Problems of training in a changing market

ROBIN STEEL
General Practitioner, Worcester

In 1969 when the Midlands Faculty sponsored a pioneer vocational training course there were less than a dozen trainees in a region of 2,500 principals who served a population of over 5 million patients. At the time of the General Practice Charter, Worcester city was a designated area and one practice vacancy failed to receive a single application from a British graduate. Now, three year vocational training is mandatory and is oversubscribed. With many well qualified applicants for practice vacancies, rumours are arising that some principals are demanding unfair partnership conditions or are relying on unwritten and dubious agreements, as happened in the early years of the NHS.

THE number of new general practitioners required for each region is not known. Requirements depend on a number of factors: the age distribution of existing principals and their health, how many family doctors will retire at the age of 60 years and how many will then return to work part-time. In addition there is a major uncertainty about average list sizes in the future and whether the Government will fund an average list of 1,700 patients or whether the DHSS working party will recommend cash limits for primary care and so prevent any expansion of the total number of general practitioners.

Selection for schemes

Selection of doctors for vocational training schemes is also a problem, as is shown in the Working Party Report, p. 673. The working party's questionnaires indicated that many applications were made by some doctors. There were problems in selecting trainees with schemes oversubscribed by a factor of 20.

One solution for this particular problem could be for the Joint Committee on Postgraduate Training for General Practice to introduce an 'UCCA' type scheme for trainees. Initially this could be confined to a few schemes. Advertisements could be synchronized for February with applications made on a single agreed form limited to five schemes in order of preference. Interviews could be arranged in April and clearance in May, leaving June and July for a second round of interviews before the starting date of 1 August. Such a procedure would not preclude local applicants or local autonomy, but could help overcome the present chaos.

Training is changing. Some ask 'are trainees having it too easy?',[1] while anecdotes overheard at the trainee conferences in Sheffield and Cambridge suggested that some trainees are still overworked and undertaught. Research has shown the characteristics of training practices that are associated with better performance of trainees.[2]

Career of first choice

A national survey of doctors who qualified in 1980[3] had an 84 per cent response rate and a total of 2,858 respondents. It showed that a third of the doctors put general practice as their first choice of career. A higher percentage of women doctors (40 per cent) put general practice as their first choice.

These figures should not lead to complacency. The College is fundamentally committed to trainees as its seed corn. Improvements in the standard of training practices are vigorously encouraged by regional education committees, who are themselves helpfully prodded by the Joint Committee on Postgraduate Training for General Practice. Apathy and conservatism must be vigorously combated. More trainees should be encouraged to conduct surveys in which schemes are constructively criticised. All involved must be sensitive to such criticisms and ready to make changes, however uncomfortable for the establishment this may be.

References

1. Murray S. Are trainees having it too easy? *Scottish Medicine* 1982; **2,** 19-20.
2. Freeman J, Roberts J, Metcalfe D *et al.* The influence of trainers on trainees in general practice. *Occasional Paper 21.*
3. Parkhouse J, Campbell MG, Hambleton BA *et al.* Career preferences of doctors qualifying in the United Kingdom 1980. *Health Trends* 1983; **15,** no. 1:12-14.

PRACTICE FINANCE

The Additional Lump Sum Retiring Allowance

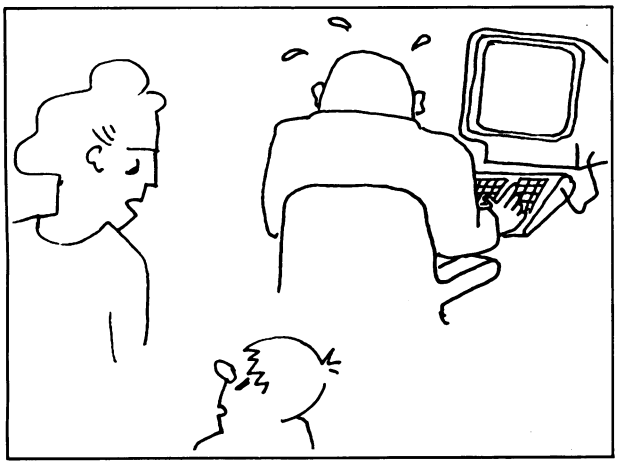
What does it provide? What does it cost? These questions are considered by Mr D. J. Shields of the Medical Insurance Agency in a follow-up to his article (February *Journal,* p. 116) on the new Added Years Scheme.

WHILST buying Added Years will have wide application, purchase of the Additional Lump Sum will relate to fewer doctors. This facility applies only to:

- Men who have been married or are still married or who marry in future provided they have pensionable service in the NHS prior to 25 March 1972.
- Women members of the scheme with pensionable service prior to 25 March 1972 who nominate their incapacitated husbands for a widower's pension.

It does not apply to men and women in the above categories who purchased, or are purchasing, their bigger lump sum in respect of pre-25 March 1972 service under the earlier (1975) arrangements. If, however, they bought or are buying only part of that service, they may now buy more or the rest of it under the new scheme.

Purchase cannot be made by a re-employed pensioner so that a doctor who has retired from the NHS and then returned to NHS practice is ineligible to purchase even



Cartoon: Professor David Metcalfe.

Dad says his new game, Lumps and Years, is the best thing since Space Invaders.

though he may be contributing to the NHS superannuation scheme in respect of his new level of NHS earnings.

Similarly excluded are those who have retained the conditions of a former pension scheme.

What is being purchased?

The tax free lump sum retiring allowance relates to retirement pension. For all service up to 24 March 1972 it will be equal to the pension payable in respect of that service. For subsequent service the lump sum is equivalent to three times the pension applicable to that latter period of service. Hence purchase of the Additional Lump Sum Retiring Allowance secures the extra two times pension in respect of pre-25 March 1972 service and ensures that, at retirement, the lump sum is three times pension based on all service and not just the post-March 1972 portion.

Incidentally, for all service on or after 25 March 1972 the lump sum is three times pension whether the member is male or female, married or single.

Lump sum or Added years or something else?

The question that is frequently and logically asked is 'Should I buy the bigger lump sum or Added Years and how do they compare with other forms of investment?'

Looking at the bigger lump sum, the only person now in a position to purchase his full entitlement is the doctor aged about 60 who is getting married for the first time. Within 12 months of his marriage he can buy his maximum eligible extra lump sum by paying cash. It is important to realize that if such a doctor does not make the purchase his lump sum retiring allowance is reduced by two thirds in respect of all his service prior to 25 March 1972.

For a doctor of similar age but who is already married, although entitled to buy the Additional Lump Sum Retiring Allowance in respect of all his pre-25 March 1972 service he can only pay extra percentage contributions, not cash. However, he is limited to an optimum additional contribution of 9 per cent. For someone aged 60 next birthday the cost of buying one year of extra lump sum is 0.48 per cent of superannuable income in each year. Hence, because of the 9 per cent limitation, the maximum number of years of bigger lump sum that this doctor can buy is 18.75 even though he may have more than 23 years of pre- 25 March 1972 superannuable service.

Furthermore, buying on the 65 scale (the only one open to him) means he incurs the double penalty mentioned in my previous article should he retire between 60 and 65.

It is apparent that the younger the doctor the fewer the years of bigger lump sum he will be eligible to purchase. Furthermore as the cost of each year reduces for younger ages the position will pertain where a more junior doctor will be able to buy his full entitlement to bigger lump sum without using his maximum 9 per cent permitted contribution.

It would not be unusual for a married doctor now aged 46 who qualified at 24 to be able to buy his full entitlement of both Added Years and Additional Lump Sum Retiring Allowance for 9 per cent of each year's superannuable income on the age 60 scale.

If the 65 scale is adopted then the option would be open to a similar doctor but now aged 50.

It follows, then, that younger doctors can secure the maximum additional benefits for a payment of less (in some cases considerably less) than 9 per cent of each year's superannuable income. However, these doctors would be making payments over a longer period so the overall cost, after allowing for tax relief, may be rather nearer the comparable overall cost for the older doctor who, whilst paying more each year, is contributing for a shorter period.

Which then is it best to buy, Added Years or bigger lump sum or indeed either?

I fear there is no categoric answer that applies to everyone—it all depends on individual personal circumstances. However, the following general comments will, I hope, enable each doctor to consider his or her own situation more comprehensively.

Some guidelines

Buying added years means securing a larger index-linked retirement pension with the appropriate increase of widow's pension and ancillary benefits. It also produces further lump sum benefits based on the additional years purchased. The pension payable is taxed as earned income.

Purchase of the Additional Lump Sum Retiring Allowance provides an extra amount of tax-free cash at retirement. However, if that money were invested for income the return could be taxed as investment income. Further, the income would not be index-linked unless invested in such as investment when the initial return would be considerably lower than were a non index-linked investment selected.

However, the cash in hand from the extra lump sum is there at once and it will take some years for the Added Years pension to equate in total to the capital, even if the pension is index-linked. Further invested capital from the bigger lump sum will be available to a doctor's widow as will any income and/or growth that capital may produce. Also such income or growth continues irrespective of the doctor's survival, whereas the pension from Added Years, like basic NHS pension, reduces by 50 per cent on the husband's death.

When contemplating buying additional benefits many factors have to be taken into account. Relative ages of husband and wife and their states of health, ages of children and present and prospective financial circumstances, both as regards income and capital.

Having decided how much it is convenient to contribute by way of additional contributions, consideration must then be given to what a similar net (that it after tax) expenditure would produce in other forms of investment. In this context may I refer back to my earlier article with particular reference to 'other variables' arising in many alternative investments?

When a doctor retires his earnings are replaced by pensions and some lump sum benefits. The pensions to which he is compulsorily committed arise from NHS and National Insurance sources. Apart from any other forms of saving he

has three optional opportunities of supplementing his retirement income:
- Buying additional benefits under NHSSS.
- Employing his wife and establishing a pension scheme for her.
- A private pension policy based on any earnings that are non-superannuable.

Subject to the expenditure being convenient it is permissible for a doctor to contribute to all three—investment in one does not preclude participation in the others. The only complication of interdependence arises where a doctor opts to forgo tax relief on his contributions to the NHSSS and effects a private pension contract based on his relevant earnings. Not only can this involve a very considerable addition to net expenditure on pension provision but, and this is not always realized, the decision to forgo tax relief on basic NHSSS contributions means that relief on any additional voluntary payments is forfeit as well.

One final point: from a tax viewpoint every doctor should employ his wife. In my view it is equally prudent and highly beneficial, taxwise, to set up a pension scheme for her. Not only will this improve the family retirement income while both husband and wife are alive, but should the husband die first in retirement, the wife's situation is improved in that the part of her income arising from her pension will not be reduced by 50 per cent.

CONTROVERSY

The need to study complementary medicine

T. S. FLETCHER
General Practitioner, Leigh, Lancashire.

'I don't really like taking drugs if I can help it—do these tablets have any side-effects?' This is just one, of the phrases being heard increasingly by general practitioners. Reports of side-effects of drugs in the national and medical press serve only to highlight one of the deficiencies of conventional medicine. It is not surprising that more patients are turning to alternative medicine as a means of dealing with their health problems. Is it not time that the College responded to the increasing opposition to allopathic medicine being voiced by our patients?

BEFORE becoming a 'fringe' doctor I spent my first years in general practice getting to know my patients and using the skills that I had learned as a trainee. However, it soon became obvious that there were many conditions that I was powerless to influence. These included many of the chronic diseases, the anxiety-depressive states and recurrent upper respiratory tract infections. The list is legion. Was all my training for general practice to be reduced to the repeat prescription—the inevitable antiobiotic; yet another anxiolytic? I could feel the seeds of discontent and disillusionment being sown. I decided to do something about this.

Four years ago I decided to undertake training in acupuncture. This was followed by training in homeopathy, for which I was fortunate enough to be granted prolonged study leave.

A surprising response

The impact on my 3,000 patients was immediate, dramatic and rewarding. Treatments with acupuncture or homeopathy did not cause rashes, stomachs were not upset, and more surprisingly patients would return saying 'I feel a lot better.'

I was, I suppose, in some sense no longer a 'real' doctor. How could I be if I stuck needles into my patients, or gave them those tablets that were all alike and weren't they only made up of sugar and water? Despite all this my patients continued to get better. Surgeries for me were no longer a trial. I could offer something else for those intractable problems. Now I could confidently treat the child with whooping cough, or glandular fever or recurrent coughs and colds, or the patient with an acute back strain, doubled up in severe pain who, after treatment, would walk out of the surgery straight and virtually pain free. All this without drugs. Was it all just a placebo response?

Need for scientific data

The sceptics dismiss these therapies without any first hand knowledge or experience of their use. They point to the lack of scientific data. But how can this be collected unless more doctors are willing to use and put these methods to the test, comparing their effectiveness with conventional methods. Clinical trials cost money; this is usually provided by the pharmaceutical companies who wish to promote their products. Who will provide the funds for trials on the alternative therapies?

Scientific trials, of which the double-blind cross-over is the accepted yard-stick, negate the individual response in disease and eliminate the doctor/patient interaction.

Medicine is not a pure science; it is also an art. Can one conduct double-blind cross-over trials on empathy, care and concern? Balint has highlighted the drug called 'Doctor'. Has this drug been tested in a trial for its effectiveness and the incidence of side-effects?

Knowledge of acupuncture and homeopathy has allowed me a greater choice of therapies. It enables me to treat the range of conditions that does not feature in the textbooks of medicine, but which we as general practitioners see often.

If we are not able to offer our patients the benefits of complementary medicine they usually seek help elsewhere. This unfortunately exposes them to the unqualified and the ruthless and, in some cases, to the dangerous.

Hostility to the orthodox

Prince Charles, President of the British Medical Association, in his address at the 150th anniversary dinner spoke of some of these problems. He opened his speech by saying 'I have often thought that one of the less attractive traits of various professional bodies and institutions is the deeply ingrained