FIG 2—Analysis of the practice age-sex register on 1 July 1983 to show percentages of "rubella protected" and "rubella risk" patients by age.

Half of the 3145 female patients in our practice aged between 10 and 40 were "rubella risk" patients before our programme started, which corresponds to the 51½, in Black "rushy." Coly 48 of (146%), "rubella corresponds to the 51½, in Black "rushy." Coly 48 of (146%), "rubella corresponds to the 51½, in Black "rushy." Coly 64%, "rubella coly 64%, "rubell

Analysis of "rubella protected" and "rubella risk" patients in 1980 and 1983 (percentages in brackets)

	Audit on I July 1980	Audit on 1 July 1983
Total No of females on practice list 11-40 years 10-40 years	3143 (100)	3151 (100)
Immunised Serologically immune Husband sterilised Patient sterilised	605 (19-2) 748 (23-8) 153 (4-9) 178 (5-7)	1099 (34-9) 1153 (36-6) 210 (6-7) 222 (7-1)
Total No "rubella protected" .	1684 (53-6)	2684 (85-2)
Serologically non-immune Refused No data	33 (1-1) 11 (0-4) 1415 (45-0)	13 (0·4) 87 (2·8) 367 (11·7)
Total No "rubella risk"	1459 (46-4)	467 (14-8)

Even if we find these patients the problem is not solved. The Strichley practice has an annual turnover rate of one in even, so that 450 female patients aged from 10 to 40 leave and join the list every year. Of those joining the list, half are likely to be "tubella risk" patients, so that every year we must immunise or screen 225 patients to find the 22 who are non-immune.

This paper reports the reduction in the number of "rubella risk" patients achieved by a general practice over four years. Several factors have contributed to this reduction. Firstly a population cannot be screened, immunised, and studied effectively unless the patients at risk can be identified by an

Secondly, the frequency of contacts with patients enables general practitioners to educate and persuade patients before a process of the contact of the contact practice and practice as the cocasion arises, often at consultations on other matters."

"Thirdly, the general practitioner has access to confidential data related to rubella, such as vasectomies and hysterectomies. General practitioners are informed as a matter of course of all immuniations at school or in maternity units. All this information may be found in the patients' medical records are ideally united to screen and immuniae. Preventive medicine is time-consuming, however: it requires a consistent practice policy, staff training, prolonged consultations, and careful documentation. The most difficult patients to protect are those who are not receiving contraceptive advice. They are hard to screen because they do not attend the surgery regularly and they may not be immunised until they are receiving adequate contraceptive affects of the contraceptive advice. They are hard to screen because they do not attend the surgery regularly and they may not be immunised until they are receiving adequate contraceptive and they are receiving adequate contraceptive and they are receiving adequate contraceptive practice programme of prevention has been the enthuisiant of the staff. All those concerned with the programme have been greatly encouraged by the results. Because of their commitment to preventive medicine the partners have been prepared to subsidist the trubella prevention programme. We estimate that it now costs at least £90 to identify and immunise a non-immune patient aged over 14 years. The DHSS fee is £20 subsidis? If a process of the partners and every member of strength and in one, to take the appropriate action." They are paid for screening for cervical cancer, why not for childbearing age on their lists, but especially those intending to become pregnant, are immune to rubells and, if not, to take the appropriate action." They are paid for screenin

I acknowledge the part played by the partners and every member of Stirchley Health Centre staff in the project.

- O'Shea S, Best JM, Banatvala JE, Marshall WC, Dudgeon JA. Rubella vaccination: persistence of antibodies for up to 16 years. Br Med J 1982; 285:235-5.

- O'Shee S, Best JM, Bransvala JE, Marshall WC, Dudgeon JA. Rabella weccasion: persistence of antibodie for up to 19-arts. Ph. Med J 1982;
 Department of Health and Social Security. Vescination against rubella. Circular 1700. London: DHSS, 1970.
 Department of Health and Social Security. Watchilds vescination. Circular CMO 1/74. London: DHSS, 1970.
 Department of Health and Social Security. Rubella vaccination. Circular CMO 1/74. London: DHSS, 1974.
 Department of Health and Social Security. Rubella vaccination. Circular CMO 1/74. London: DHSS, 1974.
 Department of Health and Social Security. Rubella vaccination. Circular CMO 01/74. London: DHSS, 1974.
 Department of Health and Social Security. The congenited rubella. Circular CMO 01/19 and CMO (1911). London: DHSS, 1981.
 Department of Health and Social Security. The congenited rubella systematic rubella. Circular CMO (1917) and CMO (1911). London: DHSS, 1981.
 Department of Health and Social Security. The congenited rubella systematic rubella. Circular CMO, 1974. PM (1975) 284: 200-10.
 Department of Health and Social Security. The congenited rubella systematic rubella. Circular CMO, 1974. PM (1975) 284: 200-10.
 Technical vaccination policy. N Eq. 1/7 Med 1975, 284: 200-10.
 Technical Vaccination of rubella immunity in a general practice position. Revision of rubella immunitation in general precision of rubella immunitation in gener

(Accepted 13 October 1983)

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Continuing Education

Have we overemphasised our needs?

D E MURFIN

This paper on continuing education is a personal opinion. The subject has become highly topical. I have asked myrelf whether the spented practitioners we have overemphasised our needs. Have other professions such as accountancy and law undergone such critical analysis over recent years? The reason for our concern about continuing education, however, lies in visible standards, for I doubt whether any general practitioner could look at his own area and be satisfied with a status que. I have the subject of the sub

Setting standards in general practice seems to be important and essential. It must be visible in terms of performance, organisation, and reasonable premises. Doctors should be able to show that they are successful at running a business and

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capable professionals. The Joint Committee on Postgraduate Training for General Practice has made great improvements in setting satisfactory standards for training in general practice. How to maintain those standards, however, has never really been established. The recent paper by Donald Irvine on quality of care emphasises how general precitioners coast along without bothering to keep abreast of advances in medical stituours and provide the type of primary care that would be regarded as not merely acceptable but highly desirable by the community.

In the early years of practice the postgraduate training allowances provides some financial incentive to attend courses. Subsequently, however, it is not necessary to attend educational functions to attan seniority allowances. Finance should not be a train the state of the standard standard and the standard standard standard to the standard standard to the standard standard to the standard standard the standard with their basic income. Although basic expenses need to be covered, I would certainly not object to removing many of these expenses if the money could be directed into another area which is helpful to general practice. It think that the standard is not that the standard in continuing education then it was a superconduction of the same and also be beneficial, and if means a superconduct that and define continuing education then it will have been worth while.

What is important?

What is Important?

The most important feature is to maintain an enthusiasm for primary care at a real and workshille concept, Since I started to practice nothing has made me dispute that primary care fulfils the needs of patients in the way it is best suited to them. Recently I provided medical care for a large number of Americans, and they continually remarked how they miss the concept of a family doctor. Although we need specialisation, we do not need it for everything. We must be prepared to time acknowledge that we are not focusing on the property of the property

resent position.

Among the things that I consider to be vitally important is

that the doctor should continue to have a sound knowledge of medical practice. He should show in his clinical performance and in his relationship with his patients a grasp of modern trends in his profession. I think that the shop window—the state of the general practitioner's practice and premister—is vitally important and that if he is sincere about reasonable performance his records can be inspected by any other general practitioner and found to be reasonably clear and well maintained. The appalling state of medical records in primary care over the past 30 years has brought no credit to our profession.

Training

The statutory training requirements for general practice are now well established. This has been a tremendous advance in primary care, and I think that we are in debt to those who have worked so hard to establish them. Though some people still doubt their efficacy, I believe that most traines consider them the state of the state of

It may seem preposterous to make a statement saying that "general practitioners need to read books." I say this because I know that many general practitioners rarely read a medical book from cover to cover. Over the years they have used books mainly for reference. But over the past 10 years or so several books have been published on general practice, which should be purchased for the practice bibary. Books on primary care seem to have taken an enormous amount of time to get off the ground, but we are now seeing more and more worthwhile publications.

Carnov showed how selective reading in journals heloed him.

publications.

Carney showed how selective reading in journals helped him considerably in his work. He stated that "selective reading can be related to journal clubs and audit groups," and he

advocated this type of learning. We enjoy a very high transferd in scientific medical journals in the United Kingdom. The motification of the control of the

Lectures or groups?

I am keen on general practitioners talking about their work both in front of an audience and in a group, but I have reservations about formal lectures in the teaching of general practice. Lectures have been based on traditional teaching and continue throughout medical school. A consensus opinion obtained among doctors would probably show that manure medical particulars would probably show that manure medical particulars with the properties of the process of the proce

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of the faculties of the college that members gain little benefit from the college after entering. These members really need a local centre where someone with some enthusiasm can structure a programme of continuing education and he in turn may remove the continuing collection and he in turn may remove the continuing collection and he in turn may remove the continuing the continui

Patients participating

Patients participating

It may seem odd to discuss patient participation when writing on continuing education in general practice. I think, not continuing education in general practice. I think, the Health Service actually functions for. It does so for patients, and they should be afforded an input into the running of the services. I think that general practice has recently shown a sensitivity to need in society which are constantly changing. This is the central theme for patient groups, practice committees, and the organisation of public meetings. Americans affectionately refer to our system of health care as socialised medicine; though I would accept that to a degree, and would on need irrespective of any other gain, we have been reluctant to allow patients to educate us.

Many doctors are extremely sceptical about the motives of general practitioners who are prepared to liaise with patient groups and community health councils. This is foolish, and in

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INVESTIBLE MEDICAL JOURNAL VOLUME 287 10 DECEMBER 1983 my experience meetings have been conducted in a friendly and positive way and doctors benefit just as much as lay people. I hope that this will continue; it could have so many things going for it, notably in improving preventative medicine and prescribing habits.

We are told that as general practitioners one of our main roles must be that of a teacher. This has probably been taken too literally in doctor education, with the result that we do not always listen to what people really want. Good communication always listen to what people really want Good communication for the property of the pro

Conclusion

Continuing education has become topical because of a rapid acceleration in vocational training, and the inversely proportional development of interest in maintaining general practitioner education. Evidence is only very slowly emerging of improvements in attitudes by general practitioners to maintaining and cuational process, and we thus have a boomerang effect whereby people are beginning to question whether the training process is really worth while. It is well known that the college membership examination, though probably a worth wood of the control of the college probably mean relatively little to most members.

I suspect that we are going to see the basic standards of primary care challenged. I suspect, too, that to protect the training of general practitioners—surely the most worthwhile advance in primary care for many years—pressure will be brought in subtle ways to maintain an educational programme for primary care doctors.

Persuave to show worthwhile standards and, though not being the shop windows of general practitional good image. This will be reflected in reasonable premises, good organisation, and being open to regular review. In turn we may well see parallel assessments in courses for general practitioners. Doctors enjoy many freedoms and though most of us are established to the control of the property of the

References

Keterences

(*Clarke WD. The development of general practice education. Medical Annual 1983;101:183-92.

[*Irvine D. Quality of care in general practice; our outstanding problem. J R Gall Gen Pract 1983;38:321-3.

*J. R. Gall Gen Pract 1983;38:321-3.

[*Koll Gen Pract 1983;38:321-3.

*Stott P. Roll Gen Pract 1983;38:486-99.

*Stott P. Milstones. London: Pan, 1983.

*Stott P. Milstones. London: Pan, 1983.

*Carmy T. A. Mohdliy and prescribing. Br Med J 1983;287:805-7.

*Davies 11T. Handbook of postgraduate medical education for the United Kingdon. London: Update Books, 1980.