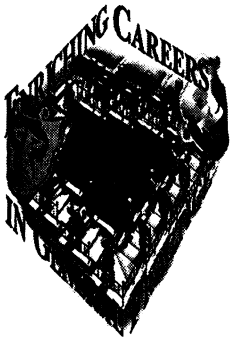
Enriching Careers in General Practice

Building morale through personal development

Stuart Handysides



This is the second in a series of articles examining ways to increase fulfilment from a career in general practice

Once general practitioners have established themselves as principals it may seem there is little else to work for. Lack of stimulation may lead to demoralisation, and it is essential that they have other ways to continue to develop their careers. Meeting other doctors to discuss cases and problems and postgraduate education often help but many doctors want to take on extra roles. The options available include undergraduate teacher, tutor for postgraudate education, and participation in medical audit advisory groups, local medical committees, or royal college faculties. Some general practitioners work part time to allow them to fit in these activities. It may also be possible to obtain extended study leave or a sabbatical to broaden experience. Others even move practice to provide new challenges.

A doctor can become a general practitioner at 27 and do the same job for 40 years. What's wrong with that? The job is well paid, working conditions in many practices are good, and general practitioners enjoy a degree of prestige and affection in their communities. Perhaps this stability is itself the problem: the "fetters of security" discourage change.[1] General practitioners have to seek out their own career goals, in contrast with many other professions.[2]

The first five years of practice hold novelty and the challenges of new responsibilities and relationships with patients, partners, and staff. After about five years, says Marek Koperski, a general practitioner in north London, "processes become automated, freeing the mind for more creative thought." The career map is not laid out but there are some worthwhile trails for the orienteering general practitioner.

Support and education

Young principals groups offer support and education to new partners, and some doctors remain in them for several years. They can provide a peer group to replace the trainee group that the new principal might otherwise miss on entering a partnership.[3] The groups offer continuing medical education and social meetings for doctors and their spouses, and often provide a forum for discussing personal and partnership problems.[4] A national network of young principals has been set up with its own journal and annual conference.

Michael Balint, a Hungarian psychiatrist, identified the unique and valuable role of general practitioners through research seminars with general practitioners in the 1950s.[5,6] Seminars for general practitioners, as originated by Michael Balint,[7] are held at the Tavistock Centre in London and in Manchester, Liverpool, and Cambridge. Some trainee groups hold seminars, and the Balint society holds weekend meetings. Balint groups meet weekly and discuss one or two cases in depth with the aim of opening the psychological baggage that we bring to our job and that affects the way we respond to our patients. Balint groups have only ever attracted a small minority of general practitioners but in Germany general practitioners are paid more if they attend them (David Watt, personal communication).

The new contract introduced a postgraduate educational allowance, which provides a financial incentive to attend educational activities. The risk is that attendance rather than professional development may become the goal.[8] Richard Savage, a course organiser for vocational training, contrasts the didactic teaching found in many courses with the uncertainty inherent in general practice. He stresses the need for general practitioners to learn to assess priorities and develop interpersonal skills and advocates a continuous journey of self motivated study along a path chosen with the help of a mentor. Roger Neighbour, general practice trainer in Abbots Langley, Hertfordshire, in a keynote speech at the inaugural conference for general practice tutors this autumn, emphasised the role of tutors as facilitators rather than teachers. Continuing medical education will take a quantum leap if tutors can improve general practitioners' self awareness.

Viewing the tasks of primary care from the perspectives of other members of the primary health care team, as medical students and trainees do, can give new insight. Visiting other practices or shadowing a consultant or manager for a day is also a valuable experience, as I heard from Rosalind Eve, a primary health care facilitator in Sheffield. "Some general practitioners are reluctant to shadow because they fear being under the scrutiny of a consultant. They have to stop defining themselves with respect to hospital doctors," she said. A general practitioner who shadowed a surgeon for a day found that more time was taken with business meetings than patients: he didn't speak to a patient until the afternoon.[9]

Teaching and training

Teaching undergraduate medical students in the surgery offers the stimulus of fresh and uncommitted minds, the opportunity to meet other general practitioners who teach, plus a small stipend. But as Geoffrey Marsh, a general practitioner in Norton, Stockton on Tees, said, "Medical students are the enemy of larger lists." Explanations take time, and surgeries may need to be rescheduled. The team has to be primed to explain to patients what is happening.

General practitioners can apply to become postgraduate trainers after three years as a principal. Each health service region runs courses for would be trainers. The practice also has to be assessed and reach standards of organisation before it can be approved for training. Medical records and hospital correspondence

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have to be filed chronologically and lists of drug treatment kept up to date. Regions set targets for the production of summaries in clinical records. Practices should be developing methods of monitoring prescribing habits and allow trainees to participate in medical audit. Training practices should have a library and assess trainees for educational purposes while they work at the practice.[10] Although a practice may have only one trainer, the agreement and support of other partners and the rest of the team is essential.

An experienced trainer may become a course organiser, coordinating a vocational training scheme, running the local trainers group, and organising the course for trainees. The final rung in this ladder is regional advisor in general practice, a post that coordinates all the vocational training within a region and oversees the continuing medical education of established principals. Some of these are part time posts.

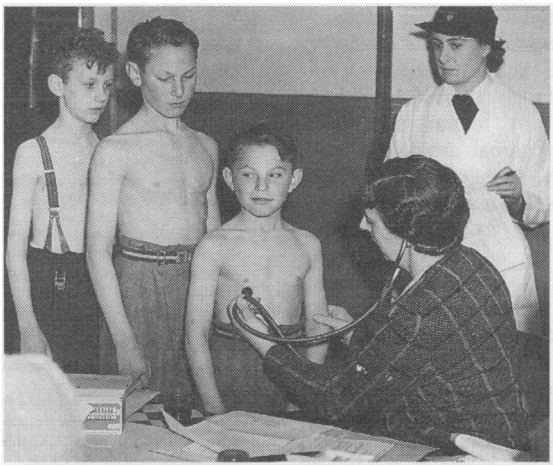
General practice tutor is another educational role. Tutors developed to administer locally the courses run for accreditation for the postgraduate education allowance, but their role can be much wider than that. Peter White, a tutor in Hampshire, said: "Tutors can help people to identify their educational needs instead of attending courses speculatively. Education should be a daily, multidisciplinary activity." At present the job is relatively undefined, what you make it, and tutors are largely self taught. They are organising themselves, however, and had their first annual conference last autumn.

Medical audit advisory groups have provided general practitioners with an opportunity for sharing information. The groups were set up after the 1990 contract to help to develop medical audit in general practice. Local facilitators visit practices annually to hear about projects in progress, suggest ways of getting started, coordinate projects between practices, and maintain momentum. The groups have responsibilities both to general practitioners and to family health services authorities, and they have had to emphasise that their role is to educate rather than to monitor.[11]

Academic posts, higher degrees, and fellowship

Lecturers, senior lecturers, and professors are employed by university departments of general practice and usually hold honorary principal appointments with local practices. I will discuss these in more detail later in the series.

Only 29% of doctoral theses in medicine are written by general practitioners,[12] despite general practitioners outnumbering consultants by two to one and 90% of contacts between patients and the health service occurring in general practice.[13] A consultant is expected to have published research, but for a general practitioner this is rare. Nevertheless, some departments do offer part time higher training in general practice—for example, Guy's and St Thomas's MSc course. St George's Hospital medical school has also taken on general practitioners as lecturers with a view to them obtaining a higher degree.[14]



TOPHAM

School doctor is one of many "bolt on accessories" to careers in general practice

Fellowship of the Royal College of General Practitioners was, until 1989, conferred by the council's fellowship committee in response to confidential nominations. Fellowship by assessment grew out of the trainer selection process and the practice visits of the *What sort of doctor?* working parties. The award of fellowship is intended to "reflect the status and seniority of a general practitioner who has submitted his work formally to the scrutiny and assessment of his peers" and act as a goal for young doctors.[15] Fellowship is open to members of more than five years' standing. To qualify general practitioners must fulfil 50 personal and 17 practice criteria. Aspiring fellows submit statements about the way they practise and videotaped consultations and are interviewed in their practices by three assessors. The aim is to reward "really good care for patients" rather than committee work.[15]

Keep running

The doctors' and dentists' review body workload survey of 1989-90 suggested that three quarters of general practitioners have an outside commitment.[16] Some sources have suggested that since the 1990 contract, general practitioners have concentrated on their work inside the practice. A third (16/45) of the general practitioners in Hertfordshire who completed my questionnaire last autumn had an outside commitment. General practitioners can work in hospital outpatient clinics, in occupational health, as police surgeons, as medical officers at sporting events, or as part of the immediate care service. They can join local medical committees, BMA divisions, medical audit advisory groups, and royal college faculties.

These, however, are the bolt on accessories. They are not the job of general practice, and they are not the reason people choose general practice as a career. The fact that many choose to take time out from their practices for other work activities suggests that there is a limit to the amount of time a doctor can spend in the intense business of consulting. The limit may vary with the personality and consulting style of the doctor,[17] the type of patients that the doctor sees, and the support received from staff, partners, other colleagues, and at home. If a doctor is not receiving enough support the quality of service, patient care, practice's reputation, and doctor's health may suffer.

Emotional support

An amazed psychologist who listened to a frank discussion about patients by doctors remarked to one that they should all be having at least two hours' psychological supervision each week. The equally amazed doctor wondered how they would find the time. Other caring professions have built support into their timetable but doctors still act as if they have no needs of their own. A study of general practitioners in Avon showed that few were able to talk frankly to their general practitioners.[18] A third were registered with their partners.

A void exists between the self medication practised by many and the service for sick doctors needed by some.[19] Some find their way to the Tavistock Clinic, where consultant psychotherapist Robert Hale has a special interest in their problems. He told me, "None of them come via the sick doctor scheme. Many worry about confidentiality, and how if they get into therapy they will disguise it from their colleagues."


KOBAL COLLECTION

A working holiday can help general practitioners obtain a new perspective

Personal support or part time work

The traditional family doctor, working day and night, is usually male and supported by a wife, housekeeper, or both. When he started practice in the 1930s Ronald Gibson, later to become a foundation fellow of the Royal College of General Practitioners and chairman of council of the BMA, was able "to retain a cook, two maids, a nursemaid, and a gardener once a week" on £600 a year. Writing in 1981, he acknowledged that the wife of a new general practitioner would be "lucky if she has domestic help for more than two hours a week or if she has assistance with the children, other than a washing machine and a spin dryer."[20] Most of the general practitioners I talked to in Sheffield, of both sexes, worked part time, although they pointed out that a 35 hour week would not normally be construed as part time.

Part time working in general practice can provide some time for domestic commitments or doing research. At present the main demand comes from women, but men are becoming attracted to the idea. In 1990 Isobel Allen, of the Policy Studies Institute, studied 1263 general practitioners. She found that nearly 90% of women and over two thirds of men thought there should be more part time principal posts.[21] Respondents were less enthusiastic about assistant posts: some doctors warned that assistants could be exploited financially and some were anxious about their lack of status and job security.

Taking time out

A few general practitioners may get up each morning for 40 years and greet the challenge of a waiting room full of patients, a ledger filling with visits, mounting administration, and the prospect of getting out of bed in the middle of the night with equanimity and satisfaction. But even the finalists in *General Practitioner's* doctor of the year award were not quite such Pollyannas. Most when interviewed included a statement about setting limits to demand.[22]

Setting limits on a daily basis is one thing, but there is also a place for longer breaks to allow you to view your job and life from a different perspective. Annual leave and study leave are available in generous portions if the partnership can agree on it, and sabbaticals and prolonged study leave of up to a year can also be negotiated. People who take sabbaticals find them rewarding. The benefits are self evident for many, but some partners may need convincing that a break is in their and the patients' long term interest. Ideally the philosophy of sabbaticals should already have been agreed and written into the partnership agreement.

I am told that stress consultants in a national news agency encourage journalists in trouble spots to have an escape route—a plan of what to do if they have had enough. For doctors possible activities include swapping practices with a doctor in another country, taking study leave to extend your professional or administrative skills and knowledge (the red book has information about applying for locum expenses; applications go through the regional adviser to the NHS Management Executive), or having a working holiday—on an expedition or as ship's doctor perhaps.[23]

Moving on

Moving from one practice to another is relatively uncommon, although recent research suggested that it does not carry the stigma that has been feared,[24,25] and guidelines about how to leave a practice have been published.[26] Neil Snowise indicated that 12% of applicants and 14% of appointed doctors had previously held posts as principals.[24] Some make a habit of changing: in 26 years Christopher Tiarks has practised in the home counties, industrial South Wales, and now in the inner Hebrides, having stopped off as a parliamentary candidate and member of the General Medical Services Committee on the way.[27] Melanie Wynne-Jones made two moves in quick succession after 10 years in practice and is glad that she did not stay put through fear of failure, but "I left patients with whom I shared an irreplaceable past, underestimating its importance."[28]

Many general practitioners tell anecdotes about the numbers of colleagues who have taken, or plan to take, early retirement. At present general practitioners are able to claim their pension at 60 and have to retire at 70. Pressure from doctors for earlier retirement has been followed by press reports that suggest that the government may be prepared to allow retirement at 50, but with much smaller pensions.[29] The medical press has found general practitioners who have retired early and felt better for it; others who are considering early retirement because they are "exhausted and disillusioned," "powerless," and "general practice has changed beyond recognition;" and others who cannot afford to retire.[30]

Limitations of personal development

There is enormous potential for satisfying work in general practice. The enjoyment of consultation; the leaven of teaching, research, or other work outside the practice; and positive relationships between partners, staff, and other practices can provide a fulfilling career. Growth of individuals in a partnership depends on, and is probably responsible for, collective growth and support in the partnership and primary health care team. The difficulties of achieving this may explain why single-handed practitioners still account for more than a tenth of all principals almost 30 years after the family doctor's charter offered incentives for working in groups.[31]

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