



Trinity College Dublin

Structure of General Practice in Ireland 1982 — 2005

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Irish College of General Practitioners

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Summary of Study

- The study provides a picture of the changing face of general practice in Ireland from 1982 to 2005.
- It compares data from three points in time, - 1982, 1992 and 2005 and from the Stress and Morale Study, 1997.
- The 2005 survey achieved a response rate of 87%.
- General Practitioner numbers have increased by 28% since 1992.
- It shows an aging cohort of general practitioners, with the predominant age in the 35 – 60 range.
- Women now constitute 30% of the GP workforce.
- 58% of practitioners now have partial or full GP training, with almost all new entrants into general practice being vocationally trained.
- There has been a fall in the numbers of private only practices and a growth in the number of GPs with private lists of over 2000 patients.
- There has been a fall in individual GPs providing out-of-hours cover during the week and at weekends, but 40% of GPs are now in out-of-hours co-operatives.
- There has been little change in basic general practitioner services, but a rise in services such as travel vaccinations and phlebotomy.
- Access to radiology has declined by 14% for skeletal x-rays and 6% for chest x-rays since 1992.
- 42% of GPs have been involved in medical student teaching in the last three years.

-
- GPs report strong participation in continuing medical education.
 - 89% of GPs now practice from purpose built and adapted premises.
 - Branch surgeries are still a strong feature of general practice service in Ireland.
 - There has been a big decline in the number of single-handed practitioners, which is now 35% of the total.
 - There has been a large increase in the number of nursing, clerical and management personnel in practices.
 - 81% of general practitioners now have appointment systems.
 - 59% of general practitioners are using age / sex registers.
 - Practices are now well equipped with clinical and diagnostic equipment and computers.
 - Stress is better controlled and morale is better than in 1997.
 - There may be important gender differences in the approach to retirement.
 - A large number of general practitioners indicate that they wish to continue practising beyond the age of 65 with appropriate safeguards.

Introduction

In 1982 the Royal College of General Practitioners surveyed GPs in the Republic of Ireland and collected information on GPs themselves for the first time¹. It included educational background, practice sizes, services and on-call arrangements. It also collected data on practice premises, partnerships, appointments, employment of ancillary staff, equipment, access to investigations and involvement of spouses in the practice.

The RCGP 1982 study formed the baseline for the 1992 survey *Changes in the Structure of Irish General Practice Over the Past Decade: 1982 – 1992*². On this occasion it was published by the newly formed Irish College of General Practitioners, founded in 1984, which has been a major stimulus for change in Irish general practice. The authors used a similar methodology to 1982 and presented the data in a format that allowed ready comparisons over the decade from 1982 to 1992.

The survey presented here uses the 1982 and 1992 methodology and presents the data in a format that again allows ready comparison of changes over 3 points in time in the last 23 years. We have also included comparisons from other work on GP stress and morale³ and some information on retirement, to assist with future workforce planning.

This report is being prepared at a time when the Health Services Executive is stating its support for the development of general practice in order to improve the health of people living in Ireland and to relieve the pressures on the secondary care sector. The data presented here are a unique measurement of the general practice workforce over the last 23 years. They also provide a picture of the strengths and weaknesses of general practice, and guidance on its ability to respond to future demands from both government and patients.

The fact that the methodology delivered by Drs Oliver, Meagher and Cole in 1982 and refined again by Dr Oliver and Dr Harry Comber in 1992 continues to be relevant and useful in 2005 is testament to the foresight and robust methodology of these early researchers in general practice.

N.B. For purposes of comparison with previous reports, the data throughout this report have been presented using the traditional pre-Health Service Executive health board areas.

Aims and Objectives

1.0 Background:

The Royal College of General Practitioners (RCGP) survey of 1982 attempted, for the first time in Ireland, to compile information relating to general practitioners themselves, their educational backgrounds, details of their estimated practice sizes, the services they provided, their off duty arrangements, and their educational involvement. It also attempted to collect information relating to their practices with reference to practice premises, partnerships, appointment systems, employment of ancillary staff, practice equipment, access to investigatory facilities and the level of involvement of spouses within the practice. The data published at the time provided a glimpse into Irish general practice at the end of 1982. Using this information, the authors attempted to identify differences in the structure of practices, which might be related to practitioner age groups, geographical areas, training, practice types and other indices.

In 1992, the survey was repeated by the Irish College of General Practitioners (ICGP), with broadly the same objectives and using the same methodology. Apart from the value of the information itself, it also provided the opportunity for direct comparisons to be made between the information in both surveys, which provided a longitudinal dimension to the study of Irish General Practice over that decade.

In 2005 it was proposed to conduct this research again, with an updated questionnaire, in order to make direct comparisons of the structure of general practice between 1982, 1992 and 2005.

1.1 Aim of Research

The primary aim of this research is to examine the changes in the structure of General Practice in the Republic of Ireland, over the period 1982 to 2005.

1.2 Objectives

The objectives were to obtain current data in the following areas:

i Demographic characteristics:

- Age
- Sex
- Marital status
- Full-time practice
- Education - Undergraduate
- Education - Postgraduate qualifications
- Postgraduate hospital experience
- Vocational training

ii Practice structure and characteristics:

- Practice type
- List sizes

iii Out of hours duty:

- Week night duty
- Weekend duty
- Off duty cover arrangements

iv Practice services:

- Services provided
- Access to diagnostic/treatment services

v Educational activity:

- Undergraduate teaching
- Postgraduate teaching
- Continuing medical education

vi Practice Organisation:

- Practice area
- Practice premises
- Ownership of premises
- Branch surgeries
- Number of GPs in the practice
- Partnerships

vii Practice staff:

- Medical Assistants
- Other staff
- Involvement of GP's spouse in the practice
- Regular working relationships with Public Health Nurse and Social Worker

viii Practice management:

- Appointment systems
- Age-sex registers
- Practice equipment
- Practice computerisation

ix Stress, morale and retirement:

- Morale
- Stress
- Retirement

Method

The task of gathering data on the structure of Irish general practice was complicated by the fact that in 2005, as in 1992 and 1982, there was no official register of Irish General Practitioners. Many Irish general practitioners, in addition to their private practices, provide primary health care as independent contractors to the minority of the population covered by the state run General Medical Services (GMS) programme. However, not all general practitioners hold such contracts, either by choice or because they have not been successful in obtaining one. All general practitioners on the other hand, may provide services, on a private basis, without restriction, to the two thirds of the population not covered by the GMS.

Thus, the total population of GPs consists of two groups; those in private practice alone, and GPs in private practice who are also participating in the General Medical Services Scheme. The latter group are easily identifiable as they are registered under the GMS scheme. Identification of the former group causes considerable difficulty. The majority of the group participate in a scheme of medical care for mothers-to-be and infants (MIS), for which they need to register with the health boards. However, there is no mechanism for the removal of doctors from these lists, and previous experience has shown that a number of doctors listed as providing mother and infant services are no longer in practice in the area.

A preliminary list of the total population of doctors for each health board region was drawn up by combining the health board GMS Scheme lists with lists provided by the regional health boards of practitioners participating in the MIS. The list was then checked to remove doctors whom we knew to be no longer in practice. In order to allow direct comparisons to the studies conducted in 1982 and 1992 the method of compiling the lists was identical to the previous studies.

The general practitioner population was estimated by this method to have been 1,821 in 1982; 1,937 in 1992 and 2,477 in 2005, a 28% increase since 1992. A 22% random sample of practitioners was drawn from the master list for each health board. This method of selection and stratification was identical to that used in 1982 and 1992. The 22% sample for all health boards combined, contained 400 GPs in 1982, 428 in 1992 and 545 in 2005. The sample was circulated in June, July and August of 2005 with a questionnaire 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 almost identical in content and structure to that used in 1982 and 1992. The questionnaire was updated as necessary, and a small number of additional questions were inserted.

Results

Introduction

Results are shown for 1982 where data were available and comparable. Where data were unavailable, results are shown for 1992 and 2005 only.

3.0 Response Rate

In 2005, 476 valid questionnaires (87%) were returned, compared to 292 (68%) in 1992 and 281 (70%) in 1982.

Table 1: Response rate by health board area, 1992 and 2005

Health board area	1982 %	1992 %	2005 %
Eastern		65	77
Midland		50	52
Mid Western		74	74
North Eastern		61	99
North Western		63	58
South Eastern		59	99
Southern		82	99
Western		80	98
All health boards combined	70	68	87

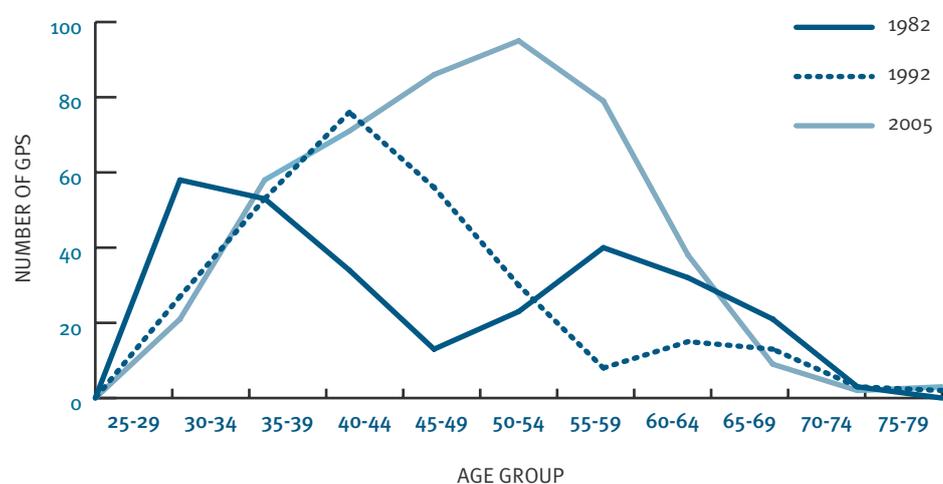
3.1 Demographic Characteristics

Introduction

This section outlines the age, sex, marital status, education, qualification and training of general practitioners over the three time periods.

3.1.1 Age

Figure 1: Age range of GPs, 1982, 1992 and 2005



The age range of the GPs taking part in the surveys in 1982, 1992 and 2005 are shown in figure 1. In 1982 they were predominately in the 30-40 and 55-65 age groups. In 1992 they were predominantly in the 35-55 age group, while in 2005 there is a more even spread between the ages of 35-60.

In 1992, a significant percentage of the GPs (8%) were found to be still in practice after the age of 64. This has declined in 2005 to 3%.

Table 2: Age distribution of GPs, by practice area type, 2005

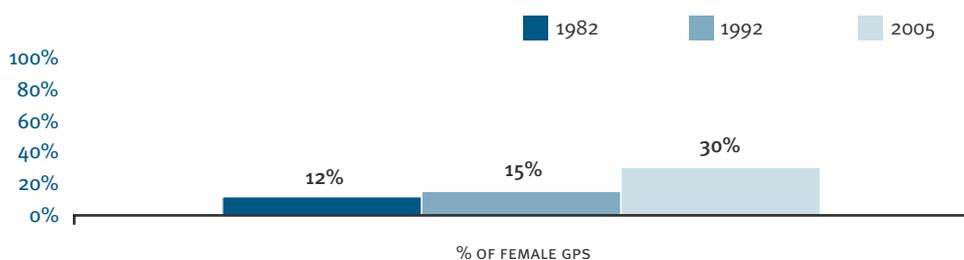
	30-34 no (%)	35-39 no (%)	40-44 no (%)	45-49 no (%)	50-54 no (%)	55-59 no (%)	60-64 no (%)	65-69 no (%)	70-74 no (%)	75-79 no (%)
Urban n=192	8 (4)	15 (8)	36 (19)	39 (20)	38 (20)	33 (17)	18 (9)	3 (2)	1 (1)	0 (0)
Mixed n=162	9 (6)	23 (14)	29 (18)	28 (17)	35 (22)	27 (17)	9 (6)	2 (1)	0 (0)	0 (0)
Rural n= 97	4 (4)	10 (10)	6 (7)	19 (20)	22 (23)	19 (20)	10 (10)	3 (3)	3 (3)	2 (3)

3.1.2 Sex

Table 3: Sex of respondents, 1982, 1992 and 2005

	1982 no (%)	1992 no (%)	2005 no (%)
Male	248 (88)	248 (85)	327 (69)
Female	33 (12)	44 (15)	141 (30)
Missing data			8 (1)
Total	281 (100)	292 (100)	476 (100)

Figure 2: Percentage of women in general practice, 1982, 1992 and 2005



The 100% increase in the number of female GPs between 1992 and 2005 is not surprising in view of the large number of female graduates and the number passing through the GP training schemes over the period.

3.1.3 Marital status

Table 4: Marital status of respondents, 1982, 1992 and 2005

	1982			1992			2005		
	male no (%)	female no (%)	all no (%)	male no (%)	female no (%)	all no (%)	male no (%)	female no (%)	all no (%)
Married	236 (95)	25 (76)	261 (93)	232 (94)	35 (79)	267 (91)	292 (89)	70 (77)	402 (85)
Single	6 (2)	4 (12)	10 (3)	10 (4)	6 (14)	16 (5)	10 (3)	16 (11)	26 (6)
Widowed	3 (1)	2 (6)	5 (2)	0 (0)	1 (2)	1 (0.3)	4 (1)	3 (3)	8 (1.6)
Other	3 (1)	2 (6)	5 (2)	6 (2)	2 (4)	8 (3)	20 (7)	13 (7)	33 (7.4)

In all three surveys, most respondents reported themselves as married. The percentage of married GPs decreased slightly in the 2005 survey, with a small increase in the numbers who are either separated or divorced. Female GPs are more likely to be single (11%) than their male counterparts (3%), as was found in both 1982 and 1992.

3.1.4 Full-time practice

Figure 3: Full-time practice, 1992 and 2005

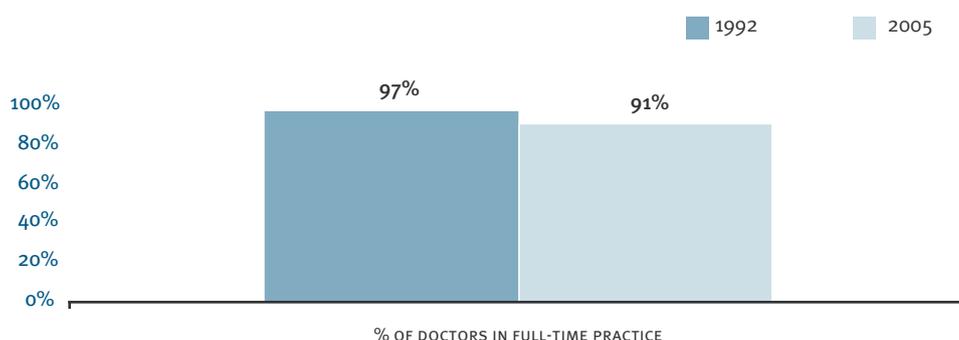


Figure 3 shows that 9% of the GPs surveyed believe themselves not to be in full-time practice. This is a significant increase on the 3% of respondents who indicated they were not in full-time practice in 1992. When analysed by gender 96% of males and 80% of females consider themselves in full time practice

3.1.5 Education – Undergraduate

Table 5: Medical School of origin, 1982, 1992, and 2005

Medical School	Pre-1982*	Pre-1992*	2005
UCD	36 (34%)	72 (41%)	144 (31%)
TCD	9 (8%)	9 (5%)	54 (12%)
RCSI	10 (9%)	17 (10%)	62 (13%)
NUIG	27 (25%)	40 (23%)	101 (21%)
UCC	23 (21%)	36 (20%)	93 (19.5%)
QUB	2 (2%)	0	3 (0.5%)
Other	0	2 (1%)	12 (3%)
Total	107	176	469

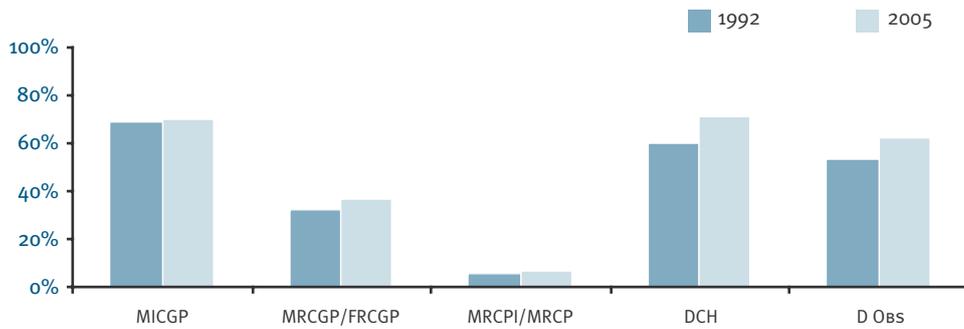
*As reported in Oliver and Comber²

The majority of respondents in 1982 (99%), 1992 (98%) and 2005 (97%) graduated from one of the five medical schools in the state.

Of the Dublin medical schools, UCD was the origin of more general practitioners than TCD and RCSI in 1992. However this gap has reduced over the last 12 years.

3.1.6 Education – Postgraduate qualifications

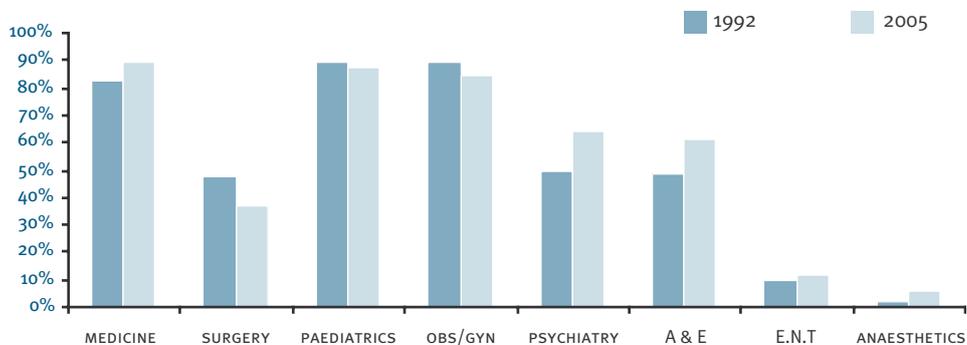
Figure 4: Postgraduate qualifications, 1992 and 2005



There has been a small overall increase in listed areas of postgraduate qualification, mainly in the areas of diplomas in paediatrics and obstetrics.

3.1.7 Postgraduate hospital experience

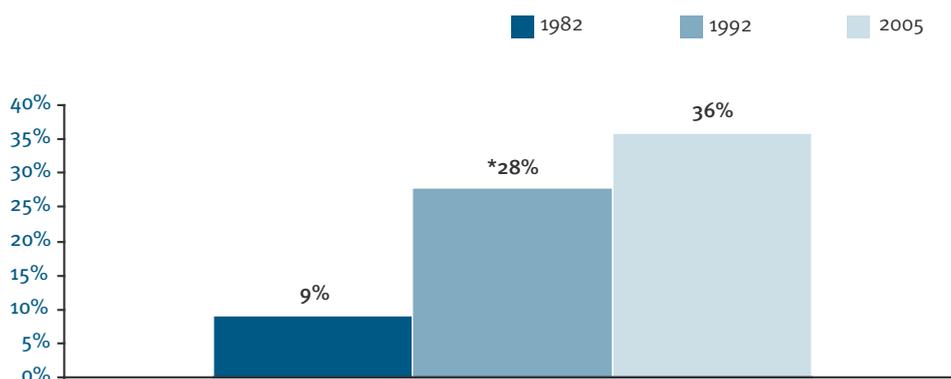
Figure 5: Percentage of GPs with at least 6 month's hospital experience, 1992 and 2005



In 2005, 89% of respondents had experience in general medicine, with 88% having experience in paediatrics and 86% in obstetrics, with little difference in the figures from 1992. However there have been significant increases in those who have held post-registration posts in the areas of psychiatry and A&E. The only significant decrease was in surgery, where percentages declined from 48% to 37%.

3.1.8 Vocational training

Figure 6: Percentage of GPs who completed a 3 year formal training programme, 1982, 1992 and 2005



There has been a considerable increase in the percentage of GPs who entered general practice between 1992 and 2005 following formal 3 year post graduate training in general practice. In 1982 9% of practitioners had completed a formal 3 year vocational training programme; in 1992 this figure had increased to 28%, while in 2005 the figure was 36%.

Table 6: Sources of Vocational Training, 1992 and 2005

	*1992	2005
Full training in Ireland	17%	25%
Full training in UK	9%	9%
Single trainee year in UK	22%	22%
Full training elsewhere	2%	2%
No formal training	50%	42%

*Recalculated percentages

Of the GPs who have undergone any kind of formal training in general practice, the majority received their training in the UK and elsewhere, including Australia and Canada. Many of those who did not complete three year's formal training, had undergone a one year general practice training programme in the UK.

Table 7: Percentage of GPs vocationally trained by age group, 2005

Age Group	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
3 year minimum vocational training	85%	70%	57%	63%	23%	8%	11%	0
1 year GP training in the UK	10%	19%	31%	35%	14%	13%	18%	6%
No vocational training	5%	11%	12%	2%	63%	79%	71%	94%

3.2 Practice Structure and Characteristics

Introduction

This section outlines the practice type, GMS, private and total list sizes of respondents over the three time periods.

3.2.1 Practice type

Table 8: Practice type, 1982, 1992 and 2005

Practice type	1982	1992	2005
Private only	11%	9%	4%
GMS and Private	89%	91%	96%

There has been a decrease in the number of GPs in private practice alone between 1992 and 2005, as was the case in the previous decade. It was found that this group of 4% in private only practice is almost entirely made up of GPs who have been in practice for less than ten years.

Table 9: Practice location and list type, 1992 and 2005

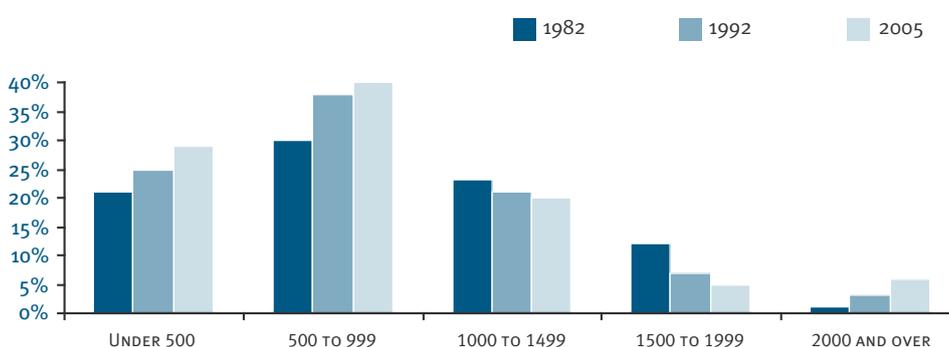
Practice type	1992			2005		
	urban	mixed	rural	urban	mixed	rural
Private only	9%	7%	2%	5%	3%	4%
GMS and Private	91%	93%	98%	95%	97%	96%

In 1992, the private only practitioners were found to be predominantly in urban areas. In 2005 there is a more even spread across area type amongst private only practitioners.

3.2.2 List sizes

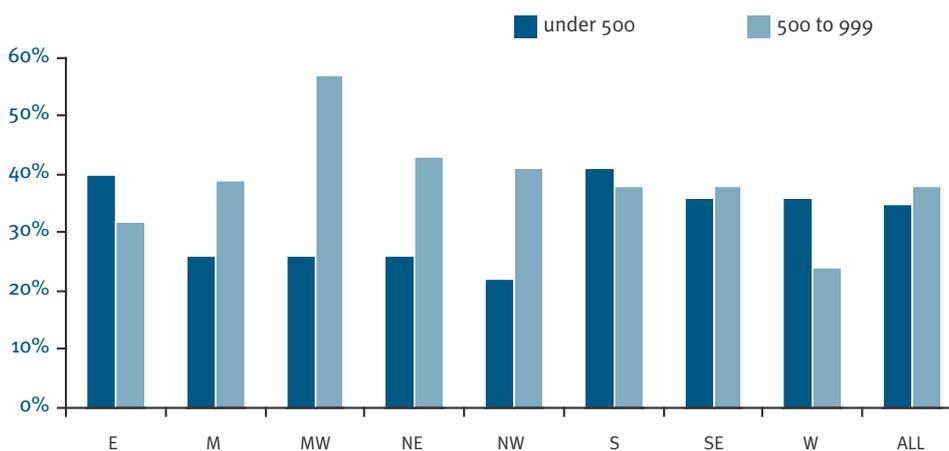
GPs were asked to estimate the size of their practices, both private and GMS. Accurate figures are available to all GPs on the size of their GMS practices, but only GPs with age/sex registers have accurate private patient statistics. Most of the figures for size of private practice lists are therefore, the respondents' own estimates.

Figure 7: GMS list sizes, 1982, 1992 and 2005



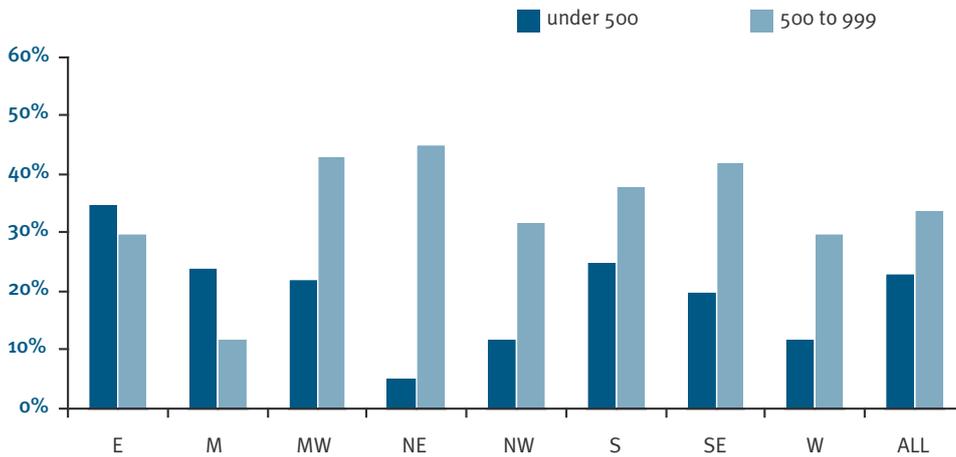
From 1982 to 2005, there has been an increase in the number of GPs with smaller list sizes (≤ 1000), while there has been an overall decrease in the number of GPs with list sizes between 1000 to 2000 and an increase in the percentage of those with larger lists of over 2000 patients.

Figure 8: GMS list sizes of less than 1000 by health board, 2005



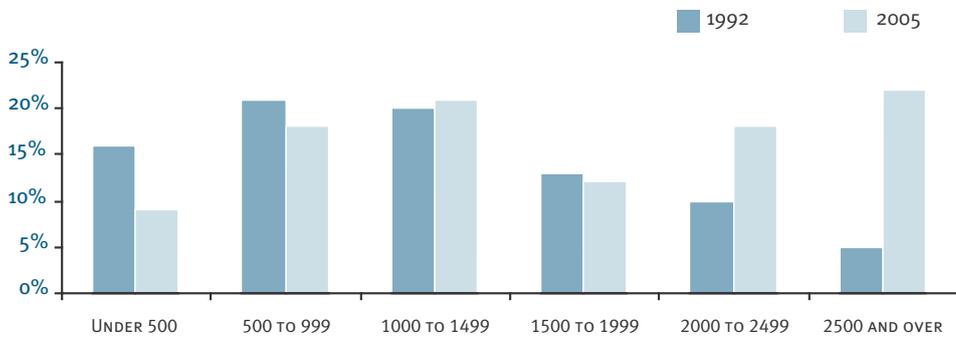
In 2005, smaller GMS patient list sizes (≤ 500) were found more commonly in the Eastern, Southern and Western health board areas, while the larger lists occurred in the Midland, Mid West, North East and North West regions. The distribution of list sizes between health boards is more uniform than in both 1982 and 1992 (fig. 9).

Figure 9: GMS list sizes of less than 1000 by health board, 1992



In 2005, less than 2% of general practitioners have lists of over 2000 in size, while 21% of general practitioners have GMS lists of 1000 to 1999 in size.

Figure 10: Private list sizes, 1992 and 2005



In 2005, more respondents than in 1992 estimated their private list sizes at over 2000, and fewer respondents estimated their list sizes at less than 2000.

3.3 Out of Hours Duty

Introduction

This section outlines the respondents' out of hours duty both during the week and at weekends. The methods of off duty cover arrangements are also examined.

As so much change has taken place in out of hour's duty between 1992 and 2005, week nights had to be measured per month in 2005 as opposed to per week, as was done in 1992. The table below is constructed in an effort to compare 1992 with 2005, where weekly figures from 1992 have been multiplied by four in order to aid comparisons between the years.

3.3.1 Week night duty

Table 10: Night cover during the week, 1992 and 2005

Number of nights per 4 week period	1992	2005
0	6%	31%
1	0%	11%
2	0%	18%
3	0%	11%
4	22%	20%
8	13%	3%
12	12%	1%
16	15%	1%
20	32%	4%

Table 10 indicates that there has been a substantial increase in the number of GPs who do not cover any nights, from 6% in 1992 to 31% in 2005. A large proportion of GPs (18%) are on duty twice a month. There has been a large decrease in the number of GPs covering every week night of the month.

3.3.2 Weekend duty

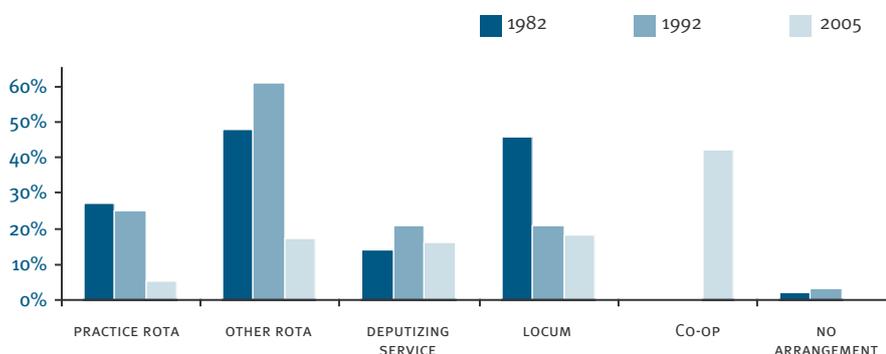
Table 11: Weekends on duty 1992 and 2005

Weekends on duty	1992	2005
None	5%	22%
One in:		
1	17%	6%
2	21%	4%
3	17%	2%
4	15%	9%
5	13%	8%
6	8%	8%
7	1%	4%
8	1%	9%
9	2%	7%
10 plus	0%	21%

Overall GPs are working fewer weekends in 2005 than they were in 1992. There has been a large increase in the numbers taking every weekend off duty, and a large decrease in the number of GPs on duty every weekend.

3.3.3 Off duty cover arrangements

Figure 11: Off duty cover arrangements 1982, 1992 and 2005



There has been a large decrease between 1992 and 2005 in the use of internal practice rotas and rotas involving other practices for off duty cover arrangements. The use of deputizing services and locums has decreased slightly. 42% of GPs are now involved in Co-ops since Dubdoc, the first co-op, opened in 1998.

3.4 Practice Services

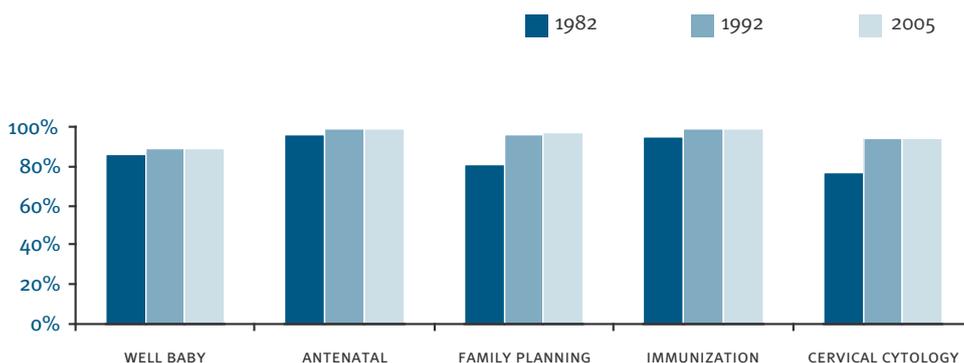
Introduction

This section outlines the range of services provided by practices during surgery hours, and the types of investigations available to the practice, without referring patients to a hospital out-patient department. The reported availability of facilities to treat patients in health board hospitals for short or long term periods was also analysed.

3.4.1 Services provided

The respondents were asked to indicate which services, from a list provided, were on offer in their practice during surgery hours. Fig. 13 shows the percentages of GPs providing the services over the three time periods.

Figure 12: Services provided by GPs, 1982, 1992 and 2005



Although there has been a small increase since 1982 in the provision of the services listed in figure 12, there has been no significant increase in the number of GPs providing these services between 1992 and 2005.

Figure 13: Percentage of GPs providing additional services since 1992

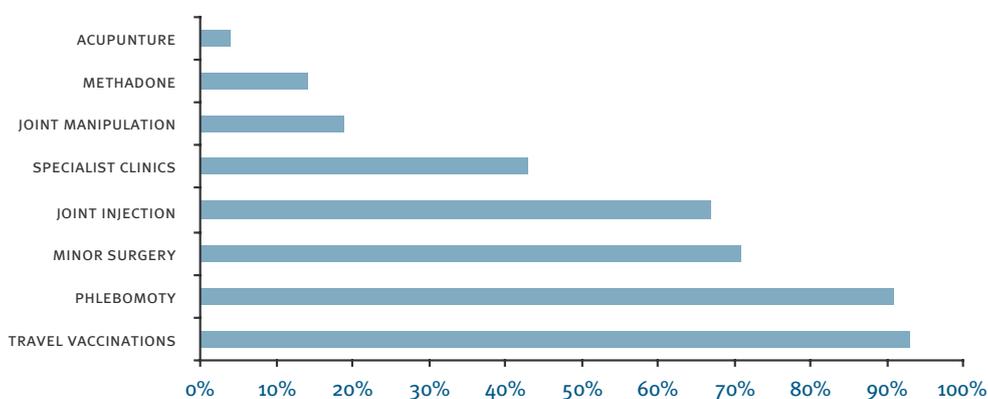
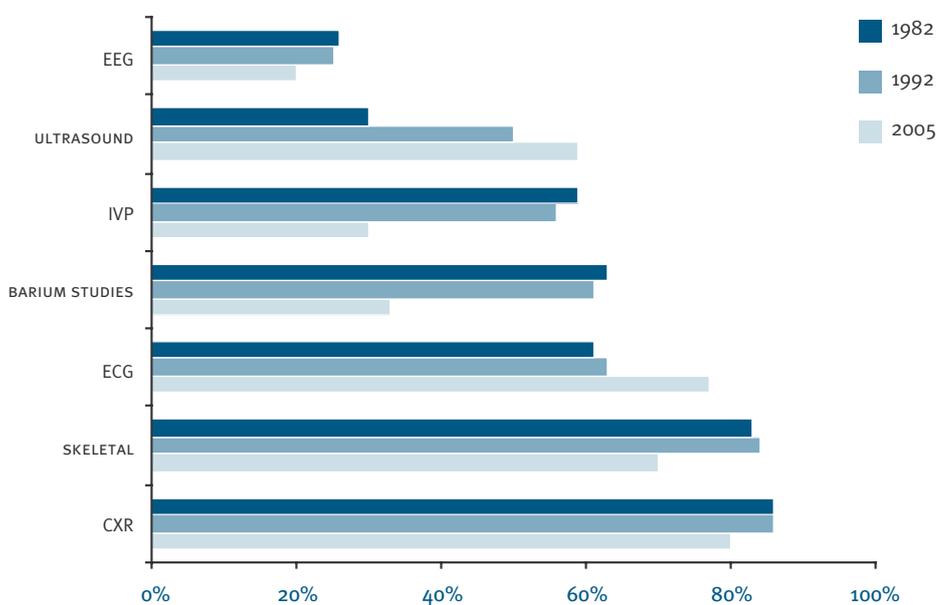


Figure 13 lists services that have become more available since 1992. Travel vaccinations and phlebotomy are widely available, as are minor surgery and joint injections. 43% of GPs provided some type of specialist clinic. The most common were: cardiovascular, asthma, diabetes, well-woman, and men’s health. Joint manipulation (19%) and methadone maintenance (14%) are provided by a much smaller number of GPs. Acupuncture is provided by only 4% of practitioners.

3.4.2 Access to diagnostic/treatment services

Figure 14: Direct access to treatment and diagnostic facilities for patients, without referral to the out-patient department, 1982, 1992 and 2005



With the notable exceptions of ultrasound in pregnancy and ECG there has been a significant decrease in the availability of access to the services listed in figure 14 since 1992. The availability of ultrasound has increased from 50% to 59%. ECG availability has also increased for the GPs surveyed from 65% to 77%.

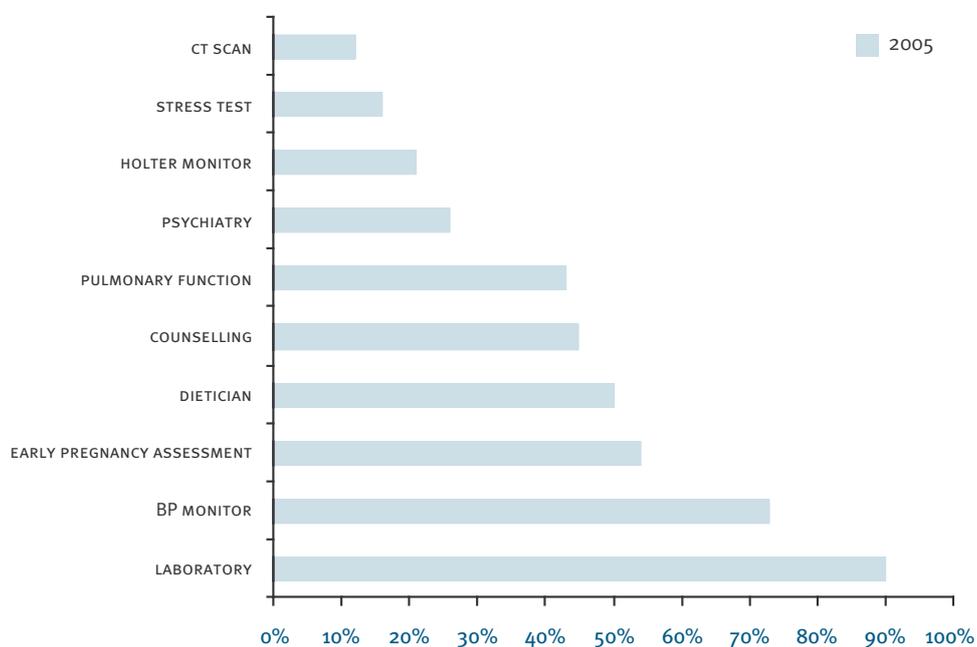
The most significant decreases have been in the availability of barium studies and IVP. Access to barium studies has decreased from 62% to 33% between 1992 and 2005 and to IVP from 57% to 30% of the GPs surveyed. These declines reflect the changes in custom and practice in diagnostic radiology.

Probably the most clinically important decrease has been in the availability of access to CXR and skeletal x-rays in the last 13 years, from 84% to 80% and from 84% to 70% respectively.

Table 12: Decrease in GP access to radiology, 1982, 1992 and 2005

	1982	1992	2005
Skeletal	83%	84%	70%
CXR	85%	86%	80%

Figure 15: Direct access to treatment and diagnostic facilities for patients, without referral to the out-patient department, 2005



With the exception of laboratory services, direct access to treatment and diagnostic facilities are severely limited, especially in the public sector. If general practice is to play a greater role in Irish healthcare, direct access needs to be developed, if necessary by circumventing the current public sector constraints.

3.5 Educational Activity

3.5.1 Undergraduate teaching

Table 13: Participation in undergraduate teaching by health board area, 1982, 1992 and 2005

	1982	1992	2005
Eastern	27%	45%	51%
Midland	22%	17%	54%
Mid-Western	20%	15%	30%
North Eastern	29%	17%	40%
North Western	11%	37%	47%
South Eastern	13%	15%	36%
Southern	35%	47%	44%
Western	21%	44%	48%
All areas	24%	36%	42%

42% of all the respondents reported being involved in undergraduate teaching of general practice within the past 3 years, an increase on the 1992 figure of 36% (Table 13).

When looked at by health board area, the largest percentage increases have been in the Midlands, Mid-Western, North Eastern, and South Eastern areas. The Southern area was the only region in which there was a decrease in the proportion of general practitioners involved in teaching. The Midlands is now the area with the highest percentage of general practitioners involved in teaching.

Table 14: Participation in undergraduate teaching by vocationally trained/not vocationally trained, 1982, 1992 and 2005

	1982	1992	2005
Vocationally trained	54%	49%	55%
Not vocationally trained	21%	33%	39%

55% of vocationally trained doctors were involved in undergraduate teaching, compared to 39% of those not vocationally trained, but the increase in teaching was not solely confined to the vocationally trained GPs.

There was a decrease in the percentage of general practice trainers who are also involved in undergraduate teaching, from 90% in 1992 to 71% in 2005.

3.5.2 Postgraduate teaching

Table 15: Trainers in General Practice by health board, 1982, 1992 and 2005

	1982	1992	2005
Eastern	4%	6%	17%
Midland	0%	8%	8%
Mid-Western	0%	4%	7%
North Eastern	6%	11%	20%
North Western	11%	11%	32%
South Eastern	6%	10%	30%
Southern	0%	0%	18%
Western	9%	11%	9%
All areas	5%	8%	18%

There has been a large increase in the number of GPs involved in postgraduate teaching, from 5% in 1982 to 18% in 2005. The largest increases can be seen in the North Western, South Eastern, Southern, and Eastern health board areas. The only decrease has been in the Western health board area, from 11% in 1992 back to the 1982 level of 9%.

Almost half of the respondents, (46%), are not involved in teaching, at either undergraduate or postgraduate levels.

3.5.3 Continuing medical education

Table 16: Participation in small group continuing medical education, 1982, 1992, and 2005

	1982	1992	2005
Eastern	32%	71%	82%
Midland	45%	82%	69%
Mid-Western	20%	53%	88%
North Eastern	56%	68%	80%
North Western	52%	62%	84%
South Eastern	42%	79%	82%
Southern	44%	60%	86%
Western	41%	60%	91%
All Areas	41%	69%	83%

Overall there has been a significant increase in ICGPCME attendance throughout the country in the last thirteen years, from 69% to 83%, continuing the upward trend between 1982 and 1992. However, in the Midland area, this trend was reversed with the percentage falling from 82% in 1992 to 69% in 2005.

3.6 Practice Organisation

Introduction

This section examines GP practice locations (urban/rural areas), type of premises and business set-up, including partnerships.

3.6.1 Practice area

In the 1982, 1992 and 2005 questionnaires an urban area was defined as a relatively small centre of population, with 5000 or more residents. However in such a centre an 'urban' practitioner would be expected to have most of his or her patients within a relatively small geographical area, and have ready access to colleagues and some hospital facilities, while a 'rural' practitioner would have scattered patient population, few nearby colleagues and be at a distance from most referral facilities. As the term 'mixed' was not precisely defined in 1982 and 1992, it was decided not to give a definition, so as not to affect the comparability of the three surveys. The 'mixed' type of practice includes patients drawn from both fairly concentrated centres of population and scattered population areas.

Figure 16: Practice area, 1982, 1992 and 2005

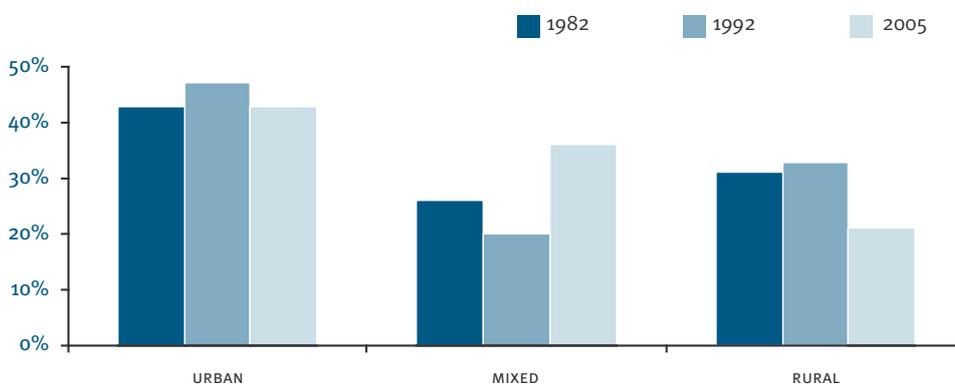


Figure 16 illustrates that while urban practices still predominate, there has been a slight decrease from 47% in 1992 to 43% in 2005, of practitioners who consider themselves in urban areas. There has been a decrease in those who consider themselves to be working in rural areas from 33% in 1992 to 21% in 2005. GPs who consider themselves to work in a mixed area have increased by 80% from 20% in 1992 to 36% in 2005.

3.6.2 Practice premises

Table 17: Type of practice premises, 1982, 1992 and 2005

	1982	1992	2005
Purpose-built	25%	27%	43%
Adapted premises	42%	46%	46%
Attached to residence	33%	27%	11%

Table 17 illustrates that the percentage of premises, adapted for the purpose of GP practice, has remained the same since 1992. However there has been a large shift to purpose built premises away from GPs practising from premises attached to their residences.

Table 18: Practice premises by practice area, 1982, 1992 and 2005

	1982			1992			2005		
	Urban	Mixed	Rural	Urban	Mixed	Rural	Urban	Mixed	Rural
Purpose-built	16%	17%	33%	19%	29%	33%	40%	43%	52%
Adapted premises	52%	47%	24%	58%	50%	28%	51%	49%	30%
Attached to residence	30%	27%	43%	23%	21%	39%	9%	8%	18%
Other	2%	0%	0%	1%	0%	0%	0%	0%	0%

Table 18 indicates that adapted premises predominate in both urban and mixed areas, but not in rural areas. In rural areas there has been a large decline in the use of GPs' residences as practice premises, with 52% now working from purpose built premises, compared to 1982 when 43% worked from premises attached to their homes.

3.6.3 Ownership of premises

Table 19: Ownership of premises, 1982, 1992 and 2005

	1982	1992	2005
Privately owned	64%	69%	72%
Health board owned	41%	11%	14%
Privately rented	21%	20%	14%

Table 19 shows that there has been a slight increase in health board owned and privately owned premises, and that the percentage of GPs renting private premises has declined to 14% in 2005 versus 21% in 1982.

3.6.4 Branch surgeries

Table 20: Percentage of GPs operating branch surgery premises, 1982, 1992 and 2005

	1982	1992	2005
All areas	43%	36%	31%
Urban	33%	28%	28%
Mixed	49%	34%	42%
Rural	57%	52%	30%

The overall percentage of GPs running branch surgery premises in addition to the main surgery has decreased from 43% in 1982, to 36% in 1992, to 31% in 2005. This decrease is particularly evident in rural practices, where the percentage has declined from 57% in 1982 to 30% in 2005. In mixed area practices, there has been an increase from 34% in 1992 to 42% in 2005.

3.6.5 Number of GPs in the practice

Respondents were asked two questions under this heading: the number of doctors working from the main surgery premises, and the number of partners in the respondents practice.

Figure 17: Percentages of GPs working from the main practice premises, 1982, 1992 and 2005

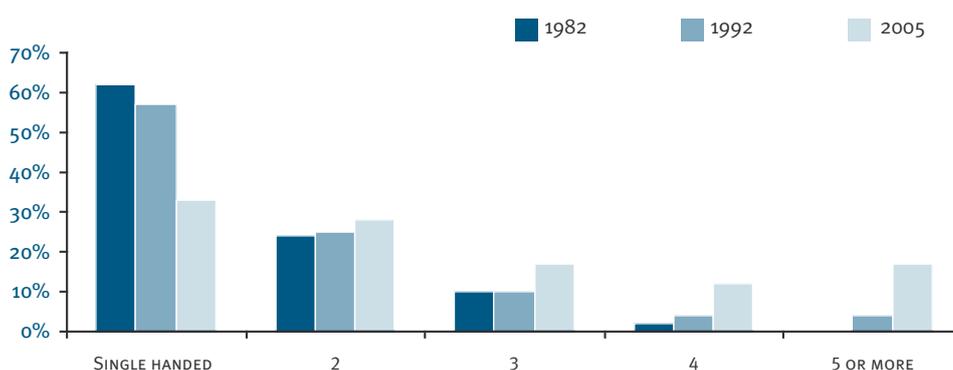


Figure 17 illustrates an overall decrease in single handed GP practices to 35% and an increase in the number of GPs working from the same premises.

Table 21: Number of GPs sharing the main practice premises by area type, 1982, 1992 and 2005

No. of GPs per premises:	1992			2005		
	urban	mixed	rural	urban	mixed	rural
1	48%	45%	79%	25%	30%	55%
2	31%	36%	16%	27%	27%	34%
More than 2	21%	29%	5%	48%	43%	11%

There has been a substantial decrease between 1992 and 2005, in the number of GPs running single handed practices across all area types, from 79% to 55% in rural areas, 45% to 30% in mixed areas, and 48% to 25% in urban areas. While there has been a slight decrease in the number of practices with 2 doctors in urban and mixed areas, there has been a large increase in the number of practices with 2 doctors in rural areas.

In all areas there has been a large increase in the number of practices with more than 2 GPs between 1992 and 2005.

3.6.6 Partnerships

Figure 18: Percentage of GPs in partnerships, 1982, 1992 and 2005

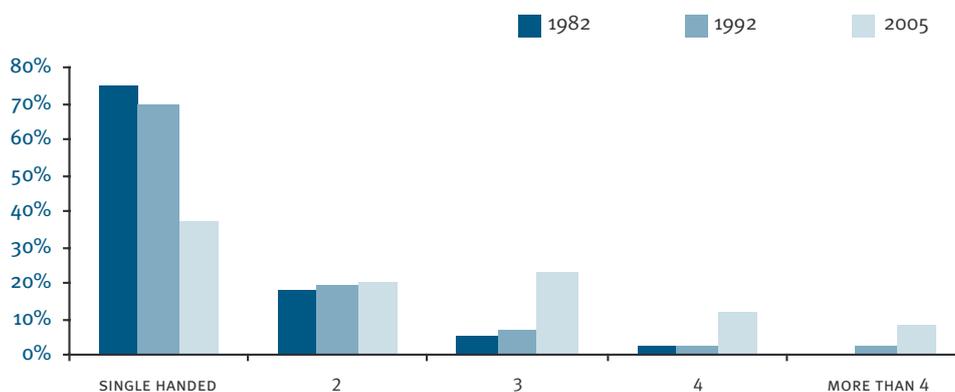


Figure 18 indicates that there has been a significant trend towards partnerships between 1992 and 2005, while there was only a slight trend towards partnerships between 1982 and 1992.

24% were in partnerships in 1982, and 30% in 1992. The 1996 National survey of general practice⁴ showed that 58% of GPs were in partnerships and this has increased further to 63% in 2005.

3.7 Practice Staff

3.7.1 Medical assistants

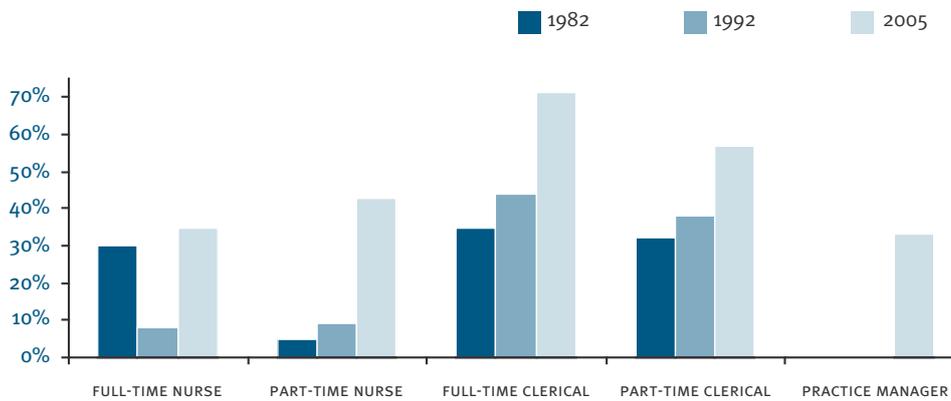
Table 22: Practices employing an assistant, 1982, 1992 and 2005

	1982	1992	2005
One assistant	11%	10%	28%
More than one assistant	1%	0	4%
Total	12%	10%	32%

Table 22 indicates a small decrease in the percentage of practices employing a medical assistant between 1982 and 1992. There was however, a substantial increase between 1992 and 2005, as the overall percentage rose from 10% to 32%.

3.7.2 Other staff

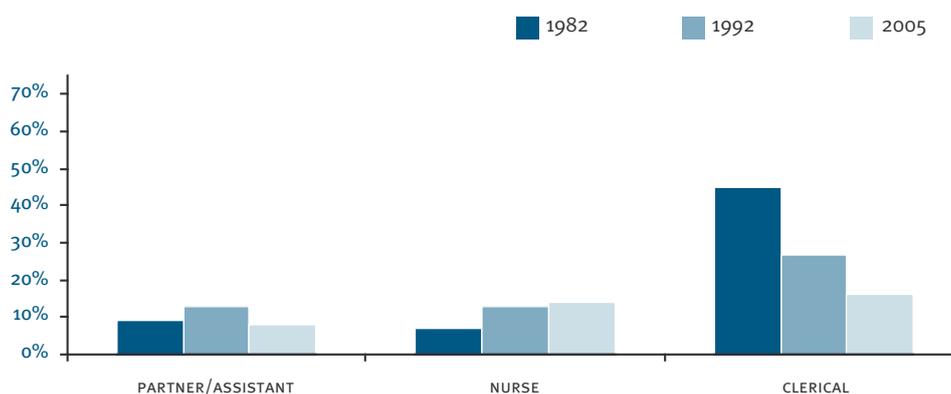
Figure 19: Percentage of practices employing staff, 1982, 1992 and 2005



There has been a large increase in the percentage of practices employing staff in all disciplines, between 1992 and 2005.

3.7.3 Involvement of GP's spouse in the practice

Figure 20: Involvement of GP's spouse in the practice, 1982, 1992 and 2005



There has been a steady decline in the involvement of the GP's spouse in the practice between 1982 and 2005. The percentage of GPs who work with their spouse as a partner or assistant has decreased from 13% in 1992 to 8% in 2005. There has been a slight increase between 1992 and 2005 in the number of GPs working with their spouse as a practice nurse, from 13% to 14%.

3.7.4 Regular working relationships with Public Health Nurse and Social Worker

In 2005 respondents were asked to indicate whether or not they had a regular working relationship with the Public Health Nurse and Social worker.

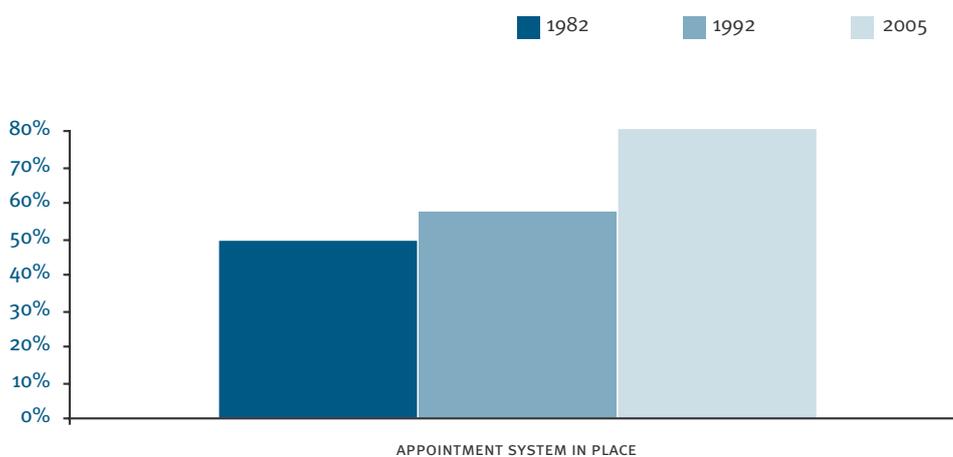
61% of GPs believe themselves to have a regular working relationship with the Public Health Nurse, while 17% believe themselves to have a regular working relationship with the Social Worker.

3.8 Practice Management

This section discusses results relating to appointment systems, age-sex registers, practice equipment and computerisation.

3.8.1 Appointment systems

Figure 21: Percentage of practices using appointment systems, 1982, 1992 and 2005



There has been a steady increase in the number of GPs using an appointment system from 50% in 1982 to 58% in 1992 to 81% in 2005.

Table 23: Appointment systems by practice area, 1982, 1992 and 2005

	1982	1992	2005
Urban	60%	66%	89%
Mixed	48%	69%	82%
Rural	38%	41%	65%

Overall, the proportion of practices having appointment systems has increased from 58% in 1982 to 81% in 2005 (Figure 23). The increase was most evident in rural areas, from 41% in 1992 to 65% in 2005, and in urban areas, from the 1992 level of 66% to a 2005 level of 89%. The smallest increase was seen in mixed areas from 69% in 1992 to 82% in 2005, however, these areas showed the highest increase between 1982 and 1992.

3.8.2 Age-sex registers

Table 24: Age-sex registers, 1982, 1992 and 2005

	1982	1992	2005
GMS only	8%	11%	11%
GMS and private	19%	22%	47%
Private only	2%	3%	1%
None	71%	63%	41%

While there was a slight overall increase in the use of age-sex registers between 1982 and 1992 from 29% to 37%, the number of GPs using age-sex registers in 2005 increased significantly to 59%.

Table 25: Percentage of vocationally trained/not vocationally trained GPs using age-sex registers, 1982, 1992 and 2005

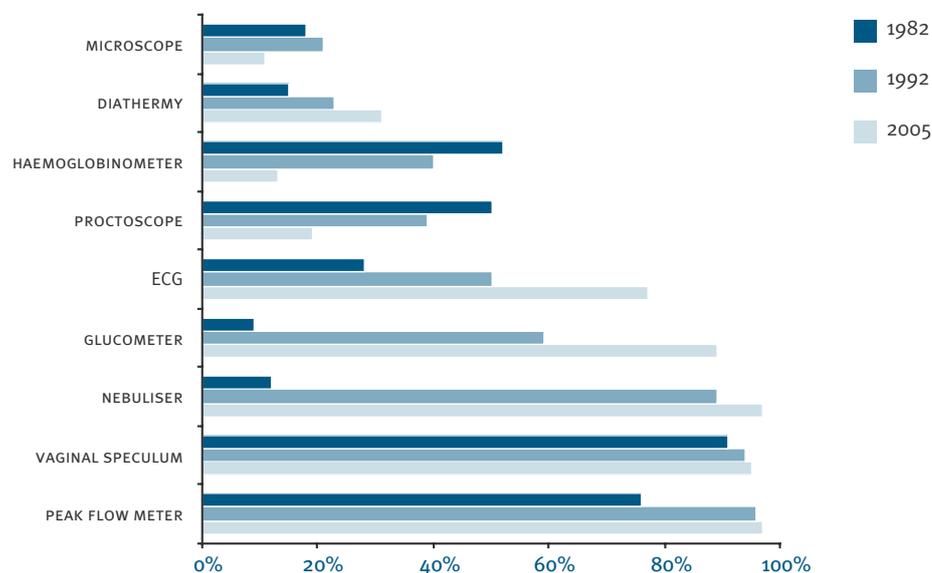
	1982	1992	2005
Vocationally trained (minimum 3 years)	31%	49%	92%
Not vocationally trained	29%	33%	58%

As was the case in 1992, age-sex registers in 2005 were far more likely to be found in the practices of doctors who have undergone a 3-year vocational training programme.

3.8.3 Practice equipment

The respondents were asked to indicate which of the items listed in figure 22, they use in their practice.

Figure 22: Equipment used, 1982, 1992 and 2005



Of the items listed in figure 22, there has been a slight increase in the use of nebulisers, vaginal speculae, diathermy and peak flow meters between 1992 and 2005. The use of glucometers (89%) and ECG machines (77%) has increased significantly since 1992 and use of microscopes, proctoscopes and haemoglobinometers has decreased.

Figure 23: Additional Services Provided, 2005

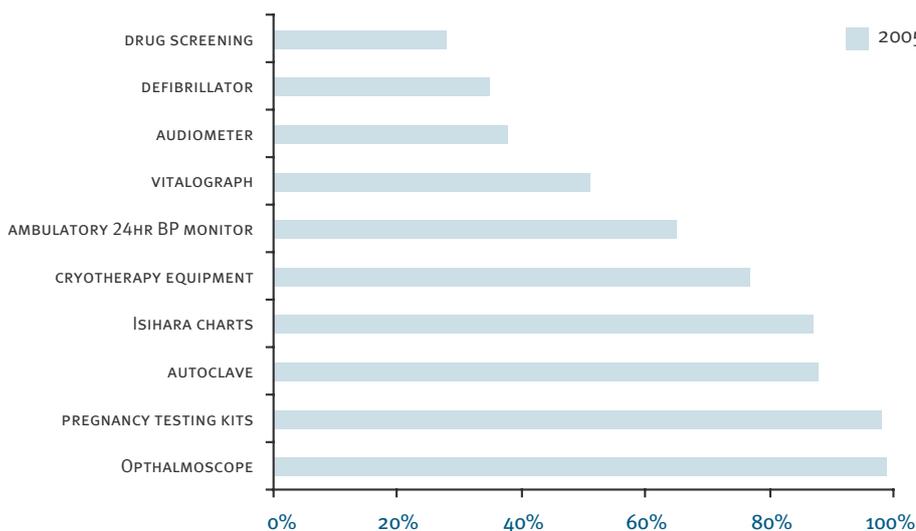
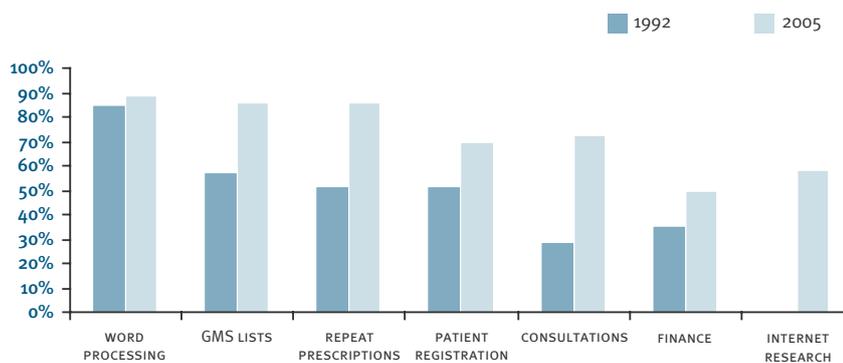


Figure 23 lists additional items of equipment about which the GPs were questioned in 2005. Ophthalmoscopes (99%), pregnancy testing kits (98%), autoclave (88%), Ishihara charts (87%) cryotherapy equipment (77%) and 24 hr BP monitors (65%) are widely available.

3.8.4 Practice computerisation

Figure 24: Uses of practice computers, 1992 and 2005



In 2005 89% of respondents used computers in the practice compared to only 27% of respondents in 1992. There has been a significant rise in the number of practices now using computerised record systems and an increase in the percentage of GPs using the computer for a variety of practice management tasks.

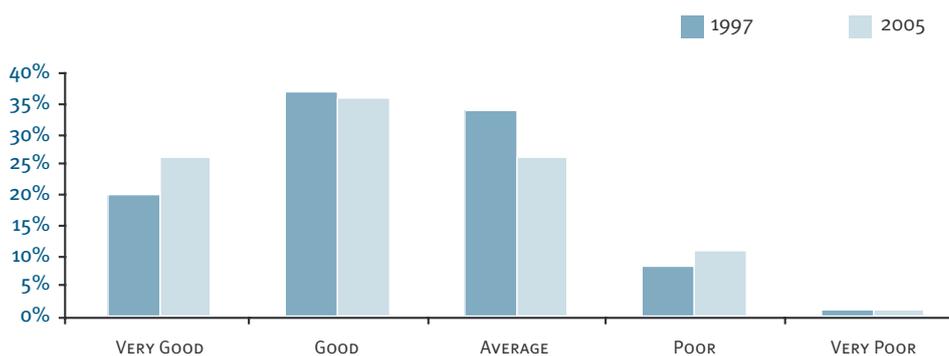
3.9 Stress, Morale and Retirement

This section examines the self-reported morale and stress levels of general practitioners. It also outlines the retirement age at which respondents feel they will realistically retire, the factors that would influence them to retire before 60 years, and the factors that may entice them to work in the GMS beyond 65 years. Stress and morale data in 2005 have been compared with a survey conducted by the department of Public Health and Primary Care (formerly Community Health and General Practice), in Trinity College and published by the ICGP in 1997³.

3.9.1 Morale

The respondents were asked to indicate from the five options in figure 25, how they would rate their own morale at that point in time.

Figure 25: Level of morale, 1997 and 2005

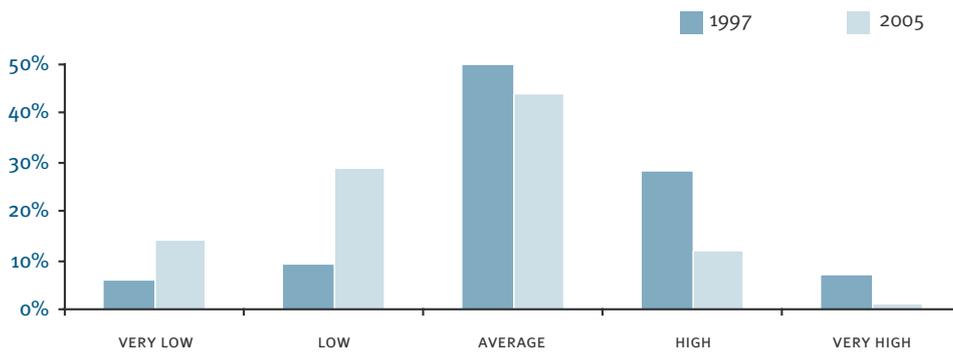


In 2005, 62% of respondents reported their morale to be either 'very good' or 'good'. 26% believed their morale to be 'average', 11% felt their morale was 'poor', and 1% felt their morale was 'very poor'.

3.9.2 Stress

Respondents were asked to indicate from the five options in figure 26, how they would rate their own stress at that point in time.

Figure 26: Level of Stress, 1997 and 2005



Of the 463 respondents who answered this question, 42% had stress levels classified as 'low' or 'very low'. 42% reported 'average' levels of stress, 14% described their stress levels as 'high', and 2% as 'very high'. There has been a significant decrease overall in the perceived stress levels amongst general practitioners between 1997 and 2005.

3.9.3 Retirement

The respondents were asked to indicate at what age they believe they will retire from general practice.

Table 26: Preferred age for retirement, 2005

	50-54	55-59	60	61-64	65	66-69	70-74	75+
All	3%	10%	24%	6%	41%	3%	12%	1%
Male	1%	5%	21%	8%	46%	3%	14%	2%
Female	6%	22%	30%	1%	30%	5%	6%	0%

Of the 476 respondents, 43% believe they will retire from clinical general practice before the age of 65. 13% plan to retire before 60, 24% at 60 years of age, and 41% at 65 years. 16% of general practitioners plan to work beyond the age of 65.

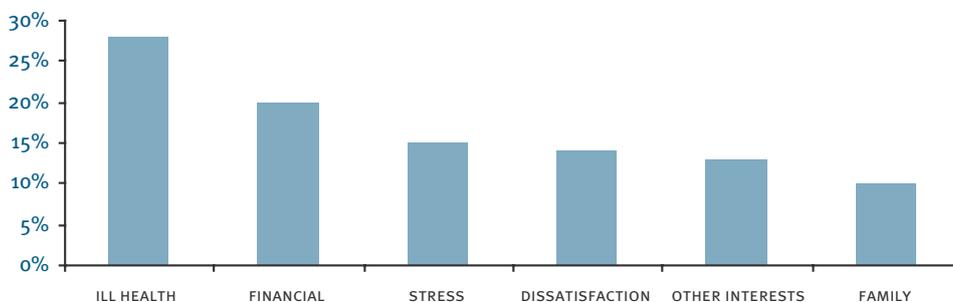
Of the male GP respondents 35% believe they will retire before the age of 65, but among the female GP population this proportion rises to 59%.

Table 27: Percentage of GPs who plan to retire before the age of 65 by age group, 2005

Age range in years:	30-39	40-49	50-59	60+
% planning to retire before 65 years	68%	52%	32%	26%

Table 27 indicates that a substantially larger proportion (68%) of GPs in the younger age group (30-39 years), than their older counterparts (60+ (26%)), plan to retire before 65 years of age.

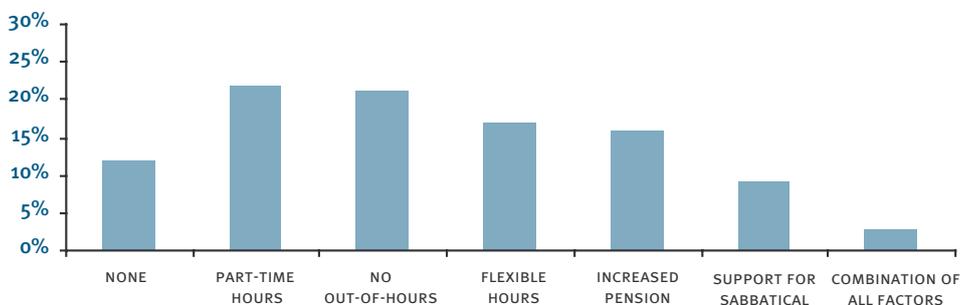
Figure 27: Factors influencing GPs to retire before 60 years, 2005



Respondents were asked to rank the factors listed in figure 27 that would influence them to retire before age 60.

Potential ill health at 28% was the highest-ranking factor. Having adequate financial security ranked second at 20%. Job stress (15%), job dissatisfaction (14%) and the ability to pursue other interests (13%) were ranked similarly. The least influential factor was the ability to devote more time to family at 10%.

Figure 28: Factors influencing GPs to continue working in the GMS beyond age 65, 2005



The respondents were asked to rank the factors listed in Figure 28 that would most influence them to continue working in the GMS beyond 65 years.

Of the respondents who answered the question, 12% felt nothing could entice them to work in the GMS beyond 65 years of age, while the remaining 88% would consider continuing on in practice under certain circumstances. The highest-ranking factor was part-time working hours at 22%, followed closely by no out-of-hours work at 21%. Flexible working hours (17%) and an increased pension (16%) ranked 3rd and 4th respectively. The least enticing factor as perceived by respondents was increased support for sabbatical (9%).

The question we asked on retirement was: “Realistically at what age do you think you will retire from clinical general practice?” A recent study from the Western Health Board area⁵ sought to establish retirement aspirations through the question “What is your ideal age of retirement?” It is perhaps not surprising that ideally GPs would report a wish to retire earlier than they could in realistic terms.

Discussion

The response rate of 86% achieved in this study indicates a high level of interest by GPs in the structure of general practice in Ireland. This may in part be because of the manpower concerns of many GPs about the future of their practices and the service they have built up. As we used the 1982 and 1992 methodology it caused some limitations in the way we could phrase questions, however we believe that providing a picture over 23 years is useful in reflecting the changes that have occurred.

There are more GPs in the country than ever before and while GPs as a profession are aging, there is a more even spread between the ages of 35 and 60 than in the two previous studies, which augurs well for short to medium term workforce supply. This together with the desire of the majority of older doctors to continue working past the age of 65 means that manpower issues in general practice can be managed and problems averted. This can be done by increasing the numbers of entrants to general practice and by retention of existing general practitioners together with schemes to keep aging doctors active for longer. Our findings on retirement differ from the Galway study (1996) because we asked 'at what age do you think you will realistically retire?' It is noticeable that younger doctors want to retire early but as doctors get older the prospects of retirement are less attractive.

There is a steady increase in the numbers of female GPs which looks set to increase in future years, judging by the preponderance of females in our medical schools and GP training schemes. There are important gender differences in the approach to retirement with 58% of women indicating that they will realistically retire at or before 60 years of age, while only 27% of men think they will retire at or before 60. This figure has to be approached with caution as female GPs are younger and may well find the prospect of retirement less attractive as they get older. This merits further study, as with the increasing numbers of females in the GP workforce it is another variable that needs to be considered in workforce planning. It will be important to provide appropriate supports in order to retain doctors, both male and female in the workforce for as long as is safe and sensible. It is notable that most GPs consider themselves to be in full time general practice leaving little room for manoeuvre on this front.

Significant changes have gone on in practices with single-handed practitioners now only representing 35% of the profession. There has been a virtual disappearance of the spouse from the surgery with a concomitant increase in attached staff.

Services provided by general practitioners have grown enormously, with some of a consumerist nature, like travel vaccinations, and others responding to changing societal needs such as methadone clinics. There have been significant changes in access to diagnostics with many practices resourcing themselves with equipment to provide services formerly seen only in hospitals, such as minor surgery and 24-hour blood pressure monitors. There have been significant changes in the areas of radiology, which reflect changes in custom and practice with for example, an increase in ultra sound and a decrease in IVPs. However, there has been a significant decrease in access to skeletal and chest x-rays, which has to be a matter of wider concern for the health services and merits action at both local and national levels.

Virtually all our doctors now entering general practice are vocationally trained which augurs well for the future of the profession. General practitioners have indicated a strong interest in undergraduate teaching with vocationally trained doctors more likely to teach at undergraduate level.

It is interesting to see that stress and morale levels are even better than in the previous TCD study in 1997 reflecting somewhat the current national mood.

In conclusion this study shows a maturing specialty that is growing in breadth and depth and is looking after its ongoing educational needs. It additionally shows that Ireland has a GP workforce that is well trained and is increasingly working together in partnerships from custom-built sites. General practice has developed many professionally driven services as well as responding to society's needs. Significant issues face general practice over the next decade but the study demonstrates a workforce that is capable of responding to more complex clinical challenges.

General practice has demonstrated achievement even when public policy has overlooked its potential to make a difference to the health of the people of Ireland.

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Appendix

2005 Questionnaire

June 2005

National Survey of General Practice

Details Of All Information Are Confidential

Section A: Practice Structure & Characteristics

1a. What Health Board Area do you currently practice in?

- | | | | |
|---------------|--------------------------|---------------|--------------------------|
| Eastern | <input type="checkbox"/> | North Western | <input type="checkbox"/> |
| Midlands | <input type="checkbox"/> | South Eastern | <input type="checkbox"/> |
| Mid Western | <input type="checkbox"/> | Western | <input type="checkbox"/> |
| North Eastern | <input type="checkbox"/> | | |

1b. What type of area do you practice in? (In this study an urban area is defined as one with a population of 5,000 or more residents)

- Urban
- Mixed
- Rural

2. What type of Premises do you work from?

- Purpose-built premises separate from doctor's residence
- Adapted premises separate from doctor's residence
- Surgery within or attached to doctor's residence
- Other (please specify) _____

3a. Is the surgery in which you practice:

- Privately (self or other doctor) Owned
- Health Board Owned
- Privately Rented

3b. Do you have a Branch surgery premises?

- Yes No

4a. How many practitioners (excluding trainees) are currently practicing in the main surgery?

4b. How many legalised partners, including yourself are present in your practice?

(Legalise means a formal partnership agreement has been signed)

5. Do you have an appointment system in your main Surgery premises?

Yes No

(Either partial or consultation only)

6. Do you maintain an Age-sex Register?

Yes, for G.M.S patients alone

Yes, for G.M.S and private patients

Yes, for private patients alone

No

7. What type of lists do you work from in your practice?

Private patients only

Private & G.M.S patients

8. What is the approx. size of your G.M.S list?

9. What is the approx. size of your private patient list?

Section B: Practice Staff

10. How many, in each of the following categories (excluding spouse) are paid by the practitioner's in the practice?

Medical Assistant

Private Nurse (trained) Full-time

Private Nurse (trained) Part-time

Clerical staff Full-time

Clerical staff Part-time

Practice Manager

11. Is your spouse involved in the practice, in any of the following positions?

Medical Assistant

Trained Nurse full / part-time

Clerical staff full / part-time

12. Do you have a regular working relationship with the District / Public Health Nurse in your area?

Yes No

13. Do you have a regular working arrangement with the Social Worker in your area?

Yes No

Section C: Out of Hours Service

14. How many weeknights are you on duty? (Mon – Fri inclusive)

15. How many weekends are you on duty? One in every

16. When you are 'Off Duty' (nights, weekends, public hols etc.) which of the following deputising arrangements do you employ?

Internal Practice Rota System

Rota System involving doctors outside your practice

Deputizing Service

Locum

Co-op

Other (please specify) _____

Section D: Practice Services / Access to Services

17. Do you offer any of the following services in your practice during surgery hours?

Well- baby examination Travel vaccinations

Antenatal Phlebotomy

Family Planning Joint manipulation

Intrauterine coil fitting Joint Injections

Immunization Methadone maintenance

Cervical Cytology Specialist clinics

Minor Surgery Please specify _____

Acupuncture _____

18. Which of the following investigatory or treatment facilities are available to you without referring your patients to the Out-patient department? (The facility must be available to both the private and non-private patients)

Laboratory	<input type="checkbox"/>	ECG	<input type="checkbox"/>
Stress test	<input type="checkbox"/>	24 hr BP Monitor	<input type="checkbox"/>
Holter Monitor	<input type="checkbox"/>	Pulmonary function test	<input type="checkbox"/>
Physiotherapy	<input type="checkbox"/>	Dietician	<input type="checkbox"/>
CXR	<input type="checkbox"/>	Skeletal X-Rays	<input type="checkbox"/>
Ultrasound	<input type="checkbox"/>	Barium Studies	<input type="checkbox"/>
CT Scans	<input type="checkbox"/>	IVP	<input type="checkbox"/>
EEG	<input type="checkbox"/>	Early Pregnancy assessment	<input type="checkbox"/>
Counselling	<input type="checkbox"/>	Psychiatry	<input type="checkbox"/>

19. Do you have facilities to treat patients in Health Board Hospitals (i.e. excluding private hospitals) for either long or short term care?

Yes No

Section E: Educational Activities

20. Have you undertaken teaching of General Medical Practice to an under-graduate Medical Student in your Practice within the past 3 years?

Yes No

21. Are you a trainer in General Medical Practice with a post-graduate General Practitioner trainee attached to your practice within the past three years?

Yes No

22. Are you a regular member of a I.C.G.P.C.M.E group?

Yes No

Section F: Equipment

23. Which of the following items do you use in your surgery?

- | | | | |
|-------------------------|--------------------------|--------------------------|--------------------------|
| Peak flow Meter | <input type="checkbox"/> | Protoscope/sigmoidoscope | <input type="checkbox"/> |
| Haemoglobinometer | <input type="checkbox"/> | Vaginal Speculum | <input type="checkbox"/> |
| Microscope | <input type="checkbox"/> | Diathermy Apparatus | <input type="checkbox"/> |
| E.C.G Machine | <input type="checkbox"/> | Glucometer | <input type="checkbox"/> |
| Nebuliser | <input type="checkbox"/> | Cryotherapy Equipment | <input type="checkbox"/> |
| Pregnancy Testing Kits | <input type="checkbox"/> | Audiometer | <input type="checkbox"/> |
| Ambulatory 24BP Monitor | <input type="checkbox"/> | Autoclave/steriliser | <input type="checkbox"/> |
| Defibrillator/ AED | <input type="checkbox"/> | Ishihara charts | <input type="checkbox"/> |
| Vitalograph/spirometer | <input type="checkbox"/> | Ophthalmoscope | <input type="checkbox"/> |
| Drug screening | <input type="checkbox"/> | | |

24. Do you use a computer in your practice?

- Yes No

25. If yes, which of the following functions are actively used?

- | | | | |
|-------------------------------|--------------------------|----------------------|--------------------------|
| Finance / Accounts | <input type="checkbox"/> | Repeat prescriptions | <input type="checkbox"/> |
| Word Processing | <input type="checkbox"/> | Internet research | <input type="checkbox"/> |
| Patient registration / recall | <input type="checkbox"/> | Other _____ | |
| Listing of G.M.S cards | <input type="checkbox"/> | | |
| Consultation records | <input type="checkbox"/> | | |

Section G: Profile of General Practitioners

26. Gender: Male Female

27. Age: _____

28. Marital Status:

- | | | | |
|---------|--------------------------|----------|--------------------------|
| Married | <input type="checkbox"/> | Single | <input type="checkbox"/> |
| Widowed | <input type="checkbox"/> | Divorced | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | | |

29. Where did you graduate as a Medical Doctor?

U.C.D T.C.D

R.C.S.I U.C.G

U.C.C Q.U.B

Other (please specify) _____

30. Which of the following Qualifications do you hold if any?

M.I.C.G.P M.R.C.G.P/F.R.C.G.P

D.C.H M.R.C.P.I/M.R.C.P

D.Obst

Other (please specify) _____

31. How long was each of the following posts held by you after full registration and prior to full-time practice?

	Not Held	6 Mths.	12 Mths.	18 Mths.	24 Mths.	More than 24 Mths.
Obs / Gynae	<input type="checkbox"/>					
Accident & Emergency	<input type="checkbox"/>					
General Medicine	<input type="checkbox"/>					
General surgery	<input type="checkbox"/>					
Psychiatry	<input type="checkbox"/>					
Paediatrics	<input type="checkbox"/>					
E.N.T	<input type="checkbox"/>					
Anaesthetics	<input type="checkbox"/>					

Others (please specify) _____

32a. Have you ever undertaken a formal, min. 3 years vocational training programme?

Yes No

32b. If yes, was this in:

Ireland UK

Other (Please specify) _____

32c. If no, did you undertake a 1 year GP trainee year in the UK/Northern Ireland?

Yes No

33a. Are you in full-time general practice?

Yes No

33b. How many sessions do you work per week in the following areas?

(A session may be defined as 2-3 hours)

Clinical GP (i.e. consulting) _____

Academic (i.e. teaching / research) _____

GP Unit _____

Other (please specify) _____

34. For how many years have you been in practice? _____

Section H: Stress and Morale

35. How would you rate your morale at this time?

(Morale: feeling of confidence in one's situation with a positive hope for the future)

Very Good Good

Average Poor

Very Poor

36. How would you rate your Stress at this time?

(Stress: perceived inability to cope with demands)

Very Good Good

Average Poor

Very Poor

37. Realistically, at what age do you think you will retire from clinical general practice?

Thank you for your time and co-operation

