Putting principals back into practice: an evaluation of a re-entry course for vocationally trained doctors

MAUREEN BAKER

JACKY WILLIAMS

ROLAND PETCHEY

SUMMARY

Background. *Current recruitment difficulties in general practice have sharpened the interest of the profession in non-principals. No re-entry course for general practice has previously been run in the UK.*

Aim. *To design and evaluate a re-entry course for general practice.*

Method. *A re-entry course was developed to help doctors return to general practice as principals. A telephone interview was carried out with each delegate prior to their attendance on the course and was repeated one month and six months after the course to measure any change in career intentions and the perceived benefit of attending the course.*

Results. *Six months after the course, 11 out of 14 delegates had taken positive steps to return to general practice or had increased their time commitment to medicine. This contrasts with only one of the control group having made any steps to change career.*

Conclusion. *The course was evaluated and found to be beneficial, particularly in terms of increasing the confidence of the delegates.*

Keywords: staff recruitment; career choice; general practitioners.

Introduction

CONCERN has recently been expressed regarding mounting problems with both recruitment and retention in general practice.[1,2,3] It has been suggested that about 20% of doctors who have obtained certificates from the Joint Committee for Postgraduate Training in General Practice (JCPTGP) do not practice as principals.[4] A previous study in Trent region demonstrated the existence of a sizeable pool of vocationally trained doctors who were not currently working as principals,[5] and found that a re-entry course would be appreciated by almost half (49%) of the responders.

No re-entry courses for general practice have previously been run in the United Kingdom, despite a clearly demonstrated demand for them[5,6] and the fact that other professions, such as teaching and nursing,[7-9] have recognized their role in workforce retention. Two re-entry courses for general practitioners (GPs) have taken place in Ireland (in 1989 and 1991),[10] but they were for a small number of delegates, some of whom had not completed vocational training. Given that the cost of undergraduate medical education alone is currently estimated at £200 000 per student, it would be economical to use the potential workforce in general practice to the maximum.[11] Recent white papers[12,13] are proposing greater flexibility for the primary care workforce, which may facilitate the return of some non-principals. The aim of our study, therefore, was to design and evaluate a re-entry course for general practice.

M Baker, FRCGP, associate adviser in general practice; J Williams, BA, research associate; and R Petchey, PhD, lecturer in general practice, Department of General Practice, University of Nottingham.
Submitted: 26 February 1997; accepted: 10 September 1997.

© *British Journal of General Practice,* 1997, **47,** 819-822.

Method

Course design and recruitment

Focused interviews were conducted (by JW) with a number of professionals from various disciplines. In addition, three focus groups were held with small groups of doctors who had previously expressed an interest in a re-entry course. Analysis of the preliminary interviews and focus groups, by means of iterated reading using tactics for generating meaning,[14] identified several course design principles: first, that rebuilding confidence would be important to these doctors; secondly, that any course should be needs based; thirdly, that content should cover both clinical and managerial aspects; and finally, that doctors have similar problems to other professionals after a period out of mainstream employment.

A course that incorporated these principles was run in Doncaster over three days in March 1996. The course offered a residential option and consisted of an educational assessment, an introductory ice-breaker, and eight tutorial sessions (Box 1). Each subject was offered an educational assessment (12 out of 14 accepted the offer) with an established trainer or vocational training scheme (VTS) course organizer to determine their further educational needs and, in particular, whether they would require a further period of time under supervision in general practice.[15]

The simulated surgery drew on the expertise of a local team who had developed this educational method.[16] The simulators assessed each consultation and a discussion took place in a small group setting with an experienced facilitator. An evaluation of each module was completed by each of the subjects. Subjects were also asked to complete a similar evaluation of the course as a whole.

The course was advertised through the medical press and by a series of news articles, and in the Royal College of General Practitioners' (RCGP) faculty newsletters. Details were also mailed to non-principals in Trent, who had previously expressed an interest ($n = 150$).

Subjects

Fourteen subjects (course delegates) applied and were accepted on the course. They were matched (by age, sex, and year of completion of vocational training) with a control group of doctors taken from an existing database. Two of these doctors had applied for the course but were unable to attend for family reasons.

Outcome measures

A telephone interview was carried out (by JW) with each of the

Rational prescribing: Tutorial on principles of practice formularies, cost-effectiveness, and appropriate use of drug information systems.
Developments in therapeutics: Tutorial on new product update, emphasizing lipid-lowering drugs, helicobacter pylori, ACE inhibitors, and the new antidepressants.
Recent advances in general practice: Discussion of models of practice, e.g. fundholding and commissioning, principals of evidence-based medicine, and future developments such as practice-based contracts.
Cardiopulmonary resuscitation: Practical demonstration and application of CPR techniques using a mannequin.
Stress management: Demonstration of techniques such as neurolinguistic programming, meditation, and relaxation.
Practice management: Tutorial on practice issues, e.g. employment, leadership, business practice, information technology, and estate management.
Employment prospects: Discussion of current options and review of innovative opportunities.

Box 1. Tutorial sessions. Each session was led by a professional from an appropriate discipline.

delegates prior to their attendance on the course. The interview covered their employment history since completing their vocational training, the factors involved in their past and current career decisions, their attitudes to general practice, their expectations of the course, and whether or not they felt that their confidence might be increased by attending the course. It was repeated one month and six months after the course to measure any change in career intentions and the perceived benefits of attending the course. Members of the control group were also interviewed by telephone before the course and one month after the course, using a similar format but omitting questions relating to the course.

Personality differences between subjects and controls were measured by means of a psychometric personality factor questionnaire: Cattell's Sixteen Personality Factor Questionnaire (16PF).[17] The 16PF was personally administered to delegates at the start of the course and repeated by post one month afterwards. It was also posted to members of the control group. These questionnaires were subjected to the Wilcoxon test.[18]

Results

Evaluation of the course

On average, seven out of 10 modules were rated as 'good' or better (Table 1). For the course as a whole, the mean scores were as follows: course content 4.3, presentations 4.4, speakers 4.2, and overall 4.5.

Analysis of telephone interviews

Delegates and controls were asked questions about their attitudes to general practice as part of the telephone interview. Following independent analysis (by JW and MB), it was found that eight (57%) of the delegates had a positive attitude towards general practice as did six (43%) members of the control group.

During the post-course telephone interviews, all the delegates were asked 'Did the course help your confidence?' Thirteen delegates responded positively and one felt that it had not made any difference.

Analysis of personality profiles

There were no differences between the delegates on the completion of the questionnaire pre-and post-course (Wilcoxon test), but personality would not be expected to change in a short space of time. Table 2 shows the mean scores for the two groups and also the Wilcoxon matched pairs signed rank test. The mean score for delegates was lower for extroversion and independence and higher on anxiety. The Wilcoxon test does not show any significant differences but is almost significant at the 5% level on extroversion and independence, and the differences are in the expected direction.

Table 1. Evaluation of course modules.

Module	No. of doctors at each session	Highest Score	Lowest score	Mode score	Mean score
Educational assessment	12	5	1	4	3.64
Group session	14	5	3	4	3.7
Rational prescribing	14	5	2	4	4
Developments in therapeutics	14	5	3	5	4.5
Recent advances in general practice	14	5	2	4	3.9
Cardiopulmonary resuscitation	14	5	3	4	4.1
Stress management	14	5	2	5	4
Simulated surgery	9	5	4	5	4.5
Practice management	12	5	2	4	4
Employment prospects	12	5	3	4 and 5	4.3

1= poor, 2= fair, 3= average, 4= good, 5= excellent.

Table 2. Analysis of second-order factors.

Second-order factors	Delegates' mean score	Controls' mean score	Wilcoxon matched pairs test
Extroversion versus intraversion	1.857	2.462	$P = 0.0741$
High anxiety versus low anxiety	1.929	1.692	$P = 0.2568$
Tough poise versus emotionality	2.00	2.077	$P = 1.0000$
Independence versus subduedness	1.929	2.385	$P = 0.0578$

Second-order factors are composite scales drawn from various combinations of the primary scales, ranging from 1–3, where the highest score relates positively to the first variable in the pair.

Career outcomes

During the six months following the course, two subjects had returned as principals and a further seven had made positive steps to return to general practice. Two more were intending to increase their medical work. Only one of the control group has made plans to return to general practice and none of the others have made any changes to their working practices, although several would welcome the opportunity to attend a re-entry course at some point.

Costs

The cost of the course (i.e. excluding development monies) was approximately £450 per delegate. Each delegate was charged £250 for the residential option or £120 for the non-residential option.

Discussion

The nature of the medical workforce in general practice has changed substantially over the past few years. A greater proportion of GPs are women and this is likely to continue to increase over the next few years.[1,19] Women doctors are more likely than men to take up part-time posts,[20] and part-time working is becoming more attractive to men than previously.[21] Many doctors are opting for early retirement[2] and the cohort of overseas doctors who came to this country to fill vacancies, very often in deprived areas and inner cities, are coming up to retirement age.[1] Substantial numbers of doctors have undergone vocational training but are not currently working as principals,[2] and these doctors must be included when planning the medical workforce.

Recent papers[2,3,21,22] have highlighted the problems of recruitment into general practice[11] and have questioned the attractiveness of general practice as a career. It is likely to take some years before general practice can return to being in the fortunate position of being the first choice of discipline for most medical graduates.[23,24] There is now an urgent requirement to maximize the use of the existing trained workforce in general practice.

The Doncaster course was designed from scratch, and the evaluation has shown that some aspects of the course were more successful than others. Future organizers might consider whether courses could be more flexible and introduce an element of learner choice.

Most of the delegates appreciated the educational assessment and felt that it informed decisions on their subsequent careers. Although only one delegate had approached their regional adviser concerning a supervised period of re-training, the others who were making steps to return to general practice discussed this option during their educational assessment but did not feel this to be necessary. Some of the GP trainers who conducted these assessments voiced concerns that the process might shake the confidence of the delegates, but this was not found to be the case. Overall, the evaluation and comments on the course were very positive.

Discussions during the introductory session of the course gave us a strong impression that many of these doctors felt isolated and professionally unsupported. Although we did not set out to measure this, comments from the evaluation of the course showed that delegates felt supported by the course.

Following this course, the majority of delegates were taking definite steps to increase their time commitment to general practice work. In addition, some of the delegates who had not taken these steps were planning to develop their careers in other ways. Although the number of doctors who attended the course was small, the investment in them in terms of education and previous experience was considerable. We are not able to state whether this course was the only factor in these doctors' decisions to return to general practice; however, the course may have acted as a catalyst in that, by choosing to attend, delegates were taking positive action to further their medical careers. Nationally, the demand for such courses needs to be assessed.

We are not aware of any comparable courses or schemes run in any other medical disciplines in this country. The results from this study would indicate that other disciplines facing recruitment problems might also find it beneficial to develop this concept.

Conclusion

Despite their costs, courses to facilitate re-entry to general practice are likely to be economic when compared with the total cost of medical education and training which would otherwise be lost (partly or wholly) to the health service. However, the underlying reasons[5] why these doctors either gave up posts as principals or did not take up a post in the first place are still unresolved.

References

1. General Medical Services Committee. *Medical Workforce - task group report.* London: British Medical Association, 1996.
2. Mathie T. The primary care workforce crisis: a time for decisive action. [Editorial.] *Br J Gen Pract* 1997; **47:** 3-4.
3. Taylor DH Jr, Leese B. Recruitment, retention, and time commitment change of general practitioners in England and Wales, 1990-1994: a retrospective study. *BMJ* 1997; **314:** 1806-1810.
4. Buchan J, Stock J. Early careers of general practitioners. [Report No 199.] Brighton: Institute of Management Studies, 1990.
5. Baker M, Williams J, Petchey R. GPs in principle but not in practice: a study of vocationally trained doctors not currently working as principals. *BMJ* 1995; **310:** 1301-1304.
6. Allen I. *Doctors and their careers - a new generation.* London: Policy Studies Institute, 1994.
7. Marshall MJ, Bruhn JG. Refresher courses and reactivation of nurses. *Nursing Outlook* 1967; **15:** 59-61.
8. Curtis P, Schneidenbach L. Successful strategies for a re-entry program - one example. *Journal of Continuing Education in Nursing* 1991; **22:** 36-38.
9. Boonyawiroj EB. Physiotherapy re-entry: A case study. *Physiotherapy* 1996; **82:** 447-455.
10. Harrington P, Shannon W, Bury G. Training doctors to re-enter general practice - a previously unmet need? *Postgraduate Education for General Practice* 1993; **4:** 99-105.
11. Olsen N. Sustaining general practice. [Editorial.] *BMJ* 1996; **312:** 525-526.
12. Department of Health. *Choice and opportunity.* London: The Stationery Office, 1996.
13. Department of Health. *Primary care: delivering the future.* London: The Stationery Office, 1996.
14. Miles MB, Huberman AM. *Qualitative data analysis.* 2nd edn. London: Sage, 1994.
15. National Health Service, General Medical Services. Statement of Fees and Allowances payable to General Medical Practitioners in England and Wales From 1st April 1990 (Red Book). London: HMSO, 1997. 80 paragraph 37.8.
16. Rashid A, Allen J, Thew R, Aram G. Performance based assessment using simulated patients. *Education for General Practice* 1994; **5:** 151-158.
17. Cattell RB, Eber HW, Tatsuoka MM. Handbook for the 16PF Institute for personality and ability testing inc. 7th edn. Illinois: Champaign, 1992.
18. Siegel S, Castellan NJ Jr. Nonparametric statistics for the behavioural sciences. New York: McGraw Hill,1988.
19. Medical Workforce Standing Advisory Committee. *Planning the Medical Workforce.* [Second Report.] London: Department of Health, 1995.
20. Allen I. *Doctors and their careers.* London: Policy Studies Institute, 1988.
21. Vaughan C. Career choices for generation X. *BMJ* 1995; **311:** 525-526.
22. Lambert TW, Goldacre MJ, Parkhouse J, Edwards C. Career destinations in 1994 of United Kingdom medical graduates of 1983: results of a questionnaire survey. *BMJ* 1996; **312:** 893-897.
23. Carlisle R, Johnstone S. Factors influencing the response to advertisements for general practice vacancies. *BMJ* 1996; **313:** 468-471.

24. Parkhouse J. *Doctors careers: aims and experiences of medical graduates.* London: Routledge, 1991.
25. Petchey R, Williams J, Baker M. 'Ending up a GP': a qualitative study of junior doctors' perceptions of general practice as a careeer. *Fam Pract* 1996; **14:** 194-199.

Acknowledgements

We are extremely grateful to the RCGP and Doncaster Health who provided the funding to carry out this project; to the pharmaceutical companies who sponsored the course dinner and provided useful literature; to Dr Lotte Newman, President of the RCGP, for her support; to the lecturers who gave up their time to attend the course and in particular to all the doctors involved; and to Ms Lindsay Groom from the Department of General Practice for advice and support.

Address for correspondence

Dr Maureen Baker, University of Nottingham, Department of General Practice, Queens Medical Centre, Nottingham NG7 2UH.

RCGP SALES

CHRISTMAS ORDERS

To ensure delivery of publications, gifts and record cards before Christmas all orders are to be received by the Sales Office at Princes Gate by Friday 12th December.

RCGP Sales, 14 Princes Gate,
Hyde Park, London SW7 1PU
Tel: 0171-823-9698 between 9.30 and 4.30
Fax: 0171-225-3047 Email: sales@rcgp.org.uk

24-hour answerphone for credit card orders:
0171-225-3048

Careers Support Forum

Applications are invited from Fellows, Members or Associates to join the new Careers Support Forum of the Royal College of General Practitioners. The aim of the Forum is to provide support and advice throughout the duration of a doctor's career in general practice.

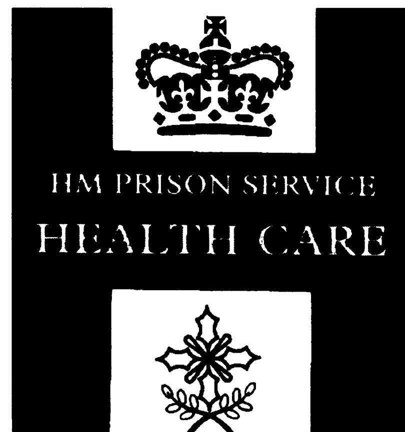
Vacancies exist for two individuals to complete the Forum. We are interested in hearing from doctors at any stage in their career in general practice from registrar through to pre-retirement, whether or not they are GP principals.

Successful applicants would be expected to attend four Forum meetings each year, initially for 2 years, for which expenses will be paid. They would also be required to participate generally in the work of the Forum.

Please forward a letter of application stating on one side of A4 what qualities you feel you could bring to the group enclosing CV to:

Dr Maureen Baker, Chair of Services Network, 14 Princes Gate, Hyde Park, London SW7 1PU. The closing date for applications is Monday, 5 January 1998.

HEALTH CARE SERVICE FOR PRISONERS



The Service provides medical care for prisoners to a standard equivalent to that in the National Health Service, and employs over 250 doctors, both full time and part time.

A programme of training is provided which recognises the specialist nature of medical work in prisons to include management: the syllabus leads to the acquisition of a Diploma in Prison Medicine.

All facilities and equipment are provided and all employed doctors are indemnified by the Service. Prison medicine is a challenging and rewarding area of medical practice. Vacancies exist both for full time and part time posts in many parts of England and Wales.

Doctors who are interested are invited to write or speak to:

Dr Roy Burrows,
Directorate of Health Care,
Cleland House, Page Street,
London SW1P 4LN,
Tel: 0171-217 6550,
Fax: 0171-217 6412.