



Department of Public Health & Primary Care
Trinity College Dublin

A National Census of Irish General Practice Training Programme Graduates 1997 — 2003

Fergus O'Kelly – Mark O'Kelly
Aisling Ní Shúilleabháin – Tom O'Dowd



Irish College of General Practitioners

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A faded, teal-tinted photograph of four people standing side-by-side. From left to right: a woman in a light-colored double-breasted coat, a man in a dark suit, a woman in a light-colored blouse and dark trousers, and a woman in a dark suit with a long necklace. They are all smiling or looking towards the camera.

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Summary of Study of Graduates 1997 – 2003

- 94% of respondents of 1997–2003 are currently working in general practice in Ireland.
- This national study of reasonably settled graduates of GP training schemes 1997–2003 shows that since 1975 female participation in general practice has grown from 6% to 70% reflecting the current gender intake of our medical schools, (70% female.)
- Over 80% of males and 40% of females are at partnership level in their practices.
- 67% of males and 29% of females are in full time clinical general practice.
- 69% of female GPs have taken maternity leave for up to 5 months at a time. 37% of males have taken brief paternity leave.
- More females (38%) than males (12%) see themselves in combined academic/GP posts but more males are currently involved in CME and research in general practice.
- As general practitioners work from part-time to full-time, this needs to be reflected in describing the GP workforce. We suggest that for planning purposes full time equivalent (FTE) refers to a full-time GP doing nine or more sessions per week. Those doing fewer sessions are expressed as a fraction of FTE.
- This study provides a good basis for recruitment and workforce planning over the next 5–10 years.
- Combining family friendly working with patient centred care will be a challenge for general practice as currently structured.



Introduction

The first structured vocational training for general practice, in the Republic of Ireland, began in 1971 in Galway and there are now twelve schemes in all with an annual national intake of approximately 120 trainees. GP training is now mandatory and funded centrally by the Health Services Executive. The investment has made a big contribution to primary healthcare and most GPs are now vocationally trained and work from purpose built or purpose adapted premises, in practices which are well equipped with diagnostic equipment and are largely computerised. Nearly half the practices are involved in teaching either at undergraduate or postgraduate level and the number of single-handed practitioners has fallen to 35%.¹ General Practice training has increased from three to four years with two of these years in general practice. This brings GP training into line with the European norm, where 50% of GP training takes place in a general practice setting.²

There are more GPs than ever, but our population has increased by 1.6% annually between 2000 and 2004 according to the OECD. Population growth alone is estimated to require 40 additional GPs annually. The cohort of GPs is ageing, with the predominant age in the 35–60 range.¹ It has been calculated that in order to maintain the current GP population ratio the number of GPs will have to expand by 77% from current levels.³ This assumption has been based on steady population growth and earlier retirement of female GPs. No data are available so far on the current work practices of newly established GPs.

Thomas *et al*³ have further estimated that 73 GPs will retire annually over the next five years and when population growth is factored in this means we need 113 new GPs to enter the workforce annually. It is planned to expand the numbers of GP training places to 150 but anxieties have been voiced in GP circles about this estimate, which on the face of it seems more than enough GP places to meet projected needs. It is based however, on the current largely male dominated model of general practice and on the assumption that every GP is largely working full time. Little is known about current work patterns of recently established general practitioners, the impact of gender changes on such patterns and also the career aspirations of modern young GPs. It is this gap that this study seeks to fill. In addition it compares current GP work patterns with other studies from earlier Irish generations where the data are comparable.

Section One: Aims and Objectives



Aims and Objectives

1.0 Background:

In 1993 the first national study of graduates of Irish general practice vocational training was undertaken. The study population consisted of all graduates of training schemes from 1975 to 1992.⁴ The study was repeated in 2002 covering graduates from 1990 to 1996.² These national studies were undertaken to determine the career pathways and attitudes to career choice of all graduates of Irish General Practice Training Programmes.

With GPs so central to primary care, and in addition reacting to concerns about workforce planning, in 2007 we decided that it was time to repeat the survey for graduates from 1997–2003 inclusive. Graduates later than 2003 were not included as it was felt they were not sufficiently long in practice to be able to provide an accurate picture of an established segment of the workforce in general practice in Ireland.

1.1 Aim of Research

The aim of this study was to examine the career pathways of all doctors who had completed a vocational training programme in general practice between the years of 1997 and 2003.

1.2 Objectives

The specific objectives were

1. **To obtain current data in the following areas**
 - Demographic characteristics
 - Vocational training
 - Current career
 - Family demands
 - Out of hours commitment
2. **To make direct comparisons with data from the two previous studies where possible.**

A close-up, slightly blurred photograph of a doctor's hand holding a pen and writing on a medical chart. A stethoscope is visible in the background, resting on the chart. The image has a teal/green color overlay.

Section Two: Method

Method

The lists of GP graduates between 1997 and 2003 were obtained from the individual vocational training schemes around Ireland and checked with the graduate database held by the Irish College of General Practitioners in March 2007. A preliminary list of 342 graduates was established; 16 graduates were removed from the list as current addresses could not be found for them. The remaining 326 were sent the first questionnaire in April 2007. A second round was sent to 149 non-respondents in May 2007, and a third round to the 110 non-respondents in June of 2007. Each questionnaire was accompanied by a covering letter, outlining the purpose of the study and assuring total confidentiality to respondents. The main body of the questionnaire used was similar in content and structure to that used in 1993 and 1997. The questionnaire was updated as necessary and a number of additional questions were inserted.

A photograph of three business professionals—two women and one man—standing together with their arms crossed. They are all smiling and dressed in professional attire. The woman on the left is wearing a dark short-sleeved top and dark trousers. The woman in the center is wearing a dark blazer and dark trousers. The man on the right is wearing a light-colored button-down shirt, a dark tie, and dark trousers. The background is a plain, light-colored wall.

Section Three: Results

Results

3.0 Response Rate

Three rounds of questionnaires were sent out to the 326 contactable graduates between April and June of 2007. The first round produced a response rate of 54% (177), the second round brought the response rate to 66% (216). The final round achieved an overall response rate of 75% (245) with 81 graduates not responding on all three occasions. Of these non-responders, 29 (36%) were male and 52 (64%) were female and 11 (14%) of the total non-respondents were living outside of Ireland.

3.1 Gender

Table 1: Gender of respondents compared for three studies 1993¹, 2002² and 2007

Graduation Year	1975-1979	1980-1984	1985-1989	1990-1996	1997-2003
Male n (%)	15 (94%)	41 (80%)	63 (62%)	82 (39%)	73 (30%)
Female n (%)	1 (6%)	10 (20%)	38 (38%)	127 (61%)	169 (70%)
Total n	16	51	101	209	242*

*missing value = 3

There has been a consistent increase in the numbers of graduating trainees in the period 1975 – 2003. It is evident that there has been a shift in the proportion of female graduates of general practice training programmes, which has risen steadily from 6% between 1975 and 1979 to 70% between 1997 and 2003.

3.2 Marital Status

Sixty two (86%) of the male and one hundred and thirty-seven (81%) of the female graduates 1997–2003 are married. There has been little change in marital status statistics since 1975.

3.3 Vocational Training

3.3.1 Acceptance onto GP Training Scheme directly from intern year

In the 1997–2003 period, 159 (65%) of graduates were accepted directly onto training programmes from the intern year. This is a small decline from 72% of interns accepted as trainees in the 1990–1996 years.

3.3.2 Reasons for Training in General Practice 1997–2003

Table 2: Respondents originally commenced training in general practice with a view to:

Staying in General Practice	230 (95%)
Getting a broad general training in medicine	5 (2%)
Using it as a stepping stone to some other aspect of medicine	2 (1%)
Using the scheme as a means of staying in the (geographic) location of choice	5 (2%)

n = 242
missing value = 3

When respondents were asked to indicate the reasons why they chose to train in General Practice the majority reported that they commenced it with a view to staying in the specialty.

3.3.3 Previous SHO experience and application to training schemes

Respondents were asked if they believed that prior SHO experience conferred an advantage on applicants from the Training Schemes' point of view.

Table 3: SHO experience as a perceived advantage to application 1990–1996 & 1997–2003

	1990–1996	1997–2003
Advantage	61 (29%)	102 (42%)
No advantage	44 (21%)	59 (24%)
No opinion	105 (50%)	83 (34%)

1997–2003: n = 244
missing value = 1

Overall 42% of trainee graduates (1997–2003) believed that SHO experience prior to commencing recognised training was a positive influence on their application in comparison to 29% of the 1990–1996 cohort. Half of the graduates 1990–1996 had no opinion on this question, compared to only one third of the 1997–2003 cohort.

3.4 Careers/Employment

3.4.1 Percentage of graduates working in General Practice

Table 4: Percentage of graduates currently working in general practice.

	1975–1989	1990–1996	1997–2003
Male	92%	86%	96%
Female	76%	81%	90%
Overall Total	87%	83%	91%

1997–2003: n= 240
missing value = 5

Each of the studies asked the respondents to indicate if they were still working in general practice.

Overall retention rates of general practice graduates remain consistently high, with an improvement in female retention between the 1975–1989 and 1997–2003 cohorts.

3.4.2 Current Employment Status

Table 5: Employment status by gender 1997–2003.

	Salaried Partner/ GP Principal n (%)	Full-time Assistant n (%)	Part-time Assistant n (%)	Locum n (%)	Single-handed Practice n (%)
Male (n=67)	55 (83%)	7 (11%)	1 (2%)	2 (3%)	2 (2%)
Female (n=151)	62 (41%)	41 (27%)	30 (20%)	16 (11%)	2 (1%)
Overall Total (n= 218)	117 (54%)	48 (22%)	31 (14%)	18 (8%)	4 (2%)

missing value = 27

GP Principal is a designation commonly used in Ireland and is taken to include: GMS contract holders, non-GMS contract holders, and some academic general practitioners who are clinically independent. Contractual arrangements evolve within this category but partners and principals, unlike assistants, can expect to have a say in the overall running of the practice.

Of the 73 male and 169 female survey respondents, 67 males and 151 female respondents answered the question on current employment status. Eighty three percent of the males are salaried partners/GP principals compared to 41% of the females; and 11% of the males are full time assistants compared to 27% of the females. Noticeably 20% of the females currently work as part-time assistants compared to just 2% of the males, and females occupy a greater number of locum positions at 11% compared to just 3% of males.

3.4.3 Clinical Sessions per week 1997–2003

Table 6: Numbers of clinical sessions per week undertaken by 217 GPs graduating from 10 national schemes between 1997 and 2003.

Number of Sessions						
	<2	3–4	5–6	7–8	9–10	11+
Male (n=67)	0	2 (3%)	1 (2%)	19 (28%)	38 (57%)	7 (10%)
Female (n=150)	4 (3%)	24 (16%)	35 (23%)	40 (26%)	44 (29%)	3 (3%)
Total (n=217)	4 (2%)	26 (12%)	36 (16%)	59 (27%)	82 (38%)	10 (5%)

*No graduates from two of the schemes for the period in question.

The questionnaire defined a clinical session as three hours face-to-face contact with patients. If 9 or more sessions are taken as full-time clinical general practice, just 43% of all graduates are currently involved in full-time clinical general practice. When broken down by gender 67% of males and 32% of females are involved in full-time practice, a ratio of almost 2:1. ($p<0.00$)

Table 7: Clinical Sessions per week by female respondents and maternity leave

Number of Sessions						
	<2	3–4	5–6	7–8	9–10	11+
Female respondents/ maternity leave (n=98)	4 (4%)	23 (23%)	29 (30%)	24 (25%)	17 (17%)	1 (1%)
Female respondents/ no maternity leave (n=44)	0	1 (2%)	5 (11%)	9 (21%)	27 (61%)	2 (5%)

Female respondents were asked to indicate how many times and for how long they had taken maternity leave.

Of the 142 female respondents to this question, 98 respondents (69%) have taken one or more maternity leaves. Of these, 18% are in full-time general practice (9 or more clinical sessions per week). Of those who have not taken maternity leaves 66% are in full time general practice. Fifty seven per cent of females who have taken maternity leave work six or fewer sessions per week compared to 13% of those respondents who have not taken maternity leave.

3.4.4 Non-Clinical Sessions per week 1997–2003

Table 8: Non-Clinical Sessions per week undertaken by graduates

Number of Sessions							
	0	1	2	3	4	5	6+
(n=64)	26 (40%)	24 (38%)	7 (11%)	3 (5%)	2 (3%)	0 (0%)	2 (3%)
(n=157)	98 (62%)	44 (28%)	6 (4%)	6 (4%)	0 (0%)	3 (2%)	0 (0%)
(n=221)	124 (56%)	68 (31%)	13 (6%)	9 (4%)	2 (1%)	3 (1%)	2 (1%)

We defined non-clinical sessions as undertaking teaching, research and continuing medical education, which are key developmental areas for general practice/primary care. Ninety-seven (44%) respondents work 1 or more non-clinical sessions per week. Thirty-eight (60%) males reported working one or more non-clinical sessions while fifty-nine (38%) females do one or more non-clinical sessions ($p < 0.0031$).

Thirty-six (95%) of the 38 male respondents undertaking non-clinical sessions also work 9 or more clinical sessions a week.

Thirty (50%) of the 59 female respondents undertaking non-clinical sessions also work 9 or more clinical sessions a week.

3.4.5 Current work region and future location plans 1997–2003

Table 9: Geographical area where respondents currently practice:

Health Board region of their GP training scheme	131 (56%)
Other health board region	90 (38%)
United Kingdom	5 (2%)
Australia/New Zealand	5 (2%)
Elsewhere	5 (2%)

n = 236
missing value = 9

Most (94%) graduates remained on in Ireland after training, with 56% currently working in the health board region of their training scheme.

Two hundred and twenty six respondents replied to the question on the geographical location of their choice in the long term. One hundred and thirty eight (61%) have plans to work in the health board area of their training scheme.

3.4.6 Career Aspirations 1997–2003

Table 10: 10 year career plans by gender for graduates 1997–2003

Career Plans								
	Happy with current position	GP Principal/ Salaried Partner	Combined Academic Post	Part-time Assistant	Full-time Assistant	Single handed	Other	Specialty other than GP
Male n=80	43 (54%)	25 (31%)	5 (6%)	2 (2%)	0 (0%)	4 (5%)	1 (2%)	0 (0%)
Female n=187	56 (30%)	52 (28%)	19 (10%)	22 (12%)	16 (8%)	0 (0%)	17 (9%)	5 (3%)

n = 267

Respondents were asked to indicate from a list where they would most like to see themselves in 10 years time. The number of responses in Table 10 (80 male and 187 female) shows that some respondents chose more than one option. Fifty-four per cent of males compared to 30% of females are happy in their current position. Eighty-three per cent of the male respondents are currently working as salaried partners/GP principals compared to 41% of the females (see Table 5) .

Ten per cent of females compared to 6% of males would like to see themselves in combined clinical and academic posts; however only 38% of the female respondents are currently involved in non-clinical sessions (research, teaching, CME) on a weekly basis compared to 60% of males. Twenty per cent of the females wish to see themselves working as either full or part-time assistants in 10 years time compared to 2% of the males.

Table 11: Employment status by gender and year of graduation 15–2003

	GP Principal/ Salaried partner	Locum	Assistant
1997–2003 (surveyed in 2007)			
Male (67)	57 (85%)	2 (3%)	8 (12%)
Female (151)	64 (42%)	16 (11%)	71 (47%)
1990–1996 *			
1985–1989 (surveyed in 2002)			
Male (53)	53 (100%)	0	0
Female (33)	20 (61%)	3 (9%)	10 (30%)
1980–1984 (surveyed in 1993)			
Male (n=35)	35 (100%)	0	0
Female (n=9)	9 (100%)	0	0
1975–1979 (surveyed in 1993)			
Male (n=15)	15 (100%)	0	0
Female (n=0)	0	0	0

*Gender not specified

Table 11 shows that an increasing percentage of female graduates now hold assistantships. Female graduates with Assistant status has increased from 30% (1985–89) to 47% (1997–2003).

3.4.7 Post Training Hospital Experience

Two hundred and thirty nine respondents answered the question as to whether they had gained any further hospital experience since completion of their GP training. Only 23% (56) reported having further hospital experience, whereas in the 1990–1996 cohort, 50% had stated that they had further hospital training.

The specific areas of further hospital training for the two cohorts are shown in Table 12.

Table 12: Further hospital experience since completion of GP training by the 1990–1996 and 1997–2003 cohorts.

	1990–1996 (n=165)	1997–2003 (n=56)
Obstetrics & Gynaecology	43 (26%)	23 (41%)
Accident & Emergency	36 (22%)	9 (16%)
Psychiatry	31 (19%)	5 (9%)
Geriatrics	19 (12%)	5 (9%)
Dermatology	0	5 (9%)
Palliative Care	0	3 (4%)
Paediatrics	7 (4%)	2 (4%)
Ophthalmology	0	2 (4%)
Other	5 (3%)	2 (4%)
Medicine	24 (14%)	0

1997–2003 n = 56
missing value = 8

Table 12 shows that there has been an increase in the proportion of those working in obstetrics and gynaecology from 26% to 41% between the two studies, with a general decrease in ratios in other areas.

3.4.8 Combining general practice with other areas of medicine

Table 13: Other areas of medicine combined with general practice.

	Academic (undergraduate/ postgraduate)	Family Planning	Sports Medicine	Other	All other areas of medicine combined
Male (n =73)	14 (19%)	2 (3%)	3 (4%)	1 (1%)	20 (27%)
Female (n= 169)	25 (15%)	9 (5%)	1 (0.6%)	3 (2%)	38 (22%)
Total (n=242)	39 (16%)	11 (4%)	4 (2%)	4 (2%)	58 (24%)

Table 13 shows that 58 (24%) of all respondents combine general practice with another area of medicine. There is no significant difference between males and females. Academic activity is the area both males and females largely combine with general practice. Females are more likely than males to combine general practice with family planning. Males are more likely to combine sports medicine with general practice. 'Other' is made up of GP unit work, occupational health and travel medicine.

3.4.9 Graduates no longer working in General Practice 1997–2003

Of the 9% (n=22) of general practitioner trainees no longer working in general practice 18% (n=4) felt they were not suited to general practice, whilst 82% (n=18) had other reasons for leaving including those listed below. No one reason was cited more often than another.

Reasons cited for leaving general practice:

- Having a young family
- Being disabled
- Maternity leave & child care costs / commitments
- Partner doing fellowship abroad
- Left for another speciality
- Liked general practice but more suited to psychiatry
- Religious vocation
- Better hours of work / better working conditions elsewhere
- Financial reasons
- Loss of confidence due to time taken out.

When asked to indicate from a list, what would have been most likely to have kept them in general practice, 17 of the 22 relevant respondents answered. Of these, 12 (71%) felt that nothing would have kept them in general practice. Two felt that paid maternity leave would have kept them in general practice, whilst job sharing (n=1), co-op availability (n=1) and part-time work (n=1) were other responses.

3.5 Family Demands

3.5.1 General Practice and family life/demands 1997–2003

Two hundred of the respondents from the 1997–2003 cohort (88%), feel that general practice is suited to their family life and demands.

3.5.2 Maternity/paternity leave 1997–2003

Ninety-eight females (69%) have taken maternity leave. The median total maternity leave taken was 10 months. The median number of times that leave was taken was 2, indicating an average of 5 months per leave.

Twenty-seven of the males (37%) have taken paternity leave. The median total paternity leave was 2 days with the median number of times paternity leave was taken being 1.

3.5.3 Sufficiency of maternity/paternity leave 1997–2003

Table 14: Sufficiency of maternity/paternity leave:

	Maternity/Paternity Leave	
	Sufficient n (%)	Insufficient n (%)
Males n=27	8 (30%)	19 (70%)
Females n=100	52 (52%)	48 (48%)

Male and female respondents who had taken paternity/maternity leave were asked to indicate if they thought the leave was sufficient. Fewer females than had actually taken maternity leave responded to the question (100 v 107).

Of those who had taken leave and who responded to the sufficiency question, seventy per cent of males and 48% of females felt that paternity/maternity leave was insufficient for their needs.

3.6 Out-of-hours commitment

3.6.1 Co-op and out-of-hours (OOH) work 1997–2003

Respondents to the current study were asked to indicate their involvement in either co-op or OOH work.

Two hundred and twenty one of the total 242 respondents answered the Co-op question and 216/242 answered the OOH question. Of these, 140 (69%) reported being involved in Co-op work and 35 (19%) in OOH work. Those who were involved in Co-op or OOH work were asked to indicate how many hours per month they worked in each category.

Table 15: Number of Co-op and OOH hours worked per month:

Hours per Month	Co-op Respondents n= 141*	OOH Respondents n= 36*
1-4	42 (30%)	9 (25%)
5-8	13 (9%)	6 (17%)
9-12	15 (11%)	6 (17%)
13-24	29 (20%)	4 (11%)
25-39	18 (13%)	4 (11%)
40 or more	24 (17%)	7 (19%)

* One additional respondent in each category compared to the overall numbers (141 v 140; 36 v 35).

Table 16: Respondents involved in Co-op or OOH work by gender:

	Co-ops or OOH n (%)
Males n=73	62 (84%)
Females n=169	97 (51%)

Table 16 indicates that a higher percentage of the male respondents participate in Co-op or OOH work in comparison to their female counterparts (84% v 51%). Further analysis of the female respondents' participation showed that there was no significant difference in rates of participation between the overall female sample and female respondents with children (87/169 (51%) v 49/107 (46%))



Section Four: Discussion

Discussion

The sample base for this survey was the graduates of GP training schemes 1997 to 2003. We anticipated that the majority of this cohort should be reasonably well established in their careers and thus give a good picture of the future of general practice. The response rate of 75% achieved in this study while excellent, is lower than the 2006 national study on the structure of general practice¹ which achieved an 87% response rate. In the current study, 25% of the graduates of the 1997–2003 GP training schemes did not respond with the majority (64%) of the non-responders being female. This may indicate that the sample was not as settled as we had hoped and that a proportion are living away or do not have professional contacts in Ireland. We checked if there were response differences across the years but this was not the case. This study has important implications for workforce planning. We have added value to our findings by comparing them with 2 previous studies from 1975 to 1992 and from 1992 to 1996.

The route into general practice remains very competitive with currently 3 applicants for every vacancy on a vocational training scheme. There has been some change with more entrants coming from the SHO years than previously. Career guidance has improved considerably with most entering general practice with a view to staying in the speciality and most graduates staying in the health board area of their training scheme. This finding supports the location of schemes in areas of special need to ensure a supply of general practitioners for local populations.

Since the 1975 era, female participation in general practice has grown from 6% to the current level of 70% which reflects the gender balance of our medical school entrants.

Because of the structure of Irish general practice we had some difficulty in defining seniority in general practice. In the end we used the definition of GP principal/salaried partner to indicate a group of general practitioners who are clinically independent and who can reasonably expect to have a say in the overall running of the practice, unlike, for example, assistants and locums. Using this definition the 1997 to 2003 cohort is well represented at senior levels within general practice. However, despite the gender balance almost twice as many males are at senior GP principal or partnership level in Irish general practice.

Nearly twice as many males are in full-time general practice (defined as 9 or more sessions per week) as females. This is another important finding in this study as it has long-term workforce implications for Irish general practice. However the more salient observation is that 43% of respondents overall could be considered to be in full time general practice. The 1997 – 2003 cohort inevitably reflects the greater family commitments of females, as women who have not taken maternity leave have broadly similar working patterns to males. This pattern

is similar in the non-clinical areas of general practice, which are the developmental aspects of practice, with more males involved in research and CME than their female counterparts. A strong female voice in the developmental aspects of general practice, such as CME and research, is necessary for both general practice and patients in a self-regulating profession. This finding goes some way to supporting Dr Martin Daly in concerns he expressed about the need for younger GPs to take leadership roles in the profession and in the health service.⁵

Our national study on the structure of general practice¹ indicates that large numbers of GPs will retire in the next 5 years. These will be mostly males, who are currently working full time. Our data show that current graduates are much less likely to work in full time clinical practice, which will lead to a significant shortfall in actual sessions available for patient consultations. This shortfall has been largely hidden because we do not express general practitioner hours in terms of full time equivalents (FTE). We need to begin to use this format to guide workforce planning. As it is, our findings show that the retiring males will be replaced by largely female GPs who will want to work reduced hours to accommodate their families. In addition some of the male replacements will also work reduced hours. This accelerates the workforce issue and gives us even less time than we thought we had to even maintain the status quo in terms of FTEs.

Thirty eight percent of females and 12% of males see themselves in combined academic GP posts, or assistantship posts in the longer term indicating a preference for employee rather than employer status. This again has implications for the structure of contractual arrangements in general practice.

The UK literature indicates that general practice is popular with more recent graduates as both males and females indicate a preference for reduced working hours, better working conditions and flexibility to accommodate domestic circumstances.⁶ The increased retention of graduates of our training schemes in general practice over the years indicates that newly qualified GPs see general practice as giving them their desired work life balance. Our previous research on stress and morale shows that GPs have achieved a measure of control of their work that previous generations have not found possible.^{1, 7} The challenge will be to combine family friendly working with patient centred care and retain the ethos of Irish general practice.

The British Household Panel Survey of 10,000 adults from 5,000 households has been ongoing on an annual basis since 1991. Recent output from this survey has focused on work and gender. The prevalence of women in part-time work continues to be a distinguishing feature of female employment in Britain. This preference persists after the children have grown up.⁸ The ICGP/TCD Structure of General Practice in Ireland 1982 to 2005 report indicates that 35% of male GPs believe they will retire before the age of 65. This proportion rises to 59% of females who believe they will retire before 65 years of age.¹

In conclusion this report provides a detailed view of the current work practices of a reasonably settled cohort of general practitioners. It allows some comparisons to be made going back over 30 years that reflect significant changes in our workforce. Taken together with our recent report on the structure of general practice in Ireland, it provides a good basis for workforce planning and recruitment and for the design and delivery of primary care services to patients. Both training and recruitment need to be expanded, as a matter of priority, to fulfil the GP needs of patients.

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