Peer-supported learning

MANY general practitioners feel undervalued and stressed.[1] Their personal development is not helped by the postgraduate education allowance (PGEA), which merely rewards attendance (and that with recycled money) and not learning.[2] PGEA-approved activities often involve passive listening and they rarely consider even the learners' educational needs let alone their needs for emotional support and understanding. Adult learners need to be actively involved in the learning activity.[3] The role of the teacher should be much more that of facilitator, looking after the process rather than the content.[4]

Useful learning is most likely to occur if difficult issues are confronted within an atmosphere of support.[5] Balint groups are a well-known example of such an approach.[6] Many groups on release courses for GP registrars attempt to provide that important balance.[7,8] When it comes to established GPs, there are few examples of such groups. Young principal groups are widespread and can be very valuable,[9] but they often err on the side of cosiness rather than confrontation. Some higher professional development courses do offer useful peer-supported learning.[10]

As far as individuals are concerned, the ancient idea of a mentor to facilitate learning and to provide support is at last being applied in general practice.[11] A Royal College of General Practitioners' Working Group[2] showed how learning could be greatly enhanced with a mentor to facilitate, and perhaps to assess, the learner's portfolio. Various initiatives are in place to develop this approach to learning (R Alliott, personal communication).

Another model of mentoring is one in which peers mentor each other. This has been shown to enhance learning in students.[12] A recent book[13] reviews a number of such initiatives in higher education, one of which has the appropriate acronym PAL (peer-assisted learning). The support offered by peers can be used in a structured way to help students to help each other within the context of their learning programme. Such a model of co-mentoring has also been tried among general practitioners. It is being developed by Dr Shake Seigel and colleagues in the West Midlands, where it provides support and aids portfolio-based learning. A recent paper from south-east Scotland[14] describes how volunteer GPs successfully acted as mentors to help their colleagues to produce portfolios.

A group of us in East Anglia have developed co-mentoring (which we call co-tutoring) using some of the principles and tools of re-evaluation counselling. This is a form of co-counselling,[15,16] which is an explicit approach to dealing with emotional blocks that inhibit rational thought. Co-tutoring differs from co-counselling in that it puts the emphasis on forward planning and feedback skills, allowing understanding and insight towards self-development. It also aims to facilitate self-development in others, raising awareness of emotional blocks and how they can get in the way. Co-counselling, on the other hand, is a therapeutic process focusing on the release of emotion, with self-development and insight being an outcome of the process. Co-tutoring and co-counselling both use the basic assumption that people are not listened to well enough in their lives and that, if they were listened to better, they would flourish. Thus, co-tutoring revisits listening skills and offers insight into how to listen well without one's own issues, thoughts, judgements and feelings getting in the way.

As in co-counselling, the roles of tutor and tutee are mutual. In keeping with adult learning principles,[4] co-tutoring pairs (or occasionally trios) set their own agenda in terms of the content, frequency and nature of meetings. The method provides a supportive base to facilitate learning in areas ranging from personal development to academic enquiry. Whatever the nature of the 'contract' between the co-tutors, it is crucial that at any one time only one participant is dealing with his or her agenda while the other is actively listening (although both may engage in each activity during any one session). Active listening involves learning some new things about listening. In normal circumstances, we usually listen casually to people, jumping in to offer comments whenever we think of anything to say. Even in a consultation, we often look for what we want to know and prepare the next question or response in our heads as we do so, thus risking missing some of what the patient is saying. The listening done in co-tutoring is purely to assist those who are talking, helping them to explore their thoughts and experience at their own pace without interruption from outside demands. Listeners do not offer solutions, but try to enable those speaking to find their own. They adopt the assumption that their listening, backed by respect and caring, will be of key significance to the speaker. The listener offers an attitude of trust in the other person's ability to think, experiment and solve problems.

Concerns have been expressed[2] about the dangers of collusion and even destructiveness in a co-tutoring relationship. In setting up co-tutoring, it is therefore essential to offer more than just the facility for colleagues to meet. The East Anglia scheme includes a two-day introductory residential course and regular follow-up days for the group. These allow participants to develop their skills in co-tutoring and to gain support and new ideas. The facilitators are also available to individual pairs for supervision. This offers extra guidance and also acts as a safety net for individuals or pairs who might be ready to explore issues in greater depth. Such supervision is educational in nature but has some parallels with that offered to workers using psychotherapeutic approaches.

What does co-tutoring achieve? For most participants, it is the support that is perceived as its most valuable aspect. This enables people to feel much more in control, not only of their own learning, but of many aspects of their professional and personal lives. A preliminary survey of participants suggests that a reduction in perceived stress among participants has indeed occurred (A Hibble, personal communication). This survey also showed that many participants had embarked on written learning plans and were involved in identifying their learning needs from their everyday work. The ability to learn from experience in this way is a fundamental characteristic of a professional and has been proposed as the main criterion for recertification.[17]

The process of active listening developed in co-tutoring has been felt by many to have improved their consulting skills. The enhancement of listening skills is perhaps the major advantage of working with a co-tutor rather than a mentor.[11] The non-hierarchical nature of the relationship is also an advantage, as it empowers all participants to be facilitators as well as learners. On the other hand, mentoring and co-tutoring are not mutually exclusive, and individual co-tutors have welcomed the opportunity of having a more experienced colleague to help guide their learning.

The growing experience of peer-supported learning is extremely encouraging. The vast majority of those who have embarked on co-tutoring are continuing into a second year. It offers a form of self-directed learning, which can generate a content congruent with the participants' learning needs.[18] It is clear that the support offered by this process builds a foundation

that has helped some participants to bring about major changes in their lives and practices.

PAUL SACKIN
General practitioner, Huntingdon, Cambridgeshire

MARION BARNETT
Medical educator, Cambridge

ANDREW EASTAUGH
General practitioner, Southwold, Suffolk

PAUL PAXTON
General practitioner, Cambridge

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Address for correspondence

Dr P Sackin, Flat 12, Stukeley Park, Chestnut Grove, Great Stukeley, Huntingdon, Cambridgeshire PE17 5AD.

Travel broadens the mind – and the clinical agenda

WHEN Thomas Cook organized the first ever package holiday by chartering a temperance train from Leicester to Loughborough in 1841, he could have had no notion of the future of tourism. As a 'cold Lazarus' at Gatwick airport today he would see a non-stop stream of humanity being processed in their thousands: divested of bulky possessions, shepherded through weird lych-gates, compressed into metal tubes, and thrown into the sky. Nearby in this nightmare he would discover matching numbers being centrifuged through red and green 'channels' into jostling crowds at revolving rubber platforms bearing a chaotic array of baggage. What on earth could be the motivation of such mass migrations? War would seem unlikely with so many women and children involved, and the motley majority would appear too expectant to be political or religious refugees. If particularly observant, though, he would also notice a pallid and anxious minority scurrying off, sometimes repeatedly, to small rooms labelled with schematic silhouettes of men and women. Progenitor perplexed, he would find it impossible to relate these scenes to the continental 'tour' favoured by his aristocratic contempories, and from which custom the term 'tourism' derives.

The pre-industrial economy was governed by the seasons, the weather and the soil conditions. Agrarian life might have been brutish and hard but at least it was varied. Quiet times in the fields could be used for repairing the sty or sowing a row of turnips. And there were special occasions to look forward to. 'Holy days' were the celebrations of annual festivals, some of them pagan, and an excuse for whole communities to feast and fête together. Labour in the new factories and mills was, in contrast, a monotonous moil. Holidays were an essential respite from the Satanic gloom and one of the 'rights' that unionized labour asserted. The Bank Holidays Acts of 1871 and 1875, and the acceptance of the standard two weeks' paid summer holiday when production ceased, set the pattern for a century.[1] The past two decades have brought enormous changes, however. Now the majority of people take at least one of their several annual holidays away from home.[2]

Whether or not tourism is the fastest growing industry in the world, as alleged, the phenomenal human activity it represents has attracted the attention of the sociologists. Holidays are variously described as socially visible leisure,[3] as times of spatial and temporal realignment,[4] and more facetiously as self-restraint replaced by self-indulgence.[4] But with demand comes exploitation, and with expectation disappointment. If the hotel really does exist and the beach really is accessible there is still no guarantee that a family forced into constant proximity in strange surroundings will 'get on' for two weeks. Self-referrals to Relate show an upswing every autumn![5] And what of the sphincter-conscious minority spotted by Mr Cook on their way to the toilet? Just as holidays have an emotional fall-out there is also a physical one.

In their paper on travellers' diarrhoea published in this edition of the journal,[6] McIntosh, Reed and Power eschew the usual xenophobic focus on laboratory exotica: 'look what horrible tropical beasties these hapless travellers have brought into our nice, clean country'.[7] They try to establish, first, the true incidence of travellers' diarrhoea as diagnosed on clinical history alone, as is the everyday procedure in general practice. They also shrewdly

acknowledge that there is a significant risk of episodic diarrhoea for people ensconced at home and define the 'true' attack rate for tourists as that which rises above this domestic plimsoll line. Their perspicacity exposes a neglected aspect of emporiatrics (emporos [Greek] = a ship passenger; iatrike [Greek] = medicine)[8] — that foreign travel is an activity undertaken by an unrepresentative sector of society in the United Kingdom (UK), and that holidays highlight social divisions. In the two weeks before departure, those booked to travel abroad were at a third less risk of 'home-grown' bowel upset than their counterparts. Foreign travel habit seems to be a proxy marker not only of higher socioeconomic standing and spending power but also of better health — the positive association consistently found in research on lifestyles and morbidity, and in another general practice study of clinical workload related to holiday travel.[9]

In their paper, McIntosh, Reed and Power also try to assess the value of pre-travel health advice. The fact that they don't attempt to define what they mean by 'advice' is no surprise in this semantic minefield. In fact, it is likely that few general practitioners would have sufficient facility to cope with more than a very small proportion of those emerging from the travel agency gleefully bearing tickets and travellers cheques. The response has been pragmatic: the setting up of 'travel clinics' delegated to practice nurses whose salaries are subsidized by the immunization fees claimed. But UK general practitioners are satisfying public demand: 'most travellers' appreciation of travel medicine stops at wondering which vaccinations are needed.'[10] Prophylactic measures are only available for some of the infections to which travellers are exposed, and in any case not all the risks are microbial. Delerium can be induced as easily by the combination of alcoholic binge and 'sonnenbrand' ('sun-branding' [German]) as by Plasmodium invasion. Who is to say that the origin of a malignant melanoma diagnosed in Glasgow in 1999 was not ultraviolet exposure in Ibiza in 1996? And although the traveller deposited in Bangkok who finds that his suitcases are in Bali may have a justifiable grouse, does not his uninhibited aggression and 'admission' to a padded cell have something to do with his pineal gland being still in Manchester?

The epidemiology of travel medicine is not the epidemiology of communicable diseases. At present only the latter discipline can claim our respect. By its very nature, I suggest, travel medicine is an ideal context for research and development in general practice. As family doctors we will be more intrigued by the disease-bearing vectors than by vector-borne diseases, and can make a unique contribution. Vast numbers of our patients are involved, the issues are important, the drain on resources significant and eccentric, and the level of our ignorance embarrassing. The challenge is also somewhat daunting: in his elegant epidemiological studies, all Will Pickles had to contend with was the ponderous progress of the weekly bus his patients took to market. Welcome on board.

NORMAN BEALE
General practitioner, Calne, Wiltshire

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Address for correspondence
Dr Norman Beale, Northlands Surgery, North Street, Calne, Wiltshire SN11 0HH.

The management of involuntary childlessness

INVOLUNTARY childlessness, defined as failure to conceive after a year of unprotected intercourse, affects around 15% of couples.[1] For some, the problem or its management can lead to physical indignity, psychological distress and social isolation.[2] Many couples eventually conceive with little or no intervention but some undergo investigation and treatment over a prolonged period, and specialist management can be slow, inadequate and expensive.[3] Publicity surrounding amazing technological advances has complicated management by raising patient expectations of a successful outcome when even the most effective assisted reproductive techniques can produce live pregnancies in no more than 30% of couples.[1]

What is the role of the general practitioner (GP) in the management of a problem for which the most advanced treatment occurs in superspecialized infertility centres? In this edition of the *Journal,* Ittner and colleagues found that half of infertile men and a quarter of infertile women would have liked their GP to initiate communication about their childlessness; none said they would have been offended by such an approach.[4] It may be that GPs can have a more proactive role in casefinding, but this approach was favoured by very few doctors in the same study and it is not clear how it would be viewed by voluntarily childless couples.

When a couple presents with this problem the most important decision the GP has to make is whether and where to refer. This requires detailed knowledge of the couple, their medical histories and the local services. Referral is indicated if the couple have been trying to conceive for a year, if the woman is aged 35 or over, or if there are known clinical indications such as a previous history of pelvic inflammatory disease. If immediate referral is not indicated, the couple may be reassured that more time could solve the problem or that some first-line investigations can be carried out in general practice.

If referral is indicated, the GP should be able to advise the couple about referral options and explain the implications of proposed investigations and treatment (a direct tertiary referral may save time in the long run, and a private referral may be feasible for some and the only option for others). At later stages the GP might be called upon to discuss the risks and outcome rates of complex assisted reproductive techniques to help patients to

make informed choices about continuing with treatment. Leaflets with detailed information including advice about patient support groups can be given if couples wish to have them.

In their review, Himmel and colleagues describe the psychological responses and stages experienced by couples with infertility.[2] Around 40% of patients in Ittner and colleagues' study said they would like their GP to provide ongoing emotional support and to help them to make decisions about future management. Half of the doctors thought they were an important source of information and advice.[4] Some infertility clinics may not have the resources to help couples deal with their psychological responses. Other clinics do offer excellent counselling services, but couples may be too overwhelmed by information at the time of an appointment to take full advantage of them. General practitioners can offer continuous, accessible care and can support their patients through distressing procedures, delays and disappointments; they can also help them in their decision to accept their childlessness or in their efforts to adopt.

When all possibilities for investigation and treatment have been exhausted, it is the GP who is likely to be the main source of support to the couple. Some couples may abandon investigations and treatment at an earlier point than others but may still experience a significant bereavement response. The GP needs to allow these patients the opportunity to grieve for the children they will never have. This may be the most important role for GPs in the management of infertility.

Guidelines have been shown to help GPs to make the best decisions about management.[5] To be effective they need to be locally relevant and straightforward to use. Postgraduate education may help in keeping doctors up to date with the latest advances. In Ittner's study most of the doctors wanted continuing education concerning involuntary childlessness.[4] Finally, the most effective management for patients will be achieved through a closer dialogue between GPs and the specialists who provide secondary and tertiary services.

JILLIAN MORRISON
Senior lecturer in general practice,
University of Glasgow

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Address for correspondence

Dr Jillian Morrison, Department of General Practice, University of Glasgow, Woodside Health Centre, Barr Street, Glasgow G20 7LR.