Women in General Practice

PHILIPPA W MORETON

Last year I finished a vocational training scheme and have now settled into full time practice in Buckinghamshire. It is recognised that there are special problems and considerations that women have to face when starting a career in general practice. I thought that it might be helpful to others to outline the thought processes that I went through at that time and the subsequent developments.

For many women the first problem is the mandatory vocational training. I anticipate that this will prove to be the biggest hurdle of all for women as the new legislation becomes effective. I was lucky because I got married at the end of my pre-registration year and was therefore able to choose a training scheme near to my husband's work. Again, it was pure luck that my husband did not have to move his business premises until I had finished my vocational training. Many women will find they have to move away in the middle of a vocational scheme. There are so many structured schemes now that there are few suitable hospital posts open to GP trainees who are trying to put together their own vocational training. This is particularly so in obstetrics and paediatrics, both specialties which many feel are essential for general practice.

In addition to this, the best contraceptive have a failure rate and some women doctors are bound to become pregnant during this time. There will also be women with young families wanting to become vocationally trained before going into general practice. The fact is that there are extremely few hospital posts that make any concessions to a woman combining medicine with domestic commitments. Many junior hospital posts require living in the hospital when on duty, and this may mean every other night away from home. Clearly, this is too much to expect from a woman with a home and small children to consider. Therefore, in the light of the present legislation, there is an urgent need to provide the necessary hospital experience on a part-time basis. Already it is possible to do a part-time training in the surgery although it may take longer. Unless this problem is given urgent priority, I feel there will be a growing group of able women doctors barred from entering general practice as principals. I think that they would be a great loss to general practice, apart from the expensive waste of training. It is conceivable that a new grade of practitioners may be created for these women along the lines of the old assistant. I find this a horrifying prospect, undermining the whole purpose of vocational training.

Once the problems of vocational training have been overcome, however, a new set of considerations arise. When I finished my vocational training in London I was looking forward to moving to a country practice where I would have time to create a proper home and at last think of starting a family. I started to look through the partnership vacancies. We had several sessions on my half-day release course entitled "Choosing a Practice," but I rapidly realised that there were no vacancies where we debated the points we would look for in an ideal practice had no relevance to my situation.

My husband's new business premises were to be in Hertford-

shire. So I drew a radius of 25 miles around the town. It was incredible how few practice vacancies came up during the next six months within that circle. I was beginning to think that we would have to move regardless and try and create a job locally afterwards. I had visions of going into the local practice and selling them the idea of a new part-time partner. I felt sure that I could convince them that they were working too hard and, as a principal practitioner working the minimum 20 hours, financially I would bring in to the practice almost as much as I would take out.

Then a vacancy came up within my chosen area. It was for a part-time job "ideally suited to a woman intending to have a family." It seemed too good to be true. The senior partner proved to be a charming man, who in partnership with two others provided old-fashioned family medicine for a list of about 8000 patients. It turned out that they were about to lose a woman doctor who had been helping them out for the past 10 years. Apparently she had started by helping with a family planning clinic and the job had evolved over the years. I was to have no list of my own but would do surrogates when the doctors were away on holiday. I would be expected to be on call during weekdays, to do all acute visits, run a family planning clinic, be on duty two nights per week, and do every Saturday morning surgery! This arrangement may well have suited somebody else, but I did not fancy what amounted to a glorified locum post. After this experience I decided to look for a full-time partnership. Having established myself in a partnership, I would be in a better position to arrange a part-time schedule later if necessary.

Then a full-time vacancy came up in a group practice working from a health centre. Having applied for the vacancy, I was invited to make a preliminary informal visit to the practice. Two things emerged from this. Firstly, the practice was exactly what I had been looking for—a new attractive health centre in a small country town. It was a partnership of five doctors who were committed to providing first-class family medicine with a list of about 11 000 patients. Secondly, it was obvious that there would be a great number of applicants for a post in such a desirable practice. This was borne out by the time taken to find my application among a huge pile of similar-looking papers! It was also obvious from my first meeting that they had not considered the possibility of a woman applicant. I went home wondering how to persuade them that what the practice wanted was a woman partner. I felt that I had to show how enthusiastic I was about the practice, so I rang the following day and asked if I could return and see the only partner I had not met—a woman, who had recently had her first baby and worked part-time. I spent the whole afternoon with her at home and learnt a great deal more about the practice, from a woman's point of view.

During the first interview I had anticipated many of the potential problems. Many of the questions were understandably related to my present and future domestic commitments, in particular the problems of pregnancy and maternity leave. I think that it is essential that women going into general practice know the exact position regarding maternity leave as laid out in the "Red Book." The position is that locum fees paid during maternity leave are not reimbursed by the family practitioner committee unless it leaves four patients with an average list of over 3000 patients each. Unfortunately, no allowance is made

Wendover, Bucks HP23 8LD
PHILIPPA W MORETON, MA, MRCGP, general practitioner

for a partner working part-time with a small list. Although the full-time partners would be coping with a list of over 3000, the partner working part-time would have to be included in the equation preventing locum fees being reimbursed. Incidentally, the position is exactly the same if a partner is away sick. I feel strongly that partnerships that include a part-time partner should not be possible unless the partner is sick or on maternity leave. This clause in the "Red Book" needs to be revised. Knowing the position, however, I was prepared to give an undertaking to pay for a full-time locum for the time that I was absent on maternity leave. If there were any complications during my pregnancy I would hope that my partners would regard this as sickness and cover me for the first month, which is their normal practice. It is possible to afford to do this when you take into account the earnings-related maternity allowance in addition to normal income.

My prospective partners were also interested in my commitment to the practice and whether we would be settling

permanently in the area. My husband was able to reassure them that it was unlikely that his business would change location. The rest of the interview went well, and I was confident that my husband's attitude to my work and the amount of support he would have to give. Obviously he would have to fill the traditional role of the GP's wife, and there was concern whether this role would conflict with his hectic business schedule. In this situation it is vital that your husband's commitment to the practice comes across. Problems such as out-of-hours telephone duties are bound to be discussed and provide an opportunity to test his willingness to be concerned. I am convinced that total support at home is a very important factor for a woman going into general practice and part of the interview is bound to be concerned with this.

I have been in the practice for a year, and it has certainly come up to my expectations. As my domestic commitments grow over the years, time will tell if my partners' faith in me was justified.

The Course Organiser

How I organise a half-day release course for trainees

COLIN H SMITH

In the Medway scheme we admit four trainees a year, and they all attend the half-day release course regularly throughout their three years. Two "one-year" trainees also attend. We have three terms of 10 sessions each and I do not think I could manage more. I share the clerical and administrative skills of the administrative secretary of the postgraduate centre and her assistant with the clinical tutor and GP tutor, and we have a most helpful librarian. My partners are very supportive and enthusiastically alert, and do my best so that I can get to the postgraduate centre at about 11 and leave at 4.15 p.m.

There is plenty of preparatory work to do, letters to write, phone calls to make, and people to talk to until 12.45 when I fetch a plate of sandwiches from the hospital canteen and bring them and some cans of light ale for a snack lunch for those who wish it. Medway Hospital has no tradition of research, no teaching hospital, and no handy university or similar facility, so we are very dependent on our own resources. Our educational resources consist of the library with a Medline computer, overhead and slide projectors, blackboards, and plenty of paper; a video camera and recorder will arrive soon.

It has taken me two years of pretty frantic activity to gain enough confidence to realise that I was doing it all wrong. My own educational experience as schoolboy, student, scoutmaster, Red Cross instructor, and trainer was quite inadequate to the task of organising appropriate experience for a bunch of highly intelligent young doctors. Fortunately they were teaching themselves while I was charging about as if everything depended on me. At the end of each term trainees are given suggestions for topics for the term after next with reference to previous

years, and I would organise speakers over the ensuing weeks. This led to quite a convincing programme known well in advance. Each session would be preceded by informal talk over lunch, or maybe a presentation by a trainee, a film, or a visiting speaker. The main speaker would present his topic, we would break for tea, and then we would finish off with a discussion. Once a term we would visit an industrial concern or prison, for example, and we would try to combine one or two visits with the neighbouring course at Maidstone.

I suppose it wasn't too bad; certainly the variety of topics and presenters, both medical and lay, was quite interesting. Indeed, when I attended my predecessor's course I was struck with how much more valuable this was than anything I had been exposed to before. But I became increasingly uneasy about the course. The trainees were polite but lacked sparkle and occasionally fell asleep. They evaluated each session according to content, presentation, and usefulness on a form, and were sometimes devastatingly critical. I became very much more enthusiastic as my unease increased and began to have sleepless nights. The extent to which the whole business was taking over my life was incredible. The monthly trainees' workshop seemed to be losing its sense of purpose, so we structured that and asked a trainer to present a topic each time. This worked fairly well for a while but seemed to frighten one trainee away. There was no time to undertake a pastoral role—visiting the training practices—and I felt chronically guilty about not using more tapes and videotapes (though they only seemed to turn people off), and even more guilty about not using role-play and fish-bowls and other marvels of group dynamics. Quizzes still after reading Pereira Gray's occasional paper on how to teach to do.¹ Quizzes still of all about failing to have proper aims and constructive objectives.

Meanwhile the half-day release course trundled on. Of some it was good, especially when the trainees presented short topics in the lunch-hour. Perhaps the most encouraging thing

Medway Postgraduate Medical Centre, Gillingham, Kent
COLIN H SMITH, MA, MRCGP, general practitioner

was when, during the course organisers' conferences, it emerged that many of my colleagues were every bit as confused and worried as I was and there was no one around who could actually tell me how to do it. It was about this time that our newest partner attended the course to talk about the problems of selecting and starting up in practice. Afterwards he told me that he thought the course had turned into a Colin Smith chat show, that I would probably make myself ill, and that that might be no bad thing because it was only when his course organiser had become ill that his course had really come alive. So I let go. I spent a fair amount of time just thinking, and, as the mist cleared various conclusions emerged. The most important of these was that I must trust the trainees and, however concerned I was, not interfere with their cohesion or stultify their enthusiasm. Everything else was secondary.

So what was to be done? The first task appeared to be to get to grips with the content of the course. A curriculum of some sort was required which the trainees could explore at the same time, whether in hospital or practice. There are so many areas relevant to general practice, especially if it is to develop as a discipline, but some lines need to be drawn. After extensive consultation with anyone who would listen I arrived at the following provisional grid.

I have divided the trainees into four small groups each

		ART			SCIENCE		MANAGEMENT	
		Autumn			Spring		Summer	
Year 1	GP in relation to the world, the country, and the NHS	Inquiry and research in general practice			Management of patients in general practice			
Year 2	Communication in general practice	The data upon which general practice is based			Management of staff in general practice			
Year 3	Skills and procedures in general practice	Clinical content of general practice			Financial management in general practice			

connected with a trainer, defined these areas in more detail, and am progressively handling over the running of the course to these groups. So far I have been overwhelmed by the enthusiastic response of the trainees. There are many problems still to be dealt with, but the future looks good.

Reference

- Pereira Gray DJ. Occasional Paper No. 4. London: Royal College of General Practitioners, 1979.

Practising Prevention

Making a start

L I ZANDER

The importance of preventive care is being increasingly stressed,¹ but the general practitioner needs to consider carefully how to best use his potential in this field. Improving our level of performance is less an issue of increasing knowledge than of changing our attitudes and the way we work. Although preventive care should not be seen as an activity that is separate or independent from normal practice management there are certain important differences that should be recognised, as they provide important guidelines on how performance may be improved.

Routine clinical care	Preventive care
Case initiated by patient	Case initiated by doctor
Nature of care is usually unpredictable	Nature of care is predictable
Demand for care is immediate	Provision is non-urgent
Focus of attention is the individual patient	Management of "target" groups
Management usually concerns the doctor	Management often provided by non-medical members of the health care team
Good records are helpful	Good information system is absolutely essential
Audit of outcome is highly complex	Audit of care provided is fairly simple

Department of General Practice, St Thomas's Hospital Medical School, London SE11 4TF
L I ZANDER, MA, MRCGP, senior lecturer

Organising care

The doctor's principal clinical activity is conducting the consultation, and the possibilities for undertaking preventive care at this time have been well described by Stott and Davis² and Small.³ During normal consulting sessions, however, the general practitioner faces the dilemma of conflicting interests, as his principal preoccupation will be to cope with the problems presented to him. If he is to play an effective part in preventive care the practitioner must assume responsibility for deciding both the nature of the care to be provided and how this is to be achieved. The scope of a preventive approach to patient care may be considered under the following headings:

Objectives	Examples of care
Prevention of certain diseases	Immunisation programmes Cervical cytology screening Long-term management—for example, hypertension
Prevention of the complication of certain conditions	Long-term follow-up—for example, postoperative care Advice about alcohol intake, smoking, diet, etc.
Prevention or modification of certain behaviour patterns	Family planning
Prevention of certain unwanted events	

As the content of much preventive care is predictable, non-urgent, and concerns specific patient groups, this should be reflected in the way that delivery of care is organised.

A team activity

The question of how and by whom different types of preventive care are to be undertaken is critical to its success, and relates to factors such as training, motivation, availability, and accessibility. The health visitor and the midwife have already well-established roles in well-baby care and antenatal supervision, and hypertension, cervical cytology, and rubella immunisation programmes are effectively carried out by trained nursing staff.⁴ The role of the nurse and other members of the team in running well-baby clinics, family planning, and health education programmes can be expanded considerably. The doctor's participation may be minimal, his critical function being to plan and co-ordinate.

Practice information system

A satisfactory data system is an absolute prerequisite if an effective programme of prevention is to be practised. The clinical record of each patient should not be considered in isolation but seen rather as the central component of an integrated information system of the total practice population. The system should aim to:

- Identify those factors whose effect on health care may be modified by preventive action.
- Identify risk factors in individuals and in vulnerable groups in the practice population.
- Provide data concerning the level of preventive care undertaken.

INDIVIDUAL CLINICAL RECORD

The patient's clinical record should include: (a) certain physical factors amenable to change—for example, weight, blood pressure; (b) certain behavioural characteristics, such as excessive smoking, drinking, or gambling; (c) occupation, identifying particular risks or stresses—for example, publican, miner; (d) family history of conditions with genetic implications; (e) allergies and sensitivities; (f) morbidity record of conditions requiring long-term follow-up (postgastrectomy patients) or long-term management (pernicious anaemia, hypertension); (g) details of what preventive procedures have been undertaken, such as immunisation, contraception (advice given and method used), and cervical cytology.

RECORD OF PRACTICE POPULATION

The age-sex register is the basic tool necessary to practice preventive care in the practice as a whole. It defines the population for whose care the practitioner is responsible, and enables him to identify cohorts of vulnerable or target groups for whom specific preventive care is indicated.

A practice morbidity register will allow monitoring of specific chronic conditions and their management, and when linked to the age-sex register will enable specific preventive programmes to be planned. Many different record formats, including summary cards, flow charts, and morbidity registers, have been designed, and the Central Information Service at the Royal College of General Practitioners will provide useful information and advice on how to set up age-sex and morbidity registers.

COMPUTERS

Having a microcomputer in the practice can make a major contribution to preventive care by facilitating data collection and retrieval. A more important benefit to be derived from its predicted widespread use⁵ is that by synthesising a range of different items of information—such as age, sex, weight, blood

pressure, and smoking habits—a level of risk identification is possible that could not be achieved by manual methods.

Audit of care

Audit is a necessary stimulus for improvement. Some form of assessment should ideally be part of every programme of preventive care, so that information concerning its delivery is readily available and regularly fed back to those responsible for providing it.

Practice organisation and administration

Preventive care implies a growing organisational function for the doctor, and good administration is necessary to successfully implement preventive care. When designing the practice information system and planning preventive care programmes it is important to ensure that as much as possible of the routine work is delegated to the clinical staff.

Summary

The fact that the general practitioner is responsible for the care of a defined and readily identifiable population gives him the possibility of playing a major part in preventive care. The degree to which he can do this will in large part depend on his willingness to decide on the nature of the care to be provided by the health care team, the attention he gives to developing a suitable information system, and his ability to ensure that optimal use is made of the available resources.

References

- Health and prevention in primary care. Report from General Practice No. 18. London: Royal College of General Practitioners, 1981.
- Pereira Gray DJ. Organising preventive medicine. *Br Med J* 1983;284: 706-11.
- Stott NCH, Davis RM. The exceptional potential in primary care management. *J R Coll Gen Pract* 1979;29:201-3.
- Small SA. Opportunities for prevention: the consultation. *Br Med J* 1982; 284:1092-3.
- Anonymous. Looking after patients with high blood pressure. *J R Coll Gen Pract* 1978;28:235-6.
- Royal College of General Practitioners. *Computer in primary care*. Occasional paper No. 13. London: RCGP, 1980.

ONE HUNDRED YEARS AGO We understand that the Duchess of Connaught's sudden removal on Sunday from Baginbode to Windsor was in consequence of the unsatisfactory state of the sanitary arrangements at Baginbode. For some weeks, very offensive smells have been observed about the house, and several of the inmates have suffered from obscure forms of indigestion. Her Royal Highness had made an excellent convalescence for nearly three weeks after her confinement, when she developed symptoms which were thought to depend on poisoning by sewer-gas. On investigation, it was found that a large soil-pipe from a disused closet had been simply cut through by a careless workman, and its open end, leading directly into the main drain, was left immediately under the flooring close to the central hall, and thus a continuous stream of sewer-gas was poured into the house. Dr Playfair advised that Her Royal Highness should be removed to Windsor without delay, to get her out of the infected atmosphere. On Sunday, Sir William Lushcroft met him in consultation, by Her Majesty's command, and completely concurred in this view. The removal was therefore at once effected. Happily, a very decided improvement in Her Royal Highness's condition is already apparent, and her symptoms no longer cause serious anxiety. (*British Medical Journal*, 1882.)