OCCASIONAL PAPER **83**

GP recruitment and retention: a qualitative analysis of doctors' comments about training for and working in general practice

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Summary

BACKGROUND AND AIMS

General practice in the UK is experiencing difficulty with medical staff recruitment and retention, with reduced numbers choosing careers in general practice or entering principalships, and increases in less-than-full-time working, career breaks, early retirement and locum employment. Information is scarce about the reasons for these changes and factors that could increase recruitment and retention. The UK Medical Careers Research Group (UKMCRG) regularly surveys cohorts of UK medical graduates to determine their career choices and progression. We also invite written comments from respondents about their careers and the factors that influence them. Most respondents report high levels of job satisfaction. A noteworthy minority, however, make critical comments about general practice. Although their views may not represent those of all general practitioners (GPs), they nonetheless indicate a range of concerns that deserve to be understood. This paper reports on respondents' comments about general practice.

ANALYSIS OF DOCTORS' COMMENTS

Training

Greater exposure to general practice at undergraduate level could help to promote general practice careers and better inform career decisions. Postgraduate general practice training in hospital-based posts was seen as poor quality, irrelevant and run as if it were of secondary importance to service commitments. In contrast, general practice-based postgraduate training was widely praised for good formal teaching that met educational needs. The quality of vocational training was dependent upon the skills and enthusiasm of individual trainers.

Recruitment problems

Perceived deterrents to choosing general practice were its portrayal, by some hospital-based teachers, as a second class career compared to hospital medicine, and a perception of low morale amongst current GPs. The choice of a career in general practice was commonly made for lifestyle reasons rather than professional aspirations. Some GPs had encountered difficulties in obtaining posts in general practice suited to their needs, while others perceived discrimination. Newly qualified GPs often sought work as non-principals because they felt too inexperienced for partnership or because their domestic situation prevented them from settling in a particular area.

Changes to general practice

The 1990 National Health Service (NHS) reforms were largely viewed unfavourably, partly because they had led to a substantial increase in GPs' workloads that was compounded by growing public expectations, and partly because the two-tier system of fundholding was considered unfair. Fundholding and, more recently, GP commissioning threatened the GP's role as patient advocate by shifting the responsibility for rationing of health care from government to GPs. Some concerns were also expressed about the introduction of primary care groups (PCGs) and trusts (PCTs). Together, increased workload and the continual process of change had, for some, resulted in work-related stress, low morale, reduced job satisfaction and quality of life. These problems had been partially alleviated by the formation of GP co-operatives.

Retention difficulties

Loss of GPs' time from the NHS workforce occurs in four ways: reduced working hours, temporary career breaks, leaving the NHS to work elsewhere and early retirement. Child rearing and a desire to pursue interests outside medicine were cited as reasons for seeking shorter working hours or career breaks. A desire to reduce pressure of work was a common reason for seeking shorter working hours, taking career breaks, early retirement or leaving NHS general practice. Other reasons for leaving NHS general practice, temporarily or permanently, were difficulty in finding a GP post suited to individual needs and a desire to work abroad.

CONCLUSIONS

A cultural change amongst medical educationalists is needed to promote general practice as a career choice that is equally attractive as hospital practice. The introduction of Pre-Registration House Officer (PRHO) placements in general practice and improved flexibility of GP vocational training schemes, together with plans to improve the quality of Senior House Officer (SHO) training in the future, are welcome developments and should address some of the concerns about poor quality GP training raised by our respondents. The reluctance of newly qualified GPs to enter principalships, and the increasing demand from experienced GPs for less-than-full-time work, indicates a need for a greater variety of contractual arrangements to reflect doctors' desires for more flexible patterns of working in general practice.

Introduction

National Health Service general practice is currently experiencing difficulty with recruitment and retention of medical staff, with fewer GPs working beyond age 60 and a growth in less-than-full-time working.[1,2] Several studies have demonstrated the reducing commitment of trained GPs to long-term principal posts and a tendency towards reduced time commitment and increased early retirement.[3-9] Retirement rates for GPs in the near future are expected to be substantial, and to vary by region, because large numbers of Asian doctors who emigrated to the UK during the 1960s and 1970s are reaching retirement age. The worst affected health authorities are in some of the most deprived areas in the UK, which have also experienced the most difficulty in filling vacancies.[10] Furthermore, the number of GP registrars declined substantially between 1989 and 1996, although it is now increasing slightly.[2]

The UKMCRG has conducted whole-cohort surveys of medical graduates from UK medical schools in particular years in which we asked structured questions about career intentions and progression. This comprised surveys at regular intervals of the graduates of 1974, 1977, 1980, 1983, 1988, 1993 and 1996. We have reported on the substantial decline in numbers of medical graduates choosing general practice as a long-term career[11] and these career choices appear to be reflected in subsequent career outcomes, with a sharp fall in the number of graduates working in general practice five years after qualification.[12] We have also reported on the importance of working hours and domestic circumstances in influencing young doctors' choice of general practice as a career.[13]

Our surveys have recently included questions about job satisfaction. As we report in detail elsewhere,[12] the majority of doctors report high levels of job satisfaction, although senior NHS GPs report slightly lower levels than their contemporaries who are NHS hospital doctors or doctors abroad. Nonetheless, of the NHS GPs in the cohorts that qualified in 1974, 1983, 1988 and 1993, 46%, 48%, 52% and 64% respectively reported high levels of job satisfaction in surveys undertaken in 1998 and 1999. Respectively, 48%, 48%, 45% and 35% reported moderate levels of job satisfaction, and 6%, 4%, 3% and 1% reported low levels. However, against this background, it is the case that fewer and fewer doctors have opted for careers in general practice in recent years. This paper is particularly concerned with the critical comments that doctors, albeit in a minority, make about general practice.

In addition to the structured questions we ask, our surveys invite respondents to write comments about any aspect of their career. In this paper, we report our qualitative analysis of comments made about general practice careers during the 1990s by four cohorts of graduates surveyed at different stages of their careers. The analyses presented here are intended to increase understanding of the following:

- Why are newly qualified doctors not attracted to general practice?
- What are doctors' views on training for, and job opportunities in, general practice?
- Why have GPs become more inclined to work less-than-full-time, to take career breaks or to retire early?
- When GPs express negative views about careers in general practice, what are their concerns?

In attempting to understand concerns expressed by doctors about working in general practice, it is important to consider its recent history. Over the past decade, general practice has experienced major changes. As part of the Conservative Government's reforms of the NHS, the internal market[14] was introduced in 1990 to bring about managed competition between self-governing hospital trusts. Some general practices voluntarily became 'fundholders', which meant that they became direct purchasers of non-acute hospital services, along with health authorities. As we have previously reported, the internal market was not well regarded by most GPs.[15] At the same time, significant changes were made to GPs' contracts by the government[16] despite being opposed by many in the profession.[17] The changes were intended to provide better choice for patients and more competition amongst doctors, to make the terms of service more specific and the remuneration system more related to performance, to strengthen the contractual relation with Family Health Service Authorities (FHSAs), and to ensure greater value for money.[14]

The new contract brought:

- requirements for GPs to provide an annual report to FHSAs containing information about staffing, premises, referrals and prescribing
- a new emphasis on regular health checks and health promotion clinics, with financial incentives for achieving target levels of population coverage for cervical cytology screening and childhood immunisations
- new requirements for GPs' availability to patients
- changes to fees and allowances, including introduction of a new postgraduate education allowance and deprivation payments.

These reforms were followed in 1991 by distribution to all households of *The Patient's Charter*, which set out the rights of citizens in relation to the NHS and introduced national standards of service.[18] This included new rights to information on local quality standards and maximum waiting times and information on how to complain about NHS services.

In 1995, a package of measures was introduced by the Department of Health to enable GPs to manage their twenty-four hour commitment more effectively. This included a change to GPs' terms of service to allow them to transfer their out-of-hours responsibility to another local GP, and funding to develop local solutions to the out-of-hours commitment, such as the setting up of GP co-operatives and out-of-hours primary care centres. By organising in teams, GPs would be able to share their out-of-hours commitment while spending less time on-call.[19]

Following the election of the Labour government in 1997, new NHS reforms were announced, which included reversal of the internal market and replacement of the two-tier system of GP fundholding by commissioning of health services by all general practices through PCGs and PCTs.[20] The introduction of PCGs and PCTs is having the effect of involving GPs more in decision making about the provision of NHS services. The 1997 reforms also introduced NHS Direct, a telephone help line staffed by nurses. In 1999, the government announced NHS Primary Care Walk-in centres aimed at providing information to the public and treatment of minor conditions from 7 am until 10 pm and at weekends, with or without appointments.

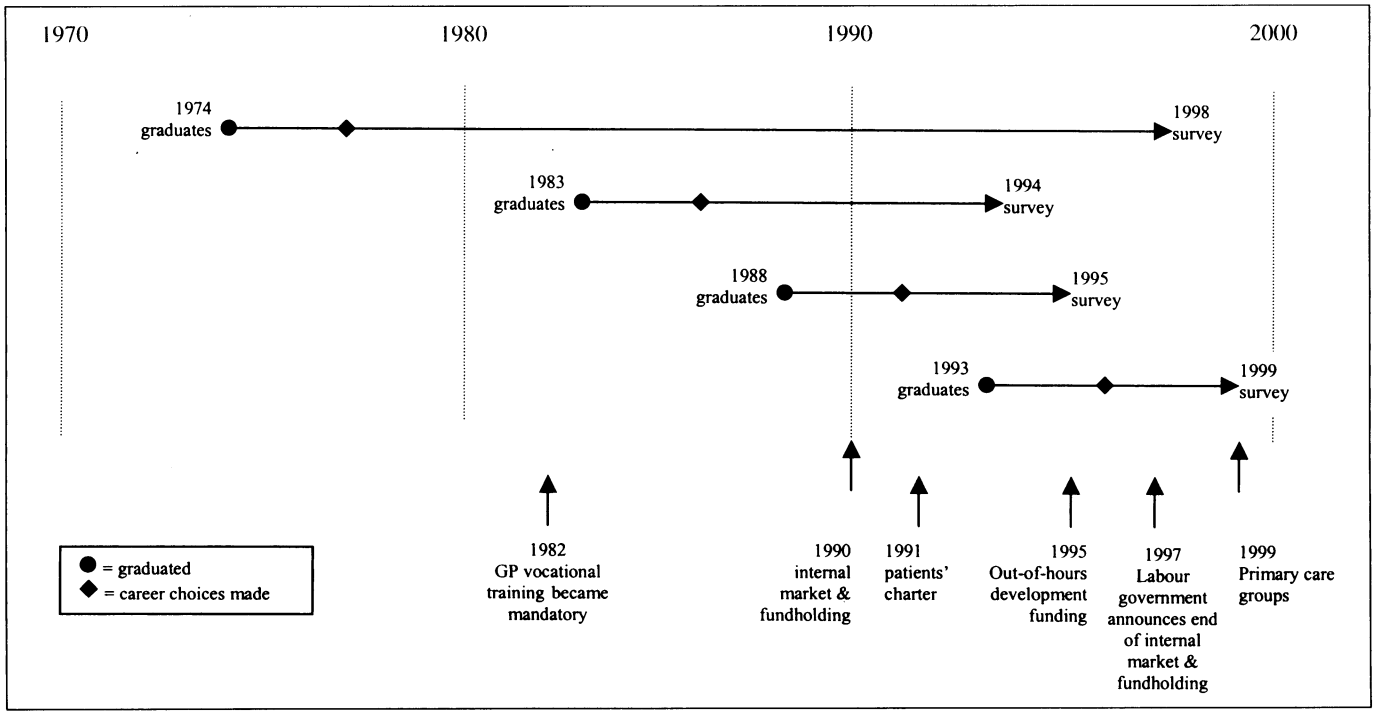
Methods

Four surveys, each of a different cohort of medical graduates, were selected for analysis of comments about general practice on the basis of their timing in relation to NHS reforms and the stage of respondents' careers (Figure 1). The surveys were conducted in 1994, 1995, 1998 and 1999, thereby collecting doctors' views on changes of NHS policy following the general election of 1997, as well as earlier views on the major NHS reforms of 1990. The cohorts surveyed graduated in 1974, 1983, 1988 and 1993, therefore providing a spectrum of respondents from the very experienced to the junior. GPs in two of the cohorts had made their career choice before the 1990 reforms, and in the other two, after. Doctors' views from the mid-1990s, as well as more recent views, have been included in this report because, as the following sections demonstrate, the impact of the 1990 NHS reforms on general practice and respondents' attitudes towards them are relevant to current issues in recruitment and retention.

In three of the surveys, the rubric inviting respondents to write comments consisted of a single sentence asking them to provide comments on "any aspect of their training, career choices or work" (Appendix 1), but in the survey of the 1983 graduates in 1994, a series of prompts were included as suggestions of topics they might wish to write about (Appendix 2). Comments were transcribed in full and imported into the NUD*IST textual analysis software program. Our analysis was based on all comments made about any aspect of general practice, by all doctors, regardless of specialty. We therefore included the views of those who had considered but rejected general practice as a career, or who had left after a period of working in general practice, or who were working as GPs abroad rather than in the UK NHS, as well as views expressed by hospital doctors about the impact of GP fundholding or commissioning on secondary care services. Relevant comments were extracted by multiple key word searching. A search strategy was developed by testing a series of key words individually and in combination, omitting any terms that did not yield additional hits (e.g. 'locum'). The final strategy used the following precise terms: GP, general practice, general practitioner, principal, retainee, retainer, fundhold, fund hold, fund-hold, vocational, VTS, commissioning, primary care, PCG, white paper, co-op, partnership, red book, practice management, salaried, FHSA, FPC, RCGP, surgeries. In each survey, a sample of comments not retrieved by this search was checked for any comments relevant to general practice; none were found. Retrieved comments were read and emergent themes were coded and developed using the method of constant comparison.[21] Data from each survey were analysed independently and comparisons made between surveys of comments coded to similar categories.

We have assured all our respondents of total confidentiality in the handling of the information they provide to us. We have included verbatim comments to illustrate points made by the respondents, but have done so in a way that we believe cannot identify individual respondents.

Figure 1. Cohorts and surveys used in the analysis, relative to timing of major NHS changes affecting general practice.



Response rates and representativeness of comments

Response rates to the four surveys ranged from 71–78%. Written comments were provided by 45% of respondents, and on some aspect of general practice by 17% (Appendix 3). Not surprisingly, most comments about general practice were made by those doctors working as NHS GPs, although a small proportion were made by those working in hospital specialties or in other medical or non-medical posts, or who were unemployed or abroad (Appendix 4). In particular, 17% of relevant comments in the survey of 1993 graduates were made by hospital doctors because at the time of the survey many were in SHO training posts. Similarly, in this survey a minority of the 1993 graduates had become GP principals, many were still in training for general practice and an unusually large proportion were working as GP locums. Thirty-two per cent of those working as NHS GPs commented on some aspect of general practice, and principals, non-principals and registrars were represented in approximately equal proportions. In all four surveys, women were more likely than men to comment on any topic and on general practice. The relative proportion of comments on general practice made by men and women varied between surveys, reflecting the recent growth in numbers of women entering the profession and, in particular, general practice (Appendix 5).

The alternative format for the comments form used in the survey of the 1983 graduates (Appendix 2) may account in part for the relatively high proportion of comments provided overall in this survey, and on topics such as leaving medicine, the NHS or the UK, and good and bad features of training (Appendix 3), as these were suggested in the rubric. While these comments may only reflect the views of a minority of respondents, they nevertheless indicate a range of concerns; in particular, reasons for the current recruitment and retention difficulties.

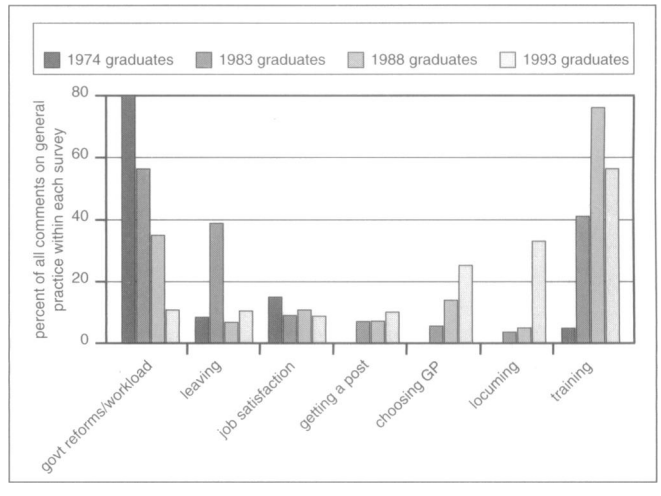
Comments about general practice were typically negative, mainly describing difficulties or frustrations with respondents' careers. The most common topic of comment amongst the two youngest cohorts surveyed was training for a career in general practice (Appendix 3). Few of the 1974 graduates commented on this, probably because of the length of time that had elapsed since their training. The most common topic of comment in the 1974 and 1983 graduates, and the second most common topic in the 1988 graduates, was government reforms and their impact upon general practice, in particular on workload. Few of the 1993 graduates commented on this, probably because they had no experience of general practice prior to the 1990 reforms. Other topics commonly mentioned in all four surveys were poor job satisfaction and morale, and leaving or having already left NHS general practice. Also commonly mentioned in the three youngest cohorts surveyed were reasons for choosing general practice and difficulties in obtaining a post of their choice. The most common topic commented upon by the 1993 graduates was their experience of, and preference for, working as locums in general practice at this stage in their career. Other topics mentioned less frequently include out-of-hours co-operatives, working hours, reasons for seeking less-than-full-time work, career breaks, family mobility, deterrents to a general practice career, and terms and conditions of non-principals.

Figure 2 illustrates the differences between the four cohorts in their frequency of comment on particular topics. Comments from the older two cohorts were predominantly about the impact of government reforms, while comments from the younger cohorts of doctors were more concerned with training, working as locums and reasons for choosing general practice. While there were differences between cohorts in the quantity of comment on particular topics, differences in the content of comments within each topic were rare. Data have therefore been pooled from all the cohorts in reporting on each topic.

The following sections describe doctors' comments about general practice careers within four broad themes:

1. Training for a career in general practice.
2. Decision making facing newly trained doctors considering or embarking on a career in general practice.
3. The changing nature of general practice resulting from NHS reforms.
4. Reduced participation in the NHS general practice workforce.

Figure 2. Relative frequency of most common topics of comment.



N.B. The total percentage shown for each graduation year exceeds 100% because some respondents commented on more than one topic.

Comments about training for a career in general practice

UNDERGRADUATE TRAINING

Those who commented about their undergraduate medical training were mainly concerned that there had been insufficient exposure to the type of work involved in general practice and a bias towards teaching the knowledge and skills required for hospital-based specialties.

Undergraduate training is largely inappropriate for GP work, and there is too little exposure. The emphasis is greatly on hospital specialties, particularly medicine and surgery. [Female GP principal, graduated 1983]

Management of problems found within a particular speciality was usually considered from the starting point of a patient in the hospital. Not enough attention was paid to the management of patients in the general practice setting. [Male GP locum, graduated 1983]

Surprise was expressed at the small amount of medical school training that was devoted to general practice, given the large proportion of medical graduates that would be required to work as GPs and the importance of primary health care in public health terms. This small amount of training and exposure to general practice was considered insufficient for making informed career decisions.

It seems outrageous to me that only two weeks of the seven years' training and house jobs were spent in general practice, when 50% of doctors end up in primary health care, and the vast majority of health care takes place in the primary care setting. [Male GP principal, graduated 1988]

I feel that if general practice had been incorporated more heavily in my undergraduate curriculum I would have made it as my career choice at an earlier stage. [Male GP registrar, graduated 1993]

Some would have welcomed training at undergraduate level in non-medical aspects of general practice work, such as communication and management skills.

More GP training as an undergraduate would be beneficial. Plus how to be a good employer, manager, accountant, innovator and computer expert. How about teaching doctors about real life as well as medical facts? My medical training is only half the job; the rest has to be picked up as one goes along with no formal training. If the government expects us to run GP practices like a business (and also hospital medicine) then they should provide the training. The demands on GPs are very high and are forever growing. One can't get by on medical skills alone. [Female GP locum, graduated 1988]

POSTGRADUATE TRAINING

Since 1982, structured vocational training schemes (VTS) have been mandatory for postgraduate training of prospective GPs. These schemes comprise a series of SHO posts (usually of six months duration) in a variety of hospital specialties, followed by a period in one or more general practices, with the whole scheme lasting three years or more.

Hospital-based training

Comments about vocational training commonly concerned criticisms of the hospital-based component of the scheme, in particular the relevance of the experience gained in these posts to a career in general practice, the level of education and training received relative to the amount of service work undertaken, and the lack of protected time for educational activity.

Respondents complained of a lack of formal teaching or assessment, with trainees mainly being expected to learn through practical experience. In addition, there appeared to be little awareness amongst consultants of the skills required for general practice work, and little effort made to relate postgraduate hospital training to a future career in the community setting.

In the [named] VTS scheme there was too little formal teaching of trainees, we were left to pick things up as we went along. [Male GP principal, graduated 1983]

My hospital VTS jobs seemed solely to be hospital orientated and no attempt was made to relate them to general practice. [Male GP principal, graduated 1988]

There was a perception that training in VTS hospital posts was treated as of secondary importance to fulfilment of a service commitment. Indeed, it was suggested that the best training posts were given to those who planned to pursue a hospital specialist career. The remaining posts, which needed to be filled to meet service commitments, were collected together under the label of a VTS and offered to general practice trainees, regardless of the educational relevance of those posts to their future careers.

The emphasis in SHO posts during vocational training was a 'service commitment' — there was very little training. [Female GP principal, graduated 1988]

I see many GP training schemes as collections of poor quality posts which would otherwise be unfilled, lumped together to make a 'GP scheme'. This exploits GP trainees and gives them no relevant training. [Male GP principal, graduated 1988]

While VT schemes were intended to provide exposure to a range of different hospital specialties, they were usually limited to four six-month posts and could not therefore ensure exposure to all hospital specialties of potential relevance to general practice. This resulted in GP trainees feeling inadequately prepared for their careers and wishing that opportunities had existed for a broader hospital training, such as shorter periods of exposure to a larger number of specialties.

The training for general practice received during hospital SHO posts was minimal and largely irrelevant. I find that I now wish I had the opportunity to spend two or three months in all specialties. For instance, I have no specific hospital experience of dermatology, ophthalmology or ENT, all of which would have been useful for a career in general practice. [Female GP principal, graduated 1988]

Another criticism of hospital-based training was that there was no protected time for education. Teaching sessions held during the lunch hour were unproductive if trainees could not escape their bleeps. Vocational trainees were also frequently prevented, by pressure of work, from attending regular teaching sessions arranged as part of the VTS. Furthermore, long working hours and onerous workloads led to severe tiredness, which could prevent trainees from undertaking private study in their personal time.

The hospital posts should have clearly demarcated times for training — not just an hour at lunch-time when bleeps are going off all round. [Female GP principal, graduated 1988]

When I was on the VTS scheme I felt that I was a junior hospital doctor first and a trainee GP second. For example, it was quite often impossible to attend the half-day release teaching sessions. [Male senior registrar in public health, graduated 1988]

The fatigue experienced once off duty also made it very hard to ever study to consolidate any knowledge gained from clinical experience. [Female GP principal, graduated 1988]

With regard to study leave, those pursuing hospital careers were perceived as being treated preferentially to vocational trainees. The former appeared to be granted study leave to prepare for their exams while vocational trainees were not allowed to attend teaching sessions arranged as part of the VTS. This led to vocational trainees feeling devalued and demoralised, and reinforced a sense of inferiority.

I applied on two occasions for study leave in my SHO years and told the priority was to 'career NHS posts not GP trainees'. [Female GP principal, graduated 1993]

SHO posts are very poor training posts with regards to general practice. Consultants on the whole have little idea of what GPs do, and can be quite derogatory. Their interests lie mainly in SHOs who choose their field as a specialty. The consequence being they receive preferential treatment with regards to teaching, training courses and, more often than not, on-call rotas. You are sometimes made to feel that you are there to do the donkey work whilst those in specialist posts have choices. [Male GP locum, graduated 1993]

General practice-based training

Training in the general practice-based year was widely seen as being greatly superior to that experienced in hospital-based posts, with the former involving formal structured training and assessment sessions, and with attention paid to individuals' educational needs.

In contrast [to hospital training], general practice has been like a breath of fresh air to me. The hours, working conditions and respect shown to me by my GP colleagues remains as refreshing as it was six months ago. For the first time in my medical career people are taking an interest in my training, encouraging me to look objectively at my strong and weak areas, and allowing me the freedom to develop my own areas of interest. Through the half-day release scheme I feel I am being fully prepared for my transition to principal. In addition it provides a forum for reflection and discussion with my trainee colleagues, something I missed in my hospital career. [Male GP trainee, graduated 1983]

However, not all respondents were complimentary about the general practice component of their VTS. A few complained that their contribution to the practice workload appeared to take precedence over their training.

Even as a GP trainee I felt that the commitment to the practice workload came before your actual training. Tutorials would sometimes disappear if a partner was away, etc. [Female CMO in community health, graduated 1988]

Others found the onerous general practice workload extremely demanding, due to the high levels of patient demand and short appointment times, and the long hours left little time or energy for the pursuit of outside interests.

I am currently in my GP trainee year and the practice is extremely busy and intense. I would have to say this is the hardest I have worked since commencing employment. The workload is huge, unrelenting, but can be very interesting. Unfortunately with the time pressure of short consultation times life can be frustrating and stressful as I feel I am doing both myself and the patient a disservice by constantly rushing to keep even vaguely to time ... Aside from the job the days are long, which leaves a limited time for outside interests. Add to this the added pressure of time to prepare for summative assessment (albeit straightforward) and the MRCGP this year is turning out to be very stressful. [Female GP registrar, graduated 1993]

A common comment was that the general practice component of vocational training was too short, especially following the introduction in 1998 of summative assessment that GP registrars now have to complete in addition to preparation for the MRCGP exam. Some respondents thought that the total length of the VTS should remain at three years but the proportion of time spent in general practice should be increased, while others suggested that additional years should be spent in general practice, possibly through creation of a 'senior registrar' post, lengthening the scheme as a whole. It was also suggested that trainees should rotate through two or more practices to provide a broader experience of practices and their populations than the more common single placement allowed.

I feel strongly that the GP registrar year must be extended and a senior registrar grade introduced. One year (especially if split into three four-month attachments) is too short a time, especially if summative assessment and MRCGP remain as separate hoops to jump through, and to gain enough experience to feel confident and ready to take on a partnership. A senior reg. grade could very usefully be introduced to develop audit and clinical governance/teaching within GP. [Female GP locum, graduated 1993]

I suspect that GP training should still involve time in acute specialties, but have longer in GP settings in more than one practice. [Male GP assistant, graduated 1993]

However, two respondents were concerned that lengthening the general practice-based component of vocational training could result in further exploitation of trainees without meeting their additional training needs. And one respondent believed that reducing the time spent in the hospital specialties could be detrimental to the overall training experience.

I think the idea of increasing the vocational training period for GPs to two years is all about further exploitation of young doctors and will not further their training needs. [Female GP principal, graduated 1988]

VTS schemes are now moving to 18 months in GP and 18 months in hospital specialties. I think this a bad move as hospital training often provides a firm basic grounding of the fundamental elements required for entering GP. [Male GP registrar, graduated 1993]

Other criticisms of the general practice year were that there was insufficient training on business and management skills, and that summative assessment was time-consuming, irrelevant and duplicated aspects of the MRCGP exam.

Variations in quality of training

The quality of training on VTS was seen as varying enormously between different schemes and posts, dependent entirely upon the skills and enthusiasm of individual consultants and GP trainers. The following are examples of good and bad training experiences arising from the qualities of individual trainers.

GP trainee year — very supportive and knowledgeable trainer. He was a mentor and commanded great respect. A great positive influence. [Female GP principal, graduated 1983]

The most enjoyable post I did as SHO was in obs & gynae. Whilst a physically demanding job it was made pleasant and useful by the consultant who was obviously interested and motivated to teach us — not just in the junior posts but the primary care aspect in which he knew I was going. [Male university research fellow, graduated 1983]

I've experienced a total apathy and lack of consideration towards me and my career from colleagues in senior posts (e.g. GP trainer/VTO) within general practice. I feel that reaccreditation as GP trainer should depend less on local contact/old boy network and more on audit of trainees after accreditation. [Male GP locum, graduated 1983]

Self-constructed training schemes

Some prospective GPs had devised their own vocational training schemes, either out of choice or because formal schemes were oversubscribed. Obtaining suitable posts was sometimes difficult and could mean having to move around the country. Isolation from formal training schemes was also cited as a problem and could mean missing out on opportunities.

At that time three-year GP schemes were very over-subscribed, so I put together my own scheme. This involved some moving around, but was good experience. [Male GP principal, graduated 1983]

I felt discriminated against as an aspiring GP for not getting on a VTS. None of the services directed at hospital GP trainees came my way. Yet I had from the outset stated my wish to become a GP and did a very good 'scheme'! My first contact with anybody from GP was when looking for a trainer! [Male GP principal, graduated 1983]

By contrast, devising one's own scheme was widely considered as having several benefits. It was suggested that most formal schemes included at least one post that was of little, if any, relevance to general practice careers. Arranging one's own scheme allowed doctors to choose those posts they considered most appropriate for their needs, which in turn improved their clinical skills and resulted in a more beneficial training experience. It was possible to ensure a broader range of posts and to spend longer in training if desired. It also provided greater flexibility, such as the ability to move between different geographical areas if needed to follow a spouse's or partner's career.

I had excellent GP training, benefiting from the opportunity to choose my own jobs, which were most appropriate to me, not having a blanket three-year scheme, which often includes inappropriate or poorly structured jobs. I chose to train this way to give me flexibility as my husband is a hospital physician (SR). [Female GP retainer, graduated 1983]

Positive views

Although the majority of comments about postgraduate training were concerned with criticisms of, or difficulties with, vocational training, a minority of those who commented expressed favourable views. They variously described vocational training as "excellent" (one male and three female GP principals, graduated 1983), "fantastic" (female GP locum, graduated 1988), "invaluable" (male GP principal, graduated 1983), "very useful" (male GP principal, graduated 1983] and a "good base for training for GP" (male GP locum, graduated 1988).

Enthusiastic good quality vocational training facilitated personal development, and helped in affirming my decision to enter general practice. [Male GP principal, graduated 1983]

A common view was that a stint in general practice, probably as part of the pre-registration year, would benefit all doctors in training, regardless of their final career destination; it would afford them the experience of a more holistic approach to patient care and provide some insight into the problems that GPs face; and it would aid relationships between GPs and hospital doctors, as the latter would better appreciate the role that GPs play.

All hospital specialists need a period in general practice to: a) learn how the 'other half' have to work; b) get some experience of working with social beings (patients) in context instead of treating them as vets treat their charges. [Male GP principal, graduated 1983]

I think it is essential to do some experience during/after HO posts ... even if graduates have no intention of doing GP, because they will appreciate GPs and patients' histories when phoned for advice/admission. They will realise how stimulating, varied and challenging [a] GP career is. [Female SHO, graduated 1993]

Comments about embarking on a career in general practice

REASONS FOR CHOOSING GENERAL PRACTICE

A common topic of comment amongst the younger cohorts surveyed concerned their rationale for pursuing a career in general practice. The most frequently cited reasons for choosing general practice were associated with lifestyle. Respondents commonly believed that opportunities for part-time working were more widely available in general practice than hospital medicine, making the former a more attractive career for both male and female doctors who wished to have a family or an active social life outside of work.

I am so glad I gave up the idea of specialist hospital training when I did and opted for GP because I cannot conceive of how I'd run my job and domestic life if I was still doing relentless on-call. I opted for GP because it gave me the opportunity of working part time both as trainee and in the future. [Female part-time GP registrar, graduated 1993]

While some doctors were content to have made this lifestyle choice, others resented having to give up a hospital career for one which they perceived as less challenging or rewarding in order to pursue a relatively normal life outside of their work.

Having gained MRCP (Paeds) I would have preferred to follow a career in Paediatrics, however an SpR rotation would not have allowed enough time with my family. A part-time SpR rotation is very poor pay because of the reduction in ADHs and the salary only just covers childcare expenses. Furthermore I believe that consultants in the future will be expected to stay in hospital overnight and at weekends — not suitable for a mother! I am bitter that the working conditions in hospital have made me sacrifice a paediatric career so I can have some time with my family. General practice is much less fulfilling and more boring, however the better pay and hours make it the only logical choice for many mothers! [Female flexible SHO, graduated 1993]

Another perceived advantage of a general practice career was that GP posts were more widely available in all parts of the country compared to those in the hospital specialities. This allowed doctors greater freedom of choice over where to live and work and to obtain GP work in whatever geographical area their spouse's or partner's job was based.

I should also be able to choose where I live and practice to a much greater degree than before. [Female SHO, graduated 1993]

I initially intended a career in general medicine but found morale so poor among my consultants that I bailed out into GP. I had always been quite interested in GP and my partner's decision to opt for a hospital career meant that I could be more mobile to follow her as a GP. [Male career break/locum, graduated 1993]

General practice was also seen as a geographically stable career relative to that of higher specialist training, since it avoided the necessity for frequent changes of location associated with hospital training rotations. General practice was therefore chosen in preference to hospital careers by those doctors who wished to settle in one location early in their careers for the benefit of themselves or their families.

The major reason that I opted for GP was based on my family circumstances. As an SHO I had two young children. The prospect was either stability for them (geographically) before the eldest started infant school ([by choosing] GP), or insecurity combined with frequent moves from schools until a consultant post was reached (GCSE age!). If better career planning had been on offer with a regionally based consultant training programme I would probably have stopped in hospital general medicine. I think it's a pity that the hospital system self-selects those who are prepared to sacrifice their families and uses this almost as selection criteria in itself. [Male GP principal, graduated 1983]

Another common reason for choosing general practice was to escape the long hours, protracted years in training, and additional stresses of studying for and sitting professional exams required for pursuit of a hospital career, with no guarantee of a consultant post at the end.

After three years of one-in-three rotations I found the prospect of continuing another few years like this rather depressing. In particular, talking to registrars with many years of experience behind them and who still didn't know whether there would be a consultantship for them at the end, was a very negative aspect of hospital training. This made me decide to switch to GP training. [Male GP abroad, graduated 1983]

I decided against hospital medicine because of the long hours on-call, and because of the way it takes over your entire life, with exams extremely difficult to pass and few senior jobs available once those exams have been passed. [Female GP locum, graduated 1988]

Concerns were also expressed about the working conditions of consultants in the future, in particular that their workload may be more onerous than in the past due to the reduction in junior doctors' working hours.

Having been GP trained and seeing how the juniors are exploited, I personally couldn't face a hospital career, especially as now with trusts a consultant hasn't as much job security as before. There is also the danger of having done all the work as a junior having to do it again as a consultant as the juniors' hours come down. What an awful prospect being a consultant paediatrician in a small DGH with only a GP trainee below you (no middle grade) — you'll be coming in for drips, etc., at the age of 55. [Male GP assistant, graduated 1988]

Choosing general practice as a career meant that the length of time spent in training was shorter than for hospital medicine, and good financial remuneration was achieved earlier, along with a better quality of life.

I have undergone a complete change in direction in my career. I was intent on a career as [named hospital specialty] and was doing very well ... when I realised something was wrong. I was spending all my time and energy on work, it would be years before I became a consultant, and I'd have missed out on a lot of my daughter's childhood. I also realised that a lot of people were becoming very disillusioned once they eventually got to the consultant grade. I realised that the potential rewards did not match the vast input of effort and sacrifice over long years of hard work and training. I realised I could be a good GP, that my training would be much quicker, I could work in a way to suit me (flexible or part-time), the financial rewards were good, and that (hopefully, though I'm not sure of this now) I'd have more time and energy for my daughter and for other interests. [Female GP trainee, graduated 1988]

In combination with lifestyle reasons for choosing general practice, a small minority of those who commented gave as an additional reason their enjoyment of the type of work involved or of their training experience in general practice.

General practice chosen as prefer working in community rather than hospital. [Male SHO, graduated 1988]

Early on in my clinical career I decided on GP — probably because the GP department at [named hospital] was so good. [Male GP principal, graduated 1988]

Other reasons for pursuing a career in general practice were associated with career aspirations rather than lifestyle. Some doctors chose to train as GPs to acquire the broad skill base required for work in the developing world. Others regarded general practice as a more flexible career in terms of the variety of interests it allowed them to pursue.

I entered into GP because it would give me the skill base to build on for future community health work in a Third World setting. [Male GP locum, graduated 1993]

As a GP I will have a much wider choice of careers to pursue. I will be able to work in developing countries for a few years. GP allows one to specialise in own interest areas e.g. assist in sports medicine, diabetes or in A&E. [Female GP registrar, graduated 1993]

Some explained that many junior doctors were entering general practice after failing to obtain a specialist registrar (SpR) post in their chosen hospital specialty. Competition for SpR posts was perceived to be fierce, meaning that in order to succeed, candidates had to do more than just meet the minimum requirements: they had to gain more qualifications and research experience prior to applying for SpR posts. This meant remaining in the SHO grade for longer than the usual two years. Concerns were expressed that doctors who opted for general practice out of necessity rather than choice may not necessarily be suited to general practice work, so that recruiting GPs by this route could potentially be detrimental to patient care.

SHOs not getting on SpR schemes despite minimum of requirements being met since insufficient posts, therefore NHS will lose people who are young enough to train outside the NHS (e.g. do law) or postgraduate graduated doctors will go into GP by necessity not choice and therefore not for patient benefit. [Female specialist registrar, graduated 1993]

DETERRENTS TO A GENERAL PRACTICE CAREER

Some of those who commented talked about factors that had deterred them from pursuing general practice as a career. Throughout both undergraduate and postgraduate medical training there was a perception that general practice was often portrayed by hospital consultants as a second class career compared to hospital medicine, and one which was entered by those who were unable to succeed in the competitive hospital environment.

I feel that in medical school GP is treated as the underdog specialty and one which a high percentage of us will fall into as though unable to do anything else. Although I am currently not planning to do GP work I have thoroughly enjoyed that which I have done and feel that it should be promoted as a positive choice at medical school as I have the impression that the specialties like to think of themselves as superior and that GP and academia are worlds apart — they don't have to be. [Female SHO, graduated 1993]

In addition, as mentioned earlier, the specific skills required for general practice work were perceived as not valued by educators, and the hospital-based postgraduate training received by vocational trainees was not always of the same standard as that received by those who planned to enter a hospital specialty.

Another commonly cited deterrent to a general practice career was a perception that heavy workloads were currently causing considerable stress and low morale amongst established GPs.

I regularly meet GPs whose lives are spoilt through work-related pressures and stress, many of whom suffer with depression, alcoholism and marriage breakdown. My career choices have been influenced in part by wanting to avoid too much work-related stress. [Female GP locum, graduated 1993]

Other deterrents to a general practice career were: the poor pay relative to that of hospital consultants, the lack of a career structure, adverse publicity and the political uncertainty surrounding the future of general practice.

As a result of one or more of these deterrents, some respondents who had undertaken general practice training had subsequently rejected a career in general practice.

As a student I was interested in public health and general practice. I retained a strong interest in public health/health policy/structural issues of health and health care after qualification but decided to go into hospital medicine. This reflects the fact that as a student you don't really get a true feeling of the power and attraction of the doctor–patient relationship. Once I started working there is enormous peer

pressure to "do the right thing", which for someone with prizes, etc. is to do a hospital specialty. [Male SHO, graduated 1988]

While I have benefited a great deal from vocational training in general practice I have now decided that I do not wish to pursue a career in this discipline. Reasons are hassle, overwork and no escape from the 24-hour commitment. I am now pursuing a career in community gynaecology/family planning/sexual health. [Female CMO/clinical assistant/GP assistant, graduated 1988]

POSTPONING PRINCIPALSHIP

While wishing to pursue a career in general practice, concern about pressure of work was also a factor in some newly qualified GPs' decision to postpone seeking a principalship.

Why have I not entered GP partnership at the end of VTS and have no intention of doing so in the near future? GP work is still not flexible enough, have to buy in, 24-hour responsibility, lack of remuneration e.g. maternity pay whilst locum costs rising, primary care groups, more work being shifted from secondary to primary care with no shift in resources, managerial responsibilities, long working days with lots of additional paperwork, self-employed, business hassles and bizarre way GPs are remunerated, numerous changes in GP contract, no longer want job for life, rising patient expectations mean it's not an attractive career option! [Female GP locum, graduated 1993]

Comments about postponing principalship were common amongst the 1993 graduates, many of whom had recently completed their vocational training when they were surveyed in 1999 and would be expected to be seeking or to have taken up a principal post. However, those that commented on this topic appeared to feel that their formal training, although complete, had not prepared them sufficiently for the challenges of a GP principalship, in particular the business aspects of running a practice or participating in GP commissioning. They lacked confidence and some would have welcomed a further period of training in general practice before embarking on their careers.

I feel that I am not alone in my current position of being qualified to join a partnership in GP but not yet/possibly never wanting to do so. Clearly this is reflected in the GP recruitment crisis as it stands. Although I do not regret training as a GP I have a strong sense that my training lacked in many areas of GP. This was not helped by the fact that my GP registrar year was split into two six-month posts, one being taken in my first year of GP training (as advised by many doctors at the time). I think new training schemes with longer periods in GP may be beneficial in giving GPs the confidence to join partnerships soon after qualifying. It would also give them better knowledge of practice management to ensure a qualified decision when choosing between practices. [Female locum SHO (private sector), graduated 1993]

Historically, GP principals have mostly remained with the same practice for the duration of their careers. The concept of 'a job for life' was unattractive to some young doctors seeking their first principalship as they didn't feel ready to commit themselves to a long-term post or to settle down in a particular geographical area.

I'm committed to medicine but don't feel ready to settle down as a principal yet — mainly for personal reasons (single, not ready for commitment, want to keep options open re further travel) although ultimately would hope to be a GP principal. [Female career break (travel), graduated 1993]

Thus, doctors' reluctance to enter principalships was influenced both by concerns about their professional competence and by their personal circumstances. Some doctors saw little point in applying for principalships while their spouse's or partner's job required them to move location frequently. Some had partners who were in higher specialist medical training rotations that involved moving every few months and who would not be able to settle in a particular hospital or locality for some years.

My husband is looking for registrar jobs in neurology and as we may be moving I am waiting until he has a registrar rotation before I look for a part-time partnership. [Female GP locum, graduated 1993]

Doctors who had postponed applying for principalships for one or more of these reasons were commonly working as locums or in salaried non-principal grades (e.g. assistant or retainer) as a way of starting a career in general practice and gaining more experience without the responsibilities of a principalship. Others were working in these grades in parallel to applying for principal posts or while waiting for a suitable post to arise.

I strongly feel people leaving VTS schemes would value more salaried posts as none of us who finished last year (all with MRCGP) have felt a partnership was the next step and we are all locuming. [Female GP locum, graduated 1993]

Since completing GP training I am doing locum work pending the 'right' GP practice for me. [Male GP locum, graduated 1993]

WORKING AS A GENERAL PRACTICE NON-PRINCIPAL

There were a number of advantages of working as a non-principal. Firstly, it provided for greater flexibility and control of working hours. For instance, locums could choose how many sessions to work and whether to do out-of-hours on-call, allowing greater freedom to pursue interests outside of their general practice work.

Life as a locum working when I want, providing 24-hour cover as and when or if I want, is less stressful in many ways. [Male GP locum, graduated 1983]

Secondly, working as a locum provided experience of a variety of different types of practices with different patient profiles; a contrasting experience to the 'ideal' training practices GPs had been exposed to during vocational training, and one which helped to boost their confidence.

Non-principal working also enabled doctors to gain more experience of general practice while avoiding the responsibilities of a principalship.

GP locum work invaluable for experience, building confidence, seeing different GP practices. [Female GP principal, graduated 1988]

Currently working as a salaried GP with no on-call and have found life outside medicine and am awake enough to enjoy it! ... The scheme has given me greater feel and insight into GP than VTS, without the responsibility. [Female salaried GP, graduated 1993]

There were several difficulties associated with working as a non-principal. Firstly, self-employed locum work tended to be short-term and intermittent resulting in periods of unemployment between jobs and a lower average income than that of principals or salaried GPs.

Work was intermittent, for at the most one month continuous employment. This inevitably led to periods of unemployment and marked reduction in income, whilst looking for a permanent GP principal's job. [Male GP principal, graduated 1983]

Locum work was not paid at a uniform rate throughout the NHS, meaning that the rate of pay had to be negotiated for each separate job undertaken and could therefore vary considerably. Although there was a rate of pay that was recommended by the British Medical Association (BMA), practices were not obliged to adhere to it, so locums were sometimes paid less than the recommended rate.

During my period of unemployment deputising work was plentiful as was locum work, although many practices offered fees for locum work well below BMA-recommended fees. [Male GP principal, graduated 1983]

Locums were not entitled to certain employment benefits enjoyed by GP principals and some other non-principal grades, regardless of their continuity of service for the NHS. These benefits included statutory maternity pay, holiday and sick pay, and membership of the NHS pension scheme. (The latter has been made available to locum GPs from April 2001.[22])

As a locum GP I feel it is unfair that we are not entitled to benefits such as statutory maternity pay/NHS pension in spite of continuity of service to NHS. [Female GP locum, graduated 1993]

As a locum GP I feel that I am treated unfairly with regard to loss of entitlement to NHS superannuation, holiday pay, sick pay. [Male GP locum, graduated 1993]

Together, lack of job security, remuneration difficulties and loss of employment rights have resulted in GP non-principals feeling that their contribution to the general practice workload is insufficiently recognised and undervalued. They are not entitled to the Postgraduate Education Allowance that has been awarded to GP principals since 1990 to facilitate their continued professional development. This means that non-principals commonly have to fund their attendance at postgraduate education sessions, including their travel and child care expenses, in addition to any course fee, as well as sometimes having to forfeit paid work to attend. This is often not economically worthwhile and discourages many non-principals from participating in professional development. Another source of discouragement is the fact that non-principals are rarely included on mailing lists for the circulation of information about postgraduate education meetings.

Locum work remains underpaid and undervalued. We have no proper support or representation. We are frequently exploited and have no real means of any redress. Our further education necessitates not only unpaid time off work, but also the full cost of any course fees/travel expenses and accommodation. A very costly exercise. [Female GP locum/CMO, graduated 1983]

I am enjoying this work but am finding it difficult to take part in postgraduate education as locums do not get sent any information on meetings. [Male GP locum, graduated 1993]

Other disadvantages of locum working were a lack of continuity of patient care, lack of experience in the managerial aspects of general practice work and feelings of isolation.

One drawback however is the lack in continuity of care of patients, which in the long run may influence one's clinical integrity. [Male GP locum, graduated 1993]

During my training year I was certainly exposed to the changing face of the NHS, but since I have been working as a locum for the last two-and-a-half years my experience, especially in the practicalities of the changes in general practice, has been somewhat restricted. I feel that this puts me at a disadvantage when applying for jobs, in that I can offer no experience of practice running, with even my theoretical knowledge being out of date. As a locum I feel very isolated. I know many doctors who, whether out of choice or not, will do locums for many years before joining a practice. It would be nice for those of us in this situation to be able to obtain some support. [Female GP locum, graduated 1988]

Some respondents from the older cohorts surveyed also commented on limitations of the previous GP retainer scheme. These have not been included here, as the scheme has been revised since these doctors were surveyed and the limitations no longer apply.[23]

DIFFICULTIES IN OBTAINING A GENERAL PRACTICE POST

Another topic of comment was concerned with difficulties encountered in obtaining a post in general practice that was suitable to the particular needs of the respondent. While there may be a shortage of GPs nationally, respondents mentioned an inability to find a post in the area where they lived or wanted to live, or of a particular type (such as part-time, without on-call, salaried, etc.).

We have already seen how some doctors' availability to take up a permanent principalship is reduced by frequent moves of location associated with their partner's career.

Similarly, other respondents explained that they were restricted in the area in which they could seek general practice work because their partner's job was fixed in a particular location, so limited local vacancies meant that they had been unable to find a post.

Overall I am very happy with my career in general practice. However, I am finding it difficult to maintain my enthusiasm at the moment as I am stuck in an unrewarding locum position because there are no principal posts available in my area. All the current talk about the desperate shortage of GPs does not apply to [named town]! It is frustrating and ultimately a drain on NHS resources that a fully trained GP who wants to become a principal is not able to. This certainly won't help encourage doctors to take up GP as a career! [Female GP locum, graduated 1993]

Family circumstances were not the only reason for seeking a post in a particular locality. Some had restricted their search to a particular area because they would like to settle there or because they hoped to work in a certain type of practice or expected a certain income and lifestyle.

1 January 1989–31 May 1994: unemployed job-choosing. ~ 30 applications. Five job interviews. Job offer eventually not in an area which I wanted to settle in. [Male GP principal, graduated 1983]

As a young vocational trained principal (joint 'senior' partner in two-and-a-half-handed teaching practice) I aimed to avoid being 'junior partner' in a practice. I looked for a city practice with a decent population mix and high earning potential. I am enthusiastic about teaching and quality service but in London look for an adequate income to support a reasonable lifestyle — living near enough my work. [Male GP principal, graduated 1983]

Some respondents were seeking a particular type of post to suit the requirements of their personal lives, such as posts without an on-call commitment, part-time or job-share posts, or non-principal posts. These types of posts were not as easily come by as these respondents would have liked.

Out-of-hours has been the strongest factor in my career choice. I waited a long time to find a well paid full-time job in a practice with full deputising cover in an area of the city where I felt safe to visit. If I were to lose my job, I would leave medicine and seek a career in industry. [Female GP principal, graduated 1988]

... there are few part time GP vacancies in my area. [Female SHO, graduated 1993]

My spouse and I ... applied for several jobs on a job-share basis, before my spouse found an attractive partnership ... [Female CMO, graduated 1983]

Ideally I would like to do a retainer scheme until my husband completes his SpR training. Unfortunately there are only 22 posts in [named region] and there is already a waiting list. [Female on maternity break, graduated 1993]

Some respondents felt that the difficulties they had experienced in obtaining general practice posts were the result of discrimination. Perceived discrimination was most commonly mentioned by married women GPs of childbearing age, regardless of whether or not they had started a family. The source of the problem appeared to stem from a set of assumptions. Firstly, that the careers of married women took second place to that of their husbands, and that this would prevent them from making a long-term commitment to a practice if there was a possibility that their husband's career might require them to move location. This was a particular problem for those women GPs who were married to doctors pursuing higher specialist training.

Having successfully completed my GPVTS and undertaking further extensive training in women's health and paediatrics to enable me to deal more effectively/comprehensively with the bulk of patients seen by a female GP, I felt well placed to apply for positions as principal in general practice. This proved to be very difficult to obtain because of bias against me, as my husband is a surgeon-in-training, and as such, not regarded as being static in one area, despite his having trained here in [named town], always worked here and a native of the area. I was told on many occasions that despite being the best candidate, I was not successful because of my husband's occupation, and have even had this in writing. On seeking advice regarding this from the [local] VTS, I was put in touch with a local eminent GP, active within the Royal College of GPs, and told to 'go home and have babies until my husband was a consultant and then try applying again'. I did not take the advice but remain amazed at the degree of sexism within general practice, and at the ignorance of the Sex Discrimination Act. [Female GP principal, graduated 1983]

Secondly, there was an assumption that within a short time of joining a practice, a young woman GP would be likely to start a family and require one or more maternity breaks. This would have both financial and workload implications for the practice. Having started a family, these women would also need to take time out from work on occasions to deal with sick children, and they may also seek to reduce their working hours to part-time.

My ability to get a post as principal in general practice is hampered by the fact that I am a female of reproductive age. Despite the fact that GPs with whom I work are very complimentary and I am fairly well qualified, they are not prepared to risk having to cope with either (a) maternity leave in terms of workload cover and cost, and (b) the possibility of my having time off to be with my child if ill — despite the fact that I am seeking part-time/job share work and my husband would and has always been the one to take time off if needed at short notice or when I have a definite commitment to patients which cannot otherwise easily be covered. [Female GP locum, graduated 1988]

Many GP practices are loathe to take on more than one 'obligatory' female partner as they expect to face maternity leave and change in hours, etc., within the first few years after a woman joins the practice. [Female GP principal, graduated 1988]

In short, it was assumed that young women GPs could not be relied upon to make a full commitment to a practice because of inevitable conflicts between their work and family responsibilities. As a result, it was common for young women respondents to be asked questions in job interviews about their family situation and their intentions to have children, despite the fact that refusing to offer a post on these grounds would contravene the Sex Discrimination Act.

I found it extremely difficult to find partnership in GP — despite having [list of qualifications] and a well recognised VTS scheme ... I failed to be interviewed for a large number of posts. It is difficult to prove but I feel there was active sexual discrimination — as a young married female with no children — yet I felt that practices were reluctant to take me on. I was also informed once I gained a practice in [named town] that I had not been interviewed due to my sex in other practices in that area. I was asked at my interview if/when I planned to have children and my husband was told they expect you to leave having children for at least three years. One of my partners told me that I should leave my partnership and work as an assistant if I have children. I have been told I will not be able to come back to work full-time. Sex discrimination is rife in GP as we are self-employed and are not covered by general employment law. [Female GP principal, graduated 1993]

When responding to questions about their family circumstances, some women felt they were disbelieved if their answers were contrary to interviewers' expectations; for example, stating that they were not likely to move away or start a family in the near future.

I completed all my training (including [list of qualifications]) before I married my long-term partner. He is undergoing [named hospital specialty] training (currently in research) in central London, and we felt secure in living in [named suburb] — never having the need to move in four years of training. However I felt that the partnership offers I went after never trusted me in my commitment to the area ... I also felt that they did not believe me when I said I was prepared to wait before starting a family. [Female GP assistant, graduated 1993]

Some job applicants felt that they may have been discriminated against on the basis of their ethnicity.

Being of ethnic background, I found it particularly difficult in obtaining interviews for choice general practice vacancies. Whilst this is difficult to prove, I believe that professionals from an ethnic minority have to be prepared to 'work harder' to achieve equal status. [Male GP principal, graduated 1983]

Comments about the changing nature of general practice

VIEWS ON THE 1990 NHS REFORMS

Comments about the internal market and fundholding were divided. Some doctors talked about how it had benefited them and their patients, and how developing the new management skills required to be a fundholder had presented a new challenge to those who enjoyed the business side of general practice and boosted their job satisfaction. Also, fundholding had brought improved communication between fundholding GPs and hospital consultants, and easier access to hospital facilities and investigations for patients of fundholding practices.

I am now the lead fundholding partner in my partnership. I received no formal preparation for these management skills in my training, but the challenge of fundholding has been a stimulus to my career after five stable years in practice. [Male GP principal, graduated 1983]

Being a GP is marvellous fun — fundholding allowed us to increase our service to patients, improve quality of care, and raise job satisfaction. [Male GP principal, graduated 1974]

However, others commented that the two-tier system of fundholding was unfair, improving care for some patients at the expense of others and causing divisions within the profession as a result.

I also feel very strongly that fundholding is fundamentally against the system of the NHS and the principles of the NHS. It is clearly a system to encourage those with more money to get services sooner for their patients. [Male GP principal, graduated 1983]

Fundholding and the trust system have further undermined everyone by 'dividing and conquering' and setting one against another rather than working together. [Male GP principal, graduated 1988]

The language used by some respondents indicates their strength of feeling on this issue. For example, respondents variously stated that they "fundamentally disagreed with" [female GP principal, graduated 1988], "deplored" [female GP trainee, graduated 1988], "strongly objected to" [male hospital registrar, graduated 1983; female GP principal, graduated 1988], or were "vehemently opposed to" [male GP principal, graduated 1983] the concept of fundholding because they considered it to be contrary to the principles of the NHS.

The 'reforms' in the NHS — 'purchaser provider split', fundholding, under-staffing and finance-led decisions — deeply dismay and disappoint me. We were trained to choose cost-effective methods, not waste money, etc., but you can only trim so much! [Female GP principal, graduated 1988]

The requirement for fundholding GPs to manage their own budget meant that the consideration of treatment costs had to be added to their decision-making processes about patient care. This introduced the potential for conflict between the care they believed to be in the best interests of their patients and the availability of funds to support it. Some saw this as shifting the responsibility for rationing of health care onto GPs, threatening their traditional role as patient advocate and potentially eroding patient trust.

I am a doctor — I cannot make decisions on patient care based on funding. I am also supposed to be a patient's advocate — I cannot do this if decisions are based solely on cost. [Male GP principal, graduated 1988]

I personally feel the medical profession has been hoodwinked by a clever government using fundholding and hospital trusts, etc. toward a market-led type health care system, which will eventually be cost-limited. As a result the medical profession will be left the responsibility of rationing health care resources in an under-funded health service. Inevitably, in the eyes of the public, it will be the medical profession who appear to be limiting health care and access to it, rather than central government. I fear this may lead to a loss of trust and esteem in the medical profession, making all our jobs more demanding, stressful and much less rewarding. [Male GP principal, graduated 1983]

The combination of fundholding and the 1990 contract brought a large increase in the amount of non-clinical administrative and audit work that GPs were required to undertake in addition to their clinical duties. This work was commonly considered not worthwhile, since it did not directly benefit patient care and the additional time spent was poorly remunerated. Also, by increasing GPs' workload, it potentially reduced the amount of time available for clinical work, thereby having a further detrimental effect on patient care.

Huge amount of additional, unpaid administrative work involved in fundholding. [Male GP principal, graduated 1983]

There is increasing pressure to have to complete academically devised reports, audits and statistics which have little benefit to patients and increase pressure on time. [Male GP principal, graduated 1974]

General practitioners found themselves having to develop non-medical skills to deal with the new administrative tasks; skills that they had not been taught during their medical training and which they perceived as being of little value to the clinical career they had chosen. Some resented the requirement for GPs to undertake these non-medical tasks and preferred them to be undertaken by more appropriately trained personnel.

My chosen career is not now what I chose over nine years ago. Training as an accountant or line manager would have been more appropriate; medical skills are becoming secondary ... I wish to be a family doctor with time for

people, and the 'tools' available to look after them correctly. My 'tools' are being systematically removed or emancipated, and my time diverted into management areas. [Male GP principal, graduated 1983]

GP should be left to doctors, business administration to business people. [Male GP principal, graduated 1974]

The new emphasis on health promotion and routine health checks contained in the 1990 contract was disliked by many GPs, as was the requirement to meet government targets for screening and immunisations. They considered these activities to be of little benefit to patients while being time consuming for themselves and other practice staff.

A lot of heartache at present with the necessary reporting and health promotion in general practice, which is surgery-time consuming for self and staff, and frustrating to achieve with no apparent benefit. [Male GP principal, graduated 1983]

I often feel like a pawn in the game, forced by government to meet 'targets' which have nothing to do with improving patients' health. [Female GP trainee, graduated 1988]

Another source of additional clinical work in general practice was a shift of medical care work from hospital trusts onto the primary care sector, a result of a drive to increase cost efficiency and competition between trusts in the NHS internal market. For instance, hospitals began to discharge patients into the community sooner than in the past, resulting in GPs having to take on their medical care, and without any additional funding.

Hospitals are off-loading more onto GP but with no transfer in funding. [Female GP principal, graduated 1988]

RAISED PUBLIC EXPECTATIONS

At the same time, public expectations of health and of NHS services have increased, resulting in greater demands being made on the primary care sector. Many respondents blame this on publication of *The Patient's Charter* in 1991 and on media-led campaigns that highlighted apparent shortcomings. No additional funding was made available to GPs to compensate for the increased workload generated from raised public expectations.

There is enormous patient pressure in GP increasing since the patient charter. It dominates every new facility we provide and without satisfactory remuneration it is hard to cope with. [Female GP principal, graduated 1974]

Patients were manipulated to have unrealistic expectations and make unreasonable demands by media, advertising and popular press along with political propaganda designed to destroy NHS general practice. [Male hospital registrar, graduated 1983]

Some believed that the public now expect good health as their right, and blame their GPs for any illnesses they suffer.

The public perception now seems to be that no-one should suffer ill health and if they do someone must be to blame — usually the GP. [Male GP principal, graduated 1983]

A commonly held view was that the public expect to be seen by their GPs immediately and to be visited out of hours as their right.

What I don't enjoy is the current pressure from patients in the 90s 'ME NOW' society. Everybody wants to be seen at the same time just when they want — impossible I'm afraid ... As a GP people can get me 24-hours-a-day and often feel they have the right in view of "Charters" rammed down their throats. [Female GP principal, graduated 1983]

These demands were considered by respondents to be inappropriate, unrealistic and time-consuming.

The main problem with practising medicine either in hospital but particularly general practice is excessive and often inappropriate patient expectation, e.g. demanding inappropriate drugs, visits, appointments, expecting incorrect treatment despite advice. [Female GP principal, graduated 1993]

Increasing expectations/demands of patients cause multiple complaints/symptoms presented at single consultations — pressure on time in consultation almost invariable. [Male GP principal, graduated 1983]

Raised public expectations, combined with information provided in *The Patient's Charter* about how to complain, have led to a climate in which patients are more likely to make complaints.

We are underpaid and used by a lot of patients as just another utility service, aggravated considerably by the patient's charter which encourages them to complain about the colour of the surgery wall paint, etc. [Male GP principal, graduated 1974]

IMPACTS OF POLICY CHANGES ON WORKLOAD AND WORKING HOURS

In combination, budgeting responsibilities and other administrative tasks introduced by fundholding and the 1990 contract, increased health promotion activity, the shift of work from the secondary care sector, and increased patient demands have led to a substantial increase in the workload and working hours of GPs. Much of the additional work was considered to be of little value to patients or GPs.

Like many others I am dismayed by the increased workload due to the political changes in the NHS which really have not benefited my patients or myself. [Male GP principal, graduated 1983]

Many believed that at the same time as their workload and working hours were increasing exponentially, the financial rewards were decreasing.

Over the past seven or eight years [since 1990], general practice has become more demanding, taken on much greater responsibilities for rationing health care, accepted the burden of the massive expansion in nursing homes in the community, as well as coping with illness and 'health issues' in a population whose expectations have become ever more focused on medical advances and appear to feel that living to 90 years of age is their 'right'. All this has had to be done with virtually no increase in manpower, very little study time available and, of course, no financial improvement in the pay for the average GP. [Male GP principal, graduated 1974]

Respondents complained of increased work intensity that threatened the time available with patients as well as the quality of GPs' work.

My enthusiasm for general practice remains. However, I have seen older colleagues extremely disillusioned due to the 1990 contract imposed with so little consultation. The trend continues to impose more paperwork and the gathering of often fairly useless information with a reduction in our time with patients — this cannot be right. [Female GP principal, graduated 1988]

I find GP now an experience of seeing patients at a speed which does not give them the time they need and leaves me feeling drained and unfulfilled. There are endless pressures to do more when there is no time left to do more i.e. the standard drops. [Male GP principal, graduated 1983]

They also complained of the necessity to work longer daytime hours in order to complete their work. The number of out-of-hours calls had also increased due to rising patient demands.

The ever increasing shift of workload from secondary to primary care without the shift of personnel or finances, plus the increasing amount of paperwork and computer work have doubled my working hours in GP over the past 15 years. I used to be able to take the children to school and collect them even when doing evening surgeries. And I was always home for bedtime. I now leave for work at 8 am and work continuously including a working lunch until I return home between 7.30 pm and 9.30 pm, when not on a half-day, when I would hope to leave work at 5.30 pm. [Female GP principal, graduated 1974]

Increasing out-of-hours commitment is intolerable; no regard from public or government that doctors too have families, friends and a social life they would like to enjoy — uninterrupted! [Male GP principal, graduated 1983]

Practice meetings about administrative issues such as fundholding had to be fitted in to the already lengthened working day and therefore tended to be held at lunchtime or in the evenings. Little, if any, time was left for professional or practice development or for GPs' personal lives.

There is little time to think or plan the best way forward for one's own professional development or for the practice. The fact that all administrative partners meetings take place between 8–11 in the evenings says something. [Female GP principal, graduated 1974]

CONCERNS ABOUT THE ADVENT OF PRIMARY CARE GROUPS

Data from the surveys of the 1974 graduates in 1998 and of the 1993 graduates in 1999 included some comments about the advent of PCGs, which had been announced in 1997. While welcomed in principle by some, this was often seen as yet another change in what had been a catalogue of changes to GPs' working practices. Some GPs were tired of change and felt unable or unwilling to withstand another one.

And now we have another reorganisation of primary care, which is likely to be overly bureaucratic and take more time away from patients. I was not in favour of fundholding — but pragmatically made it work, devolving responsibility for it to competent people within the practice. I'm not sure the same freedom of action will be possible in PCGs. [Male GP principal, graduated 1974]

I don't have any energy left for another change — hence my decision for a career move. [Male GP principal, graduated 1974]

Concerns were expressed, even by enthusiasts for PCGs, that work associated with commissioning through PCGs would be time consuming, and would therefore conflict with GPs' already onerous clinical demands and their personal lives.

In the last two years have become involved with location commissioning and now primary care groups. This is very interesting and challenging and I like to do this new work and my clinical work. But I do not have enough time and worry that the practice and my home life may suffer. I welcome the initiatives in the white paper but not sure we will be able to cope. [Female GP principal, graduated 1974]

While GP commissioning through PCGs was considered to be fairer than fundholding, the same concerns were levelled at both systems, in that GPs were likely to be blamed by the public for NHS underfunding and rationing. This was considered to further threaten GPs' relationships with patients and their role as patient advocate. Some felt that GPs' professional time should not be taken up with commissioning, it being more appropriate for administratively trained personnel to play this role with advice from GPs.

In principle primary care groups seem a good idea with potential for improving quality of care and equality of care for our patients. However, I am doubtful as to whether GPs are going to get adequate resources for this and yet bear the responsibility, thus threatening the doctor–patient relationship and our role as patient advocates. [Female GP locum, graduated 1993]

Fundholding was a semi-disaster that was made to work by the hard work of general practitioners. It took five to six years to do this. Now it all has to be dismantled to be replaced by primary care groups. How the government can expect groups of 50 or so GPs to agree on service requirements beggars belief. GPs should not be scapegoats for NHS under-funding. Decisions on rationing and withdrawal of services should be made at ministerial and

administrative levels by ministers and administrators (after hearing professional opinions). [Male GP principal, graduated 1974]

Concerns were also expressed about the level of remuneration for PCG-related work and about the mechanics of working with such large groups of GPs. Difficulties were anticipated with group decision making, dissemination of policy decisions and monitoring of spending amongst constituent practices, as well as with how GPs with little experience of, or enthusiasm for, commissioning would adapt to the new system.

The PCG work is poorly paid and PCGs as a whole are going to be under-funded. Monitoring spending of individual practices within a PCG is going to be difficult and time consuming. Communication of PCG policies to GP members is also difficult and encouraging GPs to follow them even more so! [Male GP principal, graduated 1993]

Although I think the White Paper and primary care groups are a good idea in theory they may well be a disaster in practice. I am a lead GP for Total Purchasing and it has taken years to gain the experience. How uninterested GPs can do it in the short time scale I have no idea. [Female GP principal, graduated 1974]

Some GPs whose patients had benefited from fundholding were worried about the possible loss of these benefits as a result of having to negotiate with large numbers of GPs representing a large patient population.

Fundholding allowed us to provide vastly improved facilities for our patients. We are very concerned at the thought of losing these facilities. We are at present negotiating with practices totalling over 100 000 patients — it is very unwieldy. [Female GP principal, graduated 1974]

IMPACTS OF POLICY CHANGES ON WORK-RELATED STRESS, JOB SATISFACTION AND MORALE

In the opinions of many respondents, the political changes to general practice and the resulting increase in work pressure and public expectations had led to increased work-related stress and reduced job satisfaction, morale and quality of life. Stress was considered to have resulted from the greater administrative workload and increased patient demands as well as from the process of continual change itself.

Being a country rural GP has changed so much since 1980 it is unrecognisable ... I never thought that the workload, vast amounts of paperwork and endless changing would become so stressful. [Male GP principal, graduated 1974]

Patient demands and expectations are increasing fostered by government initiatives. Coupled with the lack of resources to meet these expectations [this] leads to unacceptable stress. [Male GP principal, graduated 1974]

Concerns about the stressful nature of working in general practice were not confined to those doctors who had been in practice prior to the 1990 NHS reforms.

In GP it is not so much the long working hours — instead it is the volume of work which has to be done within those hours which is the greatest stress/burden. [Female GP principal, graduated 1993]

Reasons given for low morale or reduced job enjoyment centred around GPs' opposition to the philosophy underlying the 1990 NHS reforms. Respondents disapproved of the perceived financial basis to the changes, the financial constraints imposed upon GPs and the loss of autonomy that entailed.

General impression of changes in NHS/GP have caused morale to fall in all areas of the medical profession. I never imagined I would work in an NHS which would be so money orientated with so little concern given to patient needs. My general feeling is that patients are and will continue to suffer due to the NHS reforms. [Female GP principal, graduated 1988]

Growing dissatisfaction with conditions imposed by others on the nature of one's work in general practice. I feel that I am increasingly restrained by considerations of drug costs, length of hospital waiting lists (again influenced by budgeting constraints, etc.). I carry out certain checks of dubious value to meet government conditions and targets. Work has become less enjoyable because one is not as much in control i.e. loss of personal autonomy. Also bogged down by enormous increase in paperwork and administrative work. [Female GP principal, graduated 1983]

They also complained that the need to provide reports of practice activity reduced GPs' job satisfaction, as did the increased workload associated with unrealistic patient demands.

GP is not as enjoyable as it used to be, partly due to unrealistic public expectations, partly bureaucratic intervention, and government enthusiasm for measuring and recording process rather than outcome. [Male GP principal, graduated 1974]

The process of change itself was also blamed for lowering morale, together with the increased likelihood of litigation.

In the last few years I have become a little disappointed with general practice. Too many changes have been forced on us too fast. [Female GP principal, graduated 1983]

Working under the constant threat of complaint (or worse) is demoralising. [Male GP principal, graduated 1974]

Attitudes of the media towards doctors, combined with the wider availability of health information, have lowered the professional standing of GPs in the eyes of the public, despite the substantial increase in GPs' workload and responsibility. This has not only helped to fuel the complaints culture, but has also impacted on GPs' morale.

Medicine is becoming more and more litigious, aggravated by persistent 'doctor bashing' by the media. Opinion of the medical profession is declining and the service is very much 'taken for granted' and abused by many. [Female GP assistant, graduated 1983]

I am at times very demoralised about how both the government and the public see/treat GPs and doctors in general. I feel we are very poorly valued both financially and professionally. [Male GP principal, graduated 1988]

A few respondents commented that the longer working hours resulting from the increase in workload had impinged upon their personal lives, reducing both the amount and the quality of time spent pursuing other interests or with family.

In recent years the demands and pressures have become so great that it is eating into family time considerably and affecting my home life significantly. [Female of unknown GP grade, graduated 1974]

I am too tired in the evenings to pursue any hobby or often communicate with others in the family. [Female GP principal, graduated 1974]

One respondent complained that their mental health had suffered as a direct result of the increased administrative workload that the 1990 NHS reforms had involved.

By the time my first daughter was born I was overworked, burnt out and depressed after three years struggling to deal with the non-medical aspects of GP. The 'New Contract' was the 'last straw'. [Male GP assistant, graduated 1983]

Another blamed their physical illness on work-related stress mediated through reduced resistance to infection. Morale and quality of life had reached such a low level amongst some respondents that they wished to leave NHS general practice.

Changes in the working conditions and nature of the NHS have led me to regret the choice of career as an NHS GP. When and if the opportunity comes to change direction I will take it. [Male GP principal, graduated 1983]

However, some that wished to leave felt unable to do so for financial reasons or because of a perceived lack of alternative career opportunities.

All GPs feel demoralised and under threat, if I could change to another career without starting on the bottom rung of promotion prospects and pay, where ten years training would not be wasted, I would. [Female GP principal, graduated 1983]

If I had another career option up my sleeve I would resign from medicine completely, and follow a completely different career path. Having always wanted to be a doctor I now feel it is the last thing I want to continue with for the next 25 years! [Male GP principal, graduated 1983]

Some respondents perceived that the only worthwhile change to general practice in recent years had been the formation of GP co-operatives in 1996, designed to share the out-of-hours workload between groups of local GPs. While the intensity of work involved in working a shift for a co-operative was high, the frequency of out-of-hours shifts worked by each individual GP was reduced. Therefore, co-operatives brought enormous benefits to their members in terms of reduced work stress and improved quality of life and job satisfaction. This went some way towards mitigating the effects of the increased general practice workload caused by political changes.

The advent of GP co-operatives has been the only tiny worthwhile advance in general practice recently. [Male GP principal, graduated 1974]

GP co-ops have definitely improved the out-of-hours situation but there is no doubt that working shifts for the co-ops is very tiring. [Male GP principal, graduated 1974]

My life has been changed by a GP co-op. From one-in-three for 17 years as a principal, I now do four or five six-hour sessions a month. This has reduced my stress and increased my enjoyment. [Male GP principal, graduated 1974]

However, GP co-operatives were not formed in all parts of the country; in particular, rural areas often had no such scheme. So not all GPs have been able to reap the benefits that co-operatives brought.

Rural GPs have no deputising and no practical on-call rota with co-operative, hence out-of-hours remains a 365 day and night commitment for single handed rural practitioners. [Male GP principal, graduated 1974]

Three respondents expressed reservations about co-operatives. One was concerned that the standard of out-of-hours care provided by co-operatives was likely to be low in rural areas. Another resented having to contribute towards the cost of the scheme in addition to working for it, and another did not approve in principle of co-operatives as an answer to the out-of-hours workload problem.

Other suggested ways of reducing GPs' workloads were smaller patient list sizes and extension of the nurses' role. One respondent believed that moving practice every ten years or so might help to prevent burnout.

Comments about less-than-full-time working, career breaks and leaving NHS general practice

Respondents to our surveys commented about their intentions to reduce their time commitment to the NHS GP workforce by four different means:

1. A reduction in working hours (choosing to work less-than-full-time and/or negotiating to opt out of on-call commitments).
2. Taking temporary career breaks.
3. Early retirement.
4. Leaving NHS general practice to work elsewhere.

REASONS FOR A REDUCED TIME COMMITMENT TO THE NHS

Common reasons for seeking reduced working hours or taking a career break were: child rearing; and the pursuit of interests, such as non-medical work, studying, hobbies or travel. Many of those who had travelled commented that their experiences had a positive impact on their subsequent professional performance.

My 'part-time' full-time job means I work flat out from 8.45–3.00 finishing just in time to collect children from school ... My job is unusual in not involving any on-call — otherwise I could not have considered returning to this level of work, since my husband works long hours as a hospital consultant. [Female GP principal, graduated 1983]

I took maternity leave in the middle of my hospital rotation (December 1986–February 1987) and from December 1989 to January 1990. I then took a career break having two children to look after and have only just started back on a retainer scheme having had twins in August 1992. [Female GP retainee, graduated 1983]

I entered general practice as a full-time principal immediately after my training. After two-and-a-half years I realised that I had certain other things in life I wanted to do before settling down in GP. I in no way regret taking a complete break from medicine or travelling and working in other countries. I now have a much clearer picture of how I want to work as a GP and feel that my enthusiasm for the job has been heightened by my experience — we should all do it. [Female GP locum, graduated 1983]

Another common reason for reducing working hours, taking career breaks, early retirement or leaving NHS general practice was to reduce the work pressures that were impacting on GPs' job satisfaction and morale, as described earlier.

I am disillusioned with general practice. Main problems: (i) Unrealistic and often aggressive patient demands; (ii) Out-of-hours work; (iii) Anxiety over potential patient complaints (none yet!). I work part-time in order to limit/control stress. [Female GP principal, graduated 1988]

Six-month career break very, very worthwhile and refreshing after a hectic period of heavy rotas, etc., basically leading to 'burn-out'. [Male locum, graduated 1983]

I enjoy primary care/general practice work but feel this is no longer an acceptable career in the UK due to the mountain of paperwork and management required encroaching into both personal, family and patient time. The increasingly unreasonable demands of patients and abuse of the GPs' system is largely responsible for this career being incompatible with a family lifestyle, without complete neglect of my own personal and family needs. I have voted with my feet and emigrated. There is little chance of my return to the UK under present circumstances. [Male, graduated 1988]

There were other problems with NHS general practice that were occasionally cited as reasons for leaving it. These were partnership disagreements or other bad experiences and a lack of a clear structure for professional development. In addition, a few GPs had found it necessary to retire early on health grounds due to either mental health problems or physical disability.

Retirement early on medical grounds due to depression, post traumatic stress disorder and burnout, solely due to work as a GP. [Male GP principal, graduated 1974]

Following my operation I returned after two months to full-time GP, however, I found the workload very difficult as I had severe problems with mobility. A friend (also a GP) was amazed that I had returned to work at all and suggested retiring on health grounds, which I finally did in 1996. Since then I do about 10–12 hours GP locums for practices in my area, most of which I know, as well as two three-hour hospital clinics in osteoporosis. [Female GP locum, graduated 1974]

While some who had retired from full-time general practice on health grounds continued to work on a part-time basis as locums, others had difficulty in finding suitable part-time employment.

As I had to retire on health grounds from being a full-time GP and GP educationalist because I was unable to continue working a 50–80 hour week, I had extreme difficulty defining a new career structure. The process of medical retirement was extremely difficult with nobody able to provide specific support and advice to take me through the procedures. There seems to be no defined career structure path for doctors who have had to retire on medical grounds, but are able to continue part-time working. [Male part-time medical educationalist, graduated 1974]

Work-related stress, disillusionment with the NHS and illness or disability were not the only reasons for leaving UK general practice. Inability to obtain a GP principalship had led some respondents to revert to hospital medicine or to consider seeking medical work abroad.

I have reached a definite professional watershed. Having spent nearly two years trying to obtain a partnership in rural practice without success, I am now taking stock of my career. Vocational training for GP was excellent but I have now been left 'high and dry' by the system in spite of attempts to broaden and deepen my experience ... Consequently, although I would like to stay in the UK, failure to get into my chosen area of practice within the next few months may necessitate a move abroad. I fear such a move would rapidly become permanent. [Male, graduated 1988]

Married doctors were sometimes subject to changes in the location of their spouse's or partner's job, or, where they had married a foreigner, they may have chosen to emigrate to the spouse's home country.

I left my post as partner in general practice two months ago after 18 years in the practice. I left to accompany my husband on a two-year posting abroad. Now I'm a locum on a military base. I work as GP/casualty officer. [Female, graduated 1974]

The reason I am going to work in the USA is because my husband is American. However, I would otherwise have stayed in the UK to work as a part-time GP. [Female locum, graduated 1988]

Family mobility and inability to obtain a suitable GP post sometimes worked in combination. For instance, finding a suitable GP post could be difficult following a family move to a new area, and a permanent GP post was unlikely to be offered to someone whose spouse's or partner's job was insecure, such as during higher medical specialist training.

As a result of getting married I decided to resign my partnership in general practice in [named town]. Ideally I was looking for a part-time GP post in the [named] area (as this is where my husband previously had lived and worked, and he had no desire to move to [named town]). I found this impossible to achieve, hence my diversion into the career of a clinical medical officer. [Female, graduated 1983]

Having 'fitted' my career around my husband's (currently SR [named hospital specialty]) I have regrets ... I enjoyed my [GP] trainee year but became very disillusioned when unable to get a partnership because of my husband's 'short' contracts. I feel my current clinical assistants posts are 'dead end' jobs, I feel 'un-stretched' and they have no long-term attractions (apart from sociable hours) ... Medicine is still very difficult to combine with family commitments — particularly if your spouse is also a medic. It is also difficult to change direction in medicine. [Female, graduated 1983]

Other reasons given for leaving NHS general practice included: an unexpected change of interests after completing GP training, a long-standing aim to work abroad facilitated by general practice training and, in the case of overseas doctors, a planned return to their home country.

Initially trained in general practice I have become more interested in public health and health promotion. I hope to do a Masters and work overseas in this field in the future. [Female GP principal, graduated 1983]

I took GP training in order to be more employable abroad, but never intended to become a GP. [Male practising abroad, graduated 1983]

I moved to Jersey as I was originally brought up on the island and have family here. [Female GP principal, graduated 1983]

CAREERS OUTSIDE THE NHS

The career destinations of respondents who had left NHS general practice included: private GP work; another medical specialty; medical work abroad; medical research; employment related to medicine, such as medical editing or health-care management; full retirement or a career break involving no paid employment.

I was offered a very good post in a private practice in the city at [named place]. I have also looked hard at NHS practices and I would return to NHS if there was a reasonable practice. However, all the inner-London practices I have seen are completely soul destroying. As a private GP the working environment is far more pleasant and, more importantly, I have time to talk to my patients and investigate them quickly. The income is no more than an NHS GP and the work is if anything more demanding. [Female private GP principal, graduated 1983]

I chose GP originally because I wanted a family and thought it would be flexible, but with the New Contract I saw all control and flexibility disappearing. I resigned then and returned to paediatrics since I enjoyed community paediatrics. [Female staff grade, graduated 1983]

Full-time general practice is not compatible with pursuing research. I failed in my application to become an RCGP research practice, so I have decided to take a high-risk path and go 'free-lance'. My ultimate aim is to set up a Research Institute in Family Planning and Reproductive Health at a national level working with non-medical disciplines. [Male GP principal just resigning, graduated 1974]

Currently about to start as director of [project in developing country]. I have no regrets about being out of NHS employment at present; 1990 contract and new NHS reforms appear to be steadily destroying the morale and enthusiasm of my colleagues in general practice. [Male, graduated 1988]

Some of those who went to work abroad chose to work in the developing world. This tended to be to broaden their professional experience and personal development or for ideological reasons. Periods spent working in the developing world were commonly planned as temporary phases in respondents' careers.

My husband (a general dental practitioner) and I ... both work extremely hard, are very badly paid and face one frustration after another, but are much happier and more fulfilled than we were in UK and feel much more appreciated by patients, colleagues and the government we work for. There are many negative aspects to working for a development organisation but it provides valuable experience and cushions the many initial difficulties of

working in the 'Third World'. We are about to start a family and I anticipate being able to combine work and childrearing much more easily in Africa than Europe. [Female, graduated 1983]

I hope to be involved in medical work with refugees living in [named developing country] by the end of this year. I may work overseas for several years, but expect I shall eventually return to the UK and recommence working in GP. I think there should be more support, encouragement and incentives for British doctors to spend time working in medically needy parts of the world. My reasons may be altruistic but it would also provide a greater breadth and depth of knowledge and personality of doctors. [Female GP assistant, graduated 1993]

Those who chose to work in developed countries such as Australia, New Zealand or North America were seeking less onerous working conditions than those in NHS general practice or its VTS, and an improved lifestyle. The rate of pay was considered to be better and the working hours shorter and more flexible for those wishing to combine their work with family life or other pursuits.

I enjoyed my time out of the NHS — both working for air ambulance and in Australia. Both were considerably better paid with less hours demanded. [Female GP principal, graduated 1983]

Unfortunately the medical system in the UK has little to offer over the medical system in Australia in the post of a general practitioner. This is especially true for a female doctor who also wants to juggle a family with her career. The opportunities for females are far greater in Australia in terms of financial benefits, hours of work, support from colleagues. Because of these reasons I really have nothing which would entice me back to the UK system. [Female GP principal, graduated 1988]

The existence of private health care systems in these countries meant that patients were less likely to consult their GP over relatively trivial matters or to call them out at night, resulting in greater job satisfaction for some respondents. Out-of-hours primary care was handled by 24-hour centres or GP co-operatives.

Regrettably the GP care is semi-private although this means people only come when they are 'sick' and people only get visits when they truly need them and one is able to spend more time with less people and do a much more complete coverage of their health care. [Male GP principal, graduated 1983]

I spent almost a year working in Australia which was interesting to see a different view on private medicine (much more widespread) in differing primary care. 24-hour medical centres (to cope with GP out-of-hours work) were privately run and the standard of medicine (financially motivated and sometimes unethical) was a real eye opener. [Female GP principal, graduated 1983]

General practitioners abroad were allowed far greater freedom to structure their practices and their working arrangements to their personal requirements, and were able to pursue a greater variety of interests within general practice. The secondary care service was perceived as good in both public and private systems.

A more civilised on-call structure with a less demanding public, and an ability to structure your practice and working life along lines you feel appropriate (rather than being imposed upon you) allow much greater professional satisfaction balanced with a more harmonious family life. Stresses of work have been removed from the family home. [Male GP principal New Zealand, graduated 1983]

Working as a GP in Australia has been, and is, fantastic. I've had the opportunity to set up my own new practice and watch it grow over four years to now employ four part-time GPs. The opportunities in general practice here still allow for particular interests to be followed e.g. women's health, anaesthetics, etc. I enjoy being able to undertake minor surgery — removal of lumps and bumps, suture wounds, apply POPs. It is a great privilege to be able to directly refer patients for procedures — endoscopy/ultrasound/audiology/ nuclear scans and pathology, which is performed and reported on within a couple of days. We have excellent back-up from specialists in the private sector and good care in the public system (although the waiting lists are starting to get longer). [Female GP principal, graduated 1983]

For some respondents, the decision to emigrate had been a permanent one. For others, periods spent working in the developed world were intended to be temporary. However, some that had intended to return to the UK subsequently decided to remain abroad indefinitely.

I believe I must be one of the minority who left the UK and decided to practice permanently abroad. The following reasons are behind my decision: (i) Financial remuneration — my current income is approx. three times what I would earn in the UK (as a junior partner in a GP group); (ii) Future prospects — I could not foresee myself driving around in a second-hand Volvo estate doing house calls, and yet unable to send my children to a private school; (iii) Night visits — this must be one of the most inefficient uses of a doctor's time. To be doing house calls in the dark just because the patients request it; (iv) Low morale in GP — when I was a trainee back in 1992 the new GP contract had just been implemented and there was a general negative prospect for general practice in the UK. [Male practising abroad, graduated 1988]

After working in the UK for six months as a GP locum, I have come to NZ for a working holiday of 12–18 months. Then I will probably return to UK GP locum work. [Female GP locum, graduated 1993]

Left NHS after GP training scheme to experience medicine abroad. I did intend to return to practice in Scotland. However, I enjoy the type of practice available in Canada more than that of a GP in the UK. Here I do full inpatient care, obstetrics, and emergency medicine. Shifts and rules/regulations are less irksome and numerous. I also met my wife here and she would be unable to practice in the UK without exams/more training (she is also a GP). Therefore, I'll be practising medicine in Canada for the foreseeable future. [Male GP principal, graduated 1983]

Deterrents to returning to the UK included concerns about poor working conditions in the NHS and a perception of low morale within general practice, as well as reduced NHS pension benefits due to having been out of the scheme for a period.

I may return to general practice in the UK, but have concerns re short appointment times (and I think less patient co-operation in their health care), GP contracts and 'on-call' commitments, and GP low morale. [Female GP locum abroad, graduated 1983]

I have done equivalent work in the Republic of South Africa and now have immense difficulty in getting it accredited which I find quite unfair since I did the MRCGP while abroad and passed with a merit, which I hoped would show my commitment to staying in touch with NHS medicine. To pay for the MRCGP exam costs and flights and registration fees (£2000) on a salary in South Africa is difficult to say the least. I worry a great deal about not having a pension for when I retire since I will probably work abroad for a great deal longer due to my husband's poor work prospects in the UK. [Female practising abroad, graduated 1993]

Some respondents mentioned that some aspects of general practice working conditions in some developed countries were changing to more closely resemble the UK NHS model, and that criteria for entry into Australia as a doctor were being restricted, making working abroad a less attractive option and more difficult to achieve.

Over the last four years there have been large changes in the administration of general practice here [in New Zealand] and even larger ones are to come very similar to the UK model. There is to be a capped budget and I fear that the future here is not so good as it has been. Although I would like to stay in New Zealand on the current basis I can envisage moving back to the UK should conditions deteriorate significantly. [Male, graduated 1983]

We had planned to leave the [UK] system but circumstances regarding Australia immigration changed and we have, after a great deal of thought, decided to stay in this country. [Female GP locum, graduated 1988]

Discussion

In the early years of the NHS, the status of GPs was low and general practice was an unattractive career choice for junior doctors. It increased in popularity following the introduction of vocational training during the 1970s, which became mandatory for entrants to general practice in 1982. Amongst the cohorts studied by the UKMCRG, the percentage of graduates choosing general practice as a career peaked in the 1983 cohort, with 45% stating it as their first choice of career at the end of the pre-registration year.[24]

Since then, successive NHS reforms have changed the nature of general practice. The 1990 NHS reforms were largely viewed unfavourably. Fundholding was seen as a two-tier system that conflicted with the philosophy of the NHS by benefiting patients of fundholding GPs at the expense of others, and potentially undermining patients' trust. It is clear that for some doctors the combination of the internal market, fundholding and the 1990 contract created a substantial increase in GPs' clinical and non-clinical workload. Much of the new work was considered to have little direct benefit to patient care. The requirement to develop administrative skills was sometimes resented. In addition, growing public expectations of the NHS has increased GPs' daytime and out-of-hours workload, led to a complaints culture, and reduced the public's respect for the profession. Increased GP workloads and continual change have, for some, resulted in work-related stress, reduced job satisfaction, low morale and reduced quality of life, leading some respondents to consider leaving the profession. Other authors have also reported increased workloads and work-related stress following introduction of the 1990 GP contract,[25-29] and a recent survey found deteriorating morale amongst Scottish GPs fuelled by the changes that have affected general practice in recent years.[30] Both our data and that of other authors show that the formation of GP co-operatives has gone some way towards alleviating the burden of the 24-hour responsibility to patients and improving quality of life for those GPs with access to such schemes.[30-34] Furthermore, the work of the nurse-led telephone help line, NHS Direct, has resulted in a small but significant reduction in the workload of GP co-operatives.[35] Pressure on GPs' clinical workloads is also expected to reduce in the long term due to on-going expansion of the roles of nurses, the introduction of a new graduate mental health care worker, and recruitment and training of increased numbers of doctors.[36]

The introduction of PCGs was seen by some as yet another change in what had become a succession of changes, and concerns were expressed about the additional time that work associated with PCGs would take up and the mechanics of working with such large groups of GPs. GP commissioning, like fundholding before it, was seen as shifting the responsibility for rationing of health care from government to GPs, potentially threatening their role as patient advocate. It remains to be seen what effect the development of PCGs and PCTs will have on the non-clinical workload of GPs and their job satisfaction and morale. It is likely to affect different GPs differently, depending on the extent of their direct involvement and their previous experience of different GP commissioning or fundholding. In a recent survey, the majority of Scottish GPs were unimpressed with the performance of Local Health Care Co-operatives (the Scottish equivalent of PCGs) to date and were pessimistic about their future prospects.[30]

Our data indicate a link between the changed GP role resulting from successive NHS reforms and problems with retention of GPs in the NHS, with many seeking to reduce their time commitment to the NHS workforce through reduced working hours, temporary career breaks, early retirement or leaving the NHS to work elsewhere. We have no way of knowing whether this reduced commitment is specific to medicine or whether organisational changes affecting other professions have similar effects on their older workforce.

Child rearing commitments and the desire to pursue outside interests were cited as reasons for seeking shorter working hours or career breaks, as was a desire to reduce pressure of work. The latter, combined with job dissatisfaction, was also a common reason for taking early retirement or leaving NHS general practice. Another reason for not working in NHS general practice, either temporarily or permanently, was difficulty in finding a GP post suited to individual needs, such as less-than-full-time posts or no on-call commitment. This was often combined with problems of family mobility. Some felt they had failed to obtain posts due to discrimination, most commonly against married women of childbearing age. The openness and fairness of GP appointments could be improved through greater awareness of the law as it relates to general practice appointments procedures. It is the responsibility of all GPs to keep up to date with the laws and statutory codes of practice affecting their work, including employment law, and to avoid discriminating against doctors applying for posts on grounds of sex, race or disability.[37]

Junior doctors' awareness of work-related stress and low morale in general practice, particularly resulting from the changed GP role, may be a deterrent to choosing general practice as a career. The proportion of PRHOs choosing general practice as their first choice of career has fallen from its earlier peak of 45% in the 1983 graduates to 26% of the 1993 graduates[13] and 20% of the 1996 graduates.[11]

The choice of general practice as a career was often associated with lifestyle factors. In a survey of the graduates of 1993 at the end of their pre-registration year, we asked doctors to score the extent to which various, specified factors had influenced their choice of career. For each factor, the doctors were asked to score 'a great deal', 'a little' or 'not at all'. As reported elsewhere, 61% of those choosing general practice as their first choice of long-term career cited 'enthusiasm and commitment' as a factor that had greatly influenced their choice, compared with 70% citing 'hours or working conditions'. For comparison, 'enthusiasm and commitment' was the most common factor greatly influencing the choice of a career in a hospital medical (62%), surgical (82%) or other hospital specialty (69.5%).[13] In the present study, the most common reasons discussed for

choosing a career in general practice, as opposed to hospital medicine, were the relatively greater availability of less-than-full-time work and ease of obtaining GP work anywhere in the country, the shorter training with fewer examinations, and the potential to achieve a career post with good remuneration sooner. A small minority chose general practice to obtain the broad skill base required for work in the developing world.

Enthusiasm for the type of work involved in general practice often appeared to be secondary to lifestyle factors in choosing general practice as a career. This, together with the second class image of general practice portrayed by some hospital consultants, points to a need for general practice to be promoted as a more positive career choice during undergraduate and postgraduate medical training.

Greater exposure to general practice in medical training would be welcomed by some trainees; it could kindle enthusiasm for its work and help trainees to make more informed career decisions. General practice posts undertaken as part of the PRHO training year have been encouraged by the General Medical Council in recent years.[38] They have proved to be a popular alternative to hospital-based rotations,[39] and may encourage doctors to enter vocational training for general practice and help to facilitate closer working relationships and respect between doctors in primary and secondary care in the future.[40] Despite concerns voiced by some PRHOs, such posts were considered by consultant trainers in one region to be a valuable part of the PRHO training experience.[41]

However, education and training in hospital-based vocational training posts was widely perceived as being of poor quality, of little relevance to general practice careers and treated as being of secondary importance to meeting service commitments. The need to make training at SHO level a more valuable educational experience for doctors pursuing both hospital and general practice careers has been acknowledged[36] and ways of achieving this are now being considered. Any measures to enhance the relevance of hospital-based training to general practice may have a positive impact on recruitment.

Failure to obtain an SpR post in a hospital specialty was a reason given by some of the 1993 graduates for entering general practice. Dropout from hospital medicine has undoubtedly always provided a source of GPs, but some of those who find themselves in general practice through a lack of alternatives may be unsuited to primary care work.

Our data show a disinclination amongst some newly qualified GPs to become principals, at least in the early years after completion of registrar training. Many newly qualified GPs were working as non-principals because they felt too inexperienced to take on the responsibilities of a principalship or because they were postponing applying for a permanent post until their spouse's or partner's career was settled in a particular geographical area. Working as a self-employed GP locum provided the benefits of greater flexibility and control of working hours more than a principalship would, and an opportunity to broaden experience of clinical work in a variety of practices. This came, though, at the expense of job security, employment rights, postgraduate education allowance and continuity of patient care. These findings are consistent with other studies.[3-6,42]

Together, the breadth of the GP's role at the turn of the 21st century, the size of the workload and the increasing trend towards less-than-full-time work suggest a need for a diversification of ways of working in general practice. Alongside the traditional model of the permanent full-time GP principal with independent contractor status there needs to be a variety of types of contractual arrangement that facilitate flexible working patterns, enabling individual GPs, principals and non-principals alike, to allocate different proportions of their work time to clinical and administrative tasks. Greater acceptance is also required of the need or desire of GPs to move between practices during their careers. This is now recognised by government. The introduction of salaried GP non-principal posts through Personal Medical Services (PMS) pilot schemes[43] began such a reorganisation. PMS pilots facilitated the testing of experimental models for delivering primary care, and a range of both salaried and self-employed models have emerged. Following their success, PMS schemes are to be expanded and the government expects that by 2004 the great majority of GPs will be employed under a PMS contract.[36] However, those entering the third wave of the scheme are finding that the contract is becoming increasingly regulated, leaving little room for innovation.[44] Government enthusiasm for PMS needs to be tempered by a realisation that variety of opportunity, rather than change for its own sake, is what is required. While some GPs will be attracted to the traditional independent way of working, others will prefer the relative freedom of salaried employment.

The government hopes that expansion of PMS will help to recruit more GPs to the areas where they are most needed. In addition, cash incentives were announced in March 2001 for newly qualified GPs to work in deprived areas, on top of payments to each newly qualified GP joining the NHS and to GPs remaining in practice until age 65.[45] It remains to be seen whether these measures will make a difference to GPs' career and retirement decisions.

Those GPs who are choosing to work as salaried non-principals or as self-employed locums have rejected the traditional GP principal model and are voting with their feet for a more manageable workload and work pattern in general practice. Non-principals have been disadvantaged in many ways compared with principals and accorded lower status, but they constitute a growing proportion of the GP workforce and their contribution needs to be valued equally to that of principals and rewarded appropriately.[46]

Deprived areas have been hardest hit so far by the GP recruitment crisis. In some of these areas, initiatives have been launched with the aim of increasing recruitment of newly trained GPs by helping them to make the difficult transition from registrar to confident GP. In the Career Start scheme in County Durham[47] and the Vocationally Trained Associate scheme in London,[48] this took the form of a structured induction into general practice through continuing education and hands-on experience while on a salaried contract. Although the similar Associate Physician scheme in Merseyside did not set out to assist in the personal and professional development of newly qualified doctors, this has been a welcome side effect.[49]

There has been debate amongst general practice educationalists about lengthening the general practice component of VTS or introducing a period of higher professional training to redress the inadequacies of training schemes in preparing young doctors for the challenges of general practice today.[50] New arrangements introduced in

April 2000 should allow for greater flexibility in construction of VTS to meet individual training needs. Trainees will have greater choice over the time they will spend in general practice versus hospital specialties and the number of general practice placements undertaken, plus an option to spend longer than three years on the scheme or to take breaks between posts.[51] Spending time in several different practices during vocational training could help doctors to gain the broader experience they feel is necessary to consider a principalship, rather than seeking it through a series of locum appointments.

It is difficult to judge how much of a link there is between doctors' views about changes in general practice and the decline in interest among young doctors in making general practice their career choice. It is clear, however, that when doctors express negative views about general practice, they express concern about administrative upheavals, burdens of administration, time for personal and family life, and patients' demands. These factors may partially explain recruitment and retention difficulties in general practice. In addition, the current unpopularity of principalships and the increasing demand for less-than-full-time and non-principal posts indicates a need for greater flexibility of working patterns in general practice.

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Appendix 1. Comments sheet format used for surveys of 1974, 1988 and 1993 cohorts.

Additional comments

Please give us any comments you wish to make, on any aspect of your training, career choices or work, on this page (and continuation sheets if necessary). As with your responses to the preceding questions, your individual comments will remain totally confidential to senior researchers in the UK Medical Careers Research Group.

Thank you for your co-operation.

Please return this questionnaire to: UK Medical Careers Research Group, Unit of Health-Care Epidemiology, Institute of Health Sciences, Old Road, Oxford OX3 7BR.

Appendix 2. Comments sheet format used for survey of 1983 graduates in 1994.

Comments

Please use this opportunity for any comments you wish to make, on any aspect of your training or work, on this form (and continuation sheets if necessary). This form should be returned in the same envelope as the questionnaire. As with the questionnaire, your individual comments will remain totally confidential to senior researchers in the Medical Careers Research Group.

We are especially interested in hearing from you if you have views on, or experiences of, any of the following during your career to date:

- unemployment
- leaving or considering leaving medicine
- leaving or considering leaving the NHS
- leaving or considering leaving the United Kingdom
- choosing to work in a particular country e.g. elsewhere in the European Community
- taking or considering taking a career break
- working or considering working on a job share basis
- returning or considering returning to medicine after a career break or employment outside medicine
- availability of part-time and/or flexible working.

We are also interested in good and bad features of your training, working conditions and working environment; professional relationships; and administrative and managerial issues. Thank you for your help.

Thank you for your co-operation.

Please return this questionnaire to: UK Medical Careers Research Group, Unit of Health-Care Epidemiology, Institute of Health Sciences, Old Road, Oxford OX3 7BR.

Appendix 3. Response rates and relative frequency of most common topics of comment.

Year of graduation	1974	1983	1988	1993	
Year of survey	1998	1994	1995	1999	Total
Response to surveys:					
Original graduates	2347	3845	3739	3672	13603
Questionnaires mailed[a]	2220	3819	3713	3639	13391
Respondents	1717	2718	2885	2732	10052
Response rate (%)	77.3	71.2	77.7	75.1	75.1
Number of comments on:					
Any topic	734	1451	1231	1109	4525
Any aspect of general practice	286	647	443	296	1672
Training for a career in general practice	14	266	337	167	784
Views of government reforms and their impact on workload	229	365	155	32	781
Impact of policy changes on job satisfaction and morale	43	58	48	26	175
Leaving general practice or the NHS	24	252	30	31	337
Reasons for choosing general practice	-	36	62	75	173
Difficulties in obtaining a GP post	-	46	32	30	108
Working as a GP locum	-	23	22	98	143
Percent of respondents commenting on:	n = 1717	n = 2718	n = 2885	n = 2732	n = 10052
Any topic	42.7	53.4	42.7	40.6	45.0
Any aspect of general practice	16.7	23.8	15.4	10.8	16.6
Training for a career in general practice	0.8	9.8	11.7	6.1	7.8
Views of government reforms and their impact on workload	13.3	13.4	5.4	1.2	7.8
Impact of policy changes on job satisfaction and morale	2.5	2.1	1.7	0.9	1.7
Leaving general practice or the NHS	1.4	9.3	1.0	1.1	3.4
Reasons for choosing general practice	-	1.3	2.1	2.7	1.7
Difficulties in obtaining a GP post	-	1.7	1.1	1.1	1.1
Working as a GP locum	-	0.8	0.8	3.6	1.4
Percent of all comments on general practice:[b]	n = 286	n = 647	n = 443	n = 296	n = 1672
Training for a career in general practice	4.9	41.1	76.1	56.4	46.9
Views of government reforms and their impact on workload	80.1	56.4	35.0	10.8	46.7
Impact of policy changes on job satisfaction and morale	15.0	9.0	10.8	8.8	10.5
Leaving general practice or the NHS	8.4	38.9	6.8	10.5	20.2
Reasons for choosing general practice	-	5.6	14.0	25.3	10.3
Difficulties in obtaining a GP post	-	7.1	7.2	10.1	6.5
Working as a GP locum	-	3.6	5.0	33.1	8.6

[a]After omitting those for whom no address was available, had never registered, had died or had refused to participate.
[b]The total percentage shown for each graduation year exceeds 100% because some respondents commented on more than one topic.

Appendix 4. Occupation of respondents who commented on general practice.

	All respondents	Commented on GP	% of each occupation	% of all comments on GP
1974 graduates				(*n* = 286)
NHS GP (all grades)	712	214	30.1	74.8
Principals	671	200	29.8	69.9
Non-principals	39	13	33.3	4.5
Registrars/trainees	2	1	50.0	0.3
NHS hospital posts	641	25	3.9	8.7
Other medical posts[a]	320	35	10.9	12.2
Non-medical or unemployed	39	10	25.6	3.5
Unknown/not stated	-	-	-	-
1983 graduates				(*n* = 647)
NHS GP (all grades)	1300	461	35.5	71.3
Principals	1149	389	33.9	60.1
Non-principals	137	67	48.9	10.4
Registrars/trainees	14	5	35.7	0.8
NHS hospital posts	958	35	3.6	5.4
Other medical posts[a]	698	112	16.0	17.3
Non-medical or unemployed	115	28	24.3	4.3
Unknown/not stated	71	10	14.1	1.5
1988 graduates				(*n* = 443)
NHS GP (all grades)	940	274	29.1	61.8
Principals	618	178	28.8	40.2
Non-principals	236	74	31.4	16.7
Registrars/trainees	86	22	25.6	5.0
NHS hospital posts	1116	70	6.3	15.8
Other medical posts[a]	643	66	10.3	14.9
Non-medical or unemployed	164	29	17.7	6.5
Unknown/not stated	10	3	30.0	0.7
1993 graduates				(*n* = 296)
NHS GP (all grades)	605	183	30.2	61.8
Principals	163	35	21.5	11.8
Non-principals	262	80	30.5	27.0
Registrars/trainees	180	68	37.8	23.0
NHS hospital posts	1367	50	3.7	16.9
Other medical posts[a]	483	33	6.8	11.1
Non-medical or unemployed	104	19	18.3	6.4
Unknown/not stated	141	10	7.1	3.4
Total				(*n* = 1672)
NHS GP (all grades)	3557	1132	31.8	67.7
Principals	2601	802	30.8	48.0
Non-principals	674	234	34.7	14.0
Registrars/trainees	282	96	30.0	5.7
NHS hospital posts	4082	180	4.4	10.8
Other medical posts[a]	2144	246	11.5	14.7
Non-medical or unemployed	422	86	20.4	5.1
Unknown/not stated	222	23	10.4	1.4

[a]Includes NHS public health medicine, NHS community health, UK university, HM forces, UK other public sector, UK private sector, abroad.

Appendix 5. Sex of respondents who commented on general practice.

	All respondents	Commented on GP	% of each sex	% of all comments on GP
1974 graduates				(*n* = 286)
Men	1223	176	14.4	61.5
Women	494	110	22.3	38.5
1983 graduates				(*n* = 647)
Men	1612	316	19.6	48.8
Women	1106	331	29.9	51.2
1988 graduates				(*n* = 443)
Men	1497	197	13.2	44.5
Women	1388	246	17.7	55.5
1993 graduates				(*n* = 296)
Men	1349	96	7.1	32.4
Women	1383	200	14.5	67.6
Total				(*n* = 1672)
Men	5681	785	13.8	46.9
Women	4371	887	20.3	53.0

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