# Should all general practitioners be vocationally registered?

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ABSTRACT

Compared with vocationally registered general practitioners, generally registered general practitioners are more likely to attract concerns about their competence, more likely to require a competence review, and are more likely to have educational needs identified at review. Vocational registration is thus associated with a perceived higher level of performance than general registration. This has implications for organisations concerned with the quality of general practice services.

**Keywords**

Competence, vocational education, recertification

*(NZFP 2004; 31:17–19)*

## Introduction

The principal purpose of the Medical Practitioners Act 1995 is to protect the public, and it does that by ensuring the competence of doctors. In addition to ensuring standards for undergraduate and vocational education, the Act requires periodic recertification of vocationally registered doctors via branch advisory body programmes approved by the Medical Council. It also requires general oversight (by a vocationally registered doctor) of those doctors who are not yet vocationally registered, or who choose to remain generally registered.

General oversight was introduced as a quality assurance measure to parallel the periodic recertification required of vocationally registered doctors. It was envisaged by those planning the Medical Practitioners Bill that a number of senior doctors might avoid recertification by remaining generally registered. General oversight therefore sought to provide a collegial relationship with a vocationally registered doctor in the same branch, to oversee the professional development (educational and quality assurance) activities of the general registrant; the requirements should be as stringent as those for recertification of a vocational registrant.

This paper explores some characteristics of 'senior' generally registered doctors – i.e. those beyond the vocational education years.

## Method

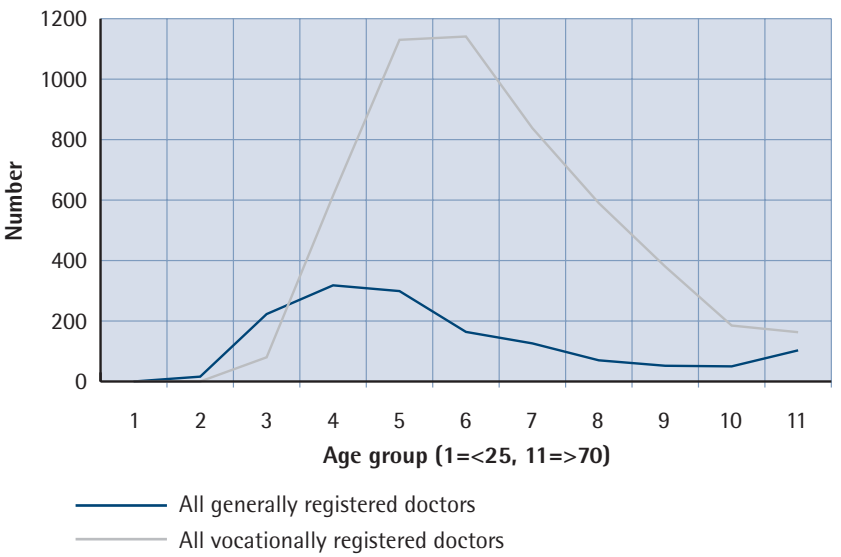
As part of a Medical Council review of general oversight, and in response to data collected from competence reviews, we analysed numbers from the medical register to identify doctors who continued to practise in a vocational branch while remaining generally registered. We therefore excluded those who had graduated less than six years earlier, and those not practising in New Zealand.

Data from competence reviews are routinely entered on a Microsoft Excel spreadsheet, and these were examined and significant data relating to generally registered doctors extracted.

## Results

On the general register on 30 September 2003 there were 1421 doctors (595 women and 826 men) who graduated in 1997 or earlier, had a

*Figure 1. All generally (n=1421) and vocationally (n=5312) registered senior doctors*



current annual practising certificate and a New Zealand address, and were not vocationally registered or in a training programme; 721 were general practitioners (GPs; 309 women and 412 men). There were 5312 vocationally registered doctors on the register; 2146 of these were GPs.

The age range of all generally and vocationally registered doctors is shown in Figure 1.

Table 1 shows the number of doctors working in a single branch, where the number of generally registered doctors was greater than 10 (several doctors – 52 of them GPs – were working across more than one branch and are excluded from Table 1).

Table 2 shows the country of graduation of doctors, where the number of generally registered doctors was greater than 10.

Figure 2 shows the age range of generally and vocationally registered GPs.

Table 3 shows the country of graduation of generally registered GPs where the number was greater than five from that country.

Of the 721 generally registered 'senior' GPs, concerns leading to consideration of a competence review had been received about 103 (14.3%). Of those, a decision was made to proceed with a competence review in 34 (4.7% of the total), and of these nine (1.3%) required remedial education. Six (0.83 %) decided to emigrate, accept a restriction on practice, or retire, rather than undergo a competence review or programme.

These figures can be compared with those for the 2146 vocationally registered GPs: 99 (4.6%; $p<0.001$), 30 (1.4%; $p<0.001$) and five (0.2%; $p<0.001$). Six (0.3%; $p<0.05$) decided to emigrate, accept a restriction on practice, or retire, rather than undergo a competence review or programme.

This clear difference between generally and vocationally registered doctors was not evident for any other specialty. We did not, for the purposes of this paper, analyse competence issues by country of graduation or gender.

*Table 1. The branch practised by generally and vocationally registered doctors, and generally registered doctors as a percentage of the total in each branch*

| Branch | GR | VR | Total | % GR |
|---|---|---|---|---|
| Anaesthetists | 25 | 468 | 493 | 5 |
| Orthopaedics | 18 | 192 | 210 | 9 |
| Public health | 16 | 163 | 179 | 9 |
| O&G | 32 | 254 | 286 | 11 |
| General surgery | 33 | 243 | 276 | 12 |
| Internal medicine | 96 | 687 | 783 | 12 |
| Paediatrics | 34 | 221 | 255 | 13 |
| Psychiatry | 91 | 415 | 506 | 18 |
| AMP | 22 | 82 | 104 | 21 |
| General practice | 669 | 2146 | 2815 | 24 |
| Palliative medicine | 12 | 27 | 39 | 31 |
| Emergency medicine | 40 | 56 | 96 | 42 |
| Primary care, other | 16 | | | |

*Table 2. The country of graduation of generally and vocationally registered doctors, and generally registered doctors as a percentage of the total from each country*

| Country | GR | VR | Total | % GR |
|---|---|---|---|---|
| NZ | 701 | 3432 | 8525 | 17 |
| Scotland | 52 | 184 | 501 | 22 |
| England | 180 | 602 | 1668 | 23 |
| S.Africa | 112 | 379 | 1050 | 23 |
| Australia | 51 | 128 | 179 | 28 |
| Sri Lanka | 46 | 106 | 329 | 30 |
| Bangladesh | 41 | 2 | 130 | 33 |
| India | 66 | 116 | 455 | 36 |
| Egypt | 11 | 12 | 65 | 48 |
| Iraq | 45 | 10 | 190 | 82 |

## Discussion

### *All generally registered senior doctors*

The age 'bulge' of the generally registered group was in the 30–45 age group, younger than the bulge in the vocationally registered group, suggesting either that some of these doctors were actually in advanced vocational education (despite not saying so in the annual work survey), or that doctors may now not be bothering to become vocationally registered. Possibly they were simply delaying it, though this cross-sectional snapshot should not be interpreted as presenting any longitudinal trend. Thirty-seven per cent were women. There was a remnant of doctors over 70 years old who had either never become vocationally registered or had allowed their vocational registration to lapse.

Country of graduation showed an even distribution, with a few exceptions, suggesting either older entry, difficulty in entering vocational education, or a culture of more readily accepting long-term general registration among some overseas educated doctors.

Half of all were GPs (we excluded several doctors working in more than one specialty). GPs were over-represented, as were doctors in the recently recognised (non-hospital) branches accident and medical practice, emergency medicine and palliative care.

### *Generally registered senior GPs*

GPs showed a similar country pattern to the total, and their age pattern was also similar, except vocational registration peaked even later. Notably, of 103 generally registered doctors over 70 years of age, 73 (71%) were GPs.

These data suggest vocational registration is seen by a substantial minority of doctors in their middle and late years of practice as unnecessary to their work, or too difficult. In general practice there is no financial and little practical incentive to become vocationally registered: the prescribing ability, remuneration and practice scopes permitted are the same. Furthermore, general registration has been seen by many as less demanding than vocational registration, with the requirements of general oversight (anecdotally) apparently easy to avoid.

Canadian research has clearly shown increasing age, nonmembership of professional organisations and geographic isolation to be independent risk factors for poor performance among family physicians.[1,2] General registration may signify a similar state of professional isolation in New Zealand. Generally registered GPs were three times as likely to attract a concern, and three times as likely to undergo a competence review, five times as likely to require a competence programme, and almost three times as likely to avoid a review or a programme by restricting their practice, when compared to vocationally registered GPs.

Thus it appears the attainment of vocational registration goes some way towards 'ensuring' the competence of GPs. That competence may result from early selection or self-selection of the group who would become vocationally registered, from vocational training, or from the nurturing educational environment provided for vocational registrants undergoing recertification via programmes approved by the Medical Council.

Generally registered GPs may therefore be considered as a 'population at risk' for poor performance. Should general oversight be more robust (or more robustly audited)? Is it time to restrict the practice of generally registered GPs to supervised posts? Should all independent GPs be vocationally registered? These data provide compelling reasons for primary health organisations and others to address these questions now.

*Figure 2. Generally (n=721) and vocationally (n=2146) registered general practitioners*

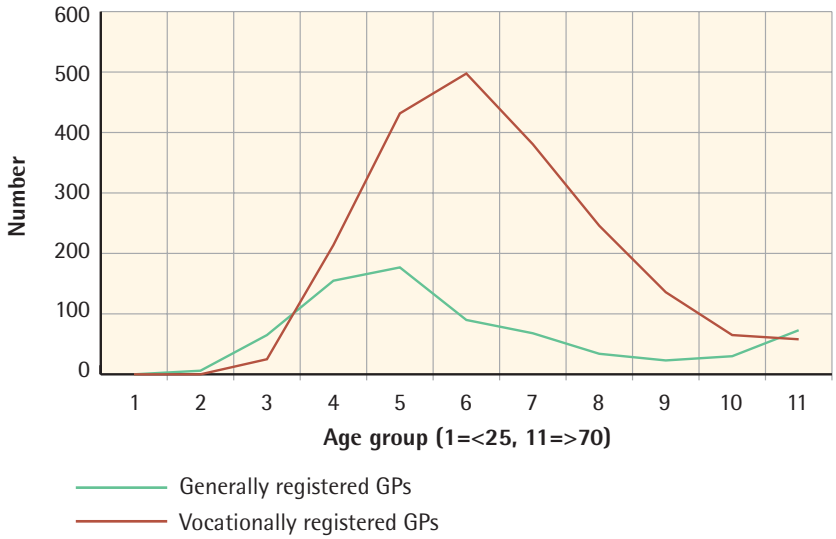



*Table 3. Country of graduation of generally and vocationally registered GPs*

| Country | GR | VR | Total | % GR |
|---|---|---|---|---|
| NZ | 397 | 1425 | 1822 | 22 |
| England | 110 | 256 | 366 | 30 |
| S.Africa | 66 | 112 | 178 | 37 |
| Scotland | 28 | 88 | 116 | 28 |
| Australia | 21 | 61 | 82 | 26 |
| India | 21 | 39 | 60 | 35 |
| Sri Lanka | 18 | 48 | 66 | 27 |
| Iraq | 7 | 0 | 7 | 100 |
| Ireland | 6 | 20 | 26 | 23 |

## Acknowledgements

Thanks to Diane Latham for the analysis of the register.

## Disclaimer

Views expressed here are not necessarily those of the Medical Council of New Zealand.

## References

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