Modular continuing medical education: our flexible friend?

THE relationship between technical advances, the needs of patients and the continuing education of family doctors is clear. Maintaining the clinical competence of nearly 30 000 general practitioners of different ages, working in different places, with different experience and ability 'has always represented the biggest challenge [for medical educationalists] and still does'.[1] At an individual level, family doctors face new challenges arising from changes in society and the far reaching reforms of the National Health Service. New relationships exist with patients, with other health professionals, with managers and within the primary health care team. The professional responsibility to continue learning is accepted by almost all established principals,[2] as is the principle of reaccreditation by nearly two thirds of respondents to the General Medical Services Committee's survey.[3]

Many conscientious practitioners locked into a day-by-day struggle for survival find it difficult, if not impossible, to resist bland, low cost, unchallenging 'refresher' courses which do not, however, contribute to long-term professional development. The privatization of continuing medical education provision may have ushered in wider freedom of choice but the quality of learning is open to question. More lectures by specialists may simply represent the dissipation of effort on inappropriate continuing medical education which reinforces dependent learning.[4] Clinical problems in general practice are rarely typical of those described in medical textbooks and good management as often depends on teamwork, individual skills of negotiation and clinical counselling as on the minutiae of medical knowledge. Hothouse forcing with facts at the expense of reflection and analysis is inappropriate for undergraduates, but is doubly so for established principals.

Continuing medical education should enable continuing professional renewal and development. Although the increased paperwork and stress following the introduction of the 1990 contract[5] can result in burnout in general practice, burnout can also be related, particularly for those not engaged in teaching or research, to the lack of a career structure and the associated intellectual challenge. Lack of stimulation may lead to demoralization but morale can be enhanced through personal development.[6] The practical difficulties of a heavy workload, family commitments, availability requirements under the new contract or inflexible partnerships can frustrate ambitions to continue purposeful learning or pursue a higher university degree. More flexible ways of helping doctors keep up-to-date and of encouraging career development are urgently needed.

Stanley and colleagues have examined learning by established professionals in relation to clinical competence and performance and in the light of the professional development of the learner.[7] In their view continuing education for general practice must be centred not on didactic education as in medical schools but on self directed learning based on experience. They propose a model to link experience and competence through the systematic utilizaton of reading, reflection and audit. They see the roles of formal education as subsidiary, facilitating the sharing and enrichment of this learning from experience and thus sustaining the motivation to learn. How much of current postgraduate education can be accepted as furthering either of these two roles?

Like other doctors, general practitioners can learn more from their patients than from textbooks. This does not mean that reading can be put aside or competence maintained from clinical experience alone. The commonest method used by doctors to keep up to date is reading.[8] Effective reading requires a direct relevance of the material to clinical work, a regular commitment of time and the evaluation of what is read. Most general practitioners were trained before critical reading was emphasized in vocational training schemes. The importance of critical reading is that it enables general practitioners to make considered decisions as to what information to absorb and what to reject.[9] The introduction of a critical reading paper in the membership examination of the Royal College of General Practitioners has already caused a dramatic change in the reading habits of candidates with a shift to researched based journals and more time spent critically discussing papers.[10] It would be difficult to argue convincingly against the value of this activity for young doctors. If this is so, is the ability to read critically and the regular exercise of this skill any less vital to the development and maintenance of competence in more experienced colleagues?

Programmes of continuing medical education have been criticized[11] as often inappropriate or inadequate in that they have failed to take account of general practitioners' specific learning needs or learners' preferences. In 1990, in its educational strategy the RCGP recognized the limitations of current education provision in preparing doctors for a career in general practice.[12] This identified as an educational priority the development of higher professional education, that is, the voluntary continuing medical educational activity usually undertaken by young principals. A working party under the chairmanship of Roger Pietroni spent two years exploring how higher professional education might be provided and how learning might be assessed and recognized by a standard setting professional body, such as the RCGP. The outcome of their work has been published recently as *Occasional paper 63, Portfolio-based learning in general practice.*[13] The essence of this system is that modules or portfolios are built up over time and collected in a format which can be recognized by a professional body. The wider use of log diaries, commentaries on books and papers read, performance review and an educational partnership with a mentor colleague offers not only new possibilities for professional development but also the promise of steady improvements in patient care.

Occasional paper 63 will be of interest not only to regional advisers and others responsible for postgraduate education, but to young and not so young principals seeking to enrich their practice by study for a higher degree. The concept of modules or portfolios built up over time will appeal particularly to busy doctors who find it impossible to secure prolonged study leave.

The vision of an individually planned programme of continuing education for all general practitioners is a noble one but the issues it raises are vital to the future of general practice and deserve clarifying by wide ranging debate and empirical research. Periera Gray in his preface to the occasional paper warns that important advances carry the danger of 'educational side-effects' and that general practitioner enthusiasts may take quite different views of this document.

Though the mentor is a facilitator rather than a teacher, in an era of severe restraints on resources the high cost in terms of time of individual mentors will need to be addressed. Consideration will also need to be given to the training requirements of the mentors themselves. In a system of independent learning which is flexible and satisfying for the individual doctor there is a need to ensure not only that the portfolio work has been

done but that learning has taken place which can be linked to external standards of practice. Pressures from patients and purchasers and the need for public confidence in the effectiveness of continuing medical education may call for an assurance of competence linked eventually to a system of reaccreditation. A crucial element of the self-directed learning of individual general practitioners must surely be audit, to identify under-performance or to reinforce appropriate practice. Further efforts will be required to engage more general practitioners in audit as a personal activity and to combat negative attitudes. If portfolio-based learning succeeds, more general practitioners will be writing about and discussing their work with colleagues. Surely this must be good for doctors and for patient care.

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Urinary incontinence in women — a conundrum

UP to 10 million people in the United Kingdom suffer from urinary incontinence.[1] It is a condition which adversely affects quality of life for many patients and causes 'social death' for some chronic sufferers.[2] It mostly affects women and up to one third worry about their incontinence.[3] However, fewer than one third of all regularly incontinent women discuss the problem with a general practitioner or nurse.[4] Indeed 20% of women referred to a urodynamic clinic had delayed seeking their general practitioner's advice for more than five years after the symptoms had become troublesome.[5] Most of these women are likely to be well used to consulting doctors about other matters, including those of a gynaecological nature.

Urinary incontinence is an imprecise medical term and not a diagnosis; 85% of patients have stress urinary incontinence and 10% have detrusor instability, although both can coexist.[6] In stress urinary incontinence the patient complains of urine leakage on coughing and on exercise and this can be replicated in the clinical examination. Specific clinical signs are absent in detrusor instability although psychological factors are more evident than in stress incontinence. Distinguishing stress incontinence from detrusor instability is important because the management strategies are different. Bladder pressure studies are now a minor inconvenience as the benefits from diagnosis and appropriate treatment are worthwhile.

There are now a variety of management strategies available to incontinent women and their medical and nursing advisers.[7] These include pelvic floor exercises, appliances, drugs and surgery. Many of these methods have been studied in controlled trials and have been shown to be safe and effective. The less invasive techniques such as pelvic floor exercises require commitment from the patient after initial instruction.

In this issue of the *Journal*, Harrison and Memel describe the use of a health promotion clinic in the management of urinary incontinence.[8] Despite attempts at generating interest among their patients and the user friendliness of their clinic only 8% of their incontinent patients attended. A leaflet was, however, sent to incontinent patients and may have made a clinic visit unnecessary. Practices thinking of using a clinic format for their incontinent patients will find the authors' experiences helpful, if disheartening.

There is little doubt that for the majority of women incontinence is a minor inconvenience. Modern pads, pants and washing facilities allow most to cope without medical or nursing assistance. Many women accept it as a consequence of childbirth yet many nulliparous women also suffer.[9] Others see it as part of ageing yet many young women are regularly incontinent of urine.[10] There is, however, a strong association between neurotic personality traits and anxiety and both detrusor instability and stress urinary incontinence.[11] It is likely that such patients may have a lower consulting threshold for their urinary symptoms than those who are less neurotic or anxious.

Women with longstanding urinary incontinence and those with neuropathic bladders are deserving of specialized support and treatment. Where appropriate continued management will inevitably involve the primary carers, whether in the patient's own home or a nursing home. Treatment of recurrent urinary infections will make the patients more comfortable, while thought about the timing of, or indeed need for, diuretics may improve quality of life. Intermittent self catheterization has been shown to be safe, simple and possible in the home.[12] Such catheterization may free some selected patients from an indwelling catheter and these patients should be considered for referral for a trial of self catheterization.

Despite the array of skills and medications available, patients are slow in coming forward. In other areas of medicine doctors feel overwhelmed by demand, much of it inappropriate. Old attitudes in medicine may have conveyed uninterest or helplessness to the incontinent patient. Urinary incontinence is now seen as a team effort involving the patient herself and her medical and nursing advisers. If we are to meet her needs we need to understand why the most important member of the team is reluctant to take part.