Survey of young principal groups in the United Kingdom

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SUMMARY. Of 164 young principal groups identified, 107 replied to a questionnaire asking for details of the groups and their activities. Eighty one per cent of the groups had been in existence for less than five years and 57% gave continuing medical education as one of the reasons for forming the group. The majority of groups were run informally and 55% had social meetings to which spouses were invited. The groups varied in size from six to 50 members and members' surgeries were the most popular meeting place. Clinical topics proved the most successful and group discussion was the preferred form of meeting. Groups formed for less than three years were less likely to have meetings with specialists than groups formed for three years or more and were more likely to have discussions about personal/partnership problems. Although 67% of the groups had sought outside help at some time 78% did not need any help at present.

These self-help groups appear to be self-sufficient and to be meeting the continuing education and personal/social needs of young principals.

Introduction

INFORMAL groups catering for the needs of general practitioners are not a new phenomenon. 'Young principal groups' or 'young practitioner groups' cater for the needs of doctors in the early years of their career in practice. Having been involved in the running of young principal groups and being aware of reports of other groups,[1-3] we decided to survey as many groups in the United Kingdom as we could.

Method

Identifying groups is a difficult task as there is no record or register of their existence or whereabouts. Three methods were used to identify groups. First, a four year cohort of new principals included in the medical list between August 1982 and July 1985 were sent a short questionnaire in envelopes marked 'This is not advertising material'. Secondly, an article was published in the medical press inviting doctors to inform the authors about local groups. Finally, course organizers were telephoned and asked for information about local groups, concentrating on those areas where there appeared to be few or no groups.

The short questionnaire to 2900 new principals produced 747 replies (26%). Of these, 416 (57%) had a local group that they could attend if they wished, and 207 (50%) were active members, 63 (15%) casual attenders, 13 (3%) no longer wished to attend meetings and 133 (32%) had never attended.

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We identified 137 groups from the short questionnaire, 14 from the response to the article, and 51 from course organizers. After cross checking for duplication we clearly identified 168 groups.

These groups were sent a detailed questionnaire asking about their activities, assuring them that any information they provided would remain confidential. A telephone reminder was made to those who failed to respond, and as a result four groups were found to have ceased to exist. Of the remaining 164 groups, 107 (65%) returned and completed questionnaires. Both open and closed questions were used to obtain information about the length of time the groups had been formed, why they had been formed, how they are organized, their membership and attendance levels, where meetings are held and how often, the content and form of meetings, the formal aims of the groups and the outside help received and needed.

Results

Only 10% of the 107 groups had been in existence for more than five years, with 81% less than five years and 9% not responding. This may partly be explained by the fact that the short questionnaire was sent only to new principals.

The question about why groups had been formed was open-ended and most groups gave multiple answers. The reasons most often given were continuing medical education, 61 groups (57%); support/social activities, 55 groups (51%); and continuation of vocational training scheme, 12 groups (11%).

Regional distribution of groups

The regional distribution of the 168 groups is shown in Figure 1. It would appear that the 107 groups are reasonably evenly

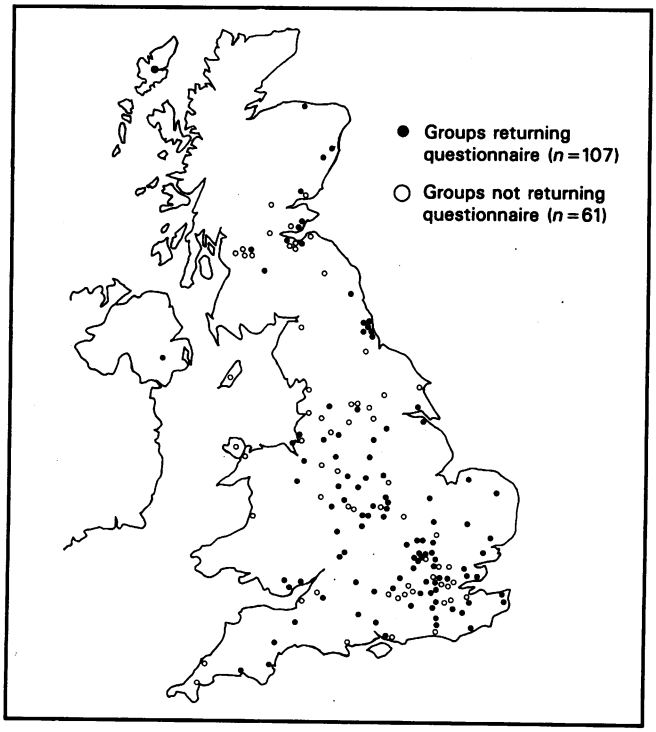

Figure 1. *Regional distribution of the young principal groups identified.*

Table 1. Features of organization of the 107 young principal groups.

	Number (%) of groups
Open to new members	105 (*98*)
Open to new principals only	35 (*33*)
Members must leave after several years as principal	18 (*17*)
Compulsory leaving age	1 (*1*)
Only one partner per practice in group	3 (*3*)
Group currently:	
Holds AGMs	9 (*8*)
Possesses a constitution	8 (*7*)
Has a committee	9 (*8*)
Keeps minutes	21 (*20*)
Has social events	59 (*55*)
Meetings organized by:	
One person	48 (*45*)
Mutual agreement	33 (*31*)
Sub-group	24 (*22*)
Funding:	
Section 63	48 (*42*)
Pharmaceutical industry	8 (*7*)

Table 2. Size of the 107 groups and venues for meetings.

	Number (%) of groups
Number of members in group	
6–9	14 (*13*)
10–19	62 (*58*)
20–29	22 (*21*)
30+	9 (*8*)
Venues for meetings[a]	
Members' surgeries	43 (*40*)
Members' homes	39 (*36*)
Local hotel	10 (*9*)
Postgraduate centre	8 (*7*)
Local hospital	5 (*5*)

[a]There was no response from two groups.

distributed across the UK with 42 (39%) in south east England, 23 (21%) in the Midlands and East Anglia, 19 (18%) in northern England, 12 (11%) in the west of England and Wales and 11 (10%) in Scotland and Northern Ireland. However, there are some gaps such as Oxford, Southampton and Exeter. The distribution generally follows the population distribution, with the notable exception of the Isle of Lewis which has a group. The highest concentration of groups is in Luton which has six while Cardiff has only one.

Organization of groups

Features of the organization of the groups are shown in Table 1. A number of groups had started out with a constitution, a committee or annual general meetings but most have now abandoned these. Of the 18 groups who insisted on members leaving after several years as a principal, 12 had five years as the limit.

Most groups (59) had social meetings to which spouses were invited; 46 did not and there was no response from the remaining two groups. Six groups met without refreshment, 63 had drinks available and 38 had a meal provided.

There were no major differences between the methods of organization of the groups.

Membership, attendance and venues for meetings

The total membership of the groups identified was approximately 1650. There was considerable variation in the size of groups (Table 2), the smallest having only six members and the largest 50. The variation in the number of members attending each meeting, however, was smaller. The mean was eight members, and even large groups of 30 or more had a mean attendance of between 12 and 14. The mean attendance for the survey population as a whole was 59%.

The most popular venues for meetings are also shown in Table 2. Seventy per cent of the meetings occurred monthly and 76% lasted between one and two hours.

Content and form of meetings

Two questions were asked about the content of meetings. An open question asked groups to indicate which topics had been successful, and a closed question asked whether meetings had been held on a stated range of topics. The results are shown in Table 3.

The relationship between the content of meetings and the reasons for forming groups was examined. Since over half of the groups mentioned continuing medical education as a reason for formation, this was used as the basis for comparison between them. However, analysis of the successful meetings of these groups revealed no differences from the rest, although groups motivated towards continuing medical education showed a slight preference for meetings on prescribing.

The most popular form of meeting was group discussion (81%), followed by meetings led by an outside person (39%).

Motivation and formal aims

Only 55% of the 107 groups listed their formal aims and many made multiple responses. Only the 57 groups that had given continuing medical education, social activities or support functions, exclusively, as their original reason for forming the group were

Table 3. Content of meetings held by the 107 groups.

	Number (%) of positive replies
Successful topics for meetings	
Clinical topics/practical medicine	64 (*60*)
Practice administration	33 (*31*)
NHS administration/green paper	22 (*21*)
Case discussion/problem patients	20 (*19*)
Personal aspects/partnership problems	15 (*14*)
Audit	12 (*11*)
Meetings held on:	
Clinical topics	104 (*97*)
Administration	97 (*91*)
Audit	72 (*67*)
Finance	72 (*67*)
Discussion with specialist colleagues	61 (*57*)
Research	33 (*31*)

Table 4. Formal aims listed by the 57 groups.

		Number of groups giving formal aim			
Reason for forming group	Total number of groups	Support	Social	Continuing education	To improve knowledge
Continuing education	33	9	6	5	9
Social	13	1	2	1	1
Support	11	5	2	3	2

examined in relation to their formal aims. The results are shown in Table 4.

These figures suggest that there is little difference between the aims of groups regardless of their original reason for formation. Of the 33 groups who gave continuing medical education exclusively as the reason for formation, only five stated it as a formal aim, whereas nine gave support as an aim.

There was no relationship between the length of time the group had been formed and the reasons for formation, formal aims and content of meetings, with the notable exception of groups that had been formed for less than three years. They were less likely to have meetings with specialists than groups that had been formed for three years or more (28 out of 66 versus 23 out of 30) and more likely to have found discussions about personal/partnership problems successful (17 out of 76 versus nil out of 20). Eleven groups did not respond to each question, and the distributions were different for each.

Outside help

Seventy-two (67%) of the groups had sought outside help at some time: 18 from general practice tutors, 14 from regional advisers in general practice, 13 from postgraduate deans, 12 from local vocational training scheme organizers, 10 from the Royal College of General Practitioners, two from the British Medical Association, two from RCGP research units and one from a family practitioner committee.

Eighty three (78%) of the groups felt that they did not need any outside help at present. Of those who did need help, 11 (10%) wanted ideas and advice on running a group, eight (7%) wanted contact with other groups and five (5%) wanted financial assistance.

Discussion

The poor response rate (26%) to the initial questionnaire sent to new principals was disappointing and to obtain the 65% response rate for the detailed questionnaire telephone reminders were necessary. The low response rates may be due to a general dislike of filling in forms and to the insularity of groups. However, the majority of the groups identified responded and thus the results can be considered representative, although they must be interpreted with caution.

The geographical distribution of groups is not easy to explain. The absence of a group in Oxford may be because there is a well organized course for newly appointed general practitioners in Oxford which fulfils the same function as a young principal group (Markus A. Personal communication). In Cardiff doctors go to group meetings for a number of years and then leave feeling their educational and social needs have been satisfied, whereas in Luton they tend not to leave and new groups are formed when the numbers become too large.

From the initial survey, it would appear that 43% of recently appointed principals do not have a local group that they can join, and among those who have a local group 32% have not attended a meeting. Perhaps general practice tutors should initiate the formation of groups in areas where they are not available.

The majority of groups (81%) responding to the detailed questionnaire had been formed since the introduction of mandatory vocational training. Indeed, 11% gave continuation of vocational training as a reason for formation of the group. Stott[3] has commented; 'It is often difficult for young practitioners to find a forum to continue the style of education to which they have become accustomed during vocational training, and more importantly to find a forum that enables them to explore their anxieties and frustrations in a peer group.'

Our study suggests that groups have been set up by young principals for themselves and they appear to be meeting the needs of their members by changing their activities over time. Holmes[2] found that his group ceased to exist once the members' needs had been met and we found some evidence of this. In such cases the groups have achieved their purpose and closure should not be regarded as failure.

It is clear from the results that most groups are run informally. Few of them keep minutes (20%) and even fewer hold annual general meetings (8%) or have written constitutions (7%). There are few limitations on membership, although 33% of groups are only open to new principals and 17% have a time limit on membership. Young principal groups cater for the needs of new principals and whatever differences there may be in the groups' stated aims, they all attempt to meet these needs in an open unstructured setting.

The social element of group meetings is clearly important. Even those groups stating continuing medical education as the reason for formation of the group gave social and support purposes as formal aims more often than continuing medical education. The pressures on a new principal are great: a new job, a young family, heavy financial commitments together with the change in status from employee to self-employed.[4] Such changes are known to be stressful, and it is not surprising that support is sought from others sharing similar experiences.

The educational element of group meetings is also important. Continuing medical education was given as the reason for formation by 57% of groups and clinical and practical aspects of general practice rate highly in the list of most successful meetings. Pendleton[5] noted the tendency of young principal groups to deal with performance review — the informality and intimacy of the groups promotes scrutiny among peers.

Meeting with consultants was one of the areas where clear differences between groups were seen. Fewer groups less than three years old had discussions with consultants than groups over three years old. This tendency to self-sufficiency is also demonstrated by the proportion using section 63 money (42%). Although 67% had approached outside agencies for advice at some time, 78% no longer required any outside help.

The other area where a difference between groups was demonstrated was in the discussion of personal/partnership problems, where 29% of groups less than three years old stated it provided one of their most successful meetings compared with none of the older groups.

The continuing education and personal/social needs of young principals are being met by young principals themselves in a deliberately independent manner. The exact nature of these early needs is the subject of a further study currently being carried out.

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