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Structure of General Practice in Ireland 1982 — 2015

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Irish College of General Practitioners

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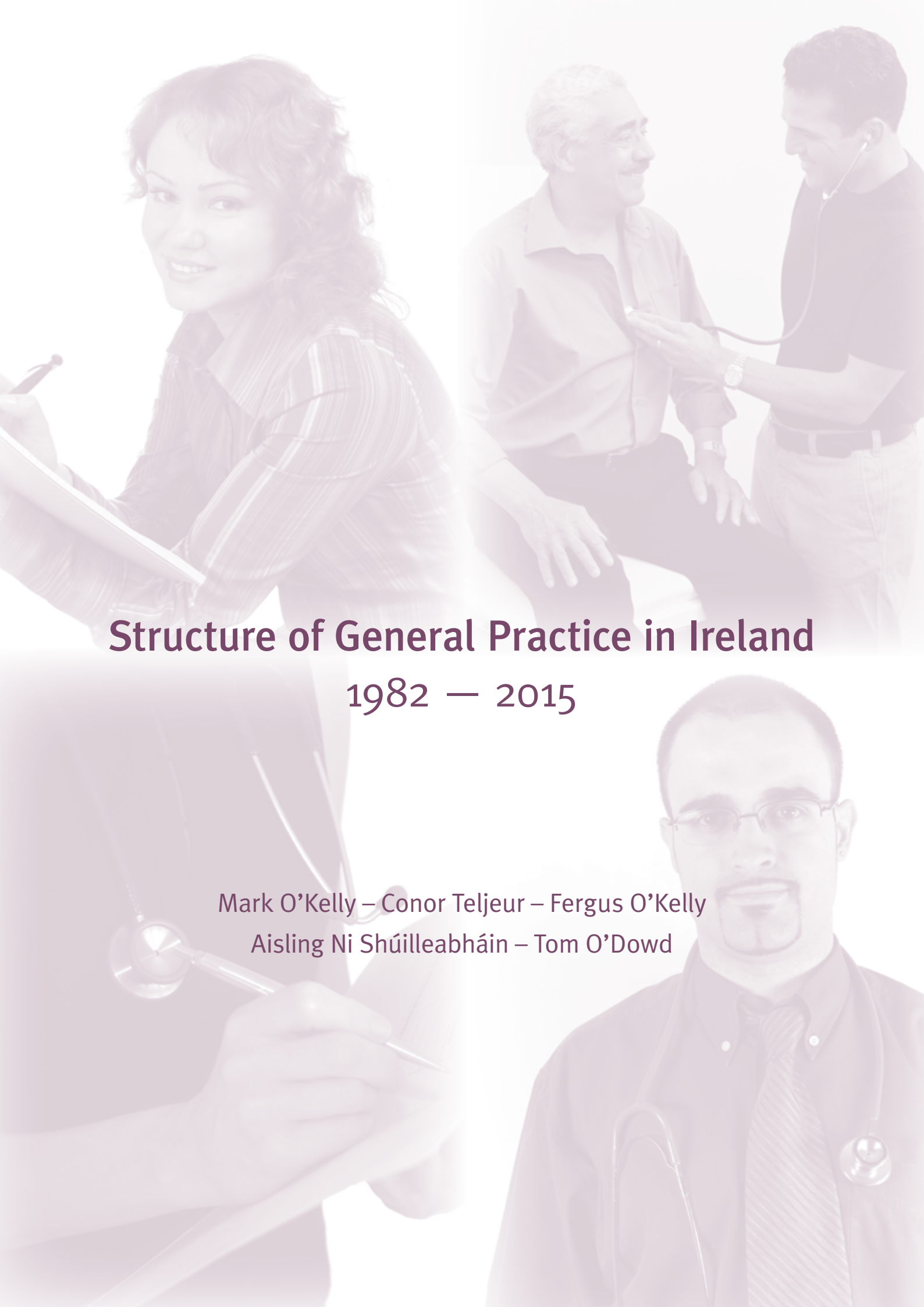
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Summary of Study

- The study provides a picture of the changing face of general practice in Ireland from 1982 to 2015.
- It compares data from four points in time, - 1982, 1992, 2005 and 2015, and from the Stress and Morale Study, 1997.
- The 2015 survey achieved a response rate of 72%.

Given the nationally representative sample and the high response rate, our survey allows us to draw firm conclusions about the state of general practice in Ireland at this time. Furthermore, due to the availability of equivalent surveys from previous years, we are able to make valid comparisons across time. As such, this survey provides the most accurate and comprehensive overview of the general practice workforce in Ireland.

- It shows general practitioner numbers have increased by 20% since 2005.
- It shows an ageing cohort of general practitioners with 14% of practicing GPs now over the age of 65.
- Women now constitute 42% of the GP workforce.
- 76% of GPs work 7 or more clinical sessions per week.
- Paperwork related to clinical work occupies between 1 and 3 sessions for 83% of GPs.
- The majority of GPs (64%) see 15 patients or more in each clinical session.
- 62% of all practitioners have been through a programme of GP training, with all new entrants into general practice being vocationally trained.
- Of the GPs who have undergone any kind of formal training in general practice, the majority received their training in Ireland (75%). The number receiving their vocational training in Ireland has increased from 34% in 1992 to 75% in 2015. In 2015, 24% of GPs completed vocational training in the UK compared to 62% in 1992.
- There has been a fall in the number of private only practices and a growth in the number of GPs with GMS lists of over 1,000 patients.
- 93% of GPs are now in out-of-hours co-operatives.

- There has been little change in basic general practitioner services since 2005 but a rise in services such as travel vaccinations and phlebotomy.
- Timely access to radiology has declined by 56% for ultrasound since 2005.
- 61% of GPs have been involved in medical student teaching in the last three years.
- GPs report strong participation in continuing medical education.
- 97% of GPs now practice from purpose built and adapted premises, with 10% practicing from a primary care centre.
- There has been a big decline in the number of single-handed practitioners from 63% in 1982 to 18% in 2015.
- There has been a large increase in the number of nursing, clerical and management personnel employed in practices.
- Practices are now well equipped with clinical and diagnostic equipment and computers.
- Stress levels have increased significantly and morale is lower than in 2005.
- A large number of general practitioners indicate that they will continue practising beyond the age of 65.

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 that 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.

In 2005 the survey was again repeated by the department of Public Health and Primary Care in Trinity College. The report provided useful insights into the changes that had occurred in general practice over a 23-year period³.

The survey presented here uses the 1982, 1992 and 2005 methodology and presents the data in a format that again allows ready comparison of changes over 4 points in time in the last 33 years. We have also included comparisons from other work on GP stress and morale⁴ and some information on retirement, to assist with future workforce planning.

This report has been prepared at a time when general practice and the health services have been subjected to large reductions in income. The data presented are a unique measurement of the general practice workforce over the last 33 years. They 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 used by Drs Oliver, Meagher and Cole in 1982, refined again by Dr Oliver and Dr Harry Comber in 1992, continues to be relevant and useful in 2015 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.

Section One: Aims and Objectives

1.1 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. The report produced in 2005 provided a picture of the changes in the structure of general practice over a 23-year period.

In 2015, the survey was again repeated, providing a picture of modern day general practice against a backdrop of the changes that have taken place over the last 33 years.

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 2015.

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
 - Vocational training
- ii Practice structure and characteristics:**
 - Practice type
 - List sizes
- iii Out of hours 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, equipment and computerisation:

- Medical Assistants
- Other staff
- Regular working relationships with Public Health Nurse and Social Worker
- Equipment
- Computerisation and chronic disease management

viii Stress, morale and retirement:

- Morale
- Stress
- Retirement

Section Two: Methods

The task of gathering data on the structure of Irish general practice was complicated by the fact that in 2015, as in 2005, 1992 and 1982, there was no official register of Irish general practitioners. In addition to their private practices, many Irish general practitioners work as independent contractors, providing health care to 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. On the other hand, all general practitioners may provide services, on a private basis, without restriction, to the two thirds of the population not covered through 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 is easily identifiable as they are registered under the GMS scheme. Identification of the former group causes considerable difficulty. The majority of the group participates 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 consistent 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 list of currently practicing GPs was drawn up, by combining the Irish Medical Directory GP database and the ICGP "Find a GP" list. The combination of these two lists has been shown previously to have excellent coverage of the GP population⁵. Duplicates were removed along with GPs known to be no longer in practice.

By this method, the general practitioner population was estimated to have been 1,821 in 1982; 1,937 in 1992, 2,477 in 2005 and 2,932 in 2015⁵, - an 18% increase since 1992. A 22% random sample of practitioners was drawn from the master list for each former health board area. This method of selection and stratification was similar to that used in 1982, 1992 and 2005. The 22% sample for all health boards combined, contained 400 GPs in 1982, 428 in 1992, 545 in 2005 and 645 in 2015. The survey was circulated to the sample in March, May and June 2015 with a questionnaire accompanied by a covering letter, outlining the purpose of the study and assuring total confidentiality to respondents. The survey questionnaire was initially sent out to the full sample in March 2015, together with a postcard for each GP, containing only their unique survey ID number, and the statement "I have returned my questionnaire". GPs were asked to return their postcards to the survey team, at the same time but separately from, their completed questionnaires, thus maintaining their confidentiality. GPs who returned their postcards were deleted from the list for subsequent mailings. These mailings took place in May and June 2015, to allow the remaining GPs on the list a further opportunity to complete the questionnaire, and to ensure that a high response rate was achieved.

A 'session' in terms of clinical, paperwork or academic workload was defined in the questionnaire as approximately three hours continuous work.

Section Three: Results

Introduction

Results are shown for 1982 where data were available and comparable. Where data were unavailable, results are shown for 1992, 2005 and 2015 only.

3.0 Response Rate

In 2015, 462 valid questionnaires (72%) were returned, compared to 476 (88%) in 2005, 292 (68%) in 1992 and 281 (70%) in 1982.

Table 1: Response rate by former health board area, 1992, 2005 and 2015

Former Health Board Area	1982	1992	2005	2015
	%	%	%	%
Eastern		65	77	67
Midland		50	52	51
Mid Western		74	74	67
North Eastern		61	99	70
North Western		63	58	100
South Eastern		59	99	85
Southern		82	99	71
Western		80	98	73
All health boards combined	70	68	88	72

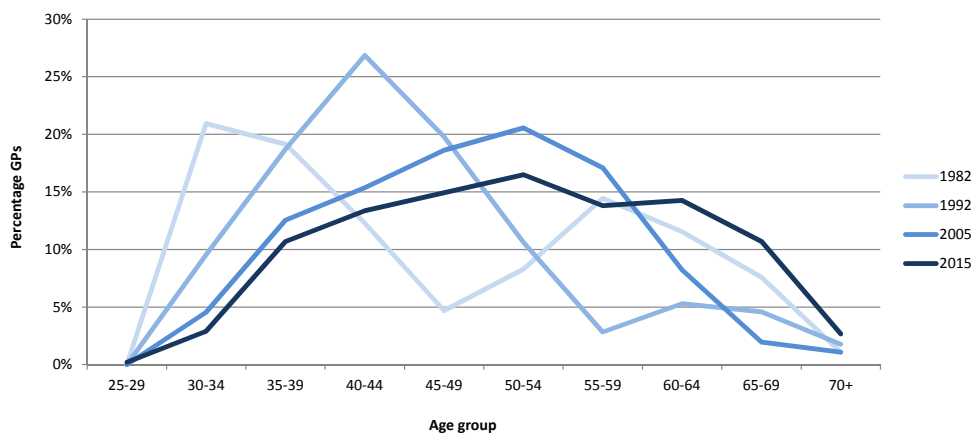
3.1 Demographic Characteristics

Introduction

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

3.1.1 Age

Figure 1: Age range of GPs by survey year



The age range of the GPs taking part in the surveys in 1982, 1992, 2005 and 2015 are shown in figure 1. In 1982 GPs were predominantly in the 30-40 and 55-65 age groups. In 1992 they were, largely, in the 35-55 age group, while in 2005 and 2015 there is a more even spread between the age ranges.

In 2015 a substantial percentage of the GPs (13%) were found to be still in practice after the age of 64. This has increased from 3% in 2005.

Figure 2: Age distribution of GPs, by sex in 2015

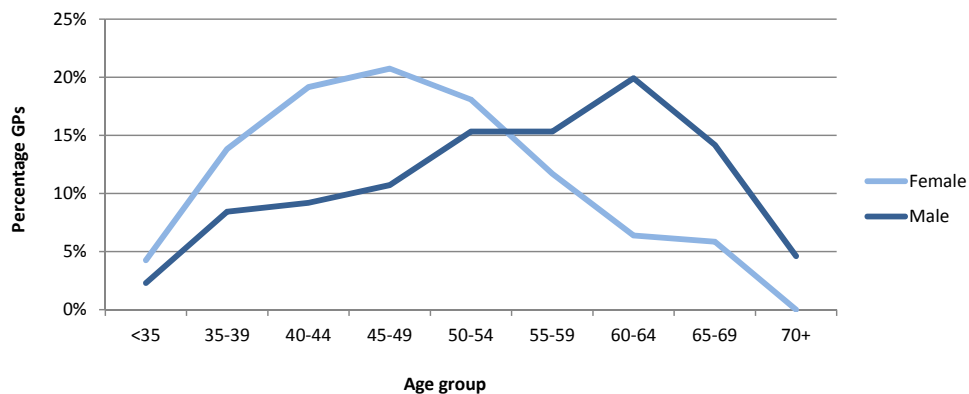


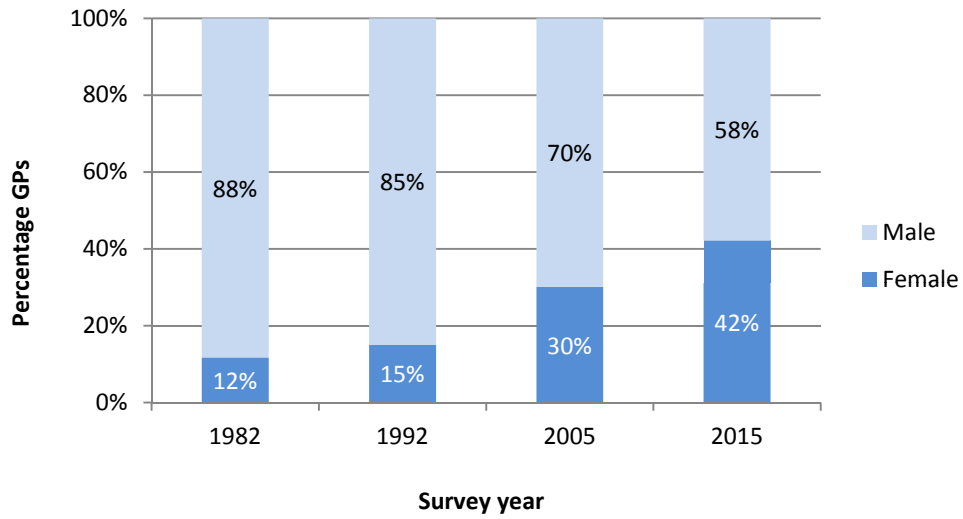
Figure 2 indicates that the majority of GPs below the age of 55 years are female, whilst the majority of GPs over the age of 65 are male.

3.1.2 Sex

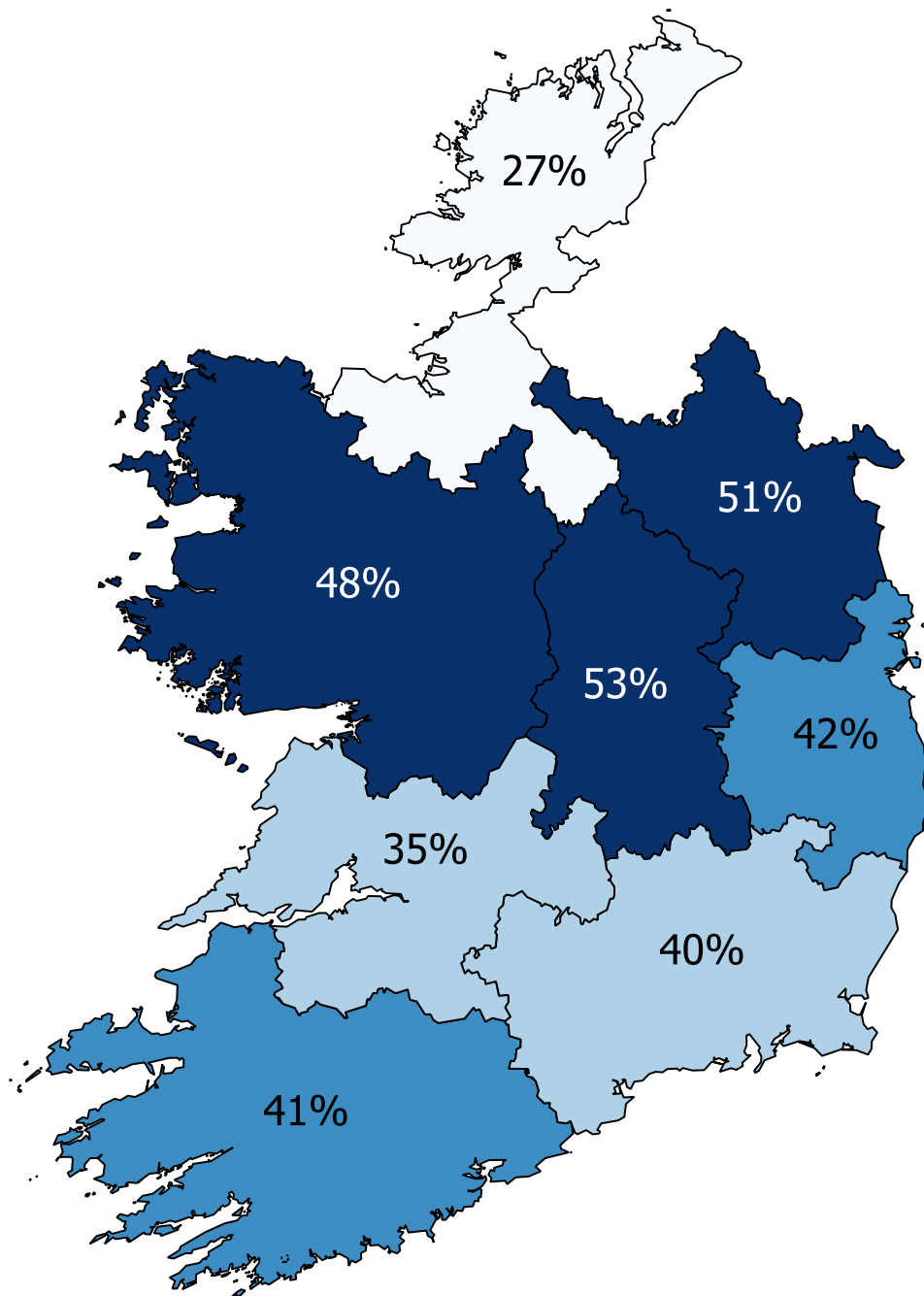
Table 2: Percentage of females/males in general practice by survey year

Year	Female	Male
1982	12%	88%
1992	15%	85%
2005	30%	70%
2015	42%	58%

Figure 3: Percentage of females/males in general practice by survey year



Map 1: Percentage of female GPs by former health board area.

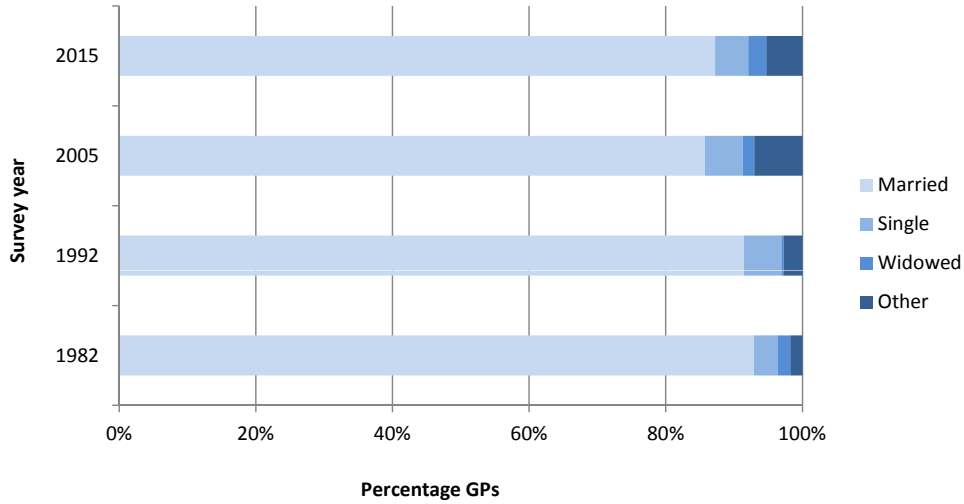


The number of female GPs has continued to rise from 12% in 1982 to 42% in 2015. The increase in the number of female GPs is not surprising in view of the large number of female graduates and the numbers of female trainees passing through the GP training schemes over the period.

3.1.3 Marital Status

Although marital and civil status is of less significance in societal terms in 2015, this question was included in the current survey to maintain comparability with the previous surveys.

Figure 4: Marital status of GPs by survey year



In all four surveys, most respondents reported themselves as married. The percentage of married GPs increased marginally in the 2015 survey, with a small increase also, in the numbers who are either separated or divorced. Female GPs are more likely to be single (7%) than their male counterparts (3%), as was found in 1982, 1992 and 2005.

3.1.4 Full-time practice

Table 3: Percentage of GPs in full-time practice by survey year

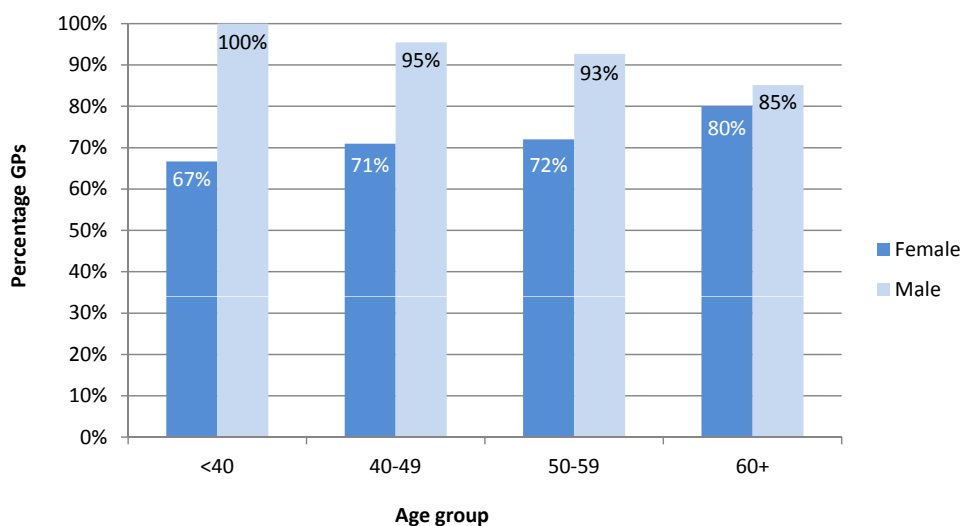
Year	%
1992	97%
2005	91%
2015	84%

Table 3 shows that in 2015, 16% of the GPs surveyed are not 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.

Table 4: Percentage of GPs in full-time practice by sex

Age	Female	Male
< 40	67%	100%
40-49	71%	95%
50-59	72%	93%
60 +	80%	85%
All ages	72%	91%

Figure 5: Percentage of GPs in full-time practice in 2015 by age and sex

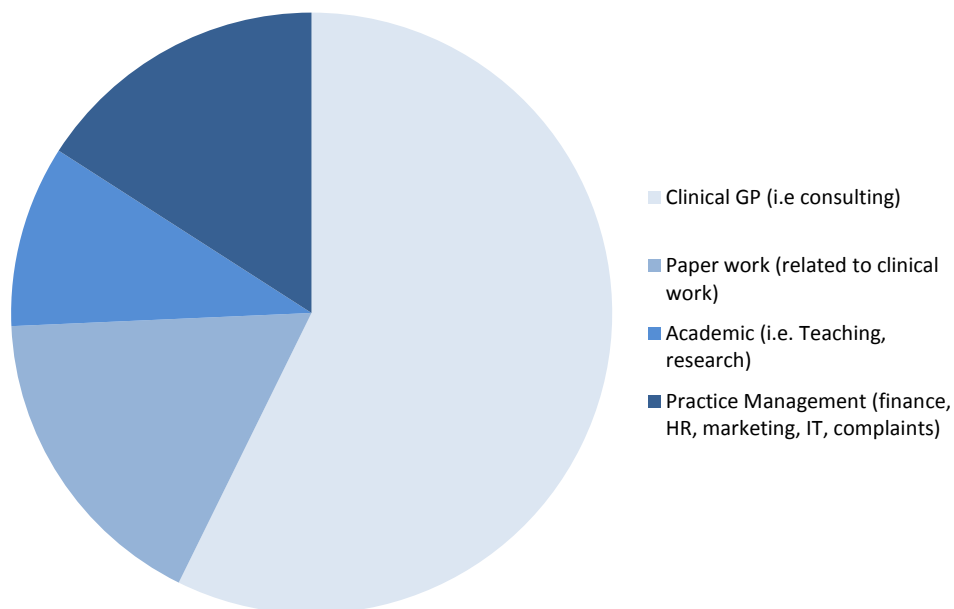


Overall 91% of males and 72% of females are working in full-time clinical general practice. Female GPs under the age of 40 years are less likely to be working full-time (67%) compared to their male counterparts (100%).

Table 5: Number of sessions worked per week by type of work

Sessions per week	Clinical GP (consulting)	Paperwork (related to clinical work)	Academic (teaching, research)	Practice Management (finance, HR, marketing, IT, complaint handling)
	% GPs	% GPs	% GPs	% GPs
0	0%	2%	19%	27%
1	1%	40%	53%	17%
2	1%	31%	19%	21%
3	3%	12%	3%	15%
4	4%	4%	2%	4%
5	6%	4%	0%	8%
6	8%	2%	0%	2%
7	11%	1%	1%	2%
8	22%	0%	0%	0%
9	27%	0%	0%	4%
10	17%	3%	0%	0%
Total	100%	100%	100%	100%

Figure 6: Typical number of sessions worked per week by type of activity



Overall 77% of GPs work 7 or more clinical sessions per week. Paper work related to clinical work occupies between 1-3 sessions for 83% of GPs. In addition 72% of GPs are involved in academic work for between 1-2 sessions per week, whilst 53% spend between 1-3 sessions on practice management.

Table 6: Number of patients seen in a clinical session by sex of GP

Patients per session	Female GPs	Male GPs	Total % of GPs
<10	4%	6%	5%
10-14	41%	25%	31%
15-19	41%	38%	40%
20-24	9%	20%	16%
25+	5%	11%	8%

The majority of GPs (64%) see 15 patients or more in each clinical session. Male GPs are more likely to see more than 20 patients per clinical session (31%) compared to their female counterparts (14%).

3.1.5 Education – Undergraduate

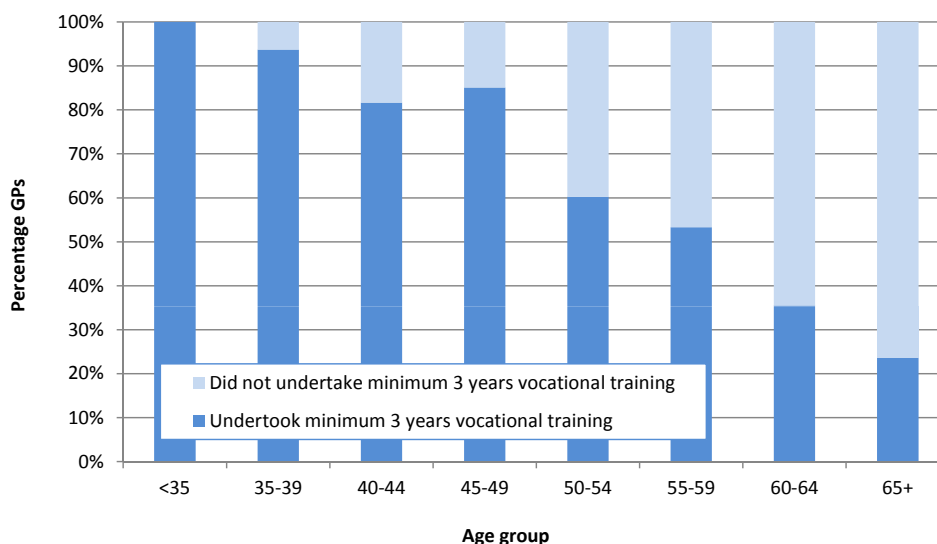
Table 7: Location from which GPs graduated as medical doctors 2015

Country	% GPs
Ireland	94%
EU	5%
Non-EU	1%

The majority of respondents in 1982 (99%), 1992 (98%), 2005 (97%) and 2015 (94%) graduated from one of the then five medical schools in the state. The first graduates of the University of Limerick will be commencing in general practice in July of 2016.

3.1.6 Vocational training

Figure 7: Percentage of GPs who completed a minimum 3 year training programme, by age, 2015



There has been a considerable increase in the percentage of GPs who entered general practice between 1992 and 2015 following formal 3-year postgraduate training in general practice. In 1982, 9% of practitioners had completed a formal 3-year vocational training programme; by 2015, this figure has risen to 62%.

Younger GPs are far more likely to have undergone vocational training in general practice with between 82% and 100% of respondents under the age of 50 years having undertaken formal training.

Table 8: Sources of vocational training by year

Country	1992	2005	2015
Ireland	34%	43%	75%
UK	62%	53%	24%
Other	4%	4%	1%

Of the GPs who have undergone any kind of formal training in general practice, the majority received their training in Ireland (75%). Those receiving their vocational training in Ireland increased from 34% in 1992 to 75% in 2015.

In 2015, 24% of GPs completed vocational training in the UK compared to 62% in 1992.

3.2 Practice Structure and Characteristics

Introduction

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

3.2.1 Practice type

Table 9: Practice type by survey year

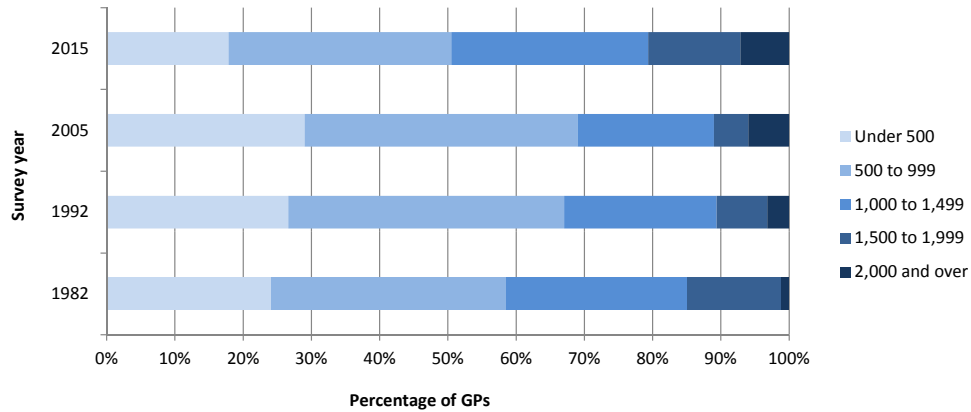
Survey year	Private only	GMS and Private
1982	11%	89%
1992	9%	91%
2005	4%	96%
2015	11%	89%

The proportion of GPs with GMS lists has been relatively stable with a small decline between 2005 (96%) and 2015 (89%).

3.2.2 List Sizes

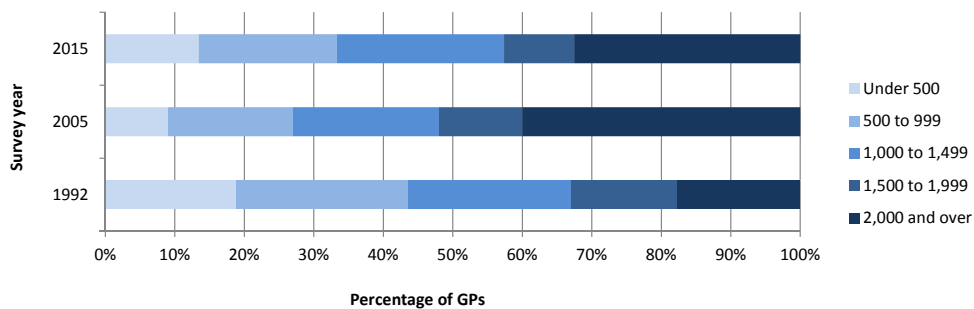
GPs were asked to estimate the size of their practices, both private and GMS. Accurate figures are available to all GPs on the size of their GMS practices, but only GPs with age/sex registers have accurate private patient list statistics. Most of the figures for size of private practice lists are therefore,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

Figure 8: GMS list sizes by survey years



From 1982 to 2015, there has been an increase in the number of GPs with larger list sizes (>1,000), while there has been an overall decrease in the number of GPs with list sizes between 1,000 to 2,000 and an increase in the percentage of those with larger lists of over 2,000 patients.

Figure 9: Private list sizes by survey years



In 2015, there are fewer GPs with private lists >2,000 and more GPs with private lists <500 when compared with figures from 2005.

3.3 Out of Hours Duty

Introduction

This section outlines the respondents' out-of-hours duty cover arrangements in 2015, with comparisons made to 2005 data.

3.3.1 Out-of-hours arrangements by year.

Table 10: Out-of-hours arrangements 2005 and 2015

Type of out-of-hours service	2005	2015
Co-op / Deputising service	58%	93%
Other rota	17%	6%
Practice rota	5%	1%
Locum	18%	0%
No arrangement	0%	0%

The first GP Co-op was introduced in 1998 and by 2005 over half of GPs were involved either in a co-op or deputising service. Table 10 indicates that in the ten years since 2005 there has been a substantial increase in the number of GPs involved in co-op arrangements. The adoption of co-operative arrangements has largely replaced the use of rotas and locums for out-of-hours cover.

3.4 Practice Services

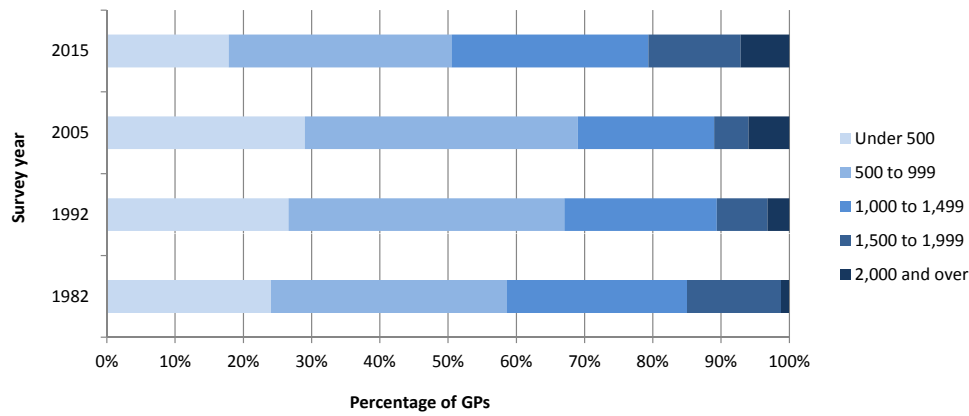
Introduction

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.

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.

Figure 10: Services offered by GPs during surgery hours – 2015



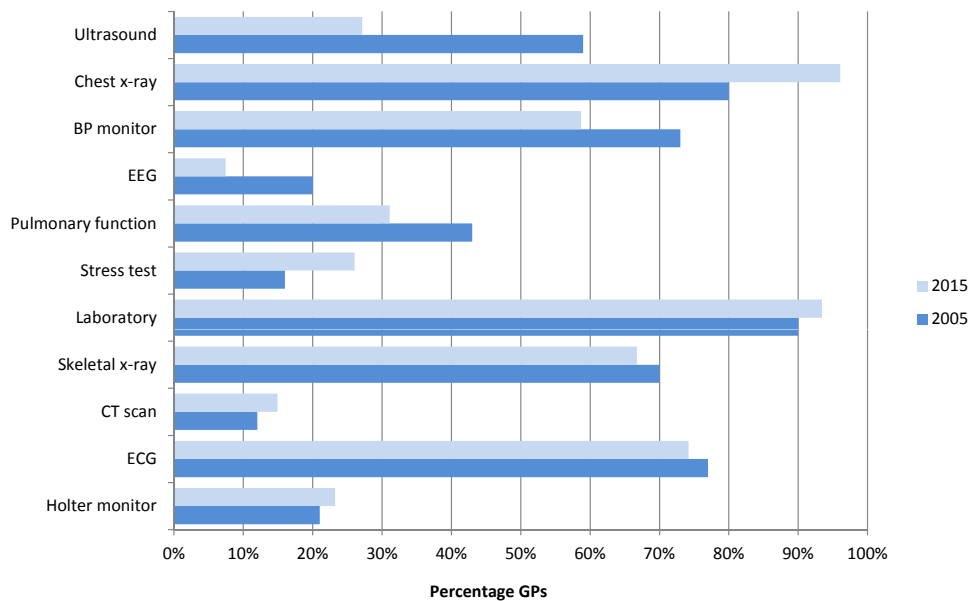
In 2015, nearly all GPs provide services for antenatal care, childhood immunisations, cervical screening, phlebotomy and six week checks. 87% of practices provide ECGs, with 83% providing 24 hour blood pressure monitoring. 91% of practices now provide travel vaccination services.

Minor surgery is available in 65% of practices, and Mirena IUs (65%), Implanon (73%), and joint injections (67%), are being provided by the majority of GPs.

Methadone maintenance programmes are now being provided by 26% of GP practices.

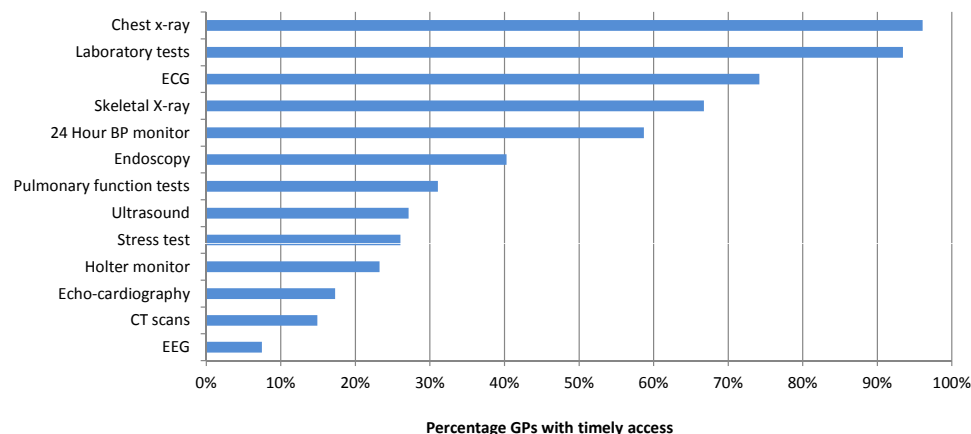
3.4.2 Access to diagnostic/treatment services

Figure 11: Direct access to timely diagnostic facilities for patients, without referral to the outpatient department 2005 and 2015



There has been a significant decrease in direct and timely access for GPs to ultrasound from 59% in 2005 to 27% in 2015. Access to EEG, pulmonary function tests and 24-hour BP monitors has also declined. However, access to CT, which remains low, has improved marginally along with improvements in access to stress tests, laboratory tests and chest X-ray.

Figure 12: Direct access to timely diagnostic facilities for patients, without referral to the outpatient department 2015



With the exception of laboratory services, ECGs and chest X-rays, direct and timely access to treatment and diagnostic facilities is severely limited, especially in the public sector.

3.5 Educational Activity

3.5.1 Undergraduate Teaching

Table 11: Participation in undergraduate teaching by former health board area and year

Health board area	1982	1992	2005	2015
Eastern	27%	45%	51%	64%
Midland	22%	17%	54%	63%
Mid-Western	20%	15%	30%	45%
North Eastern	29%	17%	40%	59%
North Western	11%	37%	47%	67%
South Eastern	13%	15%	36%	48%
Southern	35%	47%	44%	68%
Western	21%	44%	48%	70%
National	24%	36%	42%	61%

In 2015, 61% of all the respondents reported being involved in undergraduate teaching of general practice within the past 3 years, an increase from the 2005 figure of 42% (Table 11). When looked at by former health board area, the largest percentage increases have been in the Southern and Western areas. The Western area is now the area with the highest percentage of general practitioners involved in teaching.

3.5.2 Postgraduate Teaching

Table 12: Trainers in General Practice by former health board area and year

Health board area	1982	1992	2005	2015
Eastern	4%	6%	17%	25%
Midland	0%	8%	8%	16%
Mid-Western	0%	4%	7%	12%
North Eastern	6%	11%	20%	33%
North Western	11%	11%	32%	15%
South Eastern	6%	10%	30%	19%
Southern	0%	0%	18%	15%
Western	9%	11%	9%	26%
National	5%	8%	18%	22%

There has been a small increase in the number of GPs involved in postgraduate teaching, from 18% in 2005 to 22% in 2015. The largest increases can be seen in the North Eastern and Western regions.

3.5.3 Continuing Medical Education

Table 13: Percentage of GPs involved in small group CME by former health board area and year

Health board area	1982	1992	2005	2015
Eastern	32%	71%	82%	85%
Midland	45%	82%	69%	95%
Mid-Western	20%	53%	88%	88%
North Eastern	56%	68%	80%	77%
North Western	52%	62%	84%	97%
South Eastern	42%	79%	82%	94%
Southern	44%	60%	86%	89%
Western	41%	60%	91%	89%
National	41%	69%	83%	88%

Table 13 shows that 88% of GPs are now involved in small group medical education. This has increased from 41% in 1982.

Table 14: Percentage of GPs by age and sex, involved in small group CME who feel the CME Group meets their educational needs

Age band	Female GPs	Male GPs	Total
<35	86%	50%	73%
35-39	79%	56%	69%
40-44	81%	71%	77%
45-49	88%	83%	86%
50-54	84%	82%	83%
55-59	89%	78%	81%
60-64	91%	81%	83%
65+	90%	88%	88%
All ages	85%	79%	81%

Table 14 shows that there is a notable correlation between the age and sex of GPs and the feelings that CME groups meet their educational needs. Younger male GPs below the age of 39 years are less likely to feel their educational needs are being met by CME groups alone (68%), when compared with their female counterparts or those aged over 55 (81-88%).

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, 2005 and 2015 questionnaires an urban area was defined as a centre of population, with 5,000 or more residents. 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, 1992 and 2005, 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.

Table 15: Proportion of GPs by practice area type and survey year

Year	Urban	Mixed	Rural
1982	43%	26%	31%
1992	47%	20%	33%
2005	43%	36%	21%
2015	42%	37%	21%

Table 15 illustrates that while urban practices still predominate, there has been little change since the 2005 survey, where the percentage of GPs practicing in urban, mixed and rural areas remains stable. There has been no evident decline in the percentage of GPs working in rural areas since 2005, however, there remains a notable decrease compared with 1992.

Table 16: Proportion of GPs by practice area type and age of GP

Age band	Urban	Mixed	Rural
<40	51%	33%	16%
40-49	43%	35%	22%
50-59	39%	40%	21%
60+	39%	39%	22%

Table 16 illustrates that a higher proportion of GPs aged less than 40 years work in urban areas than GPs aged 40 years and older.

3.6.2 Practice premises

Table 17: Type of practice premises by survey year

Type	1982	1992	2005	2015
Purpose-built	25%	27%	43%	54%
Adapted premises	42%	46%	46%	43%
Attached to residence	33%	27%	11%	3%

Table 17 illustrates that there has been a continuing trend toward purpose built premises, with GPs moving away from practising from premises attached to their residences and adapted premises. Of the GPs working in purpose-built premises, 81% are based in a GP practice and 19% in a primary care centre.

Table 18: Practice premises by practice area 2015

Premises type	Urban	Mixed	Rural	Total
Purpose-built GP Practice	35%	45%	59%	44%
Purpose-built Primary Care Centre	9%	11%	13%	10%
Adapted premises separate from doctor's residence	53%	41%	23%	43%
Surgery within or attached to doctor's residence	3%	4%	5%	4%

Table 18 indicates that adapted premises are most common in urban areas with purpose-built premises and primary care centres most common in rural areas.

Ten percent of GPs are now working out of purpose-built primary care centres.

3.6.3 Ownership of premises

Table 19: Ownership of premises 2015

Status	%
Privately (self or other doctor) owned	66%
Privately rented	17%
HSE-owned, without rent	9%
Lease owned	7%
HSE-owned, with rent payable	1%

Table 19 shows that 90% of premises are either privately owned, rented or leased.

3.6.4 Branch surgeries

Table 20: Percentage of GPs operating branch surgery premises by survey year

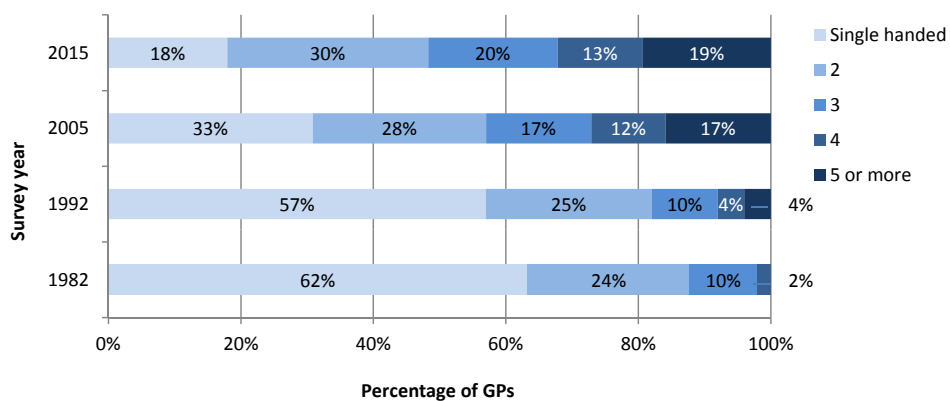
Area	1982	1992	2005	2015
Urban	33%	28%	28%	13%
Mixed	49%	34%	42%	26%
Rural	57%	52%	30%	34%
All areas	43%	36%	31%	23%

The overall percentage of GPs running branch surgery premises in addition to the main surgery has decreased from 43% in 1982 to 23% in 2015. In the last decade, this decrease is particularly evident in urban and mixed practices. In rural areas there has been no substantial change.

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 respondent's practice.

Figure 13: Numbers of GPs working from the main practice premises by year



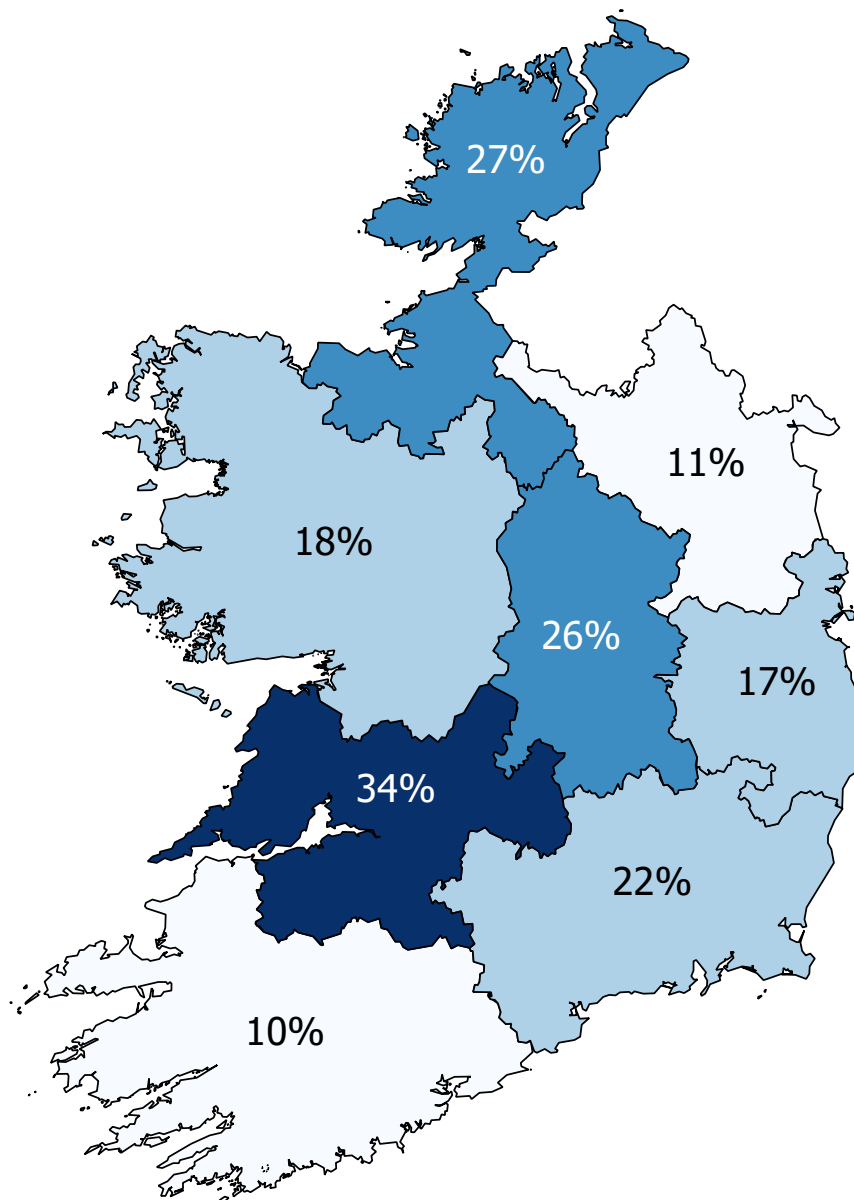
The number of single-handed practices is in continued decline from 62% in 1982 to 18% in 2015, being replaced by increasing numbers of practices with 3 or more GPs. In 2015 52% of practices have 3 or more GPs working.

Table 21: Number of single-handed GPs by area type 2015

Number of GPs	Urban	Mixed	Rural
1	15%	17%	26%
2	29%	24%	45%
More than 2	56%	59%	29%

Single-handed practices are more common in rural areas (26%) and less common in urban areas (15%).

Map 2: Percentage of single-handed practices by former health board area.



3.6.6 Partnerships

Figure 14: Percentage of GPs in partnerships 2015

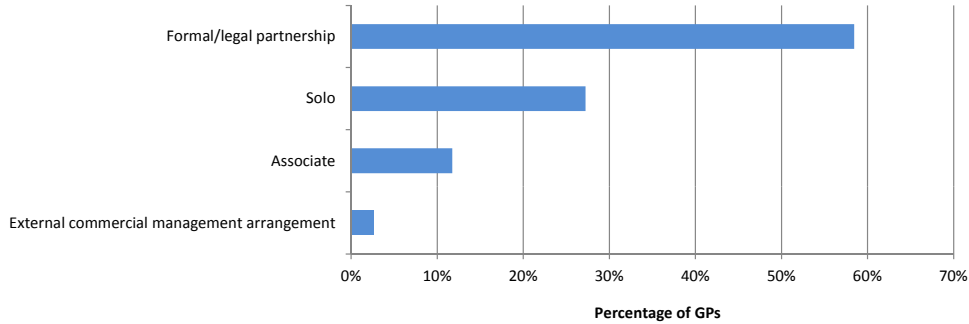


Figure 14 indicates that in 2015 58% of GPs are working in a formal legal partnership.

3.7 Practice Staff

3.7.1 Medical Assistants

Figure 15: Practices employing an assistant by year

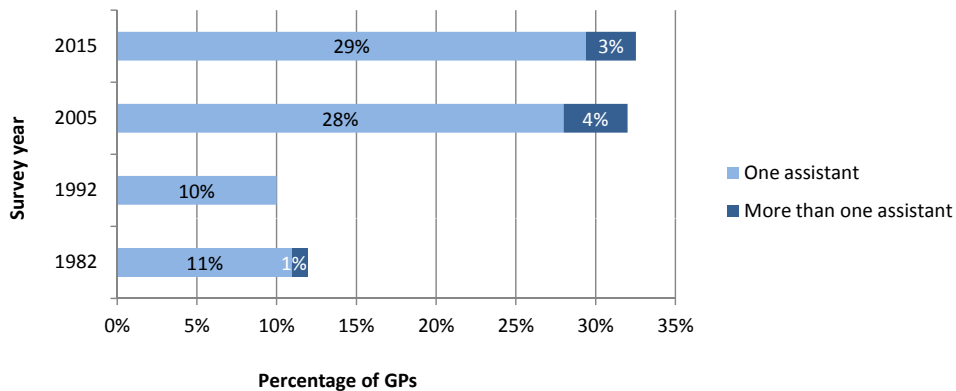


Figure 15 shows that 33% of GP practices are employing a medical assistant in 2015. (The above figures do not differentiate between full time and part time staff).

3.7.2 Other staff

Table 22: Percentage of practices employing staff by year

Year	Full time nurse	Part time nurse	Full time clerical	Part time clerical	Practice Manager
1982	30%	5%	35%	32%	N/A
1992	8%	9%	44%	38%	N/A
2005	35%	43%	71%	57%	33%
2015	40%	55%	62%	62%	58%

The percentage of practices employing a practice manager has seen a large increase from 33% in 2005 to 58% in 2015. There has also been a notable increase in the percentage of practices employing practice nurses both full time and part time during the same period, with the employment of part time practice nurses increasing from 43% in 2005 to 55% in 2015.

Table 23: Percentage of GPs in practices with different grades of practice staff in 2015

Staff position	Full time	Part time	Any
GP Assistant	23%	37%	50%
Practice Nurse	40%	55%	82%
Clerical staff	62%	62%	90%
Practice Manager	34%	28%	59%
GP Principal	74%	25%	82%

Table 23 shows that 82% of practices now employ a practice nurse.

3.7.3 Effective access to allied health care professionals

Figure 16: Effective local access to allied healthcare professionals 2015

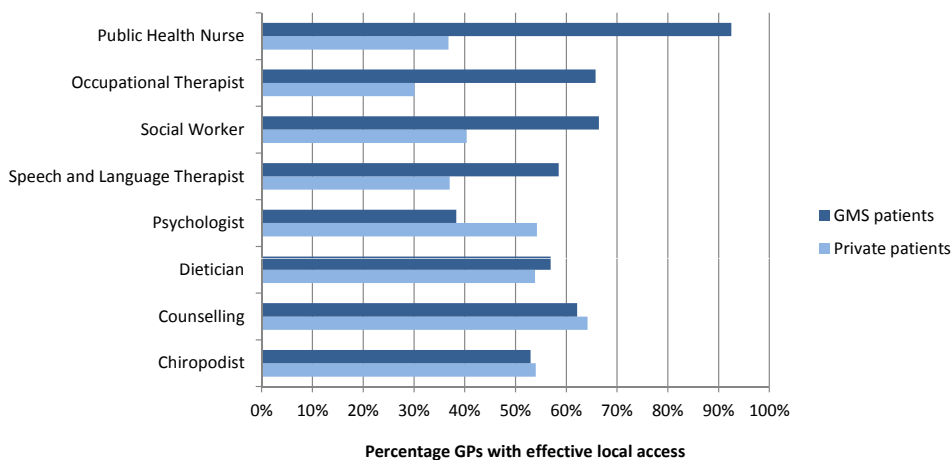


Figure 16 above, highlights that while effective access to local public health nurses is broadly acceptable, there are low levels of effective local access to the wider group of allied health care professionals; and it also highlights the disparity that exists between access for GMS and private patients. Access to psychology services is substantially lower for GMS patients, although for Occupational Therapy and Speech and Language Therapy, GPs appear to have better local access for their GMS patients.

Table 24: Regional variation in effective access to public health nurses and social workers

	Public Health Nurse		Social Worker	
	Private	GMS	Private	GMS
Eastern	48%	88%	39%	60%
Mid Western	44%	94%	31%	63%
Midland	32%	100%	63%	84%
North Eastern	28%	100%	38%	70%
North Western	53%	97%	52%	79%
South Eastern	20%	90%	33%	63%
Southern	20%	93%	37%	63%
Western	41%	94%	47%	76%

Table 24 highlights the regional variation that exists between the former health board regions, with 84% of GPs in the midlands area having effective local access to Social Workers compared to just 60% in the Eastern region.

3.8 Practice Equipment and Information Technology

This section discusses results relating to practice equipment and use of Information Technology.

3.8.1 Practice equipment

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

Figure 17: Equipment used 2015

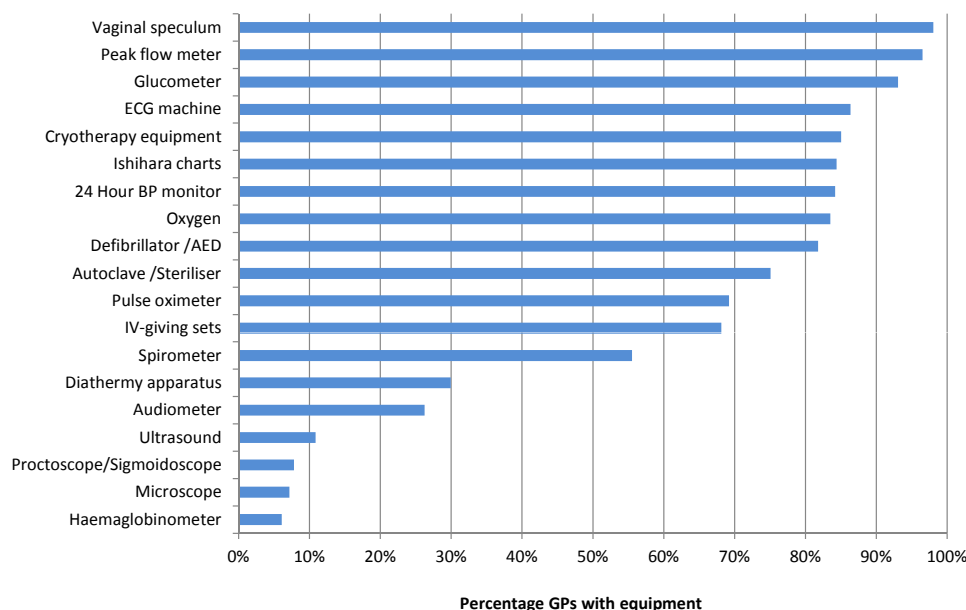
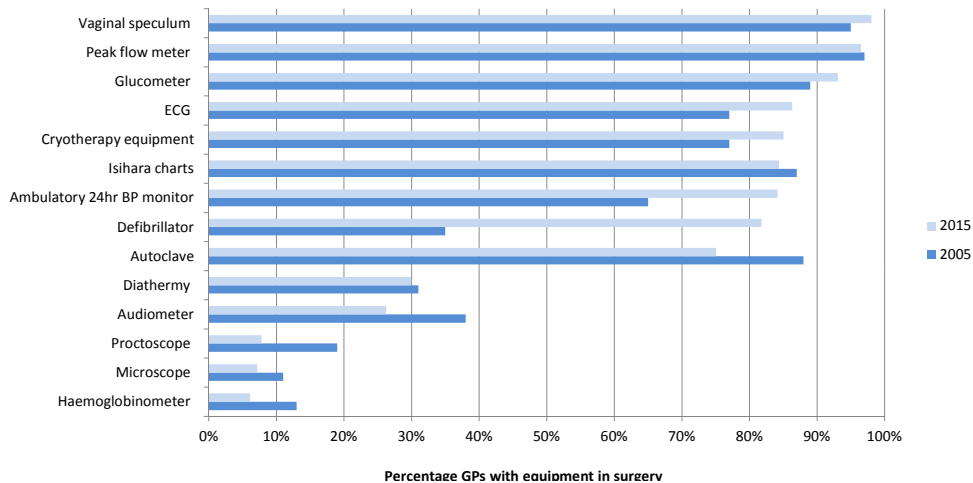


Figure 17 shows that a large majority of practices are now equipped with AEDs (82%). A small proportion of GPs are using ultrasound in practice (11%), while 56% now have spirometry equipment in practice.

Figure 18: Changes in practice equipment usage 2005 to 2015



There has been a significant increase in the number of GP practices with a defibrillator on site, from 35% in 2005 to 82% in 2015. There has also been a notable increase in the number of GP practices with cryotherapy equipment, ambulatory BP monitors and ECG machines.

The use of audiometers in practice has fallen from 38% in 2005 to 26% in 2015.

Table 25: Chronic disease clinics 2015

Clinic type	%
Diabetes	40%
Cardiovascular	20%
Asthma	10%
COPD	7%
Other	7%

Chronic disease clinics are in operation in just over 50% of Irish practices. In 2015, 40% of practices operate diabetes clinics, 20% run cardiovascular clinics including the heart watch programme, 10% run asthma clinics, whilst 7% manage COPD in a structured clinic. 'Other' at 7% included mental health and addiction, anti-coagulation, rheumatology, renal, obesity, neurological and liver clinics.

3.8.2 Practice computerisation

Ninety four percent of GPs are now using electronic medical records, with the figure at 100% in those aged less than 40, and 87% in GPs aged 60 or over.

Single-handed practices are most likely not to use any software package with 20% of these practices not using electronic records.

Figure 19: Use of electronic technologies in the practice, 2015

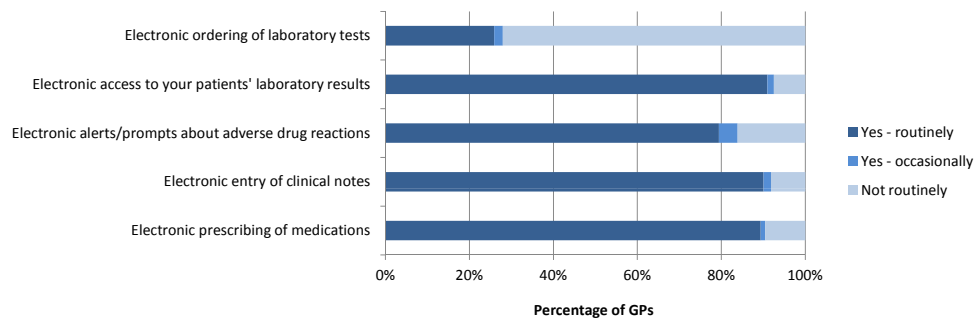


Figure 19 shows that 89% of GPs are using software routinely to facilitate electronic prescribing, 90% to record clinical notes, 79% to alert potential drug interactions, 91% to access lab results. However, only 26% are using electronic means to order their laboratory tests.

Table 26: Frequency of communicating with patients by email, 2015

Frequency	%
Often	8%
Sometimes	22%
Rarely	34%
Never	37%

A minority of GPs (8%) uses email to communicate with their patients often, whilst 37% of GPs never use email as a method of communication with patients.

Table 27: Percentage of GP with access to summary patient information, 2015

Data extract	Computerised
List of patients by diagnosis (eg HTN)	92%
List of patients by lab result (eg HbA1C)	93%
Patients due or overdue for (eg Flu vaccine)	88%
List of all medications prescribed for a patient	95%

Table 27 shows that the majority of GPs are able to use their computer systems to generate lists of patients with specific patient information to help with clinical patient management.

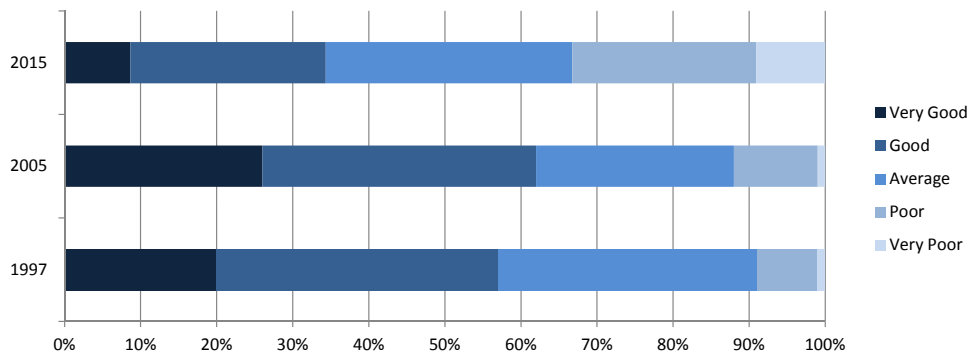
3.9 Stress, Morale and Retirement

This section examines the self-reported morale and stress levels of general practitioners. It outlines the retirement age at which respondents feel they will realistically retire, and differences by gender. Stress and morale data in 2015 and 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 1997⁴.

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 20: Level of morale by survey years

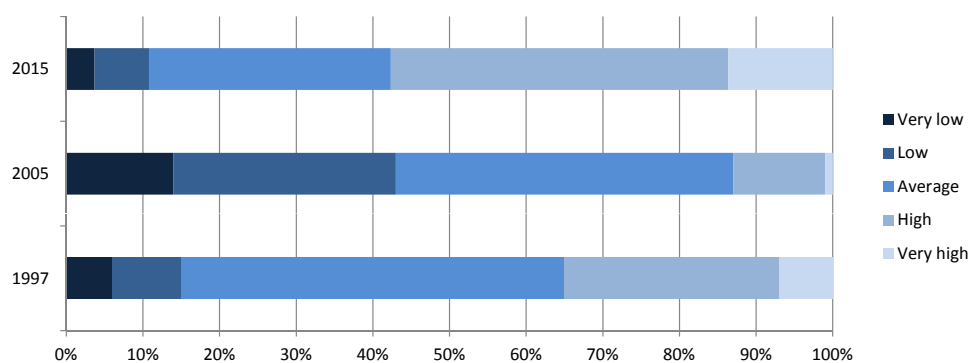


The percentage GPs reporting their morale as 'good' or 'very good' was 34% in 2015, compared with 62% in 2005 and 57% in 1997. There has been little change over time in the percentage reporting their morale as 'average'. The percentage reporting morale as 'poor' or 'very poor' has almost tripled between 2005 and 2015. In 2015, 9% rated their morale as 'very poor' and 24% as '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 21: Level of stress by survey years

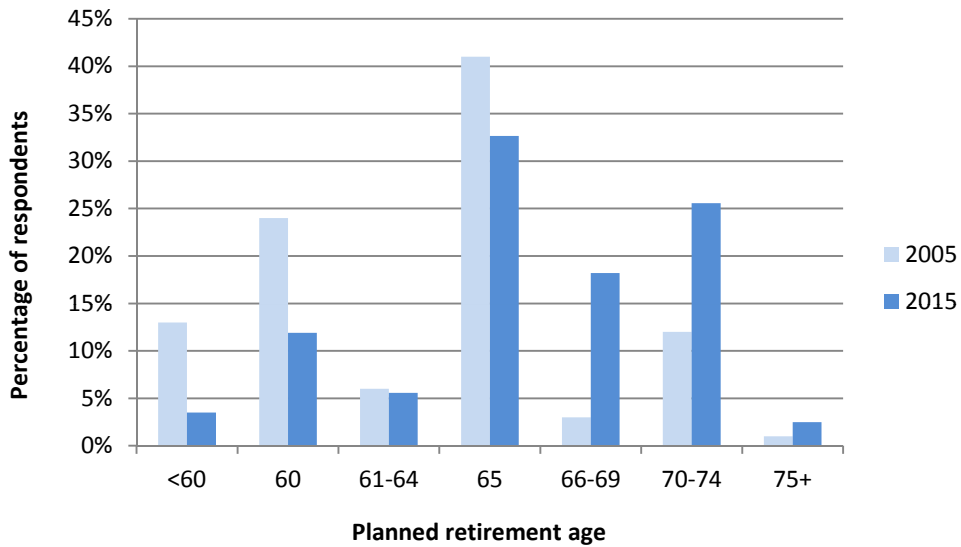


Of the 465 respondents who answered this question, 11% had stress levels classified as 'low' or 'very low', this compares with 42% in 2005. Thirty two percent reported 'average' levels of stress, whilst 58% described their stress levels as 'high' or 'very high', compared with 13% in 2005 and 35% in 1997. There has been a substantial increase overall in the perceived stress levels amongst general practitioners between 2005 and 2015. In 1997, only 14% of GPs felt their stress level was low or very low and 50% felt it was average.

3.9.3 Retirement

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

Figure 22: Preferred age for retirement 2005 and 2015



Of the 465 respondents, 21% believe they will retire from clinical general practice before the age of 65, compared with 43% in 2005. 46% of general practitioners plan to work beyond the age of 65, compared with 16% in 2005.

Figure 23: Preferred age for retirement by sex in 2015

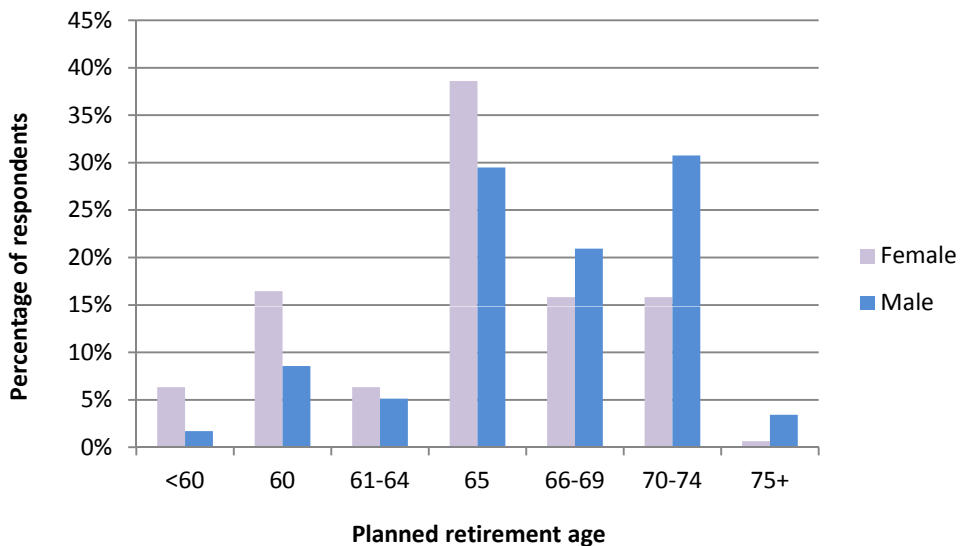


Figure 23 shows that in 2015, 33% of female GPs and 55% of male GPs plan to continue working in general practice beyond the age of 65 years.

Section Four: Discussion

This is a unique piece of research that has followed Irish General Practice over 33 years at 5 different time points. It has evolved over the years but has retained the core questions from 1982 to make valid comparisons. At a time when response rates to questionnaires are declining this study has secured a 72% response rate indicating ready cooperation from GPs.

There are a number of significant changes, especially in the last 10 years. The age spread has flattened out, particularly in the 35 – 65 age group, which will make workforce predictions more reliable. There are significantly more females in the 40 – 55 age group; women now comprise 42% of the GP workforce in Ireland. Notably, 14% of general practitioners are over 64, which is an increase of 3% in the last 10 years. In what must be good news for patients and the workforce, 46% of GPs intend to stay on after the age of 65 to the age of 70.

In this survey we recorded the numbers of sessions worked by general practitioners and it shows that 76% work 7 or more sessions per week. We also have data on the numbers of patients seen per session, which indicates that general practitioners are seeing large numbers of patients on a daily basis.

The arrival of the out-of-hours co-operatives has been embraced by general practitioners, with 93% of them working in co-ops, - an increase from 56% in 2005. This has revolutionised out-of-hours care for both doctors and patients.

Investment in general practice training and education means that most 40 year olds have been through a formal training scheme, although interestingly 25% received this training outside the State, mainly in the UK. GPs have an increased involvement in undergraduate, postgraduate and continuing medical education which has grown considerably over the 33 years of this analysis in line with the investment in education at all levels.

The other area of investment is in good quality premises. The tradition of the GP working from a converted garage or from their own home is now virtually gone. Ninety seven percent work in purpose-built or specially adapted premises, with rural doctors more likely to be in such centres than those in urban areas.

While most GPs work in urban or mixed urban and rural areas it is interesting that rural practice numbers have been stable since 2005 at 21% of the workforce. The big fall in the numbers of rural doctors occurred between 1997 and 2005.

In 1982 being single-handed was the norm at 62%. The single-handed doctor is now considerably less common at 16%. On this occasion we measured the numbers of doctors in corporate arrangements and this is at less than 3% and will be an interesting area to observe over the coming years.

General practice has invested heavily in information technology but there is not evidence of its widespread use in communication with patients. This is also likely to grow over forthcoming years.

Diagnostics, especially radiology and more specifically ultrasound, remain the big bugbear of general practice. Ultrasound access has declined from 65% to 25% in this iteration. It is evident from the equipment audit that GPs are heavy investors in miniaturised equipment but are reliant on local hospitals for diagnostics, especially for their GMS patients.

We are able to measure stress and morale in the more recent surveys and there has been a fall from 62% to 35% in general practitioners considering their morale to be good or very good. There has been a corresponding increase in poor morale from 12% to 33%. This probably reflects the morale of the nation over recent years, which is reflected in daily contact with patients. High levels of stress have increased from 12% in 2005 to 58% in 2015. Again GPs are not immune from personal, professional and patient stress, especially in hardened economic times.

GPs provide a broad range of evidence-based services to patients ranging from antenatal care through to methadone maintenance programmes. They have invested heavily in the equipment and training to allow them to provide such services. This study was conducted before the new chronic disease management programmes for childhood asthma and diabetes were introduced. It is evident that modern day general practice should be able to deliver on extended chronic disease management. This expectation is based on having a well-trained workforce operating from high quality premises and backed up by years of investment in IT. This survey, like the others, shows that chronic disease management is not yet on a systematic footing with dedicated clinics and recall facilities.

There has been a 61% increase in the numbers of GPs since 1982. The corresponding increase in public hospital consultants is from 1,095 in 1987 to 2,776 in 2015, an increase of 153%. In a well functioning healthcare system Barbara Starfield has pointed out that the numbers of specialists in hospital and in family medicine should be balanced. This is the case in Ireland now, even if we are under doctored in some areas. While the growth in consultant numbers is a measure of the focus on hospital care by both government and the health insurers, it is reasonable from now on to expect that there is equal growth in GP and hospital consultant numbers. International policy is now focused on developing general practice as part of primary care and this survey has shown that even with modest investment, general practice has steadily modernised itself and, with appropriate resources, can play a fuller and more central part in healthcare in Ireland.

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Appendix – Questionnaire

2015

National Survey of General Practice

All details supplied are confidential

Section A: Practice Structure & Characteristics

1a What former Health Board Area do you currently practice in? (please tick)

Eastern: Dublin, Kildare, Wicklow	
Midland: Laois, Longford, Offaly, Westmeath	
Mid Western: Clare, Limerick, Tipperary North	
North Eastern: Cavan, Louth, Meath, Monaghan	
North Western: Donegal, Sligo, Leitrim	
South Eastern: Carlow, Kilkenny, Tipperary South, Waterford, Wexford	
Southern: Cork, Kerry	
Western: Galway, Mayo, Roscommon	

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)

Urban	
Mixed	
Rural	

2. What type of premises do you work from?

Purpose built GP Practice	
Purpose built Primary Care Centre	
Adapted premises separate from doctor's residence	
Surgery within or attached to doctor's residence	

3. Is the surgery in which you practice:

Privately (self or other doctor) owned	
Lease owned	
HSE-owned with rent payable	
HSE-owned without rent	
Privately rented	

4. Do you have a branch / satellite surgery premises?

Yes No

5. How many practitioners (excluding trainees/registrars) are currently practising in the main surgery?

6. Regarding your practice arrangements, are you

In a formal / legal partnership in your practice?	
An Associate?	
Solo?	
Involved in an external commercial management arrangement?	

7. Do you have a GMS list? Yes No

7a If Yes, what is the approximate size of your GMS list ? _____

8. What is the approximate size of your private patient list ? _____

Section B: Practice Staffing

9. How many, in each of the following categories are remunerated by the practice?

GP Assistant full-time		GP Assistant part-time	
Practice Nurse full-time		Practice Nurse part-time	
Clerical staff full-time		Clerical staff part-time	
Practice Manager full-time		Practice Manager part-time	
GP Principal full-time		GP Principal part-time	

10. Do your patients have effective local access to the following? (Please insert Yes or No in the space provided)

	Private patients	GMS patients		Private patients	GMS patients
Public Health Nurse			Psychologist		
Occupational Therapist			Counselling		
Speech and Language Therapist			Dietician		
Chiropodist			Social Worker		

11a. Which of the following Out-of-Hours services do you employ as your primary Out-of-Hours arrangement?

Co-op only		Rota system involving doctors outside your practice	
Deputizing service only		Internal practice rota system	
Mix of co-op and deputizing Service		Locum arrangement	
Other (please specify)			

11b. If you are in a co-op, does your co-op provide an over-night Out-of-Hours service?

Yes No

Section C: Practice Services / Access to Services

12. Do you offer any of the following services in your practice during surgery hours? (Please insert Yes or No in the space provided)

6-Week check		Antenatal care		Family planning	
Mirena Coil		Immunisation		Cervical check	
Minor surgery		Cryotherapy		Acupuncture	
Travel vaccinations		Phlebotomy		ECG	
Joint injections		Methadone maintenance		24 Hour BP monitoring	
Implanon		Botox injections			

A programme for the management of any chronic disease? (please specify)

13. Are the following tasks routinely performed in your practice?

	Yes, using a <i>Computerised</i> system	Yes, using a <i>Manual</i> system	NO
Patients are sent reminder notices (e.g. flu vaccine)			
All laboratory tests ordered are tracked until results reach clinicians			
You receive an alert or prompt to provide patients with results			
You receive a reminder for Guideline based interventions			

14. In your experience, which of the following investigatory or treatment facilities are available to you in a *timely* fashion, without referring your patients to the public out-patient department? (the facility must be available to both GMS and Fee-paying patients). (Please insert Yes or No in the space provided)

(*Timely* - Occurring within an appropriate or opportune time-frame)

Laboratory tests		ECG		EEG	
Stress test		Echo-cardiography		Endoscopy	
Holter monitor		24 Hour BP monitor		CT scans	
CXR		Pulmonary function tests			
Ultrasound		Skeletal X-ray			

Section D: Equipment

15. Which of the following items do you have for use in your surgery?

Peak flow meter		Spirometer		Cryotherapy equipment	
Haemoglobinometer		Proctoscope/Sigmoidoscope		Audiometer	
Microscope		Vaginal speculum		Autoclave/Steriliser	
ECG machine		Diathermy apparatus		Ishihara charts	
24 Hour BP monitor		Glucometer		Pulse oximeter	
Defibrillator /AED		Ultrasound		Oxygen	
IV-giving sets					

16a. Do you use electronic patient medical records in your practice?

Yes

No

16b. If Yes, which system?

Socrates		Health One	
Helix Health		Other	

17. Do you use any of the following technologies in your practice?

	No	Yes, routinely	Yes, occasionally
Electronic ordering of laboratory tests			
Electronic access to your patients' laboratory results			
Electronic alerts/prompts about adverse drug reactions			
Electronic entry of clinical notes			
Electronic prescribing of medications			

18. How often does your practice communicate with patients by email?

Often Sometimes Rarely Never

19. With the patient medical records system you currently have, how easy would it be to generate the following information about your patients?

	Level of difficulty					Is this process computerised?	
	Easy	Somewhat difficult	Difficult	Cannot generate	Unsure	Yes	No
List of patients by diagnosis (eg HNT)							
List of patients by lab result (eg HbA1C)							
Patients due or overdue for (eg Flu Vaccine)							
List of all medications of a patient							

Section E: Educational Activities

20. Have you undertaken teaching of general practice to an under-graduate medical student in your practice within the past 3 years?

Yes No

21. Are you a trainer in general practice with a post-graduate trainee attached to your practice within the last 3 years?

Yes No

22a. Are you a regular member of an ICGP CME group?

Yes No

22b. If yes, do you feel the CME group meets your educational needs?

Yes No

Section G: Profile of General Practitioners

23. Sex Male Female

24. Age _____

25. Married / Civil Status:

Married / Civil Partnership Single

Widowed Divorced

Other

26. Where did you graduate as a medical doctor?

Ireland EU Non-EU

27a. Have you undertaken a formal, minimum 3 years vocational training programme in GP?

Yes No

27b. If yes, was this in:

Ireland UK Other (please specify) _____

27c. If no, did you undertake a 1 year programme?

Ireland UK Other (please specify) _____

28. Are you in full-time clinical general practice?

Yes No

**29. How many sessions per week do you work in the following areas?
(A session may be defined as approx. 3 hours)**

Clinical GP (i.e consulting)		Academic (i.e. teaching / research)	
Paper work (related to clinical work)		Practice management (finance, HR, marketing, IT, complaints)	
Other (please specify)			

29a On average, how many face-to-face consultations would you complete in a single clinical session?

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

Section H: Stress and Morale

31. How would you rate your morale at this time? (*please circle*)
(Morale: Feeling of confidence in one's situation with a positive hope for the future)

Very Good Good Average Poor Very Poor

32. How would you rate your stress at this time?
(Stress: Perceived inability to cope with demands)

Very High High Average Low Very Low

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

Thank you for your time and co-operation

