A career in general practice

IN 1971 a report on an experimental vocational training scheme for general practice concluded: 'In general, supply now seems to equal demand for such courses, but greater incentives are needed to encourage applicants other than those who would prepare themselves for general practice in any case'.[1] In 1970 the number of applicants on that scheme did not exceed vacancies, but it was estimated that the financial disincentive to undertake training amounted to more than £5,000 when the estimated earnings as a principal in the first three years was less than £14,000. The few who completed training were well placed to be selective about the practices they considered joining. Times have changed: training is now compulsory and the 100 well-qualified applicants for four places on our local training scheme is typical of most three-year programmes. In Britain today, 700 young doctors are unemployed.

Medical unemployment on a significant scale has been predicted for the future, with estimates of between 8,000 and 20,000 unemployed doctors by the year 2000. Scotland, traditionally the supplier of doctors to the world, has in training for general practice a surplus of 70 doctors over the available posts for principals, and the average list size is already below 1,800 patients.

More serious potential problems for future employment are the large over-production of doctors in EEC countries[2] and the falling average age of principals in general practice. The modal age group of general practitioners has fallen from 50–54 years in 1977 (with 14.3 per cent aged over 60 years) to 30–34 years in 1981 (with 12.8 per cent aged over 60 years).[3] Forced retirement of principals at age 65 years (1,422 in 1981), described as inevitable by the Chief Medical Officer at the 1984 Trainees' Conference, will create only a few vacancies over a short period after which there will be even fewer, while there will be increasing numbers of young general practitioners.

The potential for increasing the workload of general practice to absorb some of these young and highly trained doctors exists now. List sizes have fallen as the number of principals in general practice has slowly risen. A heavy input is required before the benefits of health promotion and prevention of illness are achieved. The inexorable shift in the burden and priority for health care from acute to chronic illness associated with our ageing population is a long-term challenge to general practice. Using official statistics, Metcalfe has demonstrated the increased care provided within the community and comments 'quarts appear to coming out of pint pots'.[4]

Dr North's paper on the experiences of trainees seeking employment, published in this issue of the *Journal,* helps to fill a gap in our knowledge and, so far, the picture is not too bleak. However, future employment prospects are uncertain. Although 17 per cent of 1982 trainees experienced a period of unemployment, by 1983 the figure had risen to 32 per cent. One third of trainees found employment in partnerships via 'the grapevine'. Indeed, almost all the trainees who found employment in general practice did so in partnerships.

Group practice, actively encouraged by the Department of Health and Social Security (DHSS), has been one of the foundation stones of the renaissance of general practice, and single-handed general practices have dropped from 43 per cent in 1952 to 14 per cent in 1980. This has allowed important benefits to become usual, such as improved premises, peer review, out-of-hours cover and time out of the practice. Most trainees train in a group practice and will wish to remain in one, but they will pay a price for this in restriction of freedom of clinical practice. As higher standards are required of training practices, the gap between training and non-training practices may widen. Twelve per cent of North's successful respondents joined their training practice, but this option can only exist for a minority. Freeling and Fitton concluded in their study of teaching practices, 'It has yet to be established that the young doctors in training will be able to function as principals in practices that lack the facilities and help to which they have become accustomed'.[5] It has been argued that trainees lack the experience for direct entry to single-handed practice — but their altruism and youthful enthusiasm may be even more vulnerable to pressure from three or four disillusioned senior partners fixed in archaic routines. Despite clarification of the Medical Practice Committee guidelines last year it is still rare for a trainee to be appointed to a single-handed practice. The guidelines do not distinguish between isolated single-handed rural practice and 'single-handed' in a health centre, where the ex-trainee will work close to (and be able to seek advice from) more experienced doctors. The single-handed doctor working in

purpose-built premises with others can have many of the advantages of partnership, while retaining freedom to organize the service he offers as he wishes.

Only 64 per cent in North's study had a practice agreement (and the fact that 94 per cent of these doctors were happy with their agreement may say more about the type of practice which has one than the actual wording). Salaried partners were less happy — 71 per cent in this position were either overseas male graduates or married females.

Clearly, for many trainees the problems do not disappear on getting a job and this is reflected in the rising number of Young Principal Groups throughout the country. The ex-trainee, weaned on peer group support, finds himself alone in an often unfamiliar environment.

The number of women entering general practice has doubled in the last 14 years and it is predicted that by the year 2000 over 50 per cent of principals will be women. The flexibility of general practice is a particular attraction. Many women patients prefer to see a woman doctor about certain problems.[6] Women doctors are more likely to have a part-time post (94 per cent in North's survey) which fits in with family commitments. Any group practice of the future wishing to offer patients a 'full' service should include a woman doctor, and changes in the regulations could allow the 'luxury' of a part-time woman doctor in practices in intermediate and restricted areas. This would help to improve the range of services to patients, the employment prospects of women doctors and reduce the average list size. The General Medical Services Committee (GMSC) has suggested a programme[7] to help the single-handed rural general practitioner with locums, which could be a starting point for such a scheme.

The policies of the Medical Practice Committee have been reasonably effective in creating an even distribution of general practitioners throughout the country outside London, but there are still doctors with list sizes of 3,500. In such practices, any emphasis on preventive medicine is precluded by the workload. A reduction in maximum list size would be beneficial in developing better services and would also mean more job opportunities for trainees. By creating posts for young doctors, there would also be opportunities for improving primary care in central London. A good working environment is necessary but prohibitively expensive for a young principal in central areas, and improved financial aid is essential.

Stocking,[8] looking to the future of general practice as an outsider, considered there were four options: (1) to dispense with the general practitioner (which she dismissed rapidly; (2) to have bigger lists, fewer general practitioners and more associated staff — at risk of losing individual and continuing care; (3) to have constant or smaller lists but at least as many general practitioners, to get to grips with the whole problem of preventive medicine and health education; (4) to muddle along — 'a well respected National Health Service activity'.

The best young graduates still see general practice as a satisfying career; we must use this resource of young idealists to raise the minimum standards of general practice. Unemployment of highly and expensively trained young doctors is unacceptable in a society whose population still has many of its health needs unmet — it is not enough just to 'muddle along'.

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Affective learning: a new approach to medicine

ONE of the more controversial aspects of training for general practice is the half-day release case discussion group. Some of these groups take on the characteristics of a Balint group and have a strong psychotherapeutic approach to the case discussions. Trainees entering such a group are confronted with a new approach to medicine — one which entails them in affective learning, that is in the emotional as well as the intellectual acceptance of new knowledge. It involves the loss of status and identity as a hospital doctor and the taking on of the new professional role of general practitioner. For this to take place, the trainee may pass through the four stages of reaction described by Kahn.[1] His observations of medical students in small groups suggests that affective learning requires giving up old beliefs and behaviour and coping with the feelings of loss until reintegration takes place.

The four stages of feeling states postulated by Kahn include confusion, denial, anger and reintegration. Individuals pass through some of these stages in order to break with the past, relinquish an old identity and allow a new identity to emerge. The 'Balint style' case discus-