Debate & Analysis

The GP workforce pipeline:

increasing the flow and plugging the leaks

BACKGROUND

The 2017 annual meeting of the Society for Academic Primary Care included a workshop for participants with an interest in recruitment and retention of GPs. This article presents emergent themes following presentations about factors affecting the attractiveness of GP work at three stages: 1) during medical school; 2) when choosing a specialty; and 3) retaining experienced GPs until normal retirement age.

Attendees encompassed 15 UK medical schools. Many were involved in undergraduate and postgraduate teaching, some with leading educational roles, some involved in admissions and career support, and also GPs, researchers, and students.

'Career': 'a journey through life and work'

Career decisions are an ongoing process, a continuum alongside vocational maturation.[1] This article separately considers issues raised in presentations and by workshop participants as they affect medical schools, Foundation Training, and experienced GPs.

STAGE 1: MEDICAL SCHOOLS AND THE WASS REPORT

Health Education England (HEE) commissioned a taskforce to investigate how students' experiences during undergraduate training influenced their views of a GP career.[2] Recent *BJGP* editorials and published recommendations to improve recruitment to GP training programmes were discussed.[3,4]

Workshop participants discussed four of the recommendations applying to medical schools:

Participating in medical school selection procedures

Admissions procedures define the future workforce and need to facilitate 'appointing appropriate applicants'. Despite stating that *'... [a]ll medical schools must ensure that General Practitioners contribute significantly in all selection processes.'*,[2] delegates confirmed that this currently varies across UK medical schools.

Tackling the 'hidden curriculum' and encourage mutual professional respect

The effects of undermining general practice as a career have been demonstrated[5] and remain problematic.[6] Addressing *'all doctors whether in primary care or secondary care'*, the recommendation is to *'take personal responsibility to create caring mutual respect in the clinical environment'*.[2]

Encouraging role models and near-peer support

The importance of GP tutors as role models who *'help students feel a useful and integrated part of the team'* (unattributed participant quote), and potentially inspirational contact between GP specialty trainees and students, should not be underestimated. Examples of positive 'near-peer support' indicate that buddy schemes involving GP registrars and medical students should be encouraged.[7]

Facilitating student GP societies

Many of the Royal College of General Practitioners (RCGP) faculty boards have appointed student liaison officers and the RCGP has supported setting up GP societies in medical schools. Workshop participants felt that fluctuations in societies' activities, due to the inherent variability of student cohorts, could be mitigated by the involvement of enthusiastic local GPs.

STAGE 2: EARLY CAREER PLANS; FOUNDATION PROGRAMME DOCTORS' CHOICE OF SPECIALTY TRAINING

The proportion of doctors entering specialty training (ST) programmes on completing Foundation Programmes (FP) has dropped from 71.3% to 50.4% during 2011–2016.[8,9] Workshop participants expressed concern that HEE appears indifferent to this trend. The introduction of less flexible training programmes was felt to have increased doctors' difficulty committing to a specialty when they lacked broad experience of medical work[10] and, in addition, the absence of comprehensive data on subsequent career trajectories (for example, leaving medicine, leaving the UK) undermined purposeful workforce planning.

Emerging evidence indicates that doctors completing FP training (F2 doctors) weigh up many factors when making career decisions, including perceptions and experiences of GP work.[11,12] Because around 38% of F2s change specialty choice during the 2-year programme,[9] it was hoped that greater opportunities to experience work (43.8% in 2012; 47.7% in 2016) would increase recruitment.[9,13] Despite mixed evidence on the success of this, many workshop participants felt that GP placements should be more readily available (or mandatory) for FP doctors, but that this could only have a positive effect if it occurred prior to ST recruitment.

Workshop participants also proposed that prior training in another specialty be a valid component of GPST requirements. A need for positive and supportive GP role models and peer-to-peer learning was felt to be important for inspiring early-career doctors to become GPs, although participants recognised that doctors have a wide range of preferences and general practice will not be attractive to all.

Finally, more research should investigate doctors' career choices, and the inextricable links between medical education and careers demand that we should not consider these in isolation from each other.

STAGE 3: RETENTION OF EXPERIENCED GPS

The National Institute for Health Research ReGROUP project (http://medicine.exeter.ac.uk/research/healthresearch/regroup/) was commissioned to develop policies to retain experienced GPs and those taking a career break from patient care. Findings include a survey of South West GPs indicating a high likelihood of quitting (37%), reducing hours (57%), or taking a career break (36%) within 5 years.[14]

Using an established methodology (a RAND/UCLA Appropriateness Method (RAM) — a modified Delphi study), a panel of GP partners rated draft policies according to 'appropriateness' and 'feasibility' for retention of GPs. Consultations with representatives of organisations involved in workforce planning considered three categories of policies/strategies aimed at: 1) protecting GPs and managing patients' expectations of general practice; 2) incentives and support mechanisms for GPs; and 3) supporting portfolio careers and the wider skill-mix in primary care.

Workshop participants discussed issues as follows.

GPs leaving the profession

Two risk groups were identified:

- 'last5' GPs (nearing retirement) whose career could be extended by strategies including altering pension arrangements, and developing a concept of restricted practice to focus interest and increase motivation for continued practice; and
- 'middle generation' (that is, GPs in

their 40s). Potential support could include the GP Returners Facebook page (https://www.facebook.com/groups/150370435366726/#_=_)[3] and establishing informal, virtual 'Beyond-First5' groups, to share issues and solutions.

Proposed retention initiatives have included: RCGP Fellowship to recognise senior GPs' experience; GP mentorship; peer support networks; career breaks; and targeted clinical commissioning group support.

Portfolio working

A GP 'portfolio' career describes those who have multiple roles within their working week, alongside their primary GP role.[15,16] There is a huge range of potential additional roles, including those involving a specialist clinical interest, medical education, or in external provider or commissioner management roles. Participants highlighted the need to understand the activities of 'portfolio' GPs and to consider what would increase their involvement in patient care. Incentivised portfolio roles could potentially match GPs' interests. Participants felt that portfolio career development should be delayed until at least 10 years post-clinical training, and that protected time and funding for GPs' involvement in medical school teaching would provide positive role models for students.

DISCUSSION

Achieving growth of the GP workforce is currently being undermined at several points and by multiple pressures. Because each individual's career is a continuum, collaboration and support for GPs throughout different career stages is important. Consistent with the principle of linking 'lead responsibility, supported by outcome measures' with Wass report recommendations, suggestions emerging from this workshop are similarly linked under three broad categories:

Structure and organisation

Inflexible requirements of training programmes can deter recruitment of doctors from other specialties. Changes in relation to this would need involvement from both the RCGP and HEE, and would require building into existing structures. For GPs nearing retirement, the BMA and NHS England could facilitate a change in contract to allow GPs to focus on a narrower range of practice; this would require both the primary care workforce and patients to alter their current expectation of career-long unrestricted practice.

Education and training

GPs are not routinely involved and lack a strong voice in medical school selection procedures; the GMC, perhaps in conjunction with the Medical Schools Council, should mandate medical schools to ensure that GPs have a tangible influence on admissions processes. An increased presence of GPs as medical school clinical tutors would allow students to appreciate the depth and breadth of knowledge underpinning GP work, as well as provide role models whose expertise differs from hospital specialists. These roles could form part of portfolio careers.

Maximising the peer factor

Educational benefits have been shown from peer-to-peer learning and positive outcomes reported with close-peer support; similar benefits are likely to emerge from supportive working during doctors' later careers. Individual medical schools could coordinate educational activities with local GP training schemes and deaneries. Later in GPs' careers, such approaches might be organised at regional, local, or practice level by GPs who coordinate their ways of working.

Factors contributing to high attrition of GPs urgently need to be reduced. Importantly, the future of general practice also requires a healthy flow of students and junior doctors who are convinced that choosing general practice will lead to professionally rewarding and sustained careers.

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REFERENCES

1. Savickas ML. The theory and practice of career construction. In: Brown SD, Lent RW, eds. *Career development and counseling: putting theory and research to work*. Hoboken, NJ: John Wiley & Sons, 2005: 42–70.
2. Health Education England. *By choice – not by chance*. HEE and Medical Schools Council, 2016.
3. Wass V, Gregory S. Not 'just' a GP: a call for action. *Br J Gen Pract* 2017; DOI: https://doi.org/10.3399/bjgp17X689953.
4. Madan A, Manek N, Gregory S. General practice: the heart of the NHS. *Br J Gen Pract* 2017; DOI: https://doi.org/10.3399/bjgp17X689965.
5. Baker M, Wessely S, Openshaw D. Not such friendly banter? GPs and psychiatrists against the systematic denigration of their specialties. *Br J Gen Pract* 2016; DOI: https://doi.org/10.3399/bjgp16X687169.
6. Alberti H, Merritt K. Confronting the bashing: fundamental questions remain. *Br J Gen Pract* 2016; DOI: https://doi.org/10.3399/bjgp16X688081.
7. Sahota K, Anderson C, Charlton R. Innovations in primary care to promote general practice as a career to medical students. *Br J Gen Pract* 2016; DOI: https://doi.org/10.3399/bjgp16X686233.
8. UK Foundation Programme Office. *Foundation Programme annual report 2011*. 2011.
9. UK Foundation Programme Office. *The Foundation Programme career destination report 2016*. 2017.
10. UK Health Departments. *Modernising medical careers: the next steps*. Leeds: DH, 2004.
11. Spooner S, Pearson E, Gibson J, Checkland K. How do workplaces, working practices and colleagues affect UK doctors' career decisions? A qualitative study of junior doctors' career decision-making in the UK. *BMJ Open* 2017; http://dx.doi.org/10.1136/bmjopen-2017-018462.
12. Spooner S, Gibson J, Rigby D, *et al*. Stick or twist? Career decision-making during contractual uncertainty for NHS junior doctors. *BMJ Open* 2017; **7(1):** e013756.
13. UK Foundation Programme Office. *The Foundation Programme annual report 2016*. 2017.
14. Fletcher E, Abel GA, Anderson R, *et al*. Quitting patient care and career break intentions among general practitioners in South West England: findings of a census survey of general practitioners. *BMJ Open* 2017; **7(4):** e013756.
15. Griffin A. 'Designer doctors': professional identity and a portfolio career as a general practice educator. *Educ Prim Care* 2008; **19(4):** 355–359.
16. Pathiraja F, Wilson M-C. The rise and rise of the portfolio career. *BMJ Careers* 2011; **342:** 27–28.