Trainee expectations of general practice

CHRISTOPHER DRINKWATER, B.A., M.B., B.Chir.
Vocational Trainee, Newcastle upon Tyne

"ONLY a small number of doctors appear to be primarily interested in and preparing themselves adequately for general practice. This may well change in a few years time. Some of the doctors so trained appear to be looking for a utopian practice." (Graham, 1972).

What is the trainee general practitioner's utopia? How does it differ from the current state of general practice? (Irvine and Jefferys, 1971). Does it reflect the kind of practice in which his training takes place? (Irvine, 1972). This survey attempts to provide the facts for tentatively answering some of these questions.

Method

A national conference of vocational trainees sponsored by the Royal College of General Practitioners and held in Newcastle upon Tyne in April 1972 provided the opportunity for this survey. The conference was attended by 92 trainee practitioners. All were asked to complete a questionnaire on their expectations of general practice. Eighty-nine (97 per cent) replied and the replies were transferred to punch cards and analysed on the University of Newcastle IBM 360/67 computer, using a standard survey analysis program.

RESULTS

1. Details of trainees

Seventy per cent of the trainees were doing three-year vocational training schemes, three per cent two-year schemes, and 27 per cent one-year trainee assistantships. Sixty-one per cent had had some undergraduate experience of general practice and 77 per cent had spent some time in general practice as postgraduates.

Eight per cent intended to enter general practice with only a basic medical qualification. Ninety-two per cent either held or sought higher qualifications (Table I).

TABLE I

QUALIFICATIONS HELD OR SOUGHT BY THE 82 (92%) OF TRAINEES INTENDING TO ENTER GENERAL PRACTICE WITH HIGHER MEDICAL QUALIFICATIONS

Qualification	*Held at present*	*Intended*
Diploma in obstetrics	27% (N=24)	27% (N=24)
Diploma in child health	5% (N= 5)	25% (N=22)
Diploma in anaesthetics	2% (N= 2)	1% (N= 1)
Diploma in psychological medicine	1% (N= 1)	—
General practice, M.R.C.G.P.	—	54% (N=48)

2. The practice

(*a*) *Location*

Fifty-seven per cent of the trainees wanted to work in a small town or rural setting and only 34 per cent expressed an interest in working in urban areas (Table II).

TABLE II

LOCATION OF PRACTICE SOUGHT

Small town	49% (N=44)
Urban–suburbs	22% (N=22)
Urban–inner city	12% (N=11)
Rural	8% (N= 7)
No preference	8% (N= 7)

The majority of the population of England and Wales live in urban areas with a population of over 50,000 (Registrar General, 1970). Trainee expectations, therefore, appear to be fulfilling, to some extent, the dictates of the inverse care law (Hart, 1971) which states that the availability of good medical care tends to vary inversely with the need for it in the population served. Unless good general practice is to be restricted to a minority of the population some means of making general practice more attractive in urban areas will have to be found.

(*b*) *The building*

Twenty-seven per cent of the trainees wanted to work in local-authority health centres. A much larger group (51 per cent) intended to work in premises owned individually or by a partnership (Table III).

TABLE III

PREFERRED OWNERSHIP OF PURPOSE-BUILT PREMISES

Partnership owned premises	44% (N=39)
Local authority health centre	27% (N=24)
No preference	20% (N=18)
Individually owned premises	7% (N= 6)
Commercially built, rented premises	2% (N= 2)

The percentage of trainees wishing to work in local-authority health centres is much larger than the current proportion of doctors working from such centres, but with the continuing expansion of the health centre programme there is every chance that these trainees will have the premises they desire.

The large groups of trainees wishing to work in individually or partnership-owned premises may show that some trainees feel that this form of ownership gives the doctor greater control over his working environment, alternatively it may be a reflection of the fact that the majority of teaching takes place in such practices (Irvine, 1972).

(c) *Size of group*

Ninety-two per cent of the trainees wanted to work in a group of between three to six partners. None of the trainees wanted to work in a group of more than 12 partners (Table IV).

TABLE IV

SIZE OF PARTNERSHIP

Two-handed practice	7% (N= 6)
Three–six partners	92% (N=82)
Seven–twelve partners	1% (N= 1)

In 1968 the Royal Commission on Medical Education suggested that groups of at least a dozen members would probably become common in urban areas. Such groups

are rare at present and probably only a few trainees have any experience of them; most trainees also wish to work in a small town or rural area where groups of this size are not practical. Despite this, the views put forward by the trainees suggest that they may feel the organisational and administrative problems of such groups outweigh their possible professional advantages.

3. The practice team

Most of the trainees considered adequate clerical staff, a practice nurse and a health visitor to be essential (Table V).

TABLE V

THE PRACTICE TEAM

Personnel	*Essential*	*Desirable*	*Unimportant*	*No response*
Receptionist/telephonist	*93%* (N=83)	*6%* (N= 5)	—	*1%* (N=1)
Practice nurse	*88%* (N=78)	*12%* (N=11)	—	—
Typist clerk	*84%* (N=75)	*15%* (N=13)	—	*1%* (N=1)
Health visitor	*72%* (N=64)	*25%* (N=22)	*2%* (N= 2)	*1%* (N=1)
Midwife	*54%* (N=48)	*39%* (N=35)	*6%* (N= 5)	*1%* (N=1)
Administrative secretary/practice manager	*45%* (N=40)	*45%* (N=40)	*8%* (N= 7)	*2%* (N=2)
Medical social worker	*24%* (N=21)	*73%* (N=65)	*1%* (N= 1)	*2%* (N=2)
Psychiatric social worker	*15%* (N=13)	*72%* (N=64)	*13%* (N=12)	—
Physiotherapist	*9%* (N= 8)	*62%* (N=55)	*27%* (N=24)	*2%* (N=2)
Chiropodist	*3%* (N= 3)	*44%* (N=39)	*53%* (N=47)	—

Since the Charter (British Medical Association, 1965) clerical staff have been employed in increasing numbers by family doctors. Local authorities, with some exceptions, have, also been increasingly willing to second their nurses and health visitors to practices (Irvine and Jefferys, 1971). Provided that both these trends continue, trainees will probably be able to work with the kind of practice team they desire.

The less favourable response to some of the other suggested members of the practice team is interesting, and may reflect, especially in the case of the administrative secretary, physiotherapist and chiropodist, the trainees' lack of experience of these personnel.

4. Arrangements for patient-care

(a) *Patient numbers*

A list size of less than 2,500 patients was preferred by 76 per cent of the trainees (Table VI)

TABLE VI

IDEAL INDIVIDUAL LIST SIZE

Less than 2000 patients	*16%* (N=14)
2001–2500 patients	*60%* (N=53)
2501–3000 patients	*18%* (N=16)
Over 3001 patients	*1%* (N= 1)
Consider list size unimportant	*3%* (N= 3)
No response	*2%* (N= 2)

Fifty per cent of all general practitioners (Department of Health, 1971) and 49 per cent of teachers (Irvine, 1972) have lists greater than 2,500 patients. Trainees, despite their belief in adequate ancillary help and the greater time that this should theoretically leave for patient care, may perhaps feel that consulting rates of 12 patients per hour are incompatible with good primary care, and see list size as the final arbiter of consulting rates.

(b) *Seeing the patient*

An appointments system was considered to be essential by 83 per cent of the trainees. Transport facilities to bring patients to the surgery were considered desirable but not essential by 66 per cent (Table VII). Despite this organisational emphasis on seeing the patient in the surgery, 93 per cent thought that home visiting was an integral part of general practice.

TABLE VII

DESIRABILITY OF APPOINTMENTS SYSTEM AND TRANSPORT FACILITIES

	Essential	*Desirable*	*Unimportant*	*No response*
Appointments system	*83%* (N=74)	*15%* (N=13)	*1%* (N= 1)	*1%* (N=1)
Transport facilities to bring patients to the surgery	*11%* (N=10)	*66%* (N=59)	*20%* (N=18)	*2%* (N=2)

How and where to see patients is a subject which has generated much interest during recent years. Appointment systems seem to be almost universally accepted (Irvine and Jefferys, 1971) and the majority of the trainees agree with this view. Alongside this acceptance of appointment systems is greater emphasis on seeing the patient in the surgery. The trainees again appear to agree with this trend, as demonstrated by the 66 per cent who thought transport facilities to bring patients to the surgery were desirable, but the large number in favour of home visiting suggests that they do not want to become full-time office doctors.

(c) *Continuity of care*

The preferred off-duty arrangement was a rota organised within a partnership, although an emergency deputising service was mentioned by one of the trainees (Table VIII). Fifty-four per cent of the trainees thought that ideally doctors in a group practice should only see patients on their own lists.

TABLE VIII

OFF-DUTY ARRANGEMENTS

Rota within partnership	*93%* (N=83)
Rota with other doctors in the area	*5%* (N= 4)
Emergency deputising service	*1%* (N= 1)
Indifferent	*1%* (N= 1)

Reconciling continuity of care with a shorter working day has been stated to be the dilemma of general practice (Stephen, 1972). Parallel to this is the concept of the individual family doctor and the erosion which this may suffer in a group practice. Off-duty arrangements and the problem of doctors seeing only patients on their personal lists are the focal difficulties. One solution to these dilemmas could be 'group continuity of care' in which a group of doctors and ancillary workers offer continuous care to a defined population. The results of this survey would seem to suggest that this is a solution favoured by a fairly large group of the trainees.

5. Some organisational aspects

An age-sex register, considered by the Royal College of General Practitioners to be the basis of any system of practice monitoring, was thought essential by only 36 per cent of the trainees. Twenty-five per cent considered a diagnostic index to be essential (Table IX), and 60 per cent considered that some form of medical audit would be valuable in general practice.

The medical record envelope (E.C.5 and 6) which has long been a source of dissatisfaction was considered inadequate by 77 per cent of the trainees.

TABLE IX

DESIRABILITY OF AGE–SEX REGISTER AND DIAGNOSTIC INDEX

	Essential	*Desirable*	*Unimportant*	*No response*
Age–sex register	*36%* (N=32)	*55%* (N=49)	*8%* (N= 7)	*1%* (N=1)
Diagnostic index	*25%* (N=22)	*62%* (N=55)	*11%* (N=10)	*2%* (N=2)

It is interesting to note the relatively low priority given to an age-sex register and a diagnostic index by the trainees. One would have thought that the 68 per cent of trainees interested in research and the 60 per cent who wanted to operate some form of medical audit would have found both these tools essential. Perhaps this poor priority is connected with the high proportion of teachers who possess neither an age-sex register nor a diagnostic index (Irvine, 1972).

The interest shown in medical audit correlates much more closely with dissatisfaction with the current medical record cards. Effective audit is probably dependent on good records and trainees obviously feel that the current E.C.5 and 6 are incompatible with good record keeping.

6. Relationships with hospitals

Sixty per cent of the trainees intended to seek sessions as clinical assistants. The most popular specialties were paediatrics (17), obstetrics (10), medicine (9) and psychiatry (8). A majority also wished to have access to and clinical responsibility for hospital beds in medicine, obstetrics and geriatrics (Table X).

TABLE X

DESIRABILITY OF ACCESS TO AND CLINICAL RESPONSIBILITY FOR HOSPITAL BEDS

Specialty	*Yes*	*No*	*Undecided*	*No response*
Medicine	*58%* (N=52)	*21%* (N=19)	*20%* (N=18)	—
Obstetrics	*62%* (N=55)	*22%* (N=20)	*14%* (N=12)	*2%* (N=2)
Geriatrics	*52%* (N=46)	*22%* (N=20)	*25%* (N=22)	*1%* (N=1)

The number of trainees wanting direct access to hospital beds is not as high as might have been expected. This may be due to trainee inexperience of general-practitioner beds but if this attitude persists, there is a danger that the development of community hospitals and of the closer links with the hospital service in general envisaged for the post-1974 Health Service will be inhibited.

The other surprising fact is that obstetrics, the focus of current controversy, was the most favoured specialty, whereas geriatrics, generally recognised as an ever-increasing problem and most suited to small local hospital units, was least favoured.

Clinical assistantships are another form of contact with a hospital. These, although favoured by trainees, have been criticised on the grounds that they are related to the service needs of the hospital rather than to the needs of general practice (Irvine and Jefferys, 1971; *Journal of the Royal College of General Practitioners*, 1972). Whether trainees agree with this criticism is unknown.

7. Additional activities

(a) *Non-hospital remunerated appointments*

Forty-five per cent of the trainees wanted to hold a remunerated appointment outside a hospital. The most frequently mentioned appointment (23 of the trainees) was with the Family Planning Association.

This proportion compares with 50 per cent of teachers (Irvine, 1972) and four fifths of all practitioners (Irvine and Jefferys, 1971) holding such appointments. A far larger proportion of trainees than of teachers or practitioners in general wanted to work for the Family Planning Association, and it would be interesting to know how vocational training schemes are dealing with this desire to know more about and to contribute more to effective family limitation.

(b) *Teaching and research*

Sixty-three per cent of the trainees wanted to become general-practice teachers and 68 per cent expressed an interest in research.

The Royal College of General Practitioners will be able to take heart from the fact that 63 per cent of the trainees wanted to become teachers. Their services will certainly be needed if, as the College recommends, vocational training is to become mandatory for future general-practice principals.

Whether the favourable response to research will ever reach fruition is debatable when one considers the relatively low priority accorded to an age-sex register and a diagnostic index, both basic general practice research tools.

Conclusions

In this survey the aspirations of a group of trainees have been expressed. The results are open to the criticism that these aspirations are based on limited experience. Expectations are, however, formed by education and these results therefore have implications for vocational training schemes. The following are the most important of these implications:

1. Trainees have little experience of large groups because of their sparsity. Such groups are possibly a means of making urban general practice more attractive, and trainees should therefore be encouraged to gain experience of these groups.
2. The smaller than expected number of trainees wishing to have access to and clinical responsibility for hospital beds can perhaps be explained by their inexperience of general-practitioner units. Trainees should be encouraged to see how such units work or there is a danger that the proposed development of community hospitals will be inhibited.
3. The relatively low priority awarded to geriatric general-practice beds is alarming if this is taken as a reflection of the trainees' interest in geriatrics. The complaint is often heard that the family doctor's severest challenge is finding a geriatric bed; a large group of trainees appear to be unaware of the implications of this statement.
4. A large group of trainees expressed an interest in medical audit and research but at the same time awarded a relatively low priority to an age-sex register and a diagnostic index. This discrepancy is almost certainly due to a lack of knowledge of these tools which should be remedied.

5. Finally, whether trainees whose expectations are not fulfilled seek career opportunities abroad, or whether they try to change the circumstances in which they find themselves will be the ultimate test of whether trainees have been taught to do rather than want new things (Byrne, 1972).

Acknowledgements

I am indebted to the organising committee of the first National Trainees' Conference for allowing me to present this questionnaire, and to the many people who discussed this project with me, particularly Drs D. H. Irvine and J. H. Walker. I should also like to thank Mr Ian Russell, Medical Care Research Unit, University of Newcastle upon Tyne, for help with the questionnai reand computer programming.

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