grey areas will certainly emerge (such as self help groups for patients with cancer), where we may have to accept on trust that the provision of support is inherently beneficial.

A second question is whether the voluntary sector should go further than providing support services. Should voluntary organisations be involved in planning and implementing policy, acting as the champion of patients' needs? The increasing recognition of the importance of the patient's perspective suggests that this is a legitimate role. Certainly it is one that many voluntary bodies want. For example, an umbrella body of 96 national voluntary organisations was formed in 1990 to influence policy and practice because of concerns about reforms to the NHS.[8] Thus the question is less whether than to what extent they should influence policy and planning.

Finally, there is the question of how to integrate the voluntary sector within the NHS. In the past, health professionals were reluctant to become involved with voluntary organisations[9] and viewed them as a threat to

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jobs or levels of pay.[10] A lack of understanding of their potential contribution may still exist: a recent survey concluded that general practitioners have "little information about voluntary organisations and what they do."[11] Clearly some initiative is required beyond the rhetoric of the recent white papers. In 1988 Black indicated that the potential rewards of NHS-voluntary sector partnerships were considerable.[9] They remain so—and largely unrealised.[12] Perhaps the role of voluntary organisations is one of the health technologies that the National Institute for Clinical Effectiveness could review.[13] Then we might gain answers to the questions of how, and to what extent, the enormous potential of the voluntary sector could be realised.

Iain K Crombie *professor*
Donald R Coid *honorary senior lecturer*

University Department of Epidemiology and Public Health, Ninewells Hospital and Medical School, Dundee DD1 9SY
(i.k.crombie@dundee.ac.uk)

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From CME to CPD: getting better at getting better?

Individual learning portfolios may bridge gap between learning and accountability

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Continuing medical education is part of the process of lifelong learning that all doctors undertake from medical school until retirement and has traditionally been viewed by the medical profession in terms of updating their knowledge. However, all career grade doctors need skills that extend beyond updating their medical knowledge in order to practise effectively in the modern NHS. Such skills include management, education and training, information technology, audit, communication, and team building. These broader skills are embraced by continuing professional development, which, in a welcome move last year, was endorsed by the Academy of Royal Colleges. Thus the colleges have now accepted responsibility for both continuing medical education and professional development of hospital doctors (with parallel arrangements for general practitioners[1]). The task is now to establish schemes and develop methods that both achieve the desired outcomes and are seen to do so.

The royal colleges are responsible for providing a framework for continuing professional development; setting educational standards; and monitoring, facilitating, and evaluating activities for their members. Their professional development schemes need to be flexible so that doctors can participate and be recognised for what they do in the context of their professional practice.[2] At the same time individuals should be able justify their activities when subjected to external scrutiny. This will become increasingly important in relation to clinical governance,[3] revalidation,[4] and poor performance procedures, which are providing the impetus for continuing professional development to become mandatory.[5]

In the United Kingdom continuing professional development schemes are currently based on acquiring credits. The advantage of this system is that time devoted to continuing professional development can be measured and recorded. The disadvantage is that it encourages a "bums on seats" approach by both participants and providers of education. It should be the quality and relevance of the activities that is important, not the quantity.[6] The undifferentiated pursuit of credits provides a false security blanket that may bear little or no relation to the real outcomes of activities aimed at professional development.

There needs to be a shift away from credit counting towards a process of self accreditation and reflection, recording learning that has occurred and applying it to practice. There is no single correct or best way of doing continuing professional development, and the methods chosen will depend on personal preference and appropriateness. They may range from self assessment multiple choice questions and journal reading to case discussions and visiting other departments or practices.[7] Learning that occurs in the context of the daily workplace is far more likely to be relevant and reinforced, leading to better practice.[8]

No matter how innovative and flexible the schemes become, the greatest challenge is to manage the interface between the requirements of professional bodies and those of employers, managers, and patients in trusts and primary care groups. The process of professional development needs to be managed.[7] The vast majority of doctors are good learners and have always just got on with their own continuing medical education and professional development—that is what being a professional means. However, the changing political climate and need to be more accountable mean that doctors now have to demonstrate that they are developing professionally and that their activities are educationally and cost effective and improve their practice.

One practical way of achieving this is through individual learning portfolios. Portfolios are not a panacea, but they are a useful tool which can be used to plan and