The black hole of general practice manpower

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ABSTRACT

Objective

To explore motivating and deterring factors for choosing and remaining in a general practice career for medical students, GP registrars and established general practitioners (GPs) in New Zealand (NZ).

Methods

A 2005 survey of convenience samples of medical students (years two to six) and GP registrars and a purposive sampling of established GPs. Qualitative analysis of positive and negative influences towards choosing a general practice career and the perceived barriers for colleagues to enter general practice and what GPs liked most and least about their work.

Results

The attraction for all groups was the ongoing relationships with patients and their families. Established GPs value their autonomy. For the next generation flexible working hours is a major attraction. Many students perceived general practice of lowly status and pay, with increasing paperwork and less stimulating than hospital medicine. Many GPs were concerned about never-ending change, bureaucracy, poor earnings, time pressures, lack of adequate resources for their patients, threat of litigation and 'burnout'.

Implications

Retention and growth of the general practice workforce requires medical school curricula changes to give students earlier, more extensive exposure to interaction with general practice. Hospital doctors need to demonstrate respect for primary care to students. A career pathway with government-assisted post-graduate education in subspecialities to provide intellectual stimulation and augment earnings might dissuade some GPs from early retirement. GPs need time and energy to interact with their patients to the benefit of both parties. Bureaucracy and work overload detract from the process.

Key words

Family physician, career choice, manpower, personnel selection

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Introduction

There has been a dramatic change in the nature of general practice in New Zealand (NZ) in the past two decades. Numbers of general practitioners (GPs) are falling, especially in rural areas.[1]

The Medical Reference Group (MRG) established to provide independent advice to the Health Workforce Advisory Committee in September 2003, is *'deeply concerned about recruitment and retention in general practice'*.[2] As well as GP-to-population ratios falling, especially in rural and deprived areas, the MRG expresses concerns about the ageing workforce; the heavy dependency on overseas trained doctors; increasing workloads and hours of work; more doctors working part-time, often outside general practice; more women in the general practice workforce; fewer doctors self-employed; low general practice remuneration relative to other branches of medicine and a generally low workforce morale. The MRG also identifies the increasing popularity in salaried or locum employment; the growing 'bureaucratic burden'; fewer students and recent graduates showing interest in a general practice career and inadequate numbers of doctors receiving general practice training.

The aim of this study was to explore the motivating and deterring factors for choosing and remaining in a general practice career for medical students, GP registrars and established GPs in the context of this workforce crisis occurring within NZ general practice.

Methods

Convenience samples of classes of 2nd and 6th year medical students in Dunedin; 4th and 5th year students in Christchurch and Auckland, and GP registrars attending seminars in Auckland and Christchurch, were invited to complete questionnaires

Table 1. Medical student's career intentions

Medical students' intention to become GPs	Dunedin (2nd + 3rd years) n (%)	Christchurch (4th + 5th yrs) n (%)	Auckland (4th + 5th + 6th yrs) n (%)	Total n (%)
Intend to	18 (19)	17 (20)	18 (20)	53 (19)
Undecided	52 (55)	38 (44)	49 (53)	139 (51)
Do not intend to	24 (26)	32 (36)	25 (27)	81 (30)
TOTAL	94	87	92	273

about general practice as a career in 2005. Purposive sampling was used to survey established GPs. The sampling deliberately included 'outliers' with respect to characteristics such as gender, years in practice and geographical location of practice and included a mix of rural and urban practices and of locally and overseas-trained doctors. Inclusion criteria for the study comprised membership of a recognised course of medical school training; membership of a training course for GP registrars, or working as an established GP. There were no exclusion criteria within those three groups.

Potential participants were provided with a participant information sheet. They were under no pressure to participate and anonymity of their responses was assured. Participants completed a semi-structured written questionnaire with free text options. Completing the questionnaire was implicit consent. The study was approved by the University of Auckland Human Participants Ethics Committee.

Questions for medical students included positive and negative influences towards choosing a general practice career, and whether they were considering this vocation. Questions for GP registrars included their aspirations with respect to future practice, the influencing factors on their choosing to become GPs, reasons they perceived were barriers for colleagues to enter general practice and what would most likely make them retire early. Established GPs were asked details about their general practice experience, the age they expected to retire, factors that influenced their staying in general practice and what they liked most and least about their work.

Quantitative analysis using descriptive statistics included demographic details; intention of students to enter general practice and retirement plans for trainee and established GPs.

A qualitative approach was used to explore influences on medical students and doctors that affect their choosing and maintaining a career in general practice and NZ. Purposive sampling of established GPs built sample diversity with respect to different subjects and themes along the main topics of interest (for example, aspects of general practice they liked most and least) to improve data robustness. Sample sizes exceeded data saturation levels of identified themes.

Data saturation was reached, with no new themes emerging. Data analysis used a general inductive approach. Individual responses were analysed to identify themes with discussions between two researchers until consensus was reached on thematic codes. Responses were collated and coded. The data were independently double-coded as a consistency check with discrepancies resolved by negotiation.

Results

Medical students

Only 19–20% of students surveyed in all three regions were intending to become GPs, about 30% were not and about half were undecided (Table 1).

The strongest positive influence students identified on their choice of a general practice career was the GPs they had met, followed by lecturers and then books they had read. By far the strongest negative influence was hospital doctors followed by student peers.

Two main themes emerged that attract students to general practice: the lifestyle it offers (*'Flexible hours'*; *'Lifestyle factors make general practice more attractive – the idea of working part-time and no on call is great'*; *'Becoming a GP is attractive in the sense that you get more time off to focus on extramural goals'*) and the opportunity for ongoing relationships with patients (*'Knowing patients and families well'*; *'family-friendly, involves a lot of patient contact and time talking; where most people come in contact with medical world'*; *'GPs deal more with the* person *as opposed to* disease*'*).

Positive experiences of GPs as role models was also an important incentive (*'I have chosen to study medicine due to experiences with my family GP'*; *'Positive and enthusiastic GPs can make a huge difference'*; *'Only after going on a general practice attachment did I seriously think about general practice as a career'*). Negative experiences with GPs were occasionally cited as a disincentive (*'I didn't enjoy my GP attachment because I didn't find my GP welcoming or helpful'*).

The greatest disincentive identified by students was the poor status awarded to GPs, especially by hospital specialists. This recurring theme was evident from 2nd year students through to trainee interns (*'Elitist attitudes of hospital doctors especially consultants probably has a negative influence on students'*; *'Impression*

from certain hospital consultants that becoming a GP is a "fallback" option, something you do if you can't make it in the hospital'; *'The general climate in our lectures suggests that GPs are relatively incompetent'*).

Students also perceived that GPs are not regarded highly by the government (*'The current climate...seems to be one of uncertainty and disillusionment – medico-legal and funding issues'*; *'Seems as though government is not really that helpful towards GPs'*; *'General practice is an unstable, underpaid profession due to political influences'*). To a lesser extent students also identified that the public perception of the GP is lowly in comparison to other medical specialists (*'There is very little knowledge that a GP is a specialist who has done further training'*; *'the job of a GP is not as prestigious as other consultant jobs'*).

A major deterrent for students choosing general practice as a career is the poor financial return relative to other specialties (*'Don't get paid enough to be a GP otherwise it would be a cool job'*; *'The thing that makes me not want to be a GP is the low pay, especially as I have a large student loan'*; *'Financial recompense is not attractive especially considering the cost of education'*) and that *'GPs work too hard for too little money'*. This is linked with the financial and business implications of practice ownership and fee-for-service (*'I think a salary or free GP system would encourage me'*; *'Don't want to own my own business'*).

Students were also concerned about the increasing amounts of paperwork and bureaucracy associated with the job (*'You are treating paper not people'*). While some students saw general practice as offering part-time and flexible hours, others perceived an onerous workload (*'GP life is their work – not much "out of medicine" time'*).

For some students general practice was perceived as less stimulating than hospital medicine (*'Tedious and boring, lacking excitement'*; *'Less interesting than a speciality – seeing 1000s of snotty-nosed kids with flu'*). Others considered general practice a difficult job (*'A bit frightening to students – don't work in a big team and have to know something (or a lot) about everything'*, *'Involves a wide range of conditions/diseases – means being comfortable in a degree of uncertainty'*).

Another key theme to emerge was students' lack of adequate exposure to, and accurate information about, general practice. Their predominant experience of general practice is seen through the eyes of hospital colleagues (*'As a student/trainee intern in the hospital, you can be exposed to a negative perception of general practice especially from younger doctors who are receiving and dealing with referrals from GPs, who often complain about the nature of the referrals. When you do your general practice run you realise the practicalities of this, the time restraints and the implications if you don't refer'*).

There was a strong desire expressed to hear about what life is like for GPs from GPs (*'GPs out there giving options at career fairs instead of hospital staff saying what they think of work as a GP'*). Students were keen to learn more about being a GP (*'More information about what GPs do early on in medical career, i.e. 2nd and 3rd years'*).

GP registrars

The 52 GP registrars surveyed came from Auckland, Christchurch and Dunedin. Seventy per cent were overseas-trained doctors. Less than two-thirds (33/52; 63%) intended to work as full-time GPs with their stated preference part-time salaried or permanent locum work. Over a third (18/52; 35%) anticipated an early retirement (under the age of 60).

Poor status of a general practice career was the major theme they identified as a reason why few of their medical peers chose general practice (*'GPs have bad reputation in hospital due to perception of some consultants. This attitude is filtered down to student level'*; *'Not valued within the medical profession – hospital drs have a poor opinion of GPs'*; *'Second cousin to real doctors'*; *'GP "knocking" by hospital specialists'*). The perception was that GPs had *'Less respect by colleagues and general public'*. There was a view that GPs received poor press (*'Media reporting on negative aspects of GP'*).

Low pay was also viewed as a major disincentive (*'Not well remunerated'*; *'Hard work for not so much money'*) along with *'Reluctant to run own business'*. They identified that the *'Training scheme not well paid compared to hospital jobs'*. Long hours were off-putting, especially in rural practice (*'Unable to take leave'*; *'Call hours too long in rural areas/smaller towns'*).

Paperwork and bureaucracy was also an issue (*'Constant changes GPs are exposed to in terms of funding/organisation'*; *'Mushrooming paperwork'*; *'Too much regulation'*).

They believed that many of their specialist peers did not choose a career in general practice because they wanted to specialise in a small area of medicine (*'Afraid of covering such a wide spectrum'*; *'Daunted by number of patients with non-medical problems, e.g. my wife just left me/I'm about to be fired'*) and considered GP an unexciting job (*'Being only a triage/referral service for anything interesting'*; *'Managing only boring insignificant things'*).

The breadth and responsibility of the job was seen to be a deterrent (*'The requirement to be a jack of all trades'*). Associated with this was concern about medico-legal issues (*'GPs more vulnerable to litigation'*; *'Easily blamed by patients/other doctors "easy target"'*.)

Lack of exposure to, and adequate knowledge of, general practice for medical students was a prominent theme amongst GP registrars as well as students (*'Lack of adequate information and exposure to primary care as a medical student'*; *'General practice as a career not emphasised at med school as all hospital-based'*).

Concern was also expressed about the lack of ongoing career advance-

ment (*'Little opportunity for job progression'*; *'Those who don't go into general practice feel they have fallen off the career ladder'*; *'Financially they are at the lowest range and can't go up into super-specialities'*).

Factors most likely causing early retirement were *'lack of support'*; *'burnout'*; *'ill health'*; *'loss of skills or knowledge'*; *'failing job satisfaction'*; *'litigation'* and *'a wish to spend more time pursuing family and personal interests'*.

Established GPs

The 102 established GPs surveyed came from rural, small town and urban areas nationwide. There was a broad mix of male and female, NZ and overseas-trained, and length of experience from a few months to 47 years. Twenty-one per cent (22/103) expected to retire early (under the age of 60). Support of colleagues, adequate holidays and control over hours worked were cited as factors with greatest influence over whether doctors continued to work in general practice.

What GPs most enjoyed in their work was *'Meeting the people'*; *'The privilege of being part of the lives of my patients'*. They valued highly ongoing relationships with their patients (*'Patient contact, continuity of care, developing relationships'*; *'Working with people at honest and exposed moments'*).

The intellectual challenges of the job (*'Very rewarding – intellectual stimulation/problem solving'*) and *'Doing something worthwhile'* were also important themes. *'Variety and diversity'* as well as *'autonomy'* were highly valued (*'Never know what the next five minutes will bring'*; *'Every day is new'*; *'Variety and until recently the freedom'*). Some GPs appreciated the lifestyle flexibility it offers (*'Adjustable schedule of work'*; *'Part-time work'*); the rewards from contact with other colleagues (*'Camaraderie with colleagues'*) and being a member of the practice team (*'Running a team, giving them space to develop and be proud of their own jobs'*).

Some GPs commented how they felt valued within their communities (*'Great community support'*; *'Status of being a GP'*). A number also cited added activities such as *'teaching'*; *'research'*; *'assessor for College of GPs'*, and *'learning new skill and procedures'* as adding to their work satisfaction.

The greatest dislike for GPs was *'Government bureaucratic paperwork'* (*'Paperwork that has no value'*). One GP who had been in a semi-rural practice for 15 years commented *'Admin/paperwork!!!! If I leave medicine, it will be due to this'*. Associated with this was dislike of the *'rapid change of rules'*; the *'never-ending change'* and the *'time pressures'* under which they worked (*'Workload, no time for family'*).

Low earning was a major concern (*'Terrible funding issue in government policy'*). There was also frustration with lack of adequate resources for their patients (*'Having to prescribe according to cost rather than evidence-based medicine'*; *'Trying to get my patients specialist evaluation'*; *'Long waiting lists'*).

For some a negative aspect of the job was dealing with difficult or boring patients (*'Patient from hell'*; *'Suburban wealthy patients with multiple minor problems drive me nutty!'*; *'The boredom of seeing the same minor ailments again and again'*).

For others the *'pressure and threat of medico-legal action'* (*'Perceived risk of malpractice – making an error'*) was an aspect they disliked about their work.

Conclusion

In the past two decades the nature of general practice in NZ has undergone a series of massive reforms. Until the 1990s the vast majority of GPs worked as independent professionals, with a fee-for-service state subsidy. In 1991 proposed government contracts replacing fee-for-service were perceived as a threat to professional autonomy. This led to the formation of independent practitioner associations (IPAs), collective organisations that contracted with the state on behalf of their members and engaged in a range of management and coordinating activities.[3] Although many GPs joined reluctantly, IPAs were perceived to be doctor-driven organisations with GPs involved in their professional and business decisions and, by 1998, 82% of GPs belonged to some form of primary care organisation.[4]

The last major reorganisation was the release of the primary health care strategy in 2001 and its subsequent implementation through the development of Primary Health Organisations (PHOs).[5] PHOs are funded by District Health Boards (DHBs) for provision of primary health care services to enrolled patients, particularly targeted to populations of greatest health need (Maori, Pacific people and those from lower socioeconomic groups). The model is a move from GP-provider fee-for-service primary health care delivery to one that is community-focused, multidisciplinary, with needs-based funding for population care. PHOs are expected to involve their communities in their governing processes. While joining a PHO is voluntary for GPs, funding discrepancies have made non-membership financially unviable for many. The first PHOs were established in July 2002. By April 2005 there were 77 PHOs with approximately 3.8 million enrolled patients and the number continues to grow.[6] PHOs vary greatly in size from 5000 to 333 000 enrolled patients with greatly differing funding formulae and structures.[7] The relationship and role of an IPA with a PHO was not defined and is also diverse.

Traditionally a GP worked full-time in a self-owned practice, provided after-hours call and home visits for patients, practised obstetrics, felt a valued member of her or his community and often retired well after the age of 60. In the urban setting there has been a significant shift towards part-time doctors working sessions in practices with no on-call duties. There has been a divergence between urban and rural practice, with the latter often struggling with heavy

workloads, frequent on-call and inability to get time off.[8]

The health reforms, particularly the development of PHOs, have led to radical changes in what it means to be a GP. While many GPs still own their businesses, employ practice nurses and other staff and provide full-time after hours cover, there has also been a growth in salaried, often part-time positions, especially in socially-deprived communities. The PHO requirement for community governance while most of the service is provided by privately owned GP practices is a potential source of tension.

Our findings show that the flexibility of working hours and the lifestyle this affords is one of the main draw cards for students and young doctors choosing general practice as a career. It is a profession increasingly favoured by women who wish to take time out to have children. Furthermore, many wish to retire before the age of 60. This has significant implications regarding the numbers needed to be recruited into the workforce.

Of concern, only about 20% of students at each centre were actively considering general practice as a career. Financial disparity between general practice and other specialties emerges as a major hurdle to recruitment and many now see ownership of a practice as a liability rather than an asset. The primary health care strategy does not address the huge funding implications of a nationwide move from private to state or community-owned practices.

The perceived inferior status of the GP reinforced to students from early in their studies also surfaces as a strong deterrent. By the time GPs are established in their practices they have lost concern about status. Feeling valued and their relationship with their patients is important to them. They like the autonomy, the variety and the clinical challenges. They value contact with colleagues and continuity of care. Lifestyle is important.

It is clear from this study that ignorance causes many blocks to a career choice in general practice. Medical students would benefit from experiencing more about the positive aspects of general practice early in their training. Negative messages they get include troublesome bureaucracy; that life as a GP will be less exciting but with a heavy workload, a greater exposure to medico-legal problems and lack of support. They often feel ill-prepared for the breadth of knowledge required to work in general practice and conclude that working in hospital will be safer, have more status, and be more financially and intellectually rewarding. Few consider lifestyle at this stage.

Negative aspects for GPs are poor pay, increasing paperwork and bureaucracy (largely stemming from the numerous health reforms), time pressures, long hours, stress, difficulties of obtaining services for their patients and medical politics. Fear of litigation is a growing concern. GPs listed demanding and boring patients as factors which could lead to early retirement, as well as loss of job satisfaction, and reduced family time.

Students and registrars expressed concern about the lack of career advancement in general practice. A number of GPs valued the development of other interests such as teaching, researching, practice and business management, and other primary care skills with possible 'sub-specialising' in an area of special interest such as drug and alcohol rehabilitation or sports medicine.

Strengths and weaknesses of the study

A strength of this study was the rich narrative data from a wide range of medical students, GP registrars and established GPs. A limitation was that the sampling method (using classes of medical students; GP seminar attendees and GPs at meetings and peer group sessions) might have introduced some selection bias. Given the convenience of purposive sampling and the predominantly qualitative nature of the research, generalisation of these findings needs to be approached with caution.

Relationship of the study to existing literature

The work force crisis is particularly an issue in rural areas and those of deprivation and high need.[9] A postal questionnaire of all NZ rural GPs (response rate 75%) identified positive aspects of the job as strong patient and community relationships and a broad scope of practice, but emphasised the negative features of being overworked, under-valued and under-paid.[8] A survey of job satisfaction found that NZ GPs, physicians and surgeons had similar levels of job satisfaction, and this was greater than that of community pharmacists.[10]

In NZ limited funded GP training positions create a barrier to general practice career development. The DHBs have the responsibility of both hospital service provision and the development of a primary care workforce. Ironically, junior doctors who do not express an early interest in a hospital speciality may be placed in jobs inappropriate for GP training (for example, cardio-thoracic surgery). There is a need to address workforce issues in both primary and secondary care.[11]

This study advances the understanding of the currently perceived influences on the choice of a career in general practice and of the willingness to continue with that career to normal retirement age. It highlights the areas of responsibility held by hospital doctors, medical educators and primary care organisations towards recruiting and maintaining a GP workforce. It reinforces the concerns raised by the Medical Reference Group regarding a potential GP workforce crisis.[2]

Implications

Established GPs have valued their autonomy. For the next generation a major attraction is the flexibility of working hours. The common thread with medical students, GP registrars and established GPs is the potential for fulfilling ongoing relationships with their patients and their families.

If we are to retain and to grow a GP workforce, medical school curricula need to give students earlier and more extensive exposure to the rewards of interaction with patients in general practice. Students need to know more about the rewards of life as a GP and about the possibilities for career development within general practice.

Numerous studies in North America and the UK concur that increasing undergraduate involvement in community-based primary care training correlates positively with entries into GP/family physician training schemes and subsequently into general practice.[12-14] A meta-analysis of the literature on speciality choice found that required family practice training runs and longitudinal primary care experiences for medical students are associated with increases in the numbers choosing primary care.[15] Overall, the number of weeks spent by students in family practice shows the strongest association with their choosing this career option.

Hospital doctors have a major influence over students' perceptions of general practice as a career. They should be aware of their responsibility to demonstrate respect for primary care, where 90% of all medical care is conducted. All involved in medical student training should be aware of national recruitment requirements in primary as well as secondary care and ensure that training programmes address these needs. The ignorance highlighted in the conclusions to the study represents a challenge for medical educators to address GP recruitment problems at an early stage. About 50% of students surveyed were undecided on their career choice and could be directed towards considering general practice. The status of primary care medicine needs to be elevated, and GP vocational training schemes need to be promoted to students and newly-qualified doctors, along with career discussions. In 2005 there were 114 applications for the 50 funded positions on the Intensive Clinical Training Programme (ICTP) registrar programme.[16] Substantially more places should be available in the programme for GP registrars.

Those doctors still willing to run practices should be highly valued by primary care organisations as part-time salaried work becomes ever more popular. Initiatives have been introduced in some rural areas providing salaries and after-hour and holiday cover to attract GPs. While such schemes may provide local solutions, care must be taken that they do not disturb the existing fragile rural GP workforce.

GP retention is a real challenge for continuing medical education. NZ has the ability to offer GPs postgraduate education in sub specialities that provide intellectual stimulation and augment earnings. GPs value a career structure that keeps them enthused and alters the focus of their work as they mature. This in turn broadens and develops treatment within primary care, relieving the burden on secondary care. Government funding should ensure that such training is accessible to GPs and that additional professional qualifications attract appropriate financial rewards. The possibility of a career pathway may dissuade some GPs from early retirement.

The rewards of getting to know and care for people and their families over time, the diversity of the job and the intellectual challenges it presents need to be promoted and nurtured and solutions found for the negative factors that are turning both students and established GPs away from a general practice career.

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