GPs in principle but not in practice: a study of vocationally trained doctors not currently working as principals

Maureen Baker, Jacky Williams, Roland Petchey

Abstract

***Objectives*—To identify doctors who are vocationally trained but not currently practising as principals in general practice; their reasons for not practising as principals; and whether the prospect of a re-entry course would appeal to this group.**

***Design*—Postal questionnaire survey based on semistructured interviews.**

***Subjects*—Doctors who had been vocationally trained but were not currently practising as principals: 351 possible subjects identified by a process of "networking."**

***Setting*—Trent Regional Health Authority.**

***Results*—166 of the doctors who replied fitted the criteria (100 women; 66 men). The out of hours commitment was ranked as the most important factor for not practising as a principal—95 women and 50 men rated it important—followed by difficulty in combining work with family commitments—84 women, 31 men. 82 respondents (49%) said they would be interested in a re-entry course if one were available.**

***Conclusions*—There is a pool of vocationally trained doctors in Trent region who are not practising as principals in general practice. More flexible working patterns and the availability of a re-entry course could make the post of principal in general practice a more attractive proposition to these doctors.**

Concern has been expressed that applications to general practice vocational training schemes have been falling.[1-3] It has also been noted that substantial numbers of doctors who have been vocationally trained for general practice are not working as principals—that is, as unsupervised doctors who hold a contract with a family health services authority or health board.[4-6]

The most recent major studies of medical staffing have not found any problem in recruitment or retention in general practice.[7-9] Since these studies were carried out, however, there have been important changes in the NHS which have had or will have major implications for the medical workforce.[10 11]

The increase in numbers of women entrants to medical schools means that there are now more women than men completing vocational training schemes.[8 12] As the participation of women in general practice work is often lower than that of male doctors,[2] these women make up fewer whole time equivalents. In addition, as general practice is perceived as becoming more stressful,[13] many general practitioners are looking to take early retirement.[2] The establishment of a task force to look at manpower reinforces the possibility of an impending problem in general practice.[14]

The Policy Studies Institute's most recent publication on doctors' careers discusses many of the problems that women doctors face in their attempt to continue in medical work.[15] One of the recommendations made in this report is that re-entry training should be available, and indeed the report commented that the near universal support for more help for women doctors to keep working was rather unexpected. Moreover, many male doctors feel they would benefit from more flexible working practices and the chance to spend more time with their families.

Against this background, we set out to identify a group of doctors who have been vocationally trained but are not currently practising as principals, to establish their characteristics and their reasons for not practising as principals. We also wished to explore whether the prospect of a re-entry course for general practice would appeal to this group of doctors.

Methods

Subjects were defined as doctors in Trent region who had been vocationally trained but were not now principals in general practice. Establishing the size and whereabouts of this group presented methodological problems, and it was accepted that we would not necessarily define a representative sample or even the total number of this specific group.

We therefore attempted to identify as many doctors as possible who met our criteria. As they could not be identified from existing registers, we identified them by a process of "networking." This involved two distinct strategies: firstly, contacting agencies such as vocational training schemes, hospital personnel departments, and locum agencies, and, secondly, contacting colleagues who might know of some of the doctors we were trying to find. We are not aware that this process has previously been used in medical research, but similar techniques have been used in social sciences research.[16 17] A total of 351 doctors were found who might fit the criteria (this compares with about 2400 principals in general practice within Trent region). Because of the method employed, which was the only means available to conduct the study, results obtained apply only to respondents and cannot be extrapolated.

Semistructured interviews were conducted with 10 doctors of various backgrounds and ages and of both sexes. From interview data a postal questionnaire was constructed and piloted. Subsequently questionnaires were sent to all the doctors we had identified, and reminders were sent to non-responders after three weeks. Replies were coded and entered on to the computer, and the data analysed by using SPSS/PC+.

Results

Questionnaires were sent to 351 doctors who had been identified as meeting our selection criteria. Replies were received from 251 (72%) doctors, yielding 166 questionnaires for full analysis. Of the remaining doctors, 46 were not practising as principals, 21 were

Office of the Postgraduate Dean, University of Nottingham, Queen's Medical Centre, Nottingham NG7 2UH
Maureen Baker, *associate adviser in general practice*

Department of General Practice, University of Nottingham, Nottingham NG7 2UH
Jacky Williams, *research assistant*
Roland Petchey, *lecturer*

Correspondence to:
Dr Baker.

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not vocationally trained, six had gone abroad, four were still on a vocational training scheme, and two had retired. The six other questionnaires were either returned to sender or found to have been duplicated on the original list.

Sixty six respondents were men (40%) and 100 (60%) women; ages ranged from 27 to 68 with a mean of 37·0 years (men) and 34·5 years (women). Table I gives details of when and where doctors graduated, whether they were currently employed in medicine, and whether or not the doctor had ever worked as a principal. Male respondents were older ($t=2·07$, $P=0·04$) and less likely to have graduated from a British medical school (Fisher's exact $P=0·00018$), but in other respects men and women were similar.

Respondents were asked to specify what form of medical work, if any, they were currently doing (table II). There was no difference in locum employment in general practice, but women were more likely than men to be employed as assistants in general practice or on the retainer scheme. When all three categories were combined, women were more likely than men to be continuing to work in general practice in some capacity ($\chi^2=7·66$, df=1, $P=0·006$). Women were more likely to be working in more than one category ($\chi^2=5·06$, df=1, $P=0·024$). Men were more likely to be employed in the categories of occupational health and public health medicine combined ($\chi^2=9·5$, df=1, $P=0·002$). Of the eight doctors not currently involved in any form of medical work, one was a man about to take up a four year medical missionary post in Rwanda after two years at Bible college, and the remaining seven were women who had at least one child under 1 year old.

Respondents were asked the importance of 22 reasons for not currently working as principals in general practice. Table III shows the responses. Ranking the items by frequency of response revealed substantial overall agreement between the sexes ($r_s=0·74$). However, there were significant differences between them on seven items. Women were more likely to mention out of hours commitment, difficulty in combining work with family commitments, no need to work, and cost of child care. Men were more likely to mention lack of professional challenge, acrimonious partnership split, and general practice not being their career intention. Some factors—problems of training, racial or sexual discrimination—were mentioned by relatively few respondents.

Respondents were asked if they were having difficulty in obtaining the education they required for general practice. Seventy (42%) felt the question did not apply to them, 52 (31%) said "yes" and 41 (25%) said "no." Those doctors who answered yes were then presented with a series of possible reasons for this difficulty and asked to rate their importance as before. Table IV shows the results.

All respondents were then asked whether a re-entry course would be of interest to them, if it were available. Eighty two (49%) doctors replied "yes," and 81 (49%) said "no." Of the 14 women currently on the retainer scheme, 12 said that they would be interested in a re-entry course (one of the two who said no was about to take up a half time principal post but said that it would have been helpful), and the seven women with young children who were not currently involved in any paid medical work all agreed that a re-entry course would be of interest. Respondents' views on the possible nature of a re-entry course are given in table V.

Fifty five women and 33 men responded to an invitation to comment. Some of these comments have been used to illustrate the discussion.

TABLE I—*Characteristics of respondents. Values are numbers (percentages)*

	Men (n=66)	Women (n=100)	Total (n=166)
Age*:			
27-32	25 (38)	46 (46)	71 (43)
33-38	22 (33)	35 (35)	57 (34)
39-44	7 (11)	15 (15)	22 (13)
45-68	12 (18)	4 (4)	16 (10)
Married or living with partner	51 (77)	86 (86)	137 (82)
With dependent children	37 (56)	69 (69)	106 (64)
Graduation:			
1980-90†	48 (73)	81 (81)	129 (78)
From British medical school	55 (83)	99 (99)	154 (93)
Currently in medical work	64 (97)	93 (93)	157 (95)
Previously worked as a principal	18 (27)	28 (28)	46 (28)

*Mean age: men=37 years; women=34·5 years; t test, $P=0·04$.
†Year of graduation ranged from 1952 to 1990.

TABLE II—*Types of medical work currently undertaken by respondents*

Category	Men (n=66)	Women (n=100)	Total (n=166)
GP locum	27 (41)	47 (47)	74 (45)
Assistant in general practice	1 (1)	12 (12)	13 (8)
GP retainer scheme	0	14 (14)	14 (8)
Hospital specialty	19 (29)	24 (24)	43 (26)
Clinical medical officer	3 (5)	10 (10)	13 (8)
Public health medicine	6 (9)	2 (2)	8 (5)
Occupational health	5 (8)	0	5 (3)
Non-NHS	4 (6)	3 (3)	7 (4)
Other medical work	7 (11)	5 (5)	12 (7)

27 Doctors were working in more than one category.

TABLE III—*Reasons for not working as principals. Factors are ranked in order of importance; values are numbers (percentages)*

Factor	Men (n=66)	Women (n=100)	Total (n=166)
Out of hours commitment	50 (77)	96 (96)**	146 (88)
Difficulty in combining work with family commitments	31 (48)	84 (84)**	115 (69)
Requirements of new GP contract	39 (60)	65 (65)	111 (67)
Increasing demand from patients	40 (62)	64 (64)	111 (67)
Possibility of complaints	29 (45)	50 (50)	80 (48)
Exploitation by partners	34 (52)	43 (43)	76 (46)
Time out before seeking post	30 (47)	46 (46)	76 (46)
Inadequate remuneration	30 (46)	36 (36)	73 (44)
Unable to find suitable post	24 (38)	37 (37)	61 (37)
No need to work	11 (17)	39 (39)**	50 (30)
Lack of professional challenge	26 (40)	18 (18)*	43 (26)
Fear of verbal or physical assault	14 (22)	27 (27)	42 (25)
Unsuited to work	19 (29)	21 (21)	40 (24)
Acrimonious partnership split	21 (32)	18 (18)*	38 (23)
Desire to leave medicine	13 (20)	25 (25)	38 (23)
Cost of child care	2 (3)	32 (32)**	33 (20)
General practice was not my career intention	20 (32)	12 (12)**	31 (19)
Badly treated as trainee	12 (19)	9 (9)	22 (13)
Inadequate training	8 (12)	12 (12)	20 (12)
Victim of sex discrimination	3 (5)	14 (14)	17 (10)
Personal illness or disability	6 (9)	7 (7)	14 (8)
Victim of racial discrimination	7 (11)	5 (5)	12 (7)

*P<0·05; **P<0·01, **P<0·0·001 for difference between sexes.

TABLE IV—*Problems in obtaining education for general practice*

Factor	Men (n=11)	Women (n=41)	Total (n=52)
Non reimbursement of course fees	11 (100)	41 (100)	52 (100)
Non-reimbursement of travel expenses	9 (82)	36 (88)	45 (87)
Courses not geared to meet the needs of principals	9 (82)	30 (73)	39 (75)
Non-reimbursement of child care expenses	1 (9)	31 (76)*	41 (78)
Absence of provision of child care	1 (9)	26 (63)*	34 (65)

*P<0·01 for difference between sexes.

Discussion

This study has established the existence of a substantial pool of doctors within the Trent region who have been vocationally trained but who are not currently working as principals. We are aware, however, that our means of identifying subjects were not entirely reliable, and we may have missed a number of doctors. Equally, some of the non-response to our questionnaire may be due to misidentification. The absence of lists or databases of the destinations of doctors after

TABLE V—*Suggestions on the nature of a re-entry course*

Factor	Men (n=21)	Women (n=61)	Total (n=82)
Re-entry course should be available	20 (95)	60 (98)	80 (98)
Re-entry course should be compulsory	9 (43)	33 (54)	42 (51)
Would be willing to make a contribution	13 (65)	45 (74)	59 (72)
Course should be evenly divided between clinical and practical issues	12 (60)	56 (92)*	69 (84)
Course should address development, confidence building, and interview training	14 (67)	51 (84)	65 (79)
Re-entry course would give greater confidence in applying for post as principal	17 (81)	55 (92)	73 (89)

*P < 0·01 for difference betweens sexes.

vocational training makes identification of subjects problematic.

EMPLOYMENT

Our results showed some interesting similarities and differences between male and female respondents. Women were more likely to be younger and to have qualified in the United Kingdom. Almost identical proportions of men and women had previously worked as principals, and similar proportions were currently engaged in medical work, reinforcing the continuing evidence that women do not drop out of medicine. The finding that 95% of respondents in our final sample are doing some form of medical work corresponds exactly with Isobel Allen's findings.[8]

Although men and women were equally likely to be found working in hospital specialties, in non-NHS medical work, or as clincial medical officers, women were more likely to be continuing to work in general practice in some capacity—whether as locums, as assistants, or on the retainer scheme. Men were more likely to be found in occupations (public health medicine and occupational health) that imply a definite career change away from general practice. Data on grade of posts was not collected systematically, but respondents in these occupations were more likely to describe themselves as being in training grades or consultants.

The work undertaken by our respondents tended to be sessional and to carry less responsibility than that of principals in general practice or doctors of consultant grade. Almost half of our respondents were working as locums in general practice. Little is known about this group of doctors and their characteristics; further work is needed to describe these doctors, their terms and conditions of employment, and their reasons for taking this work. Many of the doctors in our sample are in their 30s, in what should be their most productive years. Given that the cost to the nation of training each doctor up to qualifying is £190 000 (Department of Health, personal communication), this group of doctors represents an enormous resource for the country which might be more effectively utilised.

SEX DIFFERENCES

Men and women agreed substantially in their overall ranking of reasons for not working as principals in general practice. However, there were significant differences in their responses to some of the individual items. Women were more likely to refer to items connected with domestic responsibilities and child care (even though they were no more likely than men to have dependent children). A 47 year old woman currently working as a clinical assistant commented, "My husband being a GP, I think our children deserve better than two tired, stressed parents." Men were more likely to refer to a negative experience of general practice, such as partnership split or lack of professional challenge, or general practice not being their career intention. One male locum said "desire to develop professionally blocked by partnership"; another, now working as an assistant, stated, "I worked for six months as a GP principal... in 1991, but left partly due to a personality clash with the other partners, whom I felt exploited me and were only interested in patients as a source of remuneration." Yet another stated, "I would never consider a return to general practice unless circumstances forced me to." This pattern of response confirms the impression that men are more likely to have permanently rejected general practice as a career. Women's continuing involvement in general practice suggests that they are not fundamentally dissatisfied.

RETAINER SCHEME

It is notable that there are few doctors in Trent region on the retainer scheme for general practice and they are all women. (The information regarding doctors on the retainer scheme is held by the regional advisers in general practice.) Although this scheme is designed to help doctors continue with their profession while heavily involved with family commitments, the poor uptake of places on this scheme implies that it does not meet the needs of the people for whom it was designed.

FLEXIBILITY

The views elicited from our respondents indicate that greater flexibility in working patterns in general practice would allow more trained doctors to continue their careers as principals in general practice. The tradition of morning surgeries, then visits and paperwork, followed by evening surgery is a pattern which evolved to suit general practitioners who were, in the main, married men. A recent report from the Cabinet Office emphasised that working practices which helped combine working life with family responsibilities led to a more secure and committed workforce.[18] It should be possible to restructure the working day into more varied working patterns that would complement existing arrangements and provide more flexible service provision for patients. A 37 year old female doctor on the retainer scheme wrote: "My major factor in not returning to general practice as a partner is the difficulty we would experience as a family with two parents working long hours and involved in on call rotas."

Several factors such as those concerning problems with training and racial or sexual discrimination were ranked as being of importance by only a few of our respondents. As all respondents are vocationally trained, it is encouraging that relatively few doctors cited poor training as an important factor for not currently working as principals. We did not collect data regarding ethnicity, so it should not be concluded that this factor was not important for doctors from ethnic minorities.

RE-ENTRY COURSES

Some of the doctors who replied to our questionnaire also expressed their concerns about returning to work after long spells in which they had performed little or no medical work. A 32 year old female doctor currently not working said: "At present I am not even confident enough to do the odd locum or family planning clinic as I am so out of touch." Indeed there was strong support for the concept of a re-entry course for general practice, particularly from women currently on the retainer scheme or taking a career break to have a family. It was felt that such a course would help to build the confidence needed to apply for posts as principals. A 43 year old woman on the retainer scheme informed us that "trying to find out about possibilities for retraining is akin to knocking one's head against a brick wall." No such courses are currently available in the United Kingdom, although a short course was recently run for a small number of doctors in the Irish Republic.[19] Both our study and the recent report from the Policy Studies

Key messages

- A number of doctors in Trent are vocationally trained but not working as principals in general practice
- The out of hours commitment and difficulties in combining work with family responsibilities are the most important factors listed for not working as principals in general practice
- Greater flexibility in working patterns would help to allow more trained doctors to continue their careers as principals in general practice
- The establishment of a re-entry course would be appreciated by half of the respondents

Institute have found a demand for a re-entry course,[15] and a suitable course should now be designed and evaluated.

In line with other studies we used the term re-entry training. However, our results show that this term may not be appropriate, given that many of our respondents (particularly women) were continuing to work in general practice in some capacity.

NATIONAL NUMBERS

With so many vocationally trained doctors not working as principals in one region of the country, it seems imperative that the number of these doctors be identified at a national level. This could possibly be achieved either by looking at national cohorts of medical graduates in specific years, as in the ongoing Parkhouse studies, or by changing the system of registration with the General Medical Council so as to flag up this group. The existence of these doctors has not previously been recorded or considered in terms of staffing or resource planning. Additional data on these doctors is urgently required if a recruitment problem in general practice is to be avoided.

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Memoirs please

Some years ago we wrote an article for the *BMJ* about the life and work of Joseph Rogers, a Victorian medical man.[1] Rogers is one of only a few 19th century doctors who left a good personal record of his working life.[2] We believe that 20th century doctors should be doing the same.

Rogers opens his book with a physical description of the building in which he spent most of his working life. Its layout helped him to organise his thoughts. His book takes the reader in through the main door, into the hall, describing the smells and the atmosphere of the place, the government and ethos of the institution, and then takes a tour of the building, talking in the process about typical and memorable patients, how cases were managed, the drug regimen, nursing, clothing, cleanliness, decor, and so on. He included his personal views and experiences as well as the key events in his own professional life.

Rogers has provided historians with an invaluable source of inside information about the management and atmosphere of a Victorian workhouse infirmary and the changes which took place within it before the days of the reforms brought about by Florence Nightingale's agitation.

As historians of medicine we are constantly finding other individuals who emerge, for example, as interesting speakers in reports of Victorian medical meetings but who, when we come to investigate, have apparently left no papers, no diaries, no memoirs. In many cases almost no vestige of their existence seems to have survived beyond their name and the sparse details in *The Medical Directory*.

We are concerned that present day doctors of all disciplines should consider leaving good records of their working lives for future generations. Whether you are a doctor who can recollect the period before 1949 and can compare it with later developments or have entered the service since that time you have witnessed an important era of British medical history in an intimate way. Whatever your medical discipline or institution we would urge you to consider the importance of your experiences to future medical historians and to record them in some way.

If you feel that you could do with encouragement or help to get started look out in your own locality for a creative writing class. Remember, too, that there are other ways to record your experiences, such as in an annotated scrapbook, by video or audio tape recording, or in drawings, painting, photography, or verse. The best places for such memoirs to be lodged for future safe keeping are the libraries of the royal colleges or the Wellcome Institute in London, which has a special archive dedicated to 20th century materials.

Please also consider donating professional papers and the medical papers of deceased family members because the documentary evidence of medical lives of all eras is precious to historians. One of us (RR) is currently at her wit's end seeking the papers of a Victorian doctor by the name of Walker. Any Walker descendants out there with family papers?—RUTH RICHARDSON, *Wellcome research fellow, London, and* BRIAN HURWITZ, *senior lecturer in primary health care, London*

The Wellcome Institute for the History of Medicine, 183 Euston Road, London NW1 2BE.

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