Vocational training and recruitment into general practice

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SUMMARY. A recent survey of doctors in the practice year of vocational training indicates a strong preference for group practice from purpose-built premises (health centre and other) with multidisciplinary staffing and attachments. While it might be assumed that the introduction of mandatory vocational training would provide a continuing supply of well trained recruits into general practice, it may well raise recruitment problems for those areas where practice facilities and opportunities do not meet with expectations. This possibility is of particular concern for those metropolitan regions encompassing inner city areas which have traditionally been highly dependent on hospital-based services, but where deficiencies in primary care provision, particularly in terms of practice structure and premises, have been identified repeatedly over the past 30 years. In view of the present policies for changing the balance of care away from the hospitals, there is an urgent need to develop primary care facilities which will accord with the expectations of vocationally trained general practitioners and their population of patients.

Introduction

THE report of the 1969 BMA Planning Unit Survey (Irvine and Jefferys, 1971) concluded: "It is unlikely that in future young doctors will want to join practices which cannot provide them with proper premises and the tools for the job," while a 1972 inquiry into the preference of vocational trainees with regard to future practice expressed doubts as to whether their aspirations would be fulfilled (Drinkwater, 1972).

Stress has been placed on education in and for general practice as the key to the "elimination of poor standards of care" (RCGP, 1977). On the other hand, however competent, well trained and willing the practitioner may be to provide for patients the full range of appropriate primary care, restrictions will undoubtedly be imposed by lack of resources, particularly inadequate accommodation, equipment, staffing, and support and co-operation from other community services.

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Aim

In the light of the proposed introduction of mandatory vocational training, this paper examines some of the basic practice characteristics preferred by vocational trainees in one metropolitan region. It also assesses the opportunities available as demonstrated by the characteristics of those practices into which new principals have recently been recruited.

Method

The North East Thames Regional Health Authority (NETRHA), traditionally highly dependent on hospital-based care, is now, in common with other London regions, seeking to adapt to a reduced share of total resources and to achieve a shift to primary and community-based services in line with current national policy (DHSS, 1976a, b).

In the spring of 1977 a study was commissioned to examine the characteristics and distribution of general practitioner manpower within the region and to identify problems concerning changing the balance of care. A preliminary analysis of the DHSS General Medical Services Statistics (at 1 October 1976) had shown that, within the region, only 12 per cent of general practitioners were aged under 35, compared with 17 per cent nationally; that 12 per cent were aged 65 and over, compared with six per cent nationally; that 52 per cent of those aged 65 and over were practising in the inner London districts, and that a lower percentage of general practitioners were in group practice than in any other region in the country.

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A postal questionnaire was sent to all trainees (70) i the practice year of vocational training and to all new principals (115) recruited into practices within th region between 1 January 1976 and 1 March 1977. (A list of vocational trainees was obtained from th Regional Postgraduate Adviser in General Practice an of new principals from FPC administrators.) Bot groups of doctors were asked for information abou their personal background including medical educatio Trainees were asked for their preferences regardin future practice location and facilities, while the recruit were asked to document comparable features of thei actual practice. The response rate was 90 per cent fo trainees and 83 per cent for recruits.

Results

1. Characteristics of trainees and recruits

Forty-nine per cent of trainees and 40 per cent o recruits were foreign medical graduates, and a hig proportion of the British graduates in both groups wer female. Of the trainees only 27 per cent were graduat of London medical schools, 59 per cent of whom we women. Thirty-two per cent of the recruits were gradu ates of London medical schools, of whom 37 per ce were female.

Forty-seven per cent of the recruits had undertak vocational training, just over half of them within th region. The percentages were the same for British an foreign graduates and for male and female doctor Thirteen per cent of these doctors had been recruite into their training practices.

2. Practice characteristics

a) Structure

The practice structure and proportion of recruits i receipt of group practice allowance was significant different from the region as a whole, with 15 per ce fewer in single- and two-handed practice and 18 per ce more in partnerships of three or four ($\chi^2 = 15 \cdot 1$ $p<0 \cdot 001$) (Table 1). This difference is almost entir due to the tendency of British recruits to enter practic with three or more partners. The practice structure o the foreign recruits was significantly differe ($\chi^2 = 7 \cdot 35$, $p<0 \cdot 05$) with 45 per cent in single- an two-handed practice, and only five per cent in larg group practice. Only 10 per cent of the trainees—i.e. s foreign graduates—expressed a preference for single o two-handed practice. British male graduates show greatest preference for larger group practice, i partnerships of five or more.

In considering the likely influence of vocational trai ing on future practice, it should be noted that 69 p cent of recruits in single- or two-handed practice not undertaken vocational training and that 44 per c of the recruits without the training experience wer small practices.

b) Premises

Eighteen per cent of the recruits were practising in health centres: 21 per cent of foreign graduates compared with 12 per cent of British graduates (Table 2).

Purpose-built premises other than health centres were used by 23 per cent of the recruits—almost entirely British graduates and predominantly males—but the majority of the recruits were practising from 'adapted' premises.

Many of the trainees expressed more than one preference, the most frequent combination being for health centre or other purpose-built premises. Health centre practice was preferred by a higher proportion of foreign than British graduates, consistent with the evidence from the survey of recruits, while a greater preference for purpose-built premises other than health centres was shown by British graduates, particularly women.

c) Staffing and attachment of other professionals

While the vast majority of recruits were working in practices employing at least a receptionist, significantly fewer foreign graduates were in practices with any practice staffing ($\chi^2 = 7 \cdot 16$, $p < 0 \cdot 01$), (Table 3). All but one of the vocationally trained recruits were in practices employing at least a receptionist, but only 40 per cent employed a practice nurse compared with 50 per cent of the untrained recruits. Thirty-eight per cent of the trained recruits compared with 70 per cent of those without training claimed to have attached district nurses and health visitors. This may well imply that those who have undertaken vocational training use the word 'attachment' in its more correct form, implying co-operative working from common practice premises (DHSS, 1977a), other arrangements being appropriately described as 'alignment' or 'liaison'. Evidence from a study of community nursing manpower in the NETRHA showed that recruits in some districts claimed 'attachments' where policy for the deployment of staff in this way did not exist (Stockton *et al.*, 1978). All trainees expressed a greater preference for staffing and attachments of all grades than appeared to be available from the responses of the recruits and the evidence of the community nursing study.

3. *The trainees: future practice location*

Trainees were asked if they would seek to practise in one of the areas of NETRHA. Only 52 per cent said 'yes' categorically, of whom only 24 per cent were British—two men and six women (Table 4).

In 1969 'home ties' were shown to influence the

Table 1. Practice structure: comparative percentage distribution for recruits and trainee preferences.

	Number (100%)	Principals per practice 1-2	3-4	5 or more	Percentage in group practice
			Percentages		
NETRHA	1,723	*49*	*31*	*20*	*53*
Recruits					
Total	95	*34*	*49*	*17*	*67*
British graduates	57	*26*	*49*	*25*	*74*
British women graduates	19	*11*	*63*	*26*	*89*
Foreign graduates	38	*45*	*50*	*5*	*58*
Trainee preferences					
Total	63	*10*	*49*	*41*	
British graduates	32	—	*47*	*53*	
British women graduates	16	—	*81*	*19*	
Foreign graduates	31	*19*	*52*	*29*	

Source: computed from DHSS General Medical Services Statistics (at 1 October 1976) and surveys of recruits and trainees.

Table 2. *Practice premises: comparative percentage distribution for recruits and trainee preferences.

	Number of doctors	Percentage practising from: Health centre	Purpose built	Adapted	Home
Recruits					
Total	95	*18*	*23*	*62*	*3*
British graduates	57	*12*	*33*	*56*	*2*
British women graduates	19	*16*	*26*	*63*	*5*
Foreign graduates	38	*21*	*8*	*71*	*5*
Trainee preferences					
Total	63	*49*	*52*	*21*	*2*
British graduates	32	*38*	*59*	*22*	*3*
British women graduates	16	*38*	*75*	*31*	—
Foreign graduates	31	*61*	*45*	*19*	—

*No category was mutually exclusive.

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practice location of 60 per cent of general practitioners (Butler and Knight, 1975). In the present study a majority of the British women trainees (9/16) were married to doctors with hospital posts and four of these expressed a firm intention to seek a practice in the region, but only 17 per cent of all trainees or their spouses had a home background in south-east England. Suitable practice opportunities would therefore seem a more likely determinant for recruitment of those electing to undertake vocational training in the region.

Discussion

Several points raised by the results of this study have important implications for future recruitment into general practice in NETRHA and the likely impact of mandatory vocational training. Of major importance is the wide disparity between the type of practice being sought by young doctors, in partnership structure, premises, or opportunities for multidisciplinary working, and the availability of these practices. The evidence indicates that while there have been changes and advances in many aspects of primary care in recent years in the country as a whole, within this region there has been relative stagnation.

Partnership structure

In 1971 it was emphasized that group practice was preferred by young doctors, while at the same time the question was raised as to whether 'really advanced groups' were emerging fast enough to create career opportunities (Irvine and Jefferys, 1971). While the national trend over the last 20 years has been for increasing numbers of general practitioners to combine into group practice, the practice structure in the NETRHA now approximates to that which prevailed in the rest of the country 10 or more years ago. Thus the opportunities for newly trained general practitioners to enter practices offering the partnership arrangements they would prefer are extremely limited, particularly in the inner London districts where single- and two-handed practices predominate.

Practice premises

No comprehensive data are available nationally or regionally on the total stock of general practitioner premises, although the number of health centres and of general practitioners working in them is known. Health centre practice has been increasing consistently in recent years. In 1969 only two per cent of general practitioners in the country as a whole were working in health centres compared with 18 per cent in 1976 (Irvine and Jefferys, 1971; DHSS, 1977b). The figure for the NETRHA in 1976 was, however, only 10 per cent. While health centre practice may not be universally preferred and may not always offer optimal facilities (Irvine and

Table 3. Staffing and attachments of other professionals: comparative percentage distribution for recruits and trainee preferences.

	Number	Receptionist	Secretary	Practice nurse	District nurse	Health visitor
				Percentages		
Recruits						
Total	95	*93*	*63*	*45*	*74*	*68*
British graduates	57	*98*	*68*	*47*	*72*	*72*
British women graduates	19	*100*	*63*	*53*	*79*	*79*
Foreign graduates	38	*87*	*61*	*42*	*76*	*63*
Trainee preferences						
Total	63	*95*	*76*	*75*	*89*	*83*
British graduates	32	*97*	*80*	*75*	*89*	*83*
British women graduates	16	*100*	*75*	*69*	*88*	*88*
Foreign graduates	31	*94*	*71*	*74*	*90*	*87*

Table 4. Trainees' practice location intentions: comparative percentage distribution.

	Number (100%)	Percentage intending to practise: Within NETRHA	Outside NETRHA	Don't know
Trainee preferences				
All	63	*52*	*24*	*24*
British graduates	32	*25*	*41*	*34*
British women graduates	16	*38*	*19*	*44*
Foreign graduates	31	*81*	*6*	*13*

Jefferys, 1971), it was apparent from the surveys that it would be an acceptable option to a high proportion of young doctors entering practice.

With regard to other practice premises, little is known either quantitatively or qualitatively. It has been shown that it is not possible to generalize about the amenities or facilities available in the various categories of practice premises; Irvine and Jefferys found that in some cases older adapted premises did provide high quality facilities, but Irvine (1972) found that for the most part purpose-built premises had advantages. Although these latter premises were preferred, particularly by British doctors in training, their availability appeared limited compared with those described as 'adapted'.

The 1968 Camden study documented major deficiencies in practice premises, most of which were adapted (Sidel *et al.*, 1972). There is no reason to assume that these were unique to this inner London district. Also, in view of the persistently high proportion of elderly general practitioners and of single- and two-handed practices, it is unlikely that there have been more than marginal changes in the stock of privately owned premises during the last 10 years.

Staffing and attachments

In recent years studies of, and policies directed towards, general practice have made a number of assumptions: that the employment of practice staff leads to better organization and management enabling the doctor to work more 'efficiently and effectively' (Sidel *et al.*, 1972); that priority should be given to the attachment of community nursing staff (Irvine and Jefferys, 1971) and that encouragement should be given to the development of primary health care teams (DHSS, 1976a; 1977a) At the same time it has been pointed out repeatedly that cramped or inadequate accommodation militates against the employment of practice staff or the functionally integrated attachment of community nursing staff (Irvine and Jefferys, 1971).

An important objective of vocational training is the teaching of management and teamwork (Council for Postgraduate Medical Education in England and Wales, 1977). The majority of trainees surveyed in 1972 expressed a preference for 'team' practice (Drinkwater, 1972), and the evidence from this study is that doctors in vocational training are even more committed to the concept, particularly to the attachment of district nurses and health visitors. The probability of finding a practice within the region with the partnership structure and premises suitable for a multidisciplinary approach to primary care is unknown but the indications are that it is low.

Future recruitment

The surveys revealed a relatively high proportion of foreign trained doctors attracted into both traineeships and practice in the region. Of the British graduates in training a high proportion were women, but as far as future practice intentions were concerned few women and fewer men expressed a preference for seeking a practice within the region.

The willingness of foreign trained doctors to provide

a compensating supply of general practitioner manpower in the multiply deprived areas of the region which are being rejected by British doctors has been discussed elsewhere (Logan *et al.*, 1979). The indications are that the introduction of mandatory vocational training may well raise the expectations of overseas trained doctors in terms of facilities such as practice premises and adequate staffing, and they, in turn, may reject the areas where these facilities do not exist. Without the supply of foreign doctors, recruitment into general practice in some parts of the region might be severely constrained.

The comments of the recruits and trainees on problems of recruitment into general practice in the region reinforced the findings of the survey: 'lack of opportunities for good group practice', 'poor practice premises', 'not enough health centres', plus numerous comments on the high cost of housing and of obtaining acceptable privately owned premises. The married women doctors who said they would remain within the region had as high if not higher expectations of the type of practice they would seek. A third of the British graduates were undecided as to where they would seek to practise; the implication being that offered acceptable opportunities they might settle within the region.

Conclusion

We have concentrated on demonstrating the wide disparity between the expectations of doctors undertaking vocational training in one metropolitan region and the probability that these expectations will be met. It is discouraging to find that studies over the last 30 years have always identified the same or similar problems: too many small practices; inadequate premises; the need for more staffing and attachments (Collings, 1950; Irvine and Jefferys, 1971; Irvine, 1972; Sidel *et al.*, 1972). The key to the problem has always been felt to lie in the general improvement of practice premises, and major programmes of rebuilding or modernization have been called for (Irvine and Jefferys, 1971; Sidel *et al.*, 1972). In the present state of the economy major rebuilding schemes are unlikely to occur and the costs of construction and maintenance of major health centres are becoming prohibitive. On the other hand, the introduction of mandatory vocational training seems likely to heighten the perceptions of all new doctors coming into general practice. Policies will have to be developed to meet individual preferences and provide the job satisfaction necessary to maintain and improve the family practitioner and primary care services.

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Health services in Scotland

Other difficult questions obtrude when the variations in health care resources are added to the picture, for while Scotland has higher death rates than England it also has substantially more hospital beds of all kinds per head of the population, more general practitioners, and more community nurses. What are we to make of the apparent paradox? Does it mean that, beyond a certain level of provision, further investments in health services become counterproductive or even iatrogenic? Does it mean that medical care services in Scotland are less effective than those in England? With the pressures towards an increasingly rational approach to the disposition of health care resources, such questions assume a practical as well as an academic significance. Reflecting on them may lead to conclusions with a wider utility than that of explaining cross-national differences.

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